- Case presentation
- Presenter:pezhman aghazadeh
- Supervised by:
- Dr.Gholami emergency medicin specialist

History

Cc : weakness and dyspnea

PI: The patient is a 60 years old, bed ridden woman who had been referred by weakness and 4 times nausea and vomiting after use gabapentin300 single dose due to her back pain and losartan 50 for her HTN before her enterance.

Last night she had mild chest pain that made her take 3 times TNG as pearl so finally her chest pain was gone

She had been lethargic & sleepy after use these drugs. she had no chest pain at this time.

Dyspnea (+) no cough no fever no myalgia

History

PMH：angiography　12 years ago (no documents)

DM (_)　　HTN (+)　　IHD (-)　　DLP (-)

PSH: History of kypho scoliosis surgery 55 days ago

DH：　　Tab Losartan 50 po BD

Tab gabapentin 300 po PRN

she doesn't remember the other drugs

P/E

- GA: the middle age woman who oriented but lethargic who answered the questions.
- BP:70/p PR:98 T:37 RR:18
- Spo2 without: 80% with: 90%
- H&N: sclera icter (-) conj pale (-) NL JVP LAP (-)
- Chest: was symmetrical and in auscultation was clear
- Heart: S1 and S2 with with no any murmur
- Abd :soft, no tenderness or distention or organomegaly
- Ext : no edema, no cyanosis or clubbing
- Right limb force 4/5 left lower limb force 3/5
- The difference in limb size was not significant. R: 42 cm L:44cm

The pulses of all four limbs were weak, The limbs were cold.

Problem list

- Weakness
- Sleepy
- Hypotension
- Dyspnea
- Spo2 80%
- Coldness in distal extremities
- Filliform pulses
- Bed ridden for about 45 days

Decreased LOC an hypotension

- What are the differential diagnosis?

- What should we do at this step?

Differential diagnosis

- Toxins
- Infections (as sepsis ,encephalitis ,meningitis ,….)
- Neurologic shock (due to kypho scoliosis surgery)
- PTE
- Methabolice disorders (DKA ,myxedema coma ,GI bleeding,…)
- Cardiogenic shock (MI ,disection of aorta)

ABCD

- At this time we tried to start assess her decreased LOC as first line hospitalized care:
- A:check airways : was clear
- B:breathing: symethrical chest movment without any wheezing or rale
- C:circulation : she had hypotension without any tachycardia and filiform pulses
- Rash exam : IVC diameter about 3-3.5(dilated)
- D:disabilities:no seizure,BS:98,no signifant FND,no history for toxication

Shock state

- Because of her hypotension and absence of tachycardia or buldging JVP, primary diagnosis was originated in cardia, so shock state resuscitation items started as below:

.IV line fix

.Hydration with crystalloids slowly

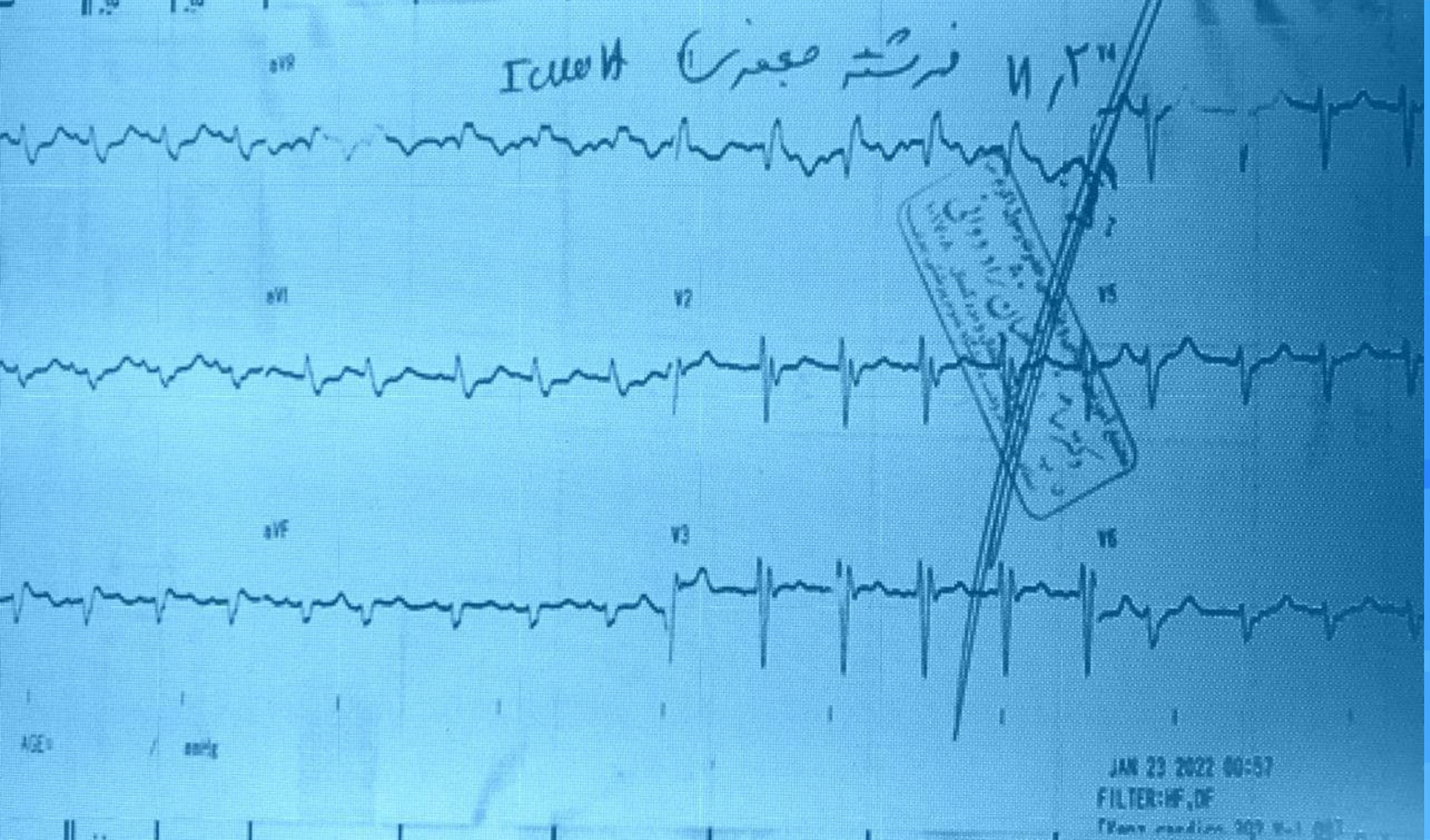
.Drip NOR EP 10macro/min

.Decided to **cv** line fix due to no good peripheral IV line.

.cardiac monitoring and pulsoxymetr

.emergent consultation with cardiologic department.

What should we do next?


JAN 23 2022 00:57
FILTER:HF,DF

Lab Data

- Mg: 2.3
- Ca: 6.6
- Na: 133
- K: 5
- BUN:22
- Cr: 2.8
- CPK: 890
- CPKMB: 58

PT: 16

PTT: 27

INR: 1.2

BS:95

AST:95

ALT: 34

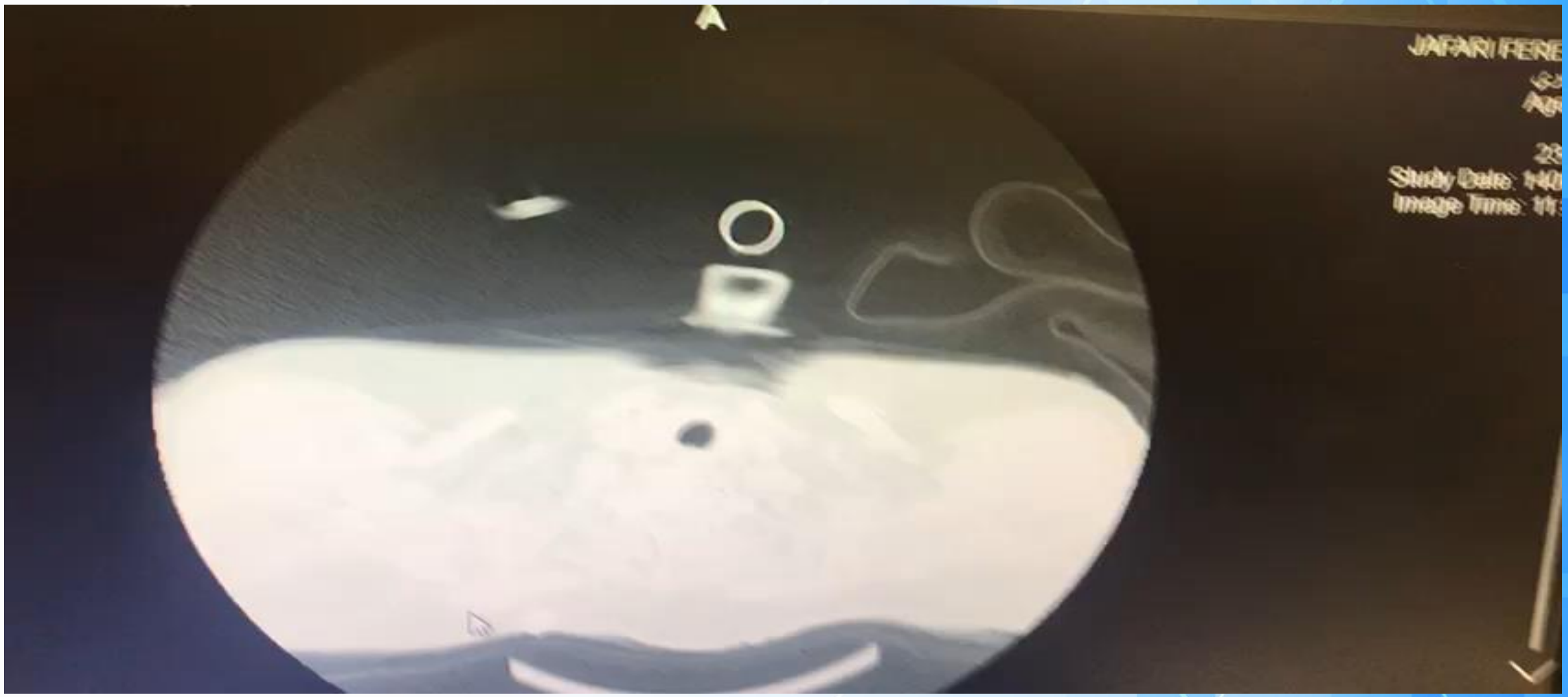
ALKP:295

trop: 973

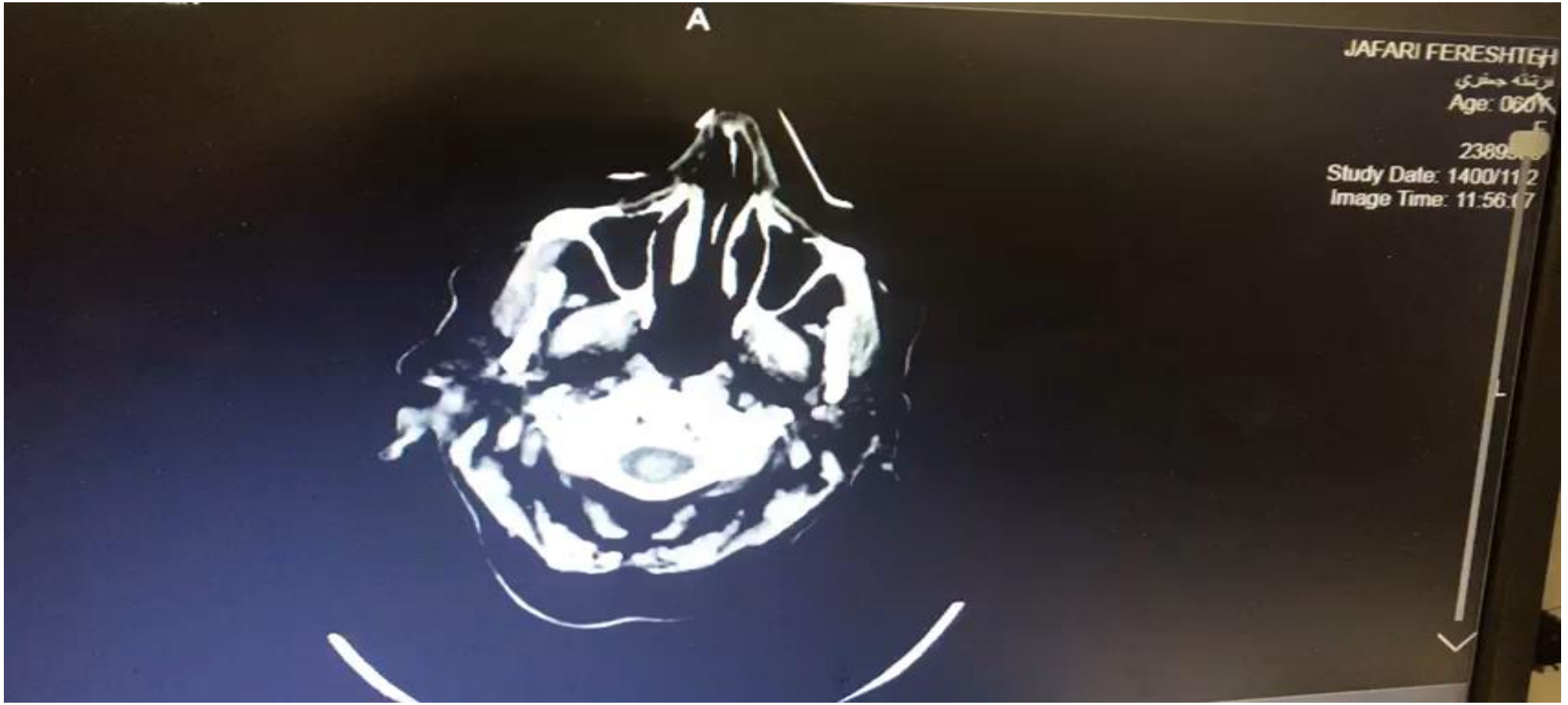
Lab findings

- VBG:
- PH:7.17
- Pco2:60
- Po2:27
- Hco3:21
- BE:-7

Chest CT



Brain CT


A
JAFARI FERESHTEH
فرشته جعفری
Age: 060Y
Study Date: 1400/11/2
Image Time: 11:56:07

What is next?

- Which consult do you perfere?
- Which medication do you prefere?
- Which para clinic do you need?

Now consult with other services

Cardiologic consultation

- Echo bedside
- Doubt on PTE recommended CTA with pulmonary embolisim criteria

Second visit after Echo:

Drip NEP

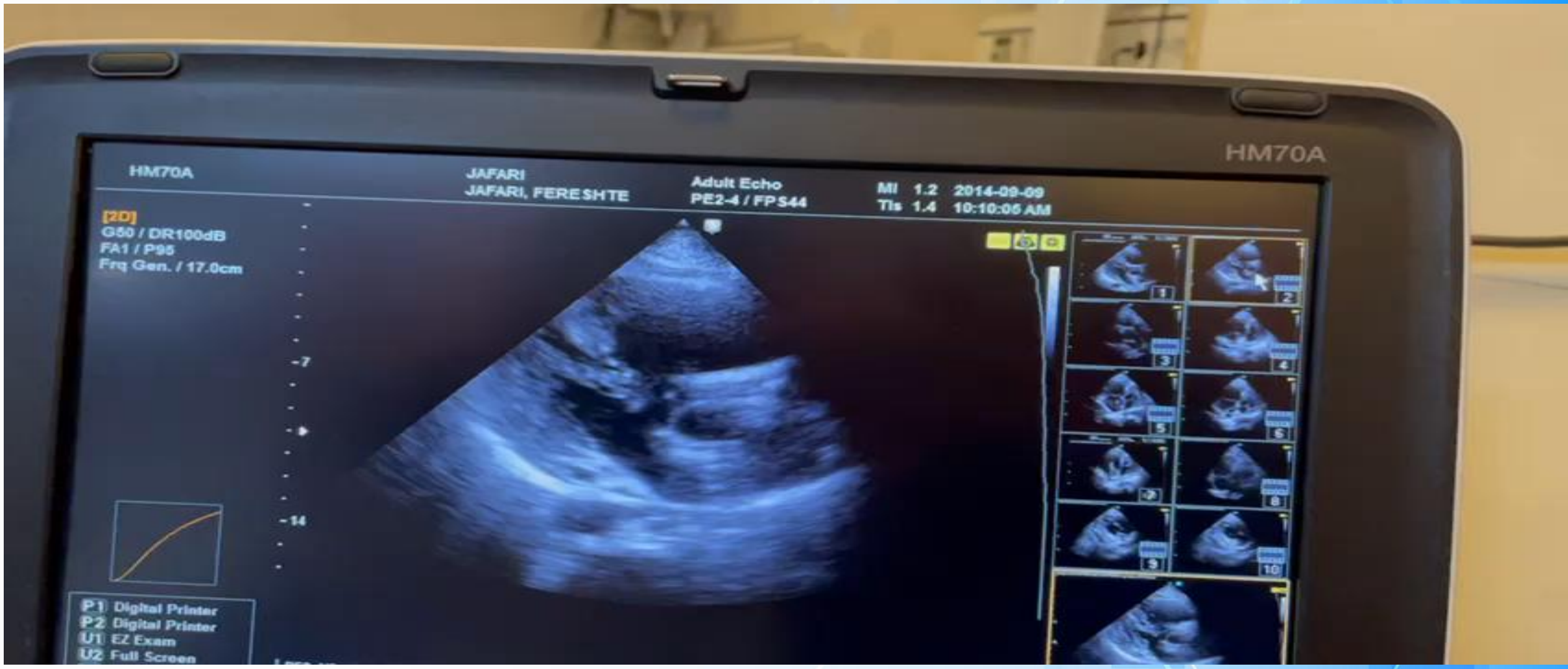
Cardiac surgery consult

Prepared for operation

Bed sided ECHO

- Normal LV size with good systolic function
- EF55%
- No significant RWMA at rest
- Fused E-A
- Severe RV enlargement with moderate systolic dysfunction
- Dilated IVC with flow retention

Bed sided ECHO



Internal concultation

- Drip NEP
- Hydration with 1lit normal salin
- Heparin 5000 sc

Neuro surgery consultation

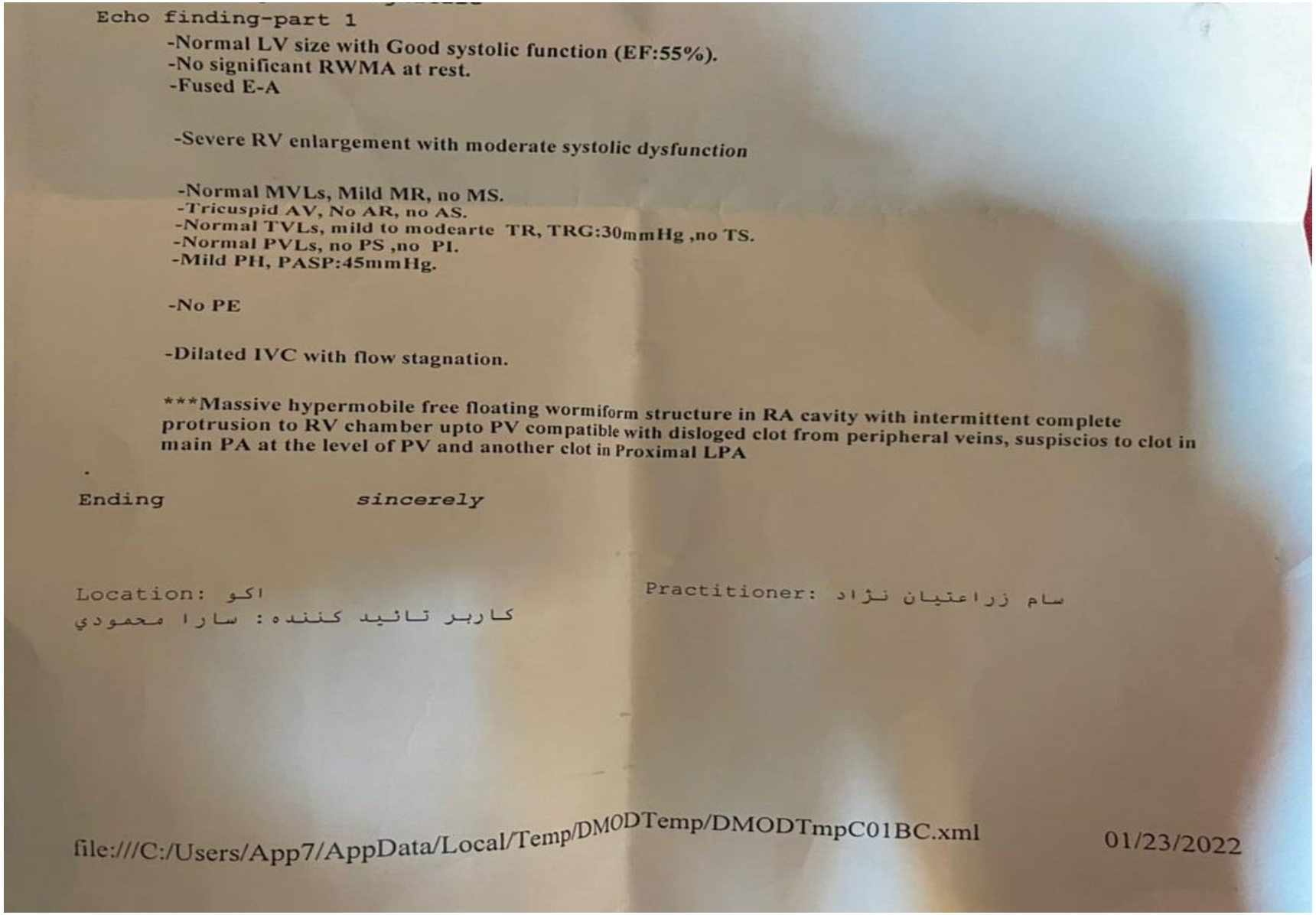
- Dors o lumbosacral MRI
- Brain CT

consult

- **Neurosurgery consult** → dorsolumbosacral MRI
- **Internal medicine consult** → d dimer check , color doppler ultrasound lower limb, Due to leukocytosis Start taking tazocin and targocid

- Cardiologist wanted to consult with cardiac surgery and finally they candidate the patient for emergent open heart surgery.

Echography



Echo finding-part 1

-Normal LV size with Good systolic function (EF:55%).
-No significant RWMA at rest.
-Fused E-A

-Severe RV enlargement with moderate systolic dysfunction

-Normal MVLs, Mild MR, no MS.
-Tricuspid AV, No AR, no AS.
-Normal TVLs, mild to modearte TR, TRG:30mmHg ,no TS.
-Normal PVLs, no PS ,no PI.
-Mild PH, PASP:45mmHg.

-No PE

-Dilated IVC with flow stagnation.

***Massive hypermobile free floating wormiform structure in RA cavity with intermittent complete protrusion to RV chamber upto PV compatible with disloged clot from peripheral veins, suspiscios to clot in main PA at the level of PV and another clot in Proximal LPA

Ending *sincerely*

Location: اکو
کاربر تائید کننده: سارا محمودي

Practitioner: سام زراعتیان نژاد

file:///C:/Users/App7/AppData/Local/Temp/DM0DTemp/DMODTmpC01BC.xml 01/23/2022

Massive Pulmonary Embolism

- **Massive Pulmonary Embolism :**Patients with massive PE can develop cardiogenic shock and multisystem organ failure. Renal insufficiency, hepatic dysfunction, and altered mentation occur commonly.
- Massive PE has a high mortality rate. Thrombosis is widespread, affecting at least half of the pulmonary arterial vasculature. Clot typically is present bilaterally, sometimes as a “saddle” PE in the main pulmonary artery.
- Dyspnea usually is the most prominent symptom; chest pain is unusual; transient cyanosis is common; and systemic arterial hypotension requiring pressor support occurs frequently. Excessive fluid boluses may worsen right-sided heart failure, rendering therapy more difficult.
- These patients may require heroic efforts to enable survival, such as extracorporeal membrane oxygenation.

surgery

finish