9/8/26 Morning Report with @CPSolvers

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

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

Scribing (Jahanvi):

CC: 82 Y F presenting with SOB for 2 weeks.

HPI: Orthopnea for 1 week before presentation, presented to ER 2 days for worsening ascites, underwent therapeutic paracentesis.

Now, acute worsening dyspnea and chest pain today, vomiting and bilateral lower extremity edema

PMH: HFpEF
Cirrhosis with massive ascites
CAD with prior failed PCI
Afib
HTN
PAD
hyperthyroidism

Meds:
Carbimazole
Edoxaban

Vitals: T: **35.5** **HR**: 115 **BP**: 131/71 **RR**:20 **Sat**: 95%RA **BMI**:
Exam: Gen: drowsy but arousable
CV: **Pulm**: **Abd**: nl
Neuro: E4V5M6
Extremities/skin: Cyanosis in distal ⅓ of peripheries (lower limb) and coolness and weak peripheral limbs

Notable Labs & Imaging:

Hematology: WBC:6100 Hgb: 7.8 (Hematocrit: 24.1%) Plt: 281 MCV: 90.3 RBC: 2.78



Chemistry:
K: 5 Ca: 8.7 BUN: 34 **Cr**: 1.97 GFR: 24
TSH: 136 (elevated) T4: <1.42 (low) T3: 47.6 (low)
VBG: Ph: 7.57, pco2: 25.6, po2 94.9, Hco3 22.9, O2 stat: 92.2, BE 2.4
Troponin :NA (d/t limitation of resources)



Imaging:
EKG: Afib with RVR
CXR: B/l pleural effusion, nodular opacity in right lower lung field
Echo: Dilated LA, normal LV, LVEF: 55% [at bl]

Hospital stay:
First Impression is acute decomp HF, treated for volume overload with IV furo, spironolactone, edoxaban continued, bisoprolol and propafenone given, additional round of pleurocentesis done, despite supportive mgt, clinical condition worsened, required amiodarone, calcium, another round of paracentesis (500ml of ascitic fluid), unfortunately passed away despite all these efforts.

Problem Representation: 82 Y F presented with cirrhosis and dyspnea, orthopnea, massive ascites, pleural effusion and edema, initially treated as HF but deteriorated despite diuresis, highlighting severe hypothyroidism and other potential factors

Teaching Points (Deb):

Shortness of Breath (SOB): Think broadly about the differential: **cardiovascular, respiratory, metabolic/endocrine, and neurologic** causes.
Assess severity immediately: **Tempo:** acute vs subacute vs chronic, **Vital signs and oxygen requirement:** Does the patient need supplemental O_2?, **Work of breathing:** Can the patient speak in full sentences? Can they walk?, Look for signs of respiratory distress, altered mental status, or poor perfusion.
- **Acute Decompensation:** Consider conditions such as **AFib with RVR, decompensated cirrhosis, hypertensive emergency, and acute pulmonary edema.**
- **Volume overload:** Think about the **heart, kidneys, and liver**. More than one organ may be involved—for example, **cardiorenal syndrome** or **hepatorenal syndrome**.
- **Cool extremities/cyanosis → think poor tissue perfusion.**
In low cardiac output states, peripheral vasoconstriction redistributes blood toward vital organs such as the **heart and brain**. Cool extremities can therefore be an important clue to inadequate perfusion.
In **heart failure**, assess both: **- Congestion:** JVD, edema, pulmonary crackles and **Perfusion:** cool extremities, altered mental status, decreased urine output.
Other clues: **Renal failure:** volume overload, edema, sodium/water retention. **Cirrhosis:** jaundice, ascites, peripheral edema
- **Management Before the Final Diagnosis:** If the patient is unstable, **stabilization comes before diagnostic certainty**.A drowsy patient with respiratory distress requires immediate assessment of **airway, breathing, and circulation**. Examine the lungs, assess whether ventilatory support/intubation may be necessary, obtain an **ECG**, and consider **lactate** and other targeted investigations.
- **Hypothyroidism / Myxedema Coma**
If a patient taking **carbimazole** develops **low free T4 with elevated TSH**, consider **iatrogenic hypothyroidism from overtreatment**.
- Myxedema coma is **severe decompensated hypothyroidism** and is often precipitated by physiologic stress, especially: Infection, MI, Stroke, Trauma/surgery, Cold exposure, Other severe systemic illness.
Physical findings can include **altered mental status, hypothermia, bradycardia, hypotension, hypoventilation, and nonpitting edema/myxedematous facial changes**. The edema results from accumulation of **glycosaminoglycans (GAGs)** in the interstitial tissues.
- **Important pearl:** In suspected myxedema coma, give **stress-dose glucocorticoids (e.g., hydrocortisone) before or with thyroid hormone** until concomitant adrenal insufficiency has been excluded. Thyroid hormone increases cortisol requirements/clearance and can precipitate adrenal crisis in a patient with unrecognized adrenal insufficiency.
- **Atrial Fibrillation:** When AFib occurs, look for the underlying trigger: **hyperthyroidism, infection/sepsis, pulmonary embolism, ischemia, electrolyte abnormalities, alcohol, or structural/valvular heart disease.**