4/28/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Lourenço(@)* ***Case Discussants****: Ravi(@rav7ks) & Kirtan(@KirtanPatolia)*

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

Scribing (Lukas)

CC: 35 yo f transient LOC while standing; duration: 1-2 minutes, no clear prodrome, no postictal confusion

HPI: 2 months history of dyspnea, retrosternal pain with exertion improved with rest. Reports Dry cough, LLE, orthopnea and PND.

ROS(-): urinary/fecal incontinence, involuntary movements, similar prior episodes, chest pain on palpation or deep inspiration, urinary or GI Sx, fever, unintentional weight loss

PMH: Redness in eyes bl 2 years ago
2x Cardiac stress test positive for ischemia

Meds: —

Fam Hx: —

Social Hx: No pets Lives with mother (Lisbon). Works in Clothing shop.

Health-Related Behaviors: No recent travels No drugs, no smoking, no alcohol

Allergies: none

Vitals: **T**: 36 **HR**: 105 **BP**: 190/130 **RR**: **Sat**: 95% on 1 l **BMI**: 24
Exam: **Gen**: hydrated, hydrated mucous membranes
HEENT: no lateral tongue bite; eyes clear **CV**: JVD **Pulm**: diminished breath sounds + rales in both lower lung fields **Abd**: wnl **Neuro**: wnl **Extremities/skin**: bl lower limb edema

Notable Labs & Imaging:
Hematology: WBC: 8 Hgb: 11,5 Plt: 477 MCV:
Chemistry: Na: wnl K: wnl Cl: wnl HCO3: wnl Cr: 0,8 BUN: Glucose: 140 Ca: wnl Mg: wnl
AST: wnl ALT: wnl ESR: 33 CRP: 20,5 LDH: ; D-Dimer: 3.000
Hs Troponin 28,1 (<18); CK: 73, myoglobin: 30, NT pro BNP 6019
UA: wnl HIV:(-), HepB: (-) , HepC: (-)

EKG: sinus rhythm,, 111/min; signs of lvh, no chronic or acute ischemic changes
CXR: cardiomegaly, peribronchial cuffing, kerley B lines, bl costophrenic blunting
Chest-CTA: cardiomegaly, moderate bl PLE, some ggos in LL. no signs of PE
Additional Labs: A1c 4,9%; total pr and albumin nl. Total cholesterol: 196 ; LDL: 139 ; ferritin 35,2
Echo: LVH, RV with preserved systolic function, aortic, mitral and tricuspid regurgitation, LV EF: 60% and septal thickness of 16mm
Ultrasound: kidney normal, unable to doppler to gaseous interposition
Treatment started: nifedipine, valsartan, bisoprolol, dapagliflozin, spironolactone
Labs: troponin 28 -> 100 stable plateau; coronary cTA: occlusion of LAD, calcium score = 8;
Coronary artery cath: 99% stenosis of LAD, stent place; left subclavian artery stenosis
HFPEF kidney function deteriorating; Cr rising -> 4 mg/dl -> Improvement after valsartan suspension;
Course: UE weakness on prolonged elevation of both arms, exertional fatigue, resolved on rest
Left radial pulse absent, right normal; both dorsal pedal pulses normal

MRA full body: focal stenosis of left subclavian artery and proximal segmental stenosis of right subclavian artery with distal patency maintained by multiple collaterals.Bilateral renal artery stenosis > 75%
PET: mild but diffuse uptake along the aortic wall, mild parietal activity
Tx: Tocilizumab + 2 stents placed in both renal arteries -> kidney function improved
Dx: Takayasu arteriitis with coronary, aortic and renal involvement

Problem Representation: 35 yo f initial presents with acute syncope, hypertension and recent hx of CAD-symptoms with 2 prior episodes of uveitis 2 years ago with rising troponin, septal hypertrophy turned out to have Takayasu arteriitis with secondary hypertension due to renal artery stenosis with stent placement in LAD and bl renal arteries Tx with Tocilizumab

Teaching Points (Sana)

- **Syncope** (transient LOC w/ spontaneous recovery) vs **Syncope mimics** (TIA, hypoglycemia, electrolyte abnormalities, intoxication, psychiatric illness).
- Causes of Syncope - Orthostasis, Reflex syncope, Arrhythmias, Structural cardiopulmonary issues.
- Eye involvement - sign of systemic illness?
- Pain and dyspnea w/ exertion - high suspicion for cardiac pathology
- Chronic timeline + stress test +ve -> heart failure?

Syncope w/ Cardiac pathology:

- Triple vessel disease (low EF) vs strategic insult - activation of vasovagal (Bezold Jarisch) reflex
- Anatomical abnormalities - LVOT (HOCM) vs AS vs PS/Pul. HTN
- Arrythmias - Mobitz T-2, Severe bradycardia, VT/V-fib

→ Elevated BP - driver (renovascular, endocrinological causes) or secondary?
→ Inc. CVP - true +ve (high rt. Sided pressure) or FP? + pulmonary exam findings suggestive of elevated lt. Sided pressures too.
→ ↑D-dimer + ↑ platelets = inflammatory pathology?

LVH:

- External (Htn) vs Endogenous/intrinsic cardiac issue
- No miss causes in young ptn - HOCM, Fabry's ds., Denon ds

HOCM:

- LVH
- Dagger Q waves
- Murmur more pronounced w/ valsalva, standing after squatting

Subcalvian A involvement - GCA, Takayasu arteritis, Behcet's, Cogan's ds, PAN
Coronary involvement - FMD, ANCA, SLE
Coronary + Subclavian = ↑ suspicion for Cogan's, Takayasu, PAN, Syphilis