2/22/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Rahul (@RahulPottabath1) **Case Discussants**: Magnus (@) & Noah (@Noah_Nakajima)

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

Scribing (Lera)

CC: 65M with acute worsening **SOB, chest pain and bl LE edema.**

HPI: Admission from ED. During past 1 week felt more weak and SOB with minimal exertion. **CP** localized centrally, pleuritic in nature. Noticed bl LE **edema** for last 2 wks.

ROS: otherwise negative.

PMH: HTN, asthma / COPD, BPH CAD s/p PCI [1st diagonal], **uncontrolled T2DM:**

Nephrotic range proteinuria in the past -> renal Bx -> chronic interstitial nephritis, severe arteriolar nephrosclerosis + globally sclerotic glomeruli

Meds: amlodipine, hydralazine, atorvastatin 40, insulin glargine vit D, iron, finasteride, tamsulosin, inhalers

Fam Hx: not relevant.

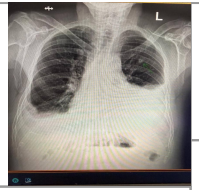
Social Hx: worked in factory with exposure to dust.

Health-Related Behaviors: no smoking.

Allergies: none



Vitals: T: afebrile **HR**: 110 **BP**: 96/56 **Sat**: 92-93% on RA
Exam: Gen: sick appearing, tired **Neuro**: AO x 4
HEENT: JVD, using additional muscles for inspiration
CV: no murmurs **Pulm**: bl crackles + wheezing
Abd: some tenderness on palpation in epigastric region
Extremities/skin: 3+ pitting edema up to the knees



Notable Labs & Imaging:

Hematology: **WBC**: 12.9 [N] **Hgb**: 8.2 [bl ~9] **Plt**: 384 MCV: 86

Chemistry: Na: 140 K: 5.8 Cl: 107 **HCO3**: 10 **Cr**: 12.5 [bl 5] **BUN**: 168
AST: 14 ALT: 25 Alk-P: 65 Bili: 0.2 Albumin: 3.3 Total Protein: 6.1
Glucose: 156 Ca: 8 **AG**: 23 Lactate 0.8

VBG: pH 7.03, O2 74, CO2 25, HCO3 6
HbA1c: 6.9% **TSH:** 2.6
Trops: 392 -> 747 -> downtrend
Respiratory viral panel: + influenza A
EKG: old LBBB, new onset Afib, no overt ST/T changes.



-> ICU transfer, started on pressors, started on emergent dialysis

CXR: new large L pleural effusion, moderate R pleural effusion.
Echo: large pericardial effusion with tamponade physiology, EF 32-35%, dilated LA and RA, mildly elevated PA systolic pressure.

-> pericardiocentesis -> vasopressor requirements went down

Fluid: Cloudy fluid, pH 7.36, glucose 156, protein 2.4, amylase 20, LDH 168, cholesterol 41 [exudative — or pseudo exudative?]

Dx: obstructive shock 2/2 cardiac tamponade in the setting of ESRD & acute decompensated HF.

Problem Representation: A 65 y/o gentlemen with Hx of uncontrolled DM presented with subacute volume overload -> acute progressive SOB, pleuritic CP and persistent hypotension in the context of worsening renal function. Found to have pericardial effusion with tamponade physiology.

Teaching Points (Masah)

- Dyspnea pyramid: cardiopulmonary pathologies, then anemia and acidosis
- With chest pain→ heart, pericardium, pleural space, rather than lungs
- r/o emergent cardiac causes: 4 (cardiac: ACS, Aortic dissection, tamponade, takotsubo) +2 (pulmonary: pneumothorax, embolism) +2 (esophageal: impaction, rupture)
- B/L LL Edema: Cardiac, cirrhosis, nephrotic, IVC compression
- Pleuritic pain: pericardium, pleural space, MSK
- Examination: low bp with tachycardia, JVD → impaired heart filling (eg. severe RHF, tamponade)
- POCUS can help us move forward with management *(Eg. If acute decompensated HF, Lasix, BiPAP –> reduce preload→ reduce ventricular filling, But if tamponade → lasix and BiPAP will worsen the condition)*
- Echo→ Pericardial Effusion: Uremic pericarditis, Viral pericarditis (Trigger: progression of his kidney disease or his flu)
- Pleurocentesis to help us identify exudative vs transudative causes