1/22/26 Morning Report with @CPSolvers

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

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

Scribing (Mohammed)

CC: 18F with chest pain 8/10 and dyspnea

HPI:
Symptoms started after med change (isotretinoin discontinued > clarithromycin started) while playing lacrosse. She has hx of nodulocystic acne and developed relapsing-remitting painful skin lesion in thigh.

ROS: No exacerbating/relieving factors. No fever. No N/V.

PMH:

Meds:
Isotretinoin
clarithromycin

Fam Hx:
Nl
Social Hx:

Health-Related Behaviors:
occasional marijuana use

Vitals: T: **38.1** **HR**: **BP**: 118/75 **RR**: 16 **Sat**: 99 % **BMI**:
Exam: Gen: in distress
Abd: flank lesion (erythematous plaque)
Extremities/skin: thigh erythematous plaque



Notable Labs & Imaging:
Hematology:
WBC: 9K (PMN elevated) Hgb: 12 Plt: 300 MCV:
Chemistry: Normal
ESR: 50 CRP: 28 - both elevated

Imaging:
EKG: no ischemic changes
CXR: clear
Echo: small eccentric AR, no vegetations, no effusion, normal LVF
Stress test: upsloping St depression inferolateral leads > Ischemia
Bx, AI > negative
Coronary-CT > **stenosis of LCA and wall thickening of aortic root and descending aorta**
Contrast-enhanced MRI **> narrowing of juxtarenal aorta and left renal artery and enhancement in the adventitious side of the aortic wall and included Common carotid artery.** Findings compatible with **aortitis**

Patient course: Skin rash was **pyoderma gangrenosum that was resolved 4 months later.** Pt. started on high-dose steroids and immune-modulating medications. She could resume sport in 4 months. Left cardiac cath was planned and probably need CABG in future.

Dx: Takayasu arteritis

Problem Representation: **18F with hx of nodulocystic acne presented with acute chest pain, SOB, and fever. Had elevated ESR, and imaging shows AR, LCA stenosis, and aortic a**

Teaching Points (Vini)
- **CP:** Rule out life threatening etiologies first. 10% of CP in the ER is young population. Congenital heart dx, traumatic, autoimmune, PE, spontaneous pneumothorax, ACS, Aortic dissection, esophageal rupture, cardiac tamponade, coronary anomalies, HOCM, nos-ischemic cardiomyopathy, toxins/substances.
- **Rash:** fever, drugs, viral exanthems. Plaque: Flat-topped, raised>1cm.
- **Fever in the context of CP**: infection until proven otherwise -> pneumonia - pleural irritation -> CP. Lungs doesn't hurt.
- **Fever + neg. Infl. markers**: is the fever real?
- Pleura, mediastinum (mass/vasculature), endocardium, myocardium, lungs. Proceed w/ CT angio, ECHO/POCUS - initial triage (endocarditis, myocarditis, pericarditis). MRI (Epidural abscess).
- **Aortic regurgitation**: endocarditis - blood cxs., LV dilation - functional regurgitation. Intrinsic issue w/ the valve vs extrinsic. Decreased perfusion of coronary - anatomical proximity. Lesion in proximal aorta affecting the coronary ostia vs valvular disease w/ thromboembolism.
- **Aortitis**: syphilis, autoimmune, large vessel vasculitis, GCA - but not in this age, SLE, **takayasu**, erythema nodosum, neutrophilic dermatosis. Infectious aortitis: salmonella, staph and strep.
- Pyoderma gangrenosum was compatible w the skin rash.

Takayasu: young woman, "pulseless disease"