10/29/26 Morning Report with @CPSolvers

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

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

Scribing (Varsha):

CC: 40YF presents to the ED with Shortness of breath x 1 day

HPI: 7 days before the current admission, the patient was D/C from the hospital after undergoing a C section for twins complicated by peripartum hemorrhage requiring 2 units of pRBC transfusion. After discharge, the patient was feeling well until 1 day before, when she began having increasing SOB on exertion and on lying down. Also had an episode of severe chest tightness waking her up from sleep. On admission to the ED, she was hypoxic on NRM → sedated and intubated. She was saturating at 93% on the ventilator, sat at 93%

ROS: No fever, syncope, cough/sputum, nausea, vomiting, or diarrhea.

PMH:
G2P3, no similar episodes in the past
C/S + PPH + pRBC transfusion
HTN
Asthma
Migraine
Seizure disorder
Obesity

Meds: Albuterol
Formoterol and budesonide
NSAIDs
Levetiracetam
Omeprazole

Fam Hx: HTN in father

Social Hx: NA

Health-Related Behaviors: -

Allergies: -

Vitals: T: afebrile **HR**: 115 bpm **BP**: 140/95 **RR**: 28 **Sat**: 87 % on RA
Exam: Gen: distress and tachypnea
HEENT: elevated JVP
CV: tachycardia, regular rhythm, distant heart sounds
Pulm: diminished sounds b/l, no wheeze, uses accessory muscles
Abd Neuro MSK/skin: : normal
Extremities 2+ pitting edema, cool, distal pulses palpable

Notable Labs & Imaging:
Hematology:
WBC: 18.8K, neutrophils (13k) Hgb: 8 (7.5) Plt: 546 MCV:
Chemistry:
Na: 140 K: 4.3 Cl: 107 HCO3: 13 Ca: Mg: BUN: 17 Cr: 0.7
Glu: 92 anion gap 20 AST:51 ALT: NORMAL ALP: 241 T. Bili: T. protein: Alb:
ESR: CRP: LDH: 661 Trop 0.04, BNP 11K, lactate 2.8

EKG: sinus tachy 118 bpm, normal axis, isolated St elevation in V2, no TWI or Q waves
CXR: (after intubation): Low lung volumes, moderate cardiomegaly, R middle and basal parenchymal opacity with air bronchograms, and moderate R pleural effusion. No evidence of pulmonary edema.
CTPA: negative for PE, + RML and RLL consolidation, pleural effusion
ECHO: normal LV wall thickness and cavity size, LVEF 20%, severe LV hypokinesis, RV free wall hypokinesis → consistent with non ischemic cardiomyopathy, Mild MR with normal valve morphology, no pericardial effusion
Pt was diuresed and on inotropes, had multiple episodes of non sustained VT, improved with Rx
Dx: Peripartum cardiomyopathy

Problem Representation: 40Y/F presents on day 6 postpartum with rapidly progressive SOB requiring intubation. Physical exam revealed significant respiratory distress, elevated JVP and diminished breath sounds. ECHO findings was consistent with non ischemic type of cardiomyopathy, severe HF with LVEF 20%, consistent with peripartum cardiomyopathy

Teaching Points (Patrick T)

- Consider PE for acute dyspnea with ↑RR, ↑HR among a broader DDx.
  - Postpartum period has increased risk for PE.
  - Breath sounds typically normal with PE
- Yield of CXR for dyspnea is often higher when accompanied by hypoxemia
- Transfusion + dyspnea invokes TACO or TRALI, however concern for either is lessened by longer interval between transfusion and dyspnea
- Flash pulmonary edema often associated with rapid rise in left-sided pressures transmitted into pulmonary veins. Typically not associated with extravascular fluid extravasation outside the lungs
- Physiologic changes in pregnancy include: Hgb lower (anemia defined below 11 in 3rd trimester), elevated AlkP from placenta
- Hyperacute HF associated with mitral regurgitation -> asymmetric pulmonary edema
- Peripartum cardiomyopathy can present over days to weeks to months; but, can also present hyper-acutely as in this case
- Risk factors for peripartum cardiomyopathy: patients baseline health / co-morbidities, genetics, and environment (including psycho-social stress that the patient may be facing)