7/6/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Anmolpreet Kaur (@anugrewal19)* ***Case Discussants****: Youssef (@saklawiMD) & Magnus (@)*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Sana)

CC: 47 M w/ retrosternal chest pain for 3 hrs.

HPI: Similar episode 1 day ago radiating to the right arm, relieved on taking antacids. Presented today with sudden onset retrosternal CP (9/10 intensity-more severe and persistent than before) 3 hrs ago a/w diaphoresis, prompting him to seek care.

ROS: No N/V, SOB, abdominal pain, loose stools, palpitations, fever or cough.

PMH:
HTN since 1 yr
Rt. LL prosthetic (amputated 20 years ago)

Meds:
Amlodipine 5 mg OD

Fam Hx: -

Social Hx: lives in India

Health-Related Behaviors:
Smoker (6/day) for 7 years

Allergies: none

Vitals: T: afebrile **HR**: 47 **BP**: 120/70 **RR**: 23 **Sat**: 96% on RA

Exam: Gen: in visible distress and pain

HEENT: no pallor, normal pupils

CV: S1, S2 heard, bradycardia

Pulm: nl **Abd**: nl

Extremities/skin: Rt. LL prosthesis, good perfusion

Notable Labs & Imaging:

Hematology:

WBC: 8300 (63% N) Hgb: 13.9 Plt: 252,000

ABG: CO2: 29, lac: 1.7, hco3: 19.2

Chemistry:

Na: 133 -> 139 K: 2.8 -> 4.1 Cl: 104 HCO3: 19.2

Cr: 0.6 BUN: 24 Glucose: 236 Mg: 1.9

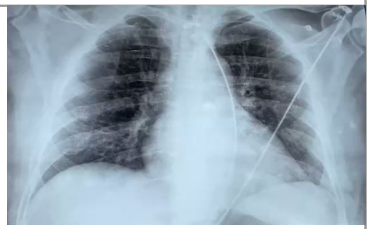
AST: 41 ALT: 34 Bili: 0.4 Albumin: 4.4 Total Protein:6.9 ESR: 18

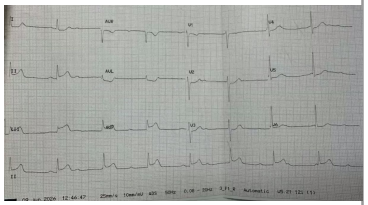
Lipid profile - T.cholesterol: 160, LDL: 111, HDL: 41 apoA: 129, apoB 86.7

Coags nl TSH: 0.75

UA: few RBCs, otherwise unremarkable

Trop: 61, BNP :22





Imaging:

CXR: nl

EKG: ST elevations in II, III, aVF

ST depressions - aVL, V1-3 [posterior wall involvement];

AV dissociation - complete heart block

POCUS: regional abnormalities, EF=48%

Atropine, disprin, clopidogrel, atorvastatin, heparin administered

CAG: 100% blockage in mid RCA, rest-normal

Dx: ACS w/ inferoposterior wall MI

Problem Representation: 47 y/o M k/c/o HTN, presenting with acute onset retrosternal chest pain, found to be bradycardic and hypokalemic w/ EKG changes concerning for MI and CAG w/ 100% blockage of mid RCA.

Teaching Points (Simmy):

Approach to Chest pain:

- **Life threatening vs Benign(Chest pain Schema)**
- **Acute pathology: ACS rule out, Pulmonary Embolism, Pneumothorax**
- **Ask for risk factors,(Age) —> Young patients: Bad genes, Bad behavior, Bad luck. Myocarditis, Pericarditis- Common causes in young patients after ruling out the other obvious causes. Physical Exam : Focus on Vitals, Chest Auscultation, Pulse exam.**
- **Chest pain + Bradycardia is unusual. Sinus Bradycardia (Vagal, Electrolytes, Ischemia, Endocrine, Drugs) vs Arrhythmia(Ischemia/Infiltration) EKG is the key.**
- **CXR to rule out the probable diagnosis: Pneumonia, Pneumothorax, Aortic Dissection.**
- **ST Elevation: Ischemia/Plaque rupture vs Secondary cause. Look for coronary artery distribution and reciprocal changes for ischemia causes.**
- **Inferior wall MI→ Think of RCA obstruction.**