



5/29/26 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: (Anmolpreet) Case Discussants: Rabih(@) & Ravi(@)
<https://clinicalproblemsolving.com/present-a-case/>

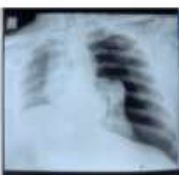
Scrubbing (Lukas)
CC: 49 yo male ED presentation progressive worsening SOB associated with CP 1 day prior to presentation

HPI: 4 days prior: patient traveled from Vancouver to India on a 22 hour long journey; seated for approx. 14 hours. Upon airport arrival, he lifted luggage, developed sudden onset sharp left sided chest pain radiating to the back. Outside care facility -> He received injections of enoxaparin and pantoprazol then returned home. 1 day prior to admission he developed progressive SOB associated with worsening CP especially with deep inspiration. On day of presentation CP intensified rated 10/10.

ROS: subjective fever overnight

PMH:
HFN
T2DM
CAD post angioplasty -> stents in Proximal left circumflex artery, middle anterior descending artery and left main coronary artery
Chronic lung disease due to COVID 2021 (ICU + 3 months ventilation)
Lungs 60% damaged
Meds:
Aspirin 81 mg 1x
Ticagrelor 90 mg 2x
Atorvastatin 80 mg 1x
Bisoprolol 2.5 1x
Ramipril 5 mg 1x
Escitalopram 10 mg 1x
Magnesium 2x
Vitamin D 1000 1x
Metformin 500 mg 1x
Synjardy (Empagliflozin + Metformin) 12.5 mg 1x

Fam Hx:
ND
Social Hx:
No animals
Health-Related Behaviors:
No smoking or alcohol
No actively working because of his comorbidities
Allergies: -



Vitals: T: afebrile HR: 111 BP: 120/60 RR: 28 Sat: 94 on RA, 99 on high flow mask BMI: -
Exam: Gen: visible distress and pain, conscious and oriented 4x no pallor
HEENT: no icterus
CV: s1 and s2 heart, tachycardic
Pulm: air entry decrease on the left side
Abd: -
Neuro: pupils equal and reactive, wnl
Extremities/skin: wnl



Notable Labs & Imaging:

Hematology:

WBC: 12.7 (normal differential) Hgb: 13.3 Plt: 185 MCV: 86.4

Chemistry:

Na: 140 K: 4.8 Cl: 105 HCO3: Cr: 0.7 BUN: 25 Glucose: 118 Ca: Mg: 1.96
AST: 24 ALT: 29 Alk-P: Bilir: 0.95 Albumin: 4 Total Protein: 6.5
ESR: 69 CRP: 19.43 LDH: Ca: 9.56 P: 3 Mag: 1.96
Ph: 7.42 pCO2: 32 pO2: 108 lactate: 1.4 HCO3: 20.8 Total Cholesterol: 81 mg/dL RBS: 118 mg/dL BNP: 30 Troponin: 6 (normal ng/L)
UA: 2+ proteinuria, 52-56 rbc/s, culture: negative
Viral markers: negative

Imaging:

EKG: Sinus Tachycardia
POCUS echo: 4 chamber inconclusive
Echo 2 days later: LV normal, normal systolic and diastolic function, LVEF 60%
CXR: left sided Tension Pneumothorax
Rx: PCD was inserted, 1 liter of air evacuated
2021 Covid was associated with pneumomediastinum right upper lobe PE, right lung abscess, left lower lobe abscess, mrsa ventilator associated pneumonia with sepsis

Ultrasound chest: minimal residual left sided pleural effusion

Dx: secondary spontaneous pneumothorax in the setting of severe post-covid structural lung disease

Problem Representation: 49 yo male with many comorbidities including chronic lung disease presentation to the ED 4 days after long travel and sudden onset of CP after heavy lifting who was initially treated with enoxaparin and pantoprazol which turned out to be Tension Pneumothorax

Teaching Points (Manasa)

High altitude changes in pressure, oxygen, long hours of immobility can precipitate ACS, thromboembolism, acute spontaneous pneumothorax, barotrauma.

Chest pain character> Pleuritis, pericarditis, Lung-related. .

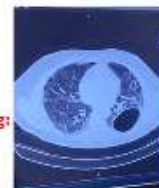
Ticagrelor> SOB, bleeding,

Wide PP> Valvular causes, anemia.

Elevated markers> infection, metastatic cancers or a widespread disease. Low voltage ECG leads could indicated an anterior obstruction such as edema, air.

Process refractory to enoxaparin: PTX> PE

Tachycardia, hypoxemia? APE, infection, increased intrathoracic hypertension



Prior lung imaging: