8/3/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: (@Simmy)* ***Case Discussants****: (@Jeffrey) & (@Maddy)*

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

Scribing (Jahanvi):

CC: 65y M presented with **c/ o shortness of air**

HPI: It started **last night** when he was at rest, worsened with lying down.

He gets out of breath when he walks to his garden (a few yards) and has been going for weeks.

He also has an occasional cough with **thick, whitish sputum production.**

He uses **home oxygen** at 2 L.

Patient is noncompliant with all his medications

ROS:

PMH: **COPD** (chronic obstructive pulmonary disease)
Myocardial infarction
Past Surgical History:
CABG in 1998, **Stent placement** in 2001, **MRCP** 07/10/24

Meds: Albuterol Sulphate 90 mcg 1 puff q6h PRN
Apixaban 15 mg PO BID
Aspirin 81 mg PO Daily
Atorvastatin 40 mg PO HS
Carvedilol 6.25 mg PO BID
Entresto 24-26 mg PO BID
Furosemide 40 mg PO
Empagliflozin 10 mg PO
Nitroglycerine 0.4 mg SL

Fam Hx: NA

Social Hx: He lives by himself; his daughter lives close by. **Smoked cigarettes 1-2 PPD since 1974 but quit in 2023**. He is currently disabled but used to work at the glove factory.

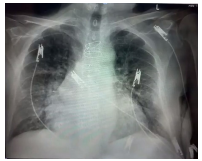
Health-Related Behaviors: high salt diet and non compliance with medications

Allergies: NA

Vitals: T: 98.2 **HR**:103 **BP**: 137/89 **RR**: 25 **Sat**: **BMI**:
Exam: Gen: Alert, awake and oriented to TPP
HEENT: NS
CV: Regular rate, rhythm, No JVD, No PMI, Normal S1/S2
Pulm: Normal on inspection, Normal resp effort
Abd: NS
Neuro: NS
Extremities/skin: Significant **b/l pitting edema +3**

Notable Labs & Imaging:

Hematology:
WBC: 10.62 (elevated)
Chemistry:
Lactic acid: 4.1; D dimer: 3.81
BGA: Ph- 7.5, pco2: 21 po2: 114 hco3 : 17
BNP: 19000 Troponin: 93
Urinalysis: NS
Imaging:
CXR: as above



CTPA: There are filling defects seen at the right lower lobe segmental artery consistent with pulmonary artery emboli.
2. There are ground-glass changes with interlobular septal thickening suggesting edema. There is a moderate right pleural effusion and a small left pleural effusion.
3. There is peribronchial thickening suggesting bronchitis and some emphysematous changes.
Echo: LVEF: 25-20%, eccentric LVH, moderate elevated RSVP: 53-63, LV dilations
Doppler US: Partial compressibility of Left femoral and proximal greater saphenous vein concerning for non occlusive DVT.

Final Diagnosis: **Pulmonary Embolism**

Problem Representation: 65Y M with COPD on home oxygen, ischemic cardiomyopathy and CAD presented with acute worsening dyspnea and progressive exertional breathlessness. CTPA revealed right lower lobe segmental pulmonary emboli, with doppler USG confirming a non-occlusive DVT. Further history revealed non compliance with medications, highlighting importance of adherence and PCP visit.

Teaching Points (Evan)

-Exertional dyspnea - prioritize cardiopulmonary (need to increase cardiac output/oxygen exchange during exercise
-Are they decompensating right now? Accessory muscles/encephalopathic
-Current state (vitals and exam) vs recent trajectory (hpi)
-Positional - elimination of gravity , water changes , blood vessels (orthostatic hypotension)
-HR increased and RR increased - he is compensating well right now.
-Social history is used to broaden the differential and to help establish timeline.
-Prognosis - history tells us his compensation ability is not the best
-COPD - smoking RF , spectrum of emphysema to chronic bronchitis , to make dx need symptoms and spirometry results. 1/3 don't get spirometry testing.
-COPD exacerbation - would expect wheezing. Heart failure exacerbation - bilateral pitting edema (heart/liver/kidney) - here pt has ischemic cardiomyopathy history - further w/u is BNP/echo/hepatojugular reflux
-Acute vs chronic pulmonary embolism on imaging- R heart strain points toward acute - check for med adherence/timeline
-Is the ejection fraction proportional on R and L. PE / pulmonary hypertension can contribute
-HF is a clinical diagnoses - need signs and labs consistent with overload