Site Visit 2: HandP

Name: [redacted]
Address: 123 45th St, Queens, NY 11419
DOB: [redacted]
Location [redacted] ospital
Religion: Hindu
Source of information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transportation: EMS

CC: “I finished my abx for my PNA but my chest pain wont go away. It's keeping me up at night because when I lie down, the chest pain gets worse” x4 days.

HPI: [redacted] is a 23-year-old F w/ no significant pmhx w/ cc of persistent, b/l chest pain x1 week. The CP radiates to the arms, is worse in the lying position, and is relieved when leaning forward. 1 week ago, the patient reported influenza-like symptoms (fever, sore throat, body aches, and chills) and presented to the hospital when she developed CP. She was diagnosed w/ and tx for PNA. Pt completed her PNA abx, had resolution of respiratory symptoms, but her fever and chest pain persisted, prompting her to return to the ER. She also reports 2 episodes of vomiting yesterday. Pt denies HA, slurred speech, focal neural deficits, or facial droop. Pt denies hx of COC use, breast cancer, smoking, pregnancy, recent travel, or hx of DVT. Presentation is concerning for acute pericarditis following recent illness.

PMHx:
None

Immunizations:
Influenza (2026)
Covid (4 doses)
MMR and TdaP (up to date, dates unknown)
Childhood vaccines (dates unknown)

PSH:
None

Medications:
None

Allergies:
None

FHX:
Mother - 55 yo, SLE w/ hospitalization for kidney issue
Father - 60 yo w/ htn
Grandparents - ?
Social Hx:
Living Situation: happily w/ supportive parents

Kids: none
Social life: supportive friend group, frequents the city
Psych: denies depression or anxiety
Profession: elementary school teacher
Diet: home-cooked food, Uber Eats 2-3x per week
Sexual hx: sexually active w/ 1 partner for 5 years, no protection
Smoking: denies
ETOH: socially, weekends 3-4 drinks
Drugs: denies
Recent travel: denies
Sleep: 7-8 hours nightly, no issues falling or staying asleep

ROS:
Constitutional: see hpi. Denies unexplained weight loss.
Skin, Hair, Nails: denies rashes, masses, ulcers, edema, or hair loss.
Head: denies HA or trauma
Eyes: denies changes in vision or ocular pain
Nose/Sinus: denies congestion, rhinorrhea, or allergies
Mouth/Throat: denies sore throat, difficulty swallowing, or hoarseness
Neck: denies recent trauma, masses, or nuchal rigidity
Breast: denies fhx of breast cancer, masses, or discharge
Pulm: see hpi.
CV: see hpi. denies palpitations or syncope.
GI: denies NVD, changes in appetite, or stool consistency
GU: denies pruritus, retention, discharge, or AUB.
Nervous: denies weakness, paresthesia, numbness, confusion, facial droop, or slurred speech
MSK: reports pain radiating to the arms
Peripheral Vascular: denies peripheral edema, numbness, or paresthesias
Heme: denies easy bruising, bleeding, or hx of bleeding disorders
Endo: denies confusion, heat or cold intolerance
Psych: pt denies anxiety, depression, suicidal ideation, or memory loss

Physical exam:
General: Pt is in NAD AO3, sitting in hospital chair, well kempt and pleasant.

Vital Signs:
BP: Right seated: 102/70 - 125/82
RR: 18
P: 92-112
T: 98 - 100.3
O2 sat: 93-95% RA

Height: 162cm Weight: 67kg BMI: 25.5

Eyes: PERRLA, no injection or purulence

Nose: no polyps or deviation. Moist mucus membranes

Mouth and Pharynx: uvula midline, moist membranes, no rashes, masses, or lesions.

Neck: trachea midline, supple, no JVD, no lesions.

Upper extremity: radial and brachial pulses 2+ b/l

Heart: RRR, no S3 or S4. blood pressure wnl. Pericardial friction rub present

Lung: lungs clear to auscultation b/l

Abdominal exam: non-distended, no lesions or rashes, bowel sounds present in all 4 quadrants, soft, no masses present, non-tender to light and deep palpation

Lower Extremity: no varicosities, no pedal edema, DP and TP 2+ b/l

Labs and Diagnostics:

	3/26	3/27	4/2
WBC	13.9	18	8.95
Hgb	12	8.7	10.7
Iron Studies			
Ferritin		267 (10-150)	
Iron total		22 (60-170)	
Transferrin Saturation		9% (20-50%)	
Haptoglobin		509 (30-200)	
Rheum/Inflam			
CRP		391 (< 3)	
C3		267 (80-160)	
C4		46 (16-48)	
Total hemolytic complement		102 (30-75)	High - inflammation Low - “consumption” fighting autoimmune attack
Alpha 1 and 2 protein		Increased	(acute inflammation)
ANA		1:320 (<1:40 or < 1:80)	

ANA pattern		Homogenous	
RF		20 (<14)	
Silica clotting time S/C Ratio		1:3.2 (<1.2)	(if >1.2 suggests + lupus anticoagulant)
Calprotectin		77 (<50)	(suggests GI inflammation)
Infectious			
Coxsackie		B1-6 Positive	A - negative

Imaging:

- TTE
    - Thickened pericardium
    - small, posterior LV effusion (increased over time)
- EKG
    - 1st) tachy
    - 2nd) mild ST elevation in V2 and V3, non-specific T wave abnormalities
- CT Chest
    - No PE
    - Increased small L>R pleural effusion w/ dependant opacities suggesting atelectasis -> correlate to PNA
    - Increased small to moderate pericardial effusions w/ slight peripheral enhancement.
- RUQ US
    - 6mm gallbladder thickening (nonspecific) + small b/l pleural effusion

Orders:

- Admit to telemetry
- Continuous cardiac monitoring
- Vital signs q6h
- Strict I&O
- Daily weight

Labs:

- Trend CBC, CMP q24h
- ESR, CRP (trend inflammation)
- Trend troponins (normal)
- Repeat ANA panel

Consults

- Cards
- Rheum

Assessment:

[redacted] is a 23-year-old female with no significant PMHx presenting with pleuritic, positional chest pain following a viral illness, associated with low-grade fever and elevated inflammatory markers. Her physical exam is remarkable for a pericardial friction rub. Imaging shows pericardial thickening and effusion. This presentation is most consistent w/ acute pericarditis, likely caused by Coxsackie B. However, positive ANA and her family history of SLE raise concern for autoimmune pathology. There is currently no evidence of PE or MI.

Ddx

1) Acute pericarditis
2) SLE
3) PE (r/u)
4) MI (r/u)
5) Anemia

Problem List / Plan

1) Acute Viral (coxsackie) Pericarditis
    a) Clinical symptoms and exam findings correspond w/ pericarditis despite ECK not showing diffuse ST elevations. Start high-dose naproxen and colchicine. Avoid strenuous activity. Monitor for tamponade (JVD, hypotension, pulsus paradoxus). Serial TTEs
    b) Why viral and not autoimmune?
        i) C3 and C4 levels are typically low (consumed) during an acute SLE flare-up. This pts C3 and C4 were elevated along w/ coxsackie infection, indicating viral etiology w/ strong possibility of underlying SLE.
2) Pericardial Effusion
    a) Monitor w/ repeat TTEs. No intervention needed unless hemodynamic compromise or signs of tamponade
3) Possible Systemic Lupus Erythematosus
    a) Rheum consulted and ordered labs. F/u outpt for further management and prevention.
4) Anemia of inflammation
    a) Low iron, high ferritin, low transferring saturation, and high haptoglobin are classic for anemia of chronic disease or inflammation.
        i) Treat underlying inflammation
5) Nausea/vomiting
    a) Elevated calprotectin and GB thickening could indicate lupus inflammation of the gallbladder. GI consult