2/11/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Mohammed(@@ZubaidiK20713)* ***Case Discussants****: Sharmin(@Sharminzi) & Sarah B(@sarahkblaine)*

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

Scribing (Gillian)

CC: 20 yr old m w/ chest pain and sob for 2 yrs.

HPI: started 2 yrs ago w/ intermittent episodes of sob and chest pain. Unpredictably at rest or exertion. Last for max 30 min. Frequent admissions to ED. Outside of episodes, no sx on exertion.

Last episode 2 wks ago w/ gradually increasing severe chest pain, sob, palpitations. Unlike others bc it was continuous. Found to be hypertensive and EKG showed ST depression lateral leads. Resolved spontaneously. Admitted to CCU. Discharged on aspirin + clopidogrel.

ROS: no syncope, cough, fever, weight loss, night sweats

PMH: htn diagnosed 2 yrs ago, panic disorder 1 yr ago,
2 ccu admissions 2 yrs ago + 1 admission 2 weeks ago

Meds: bisoprolol, aspirin, clopidogrel, benzos prn

Fam Hx: 1. Consanguinity (parents are cousins, paternal grandparents are cousins)
2. 27 yr o sister has HF diagnosed at 23 yr

Social Hx:
Learning difficulty (dropped out school in second grade and dependent for activities of daily living)

Vitals: T: 37 **HR**: 72 **BP**: 130/77 **RR**: 16
Exam: Gen: tall, thin young man, no distress, speak in full sentences; marfanoid habitus
CV, Pulm, Extremities: unremarkable

Notable Labs & Imaging:

Hematology:
WBC: 6 Hgb: 13 MCV: 90

Chemistry:
Na: nl K: nl Cl: nl HCO3: nl Cr: 1.4 BUN: 23 Glucose: nl Ca: nl Mg: nl
AST: nl ALT: nl Alk-P: nl
Trop: unremarkable (elevated two weeks ago)

Imaging:
EKG: resting nl
CXR: nl
Echo: LVH, nl EF, RV dilation; repeated w/ similar results
Chest CT iv contrast: normal coronary artery, normal aorta, no dissection, multiple, bilateral, eccentric pulmonary thrombi and arterial webbing in small segmental branches
CT abdomen: unremarkable
Brain MRI: multiple lacunar infarcts in various stages of evolution
Coagulation panel: unremarkable; autoimmune: ANA and APLS neg
Follow up with rare disease: blood homocysteine: 145 umol/L; methionine: 5x nl limit

Dx: Homocystinuria

Problem Representation: 20 yr old w/ marfanoid habitus, learning disability, and fh of hf presenting with intermittent chest pain, sob, and palpitations for 2 years.

Teaching Points (Dadmehr)

CP & SOB: r/o scary dangerous ddx first especially if acute.

When pt presents with chronic issue: Establish if chronic vs acute on chronic (what prompted the pt to come in)

Young person = > less likely atherosclerotic but vasospasm or dissection could still cause ACS in addition to anomalous coronary anatomy

Rheumatic vs genetic cardiomyopathies (given family hx)
Look for signals in HPI to point towards any genetic metabolic storage diseases

Important to consider genetic connective tissue disorders like Marfan syndrome/Loeys-Dietz since it can have consequences like aortic root dilation

Check ASCVD risk factors since genetic hyperlipidemic syndromes are still possible since there are signs of ischemia (ECG+troponin).

Thinking about hypercoagulable states: both venous & arterial clots => consider APLS since the treatment is different;

Clots in both right and left side: SUPER coagulable or connection between the two sides of the circulation: consider bubble study

Homocystinuria possible given family hx, learning difficulty, body habitus and hypercoagulable state => check blood homocysteine & methionine levels

Homocystinuria treatment = Long-term anticoagulation + vitamin B6 + Folate + B12 + protein restricted diet (low methionine-diet)