CASE PRESENTATION

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POST GRADUATE
DEPT OF GENERAL MEDICINE

CASE 1

- Age-22yr
- Sex-male
- Occupation- NCC cadet
- Residence : Nalgonda

CHIEF COMPLAINTS

- Breathlessness since 30 minutes.
- Chest pain since 30 minutes.
- One episode of syncope .

History of Presenting Illness

- Patient was apparently asymptomatic till morning, then developed breathlessness while marching in his morning parade; which was sudden in onset (Grade IV NYHA).

- Chest pain:retrosternal sudden onset, radiating to left shoulder and neck, squeezing type,not relieved at rest, Associated with palpitations.

- Followed by a syncopal attack, which was associated with profuse sweating and loss of consciousness, he regained consciousness within 2 minutes.
- No h/o fever, cough, expectoration.
- No h/o headache, seizures.
- No h/o perioral numbness or carpopedal spasms

PAST HISTORY

No h/o hypertension , diabetes , stroke, seizures, CAD, congenital heart disease.

No h/o similar episodes in the past.

PERSONAL HISTORY

diet-mixed

appetite-normal,

Bowel and bladder habits : regular

no habits

no h/o allergies

FAMILY HISTORY

His father died at the age of 38yrs during work (lifting heavy weights),sudden death.

Younger sibling-male,asymptomatic

DRUG HISTORY

No h/o past drug usage.

No h/o drug allergies.

GENERAL PHYSICAL EXAMINATION

- Patient is conscious, oriented, well built and well nourished.
- On examination-no pallor , icterus , cyanosis , clubbing, oedema, JVP-not raised.
- VITALS

PR-120bpm,irregularly irregular, low volume,

normal character of vessel wall

apex pulse defecit-15

BP- 90/60mmof Hg, left arm, supine position,mean BP after 3 readings

RR-20cycles/min, abdomino thoracic, normal pattern

Temp : 98.6 degrees Fahrenheit

SpO2 : 97% at room air

CARDIOVASCULAR SYSTEM

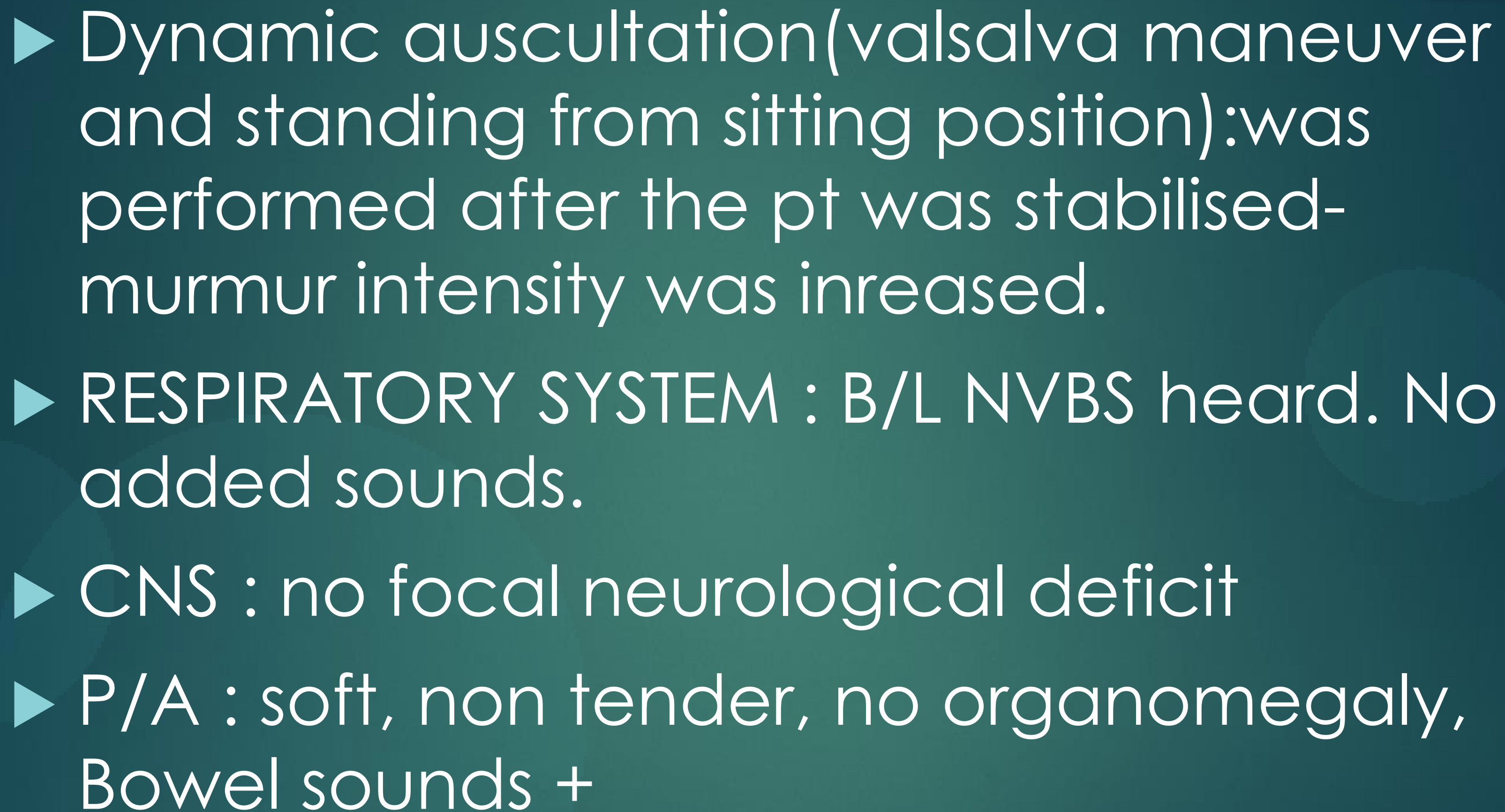
- Inspection : no chest deformity seen, jerky apical impulse seen in 5th and 6th ICS.
- Palpation : heaving apex. No parasternal heave, no thrills.
- Auscultation :

Mitral : Variable S1, S2,short systolic murmur heard grade 3/6 soft blowing type, crescendo-decrescendo variety.no click.

Tricuspid : Variable S1,S2

Aortic : S1,variable,s2+, no murmur

Pulmonary : S1variable,s2+ no murmur.


Dynamic auscultation(valsalva maneuver and standing from sitting position):was performed after the pt was stabilised- murmur intensity was inreased.
RESPIRATORY SYSTEM : B/L NVBS heard. No added sounds.
CNS : no focal neurological deficit
P/A : soft, non tender, no organomegaly, Bowel sounds +

Provisional diagnosis

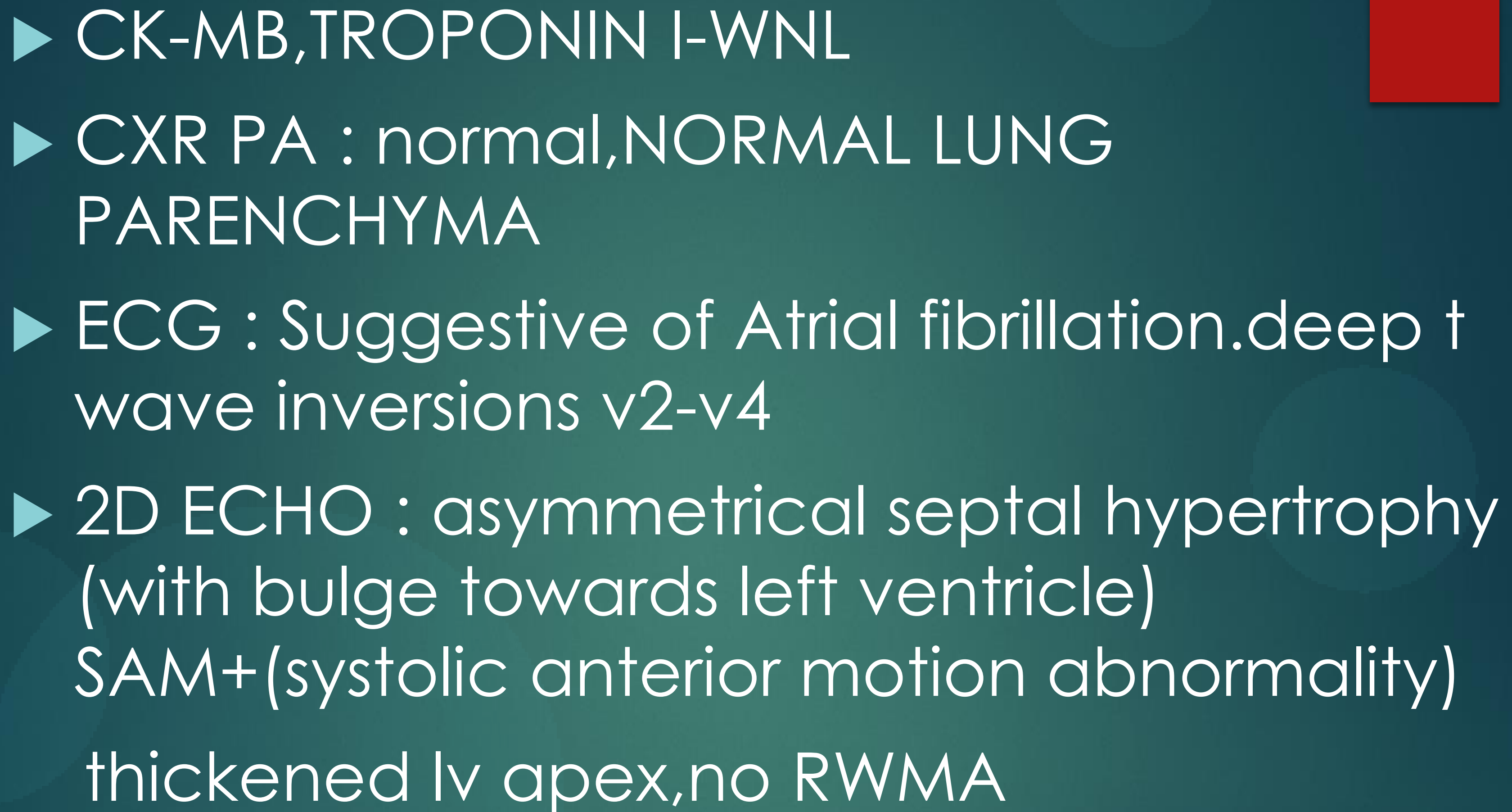
- AF FOR EVALUATION

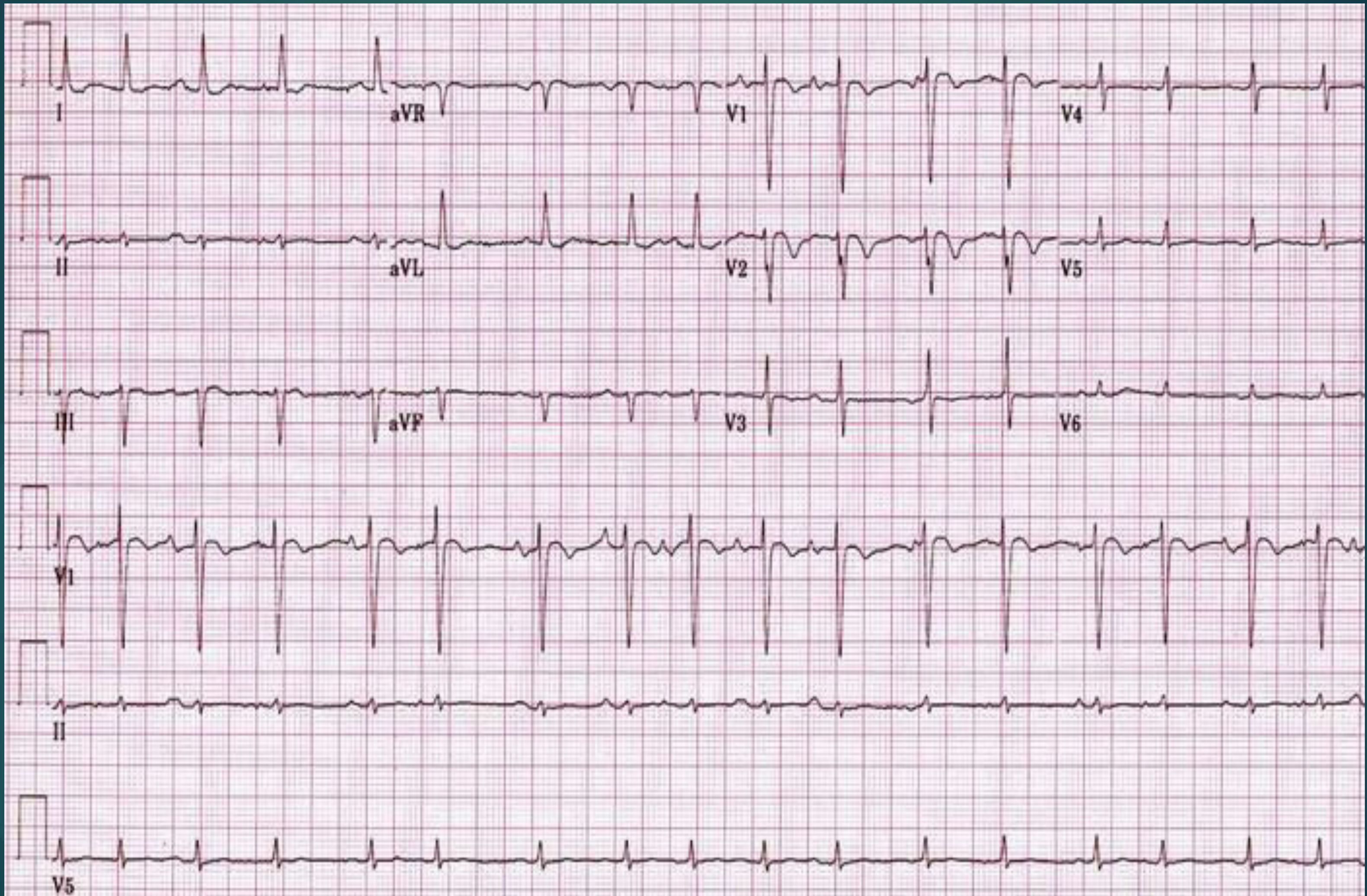
INVESTIGATIONS

- CBP : Hb : 14 gm%, TLC : 6000/cu.mm, Plts : 2,50,000/cu.mm
- CUE : WNL
- RFT : Urea : 26 mg%, Creatinine : 0.8 mg%
- LFT : WNL
- S. electrolytes : Na : 138 meq/l, K : 4.4 meq/l

Cl : 101 meq/l

- RBS : 88 mg/dl
- T3,T4,TSH-WNL


CK-MB,TROPONIN I-WNL
CXR PA : normal,NORMAL LUNG PARENCHYMA
ECG : Suggestive of Atrial fibrillation.deep t wave inversions v2-v4
2D ECHO : asymmetrical septal hypertrophy (with bulge towards left ventricle) SAM+(systolic anterior motion abnormality)
thickened lv apex,no RWMA



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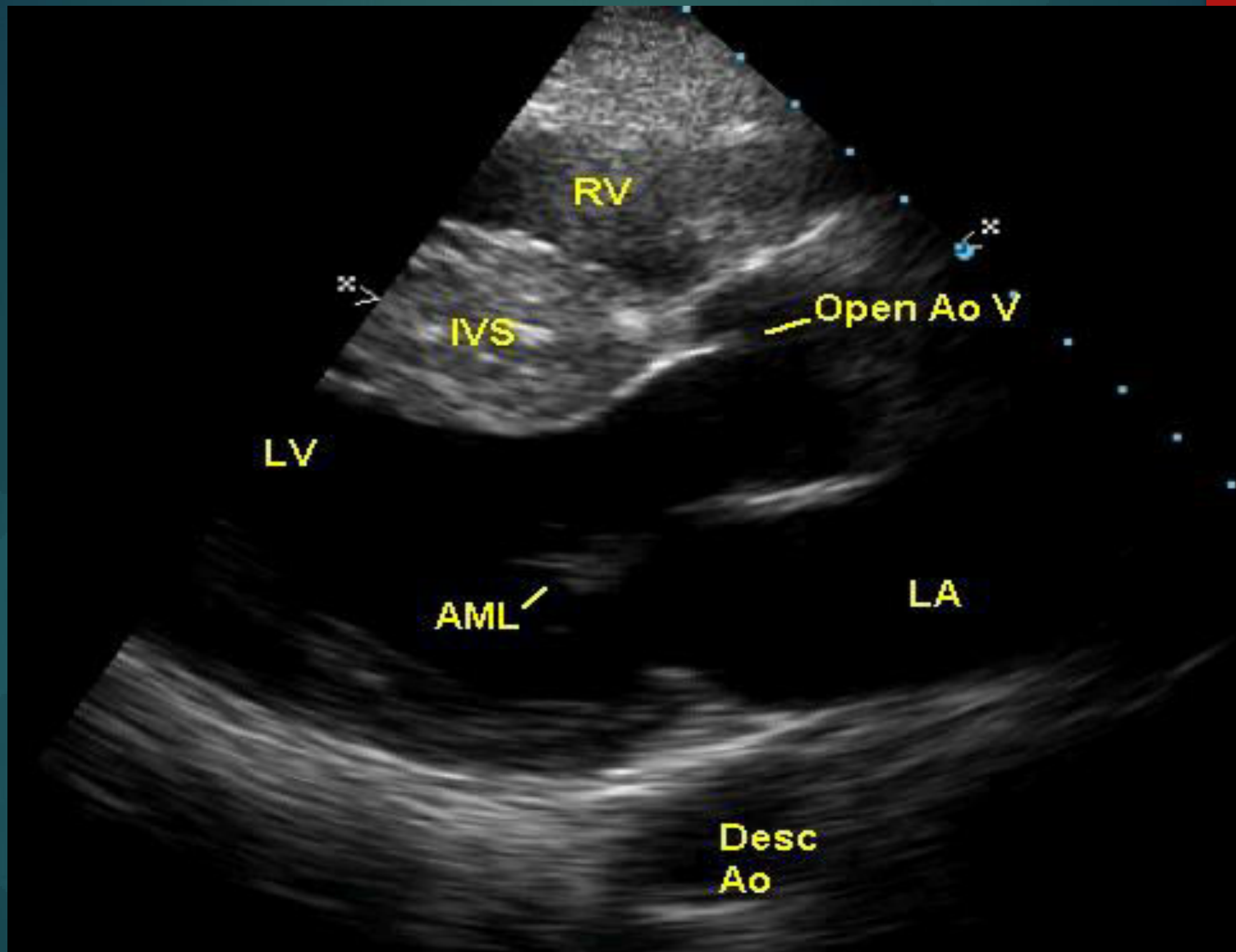
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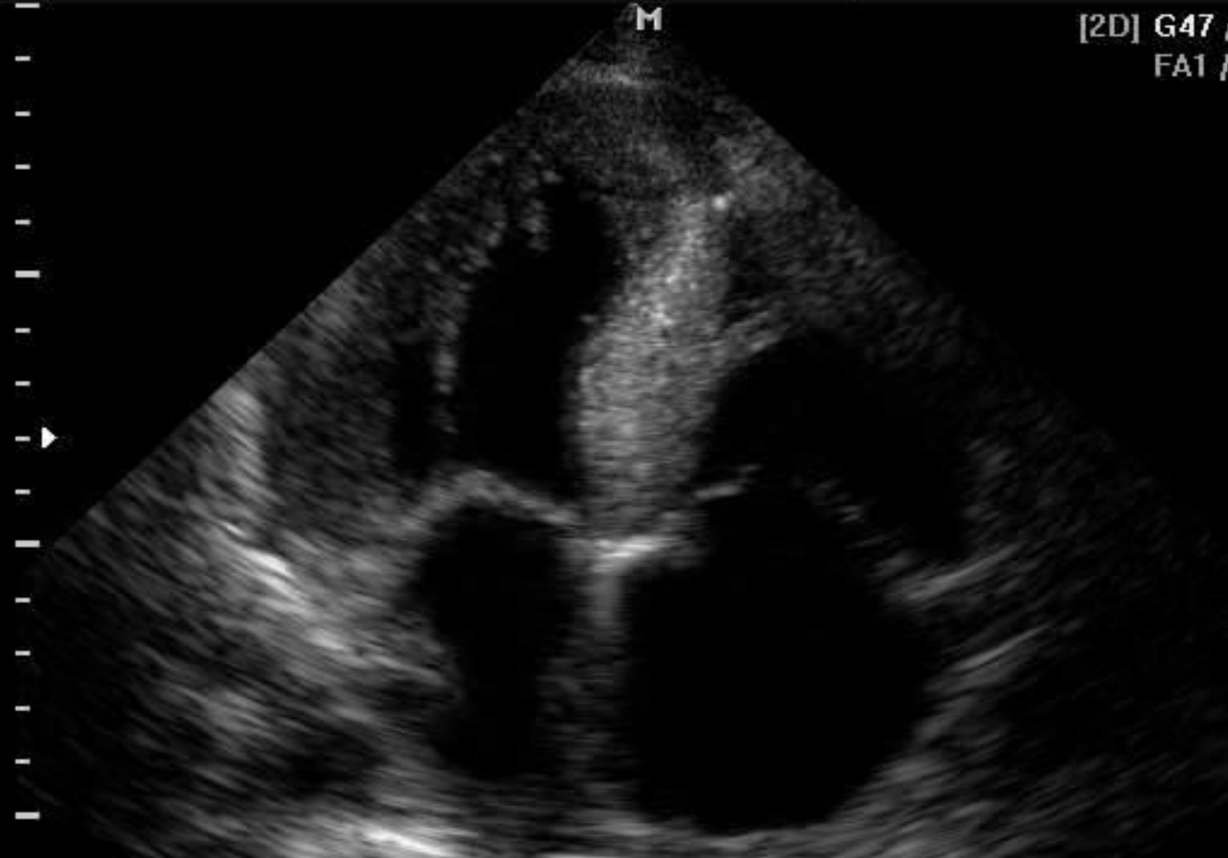
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Hypertrophic cardiomyopathy

FINAL DIAGNOSIS

- Hypertrophic obstructive cardiomyopathy with atrial fibrillation.

Management

- Tab amiodarone 200mg tid
- REFERRED TO HIGHER CENTRE

Case 2

- Age-38yr
- Sex-male
- Occupation- school teacher
- Residence : Nalgonda

Chief complaints

- Abdominal distension-3 weeks
- Swelling of legs -2 weeks
- Chest pain-1 day
- 1 episode of syncope

History of presenting complaints

- h/o abdominal distension since 3 weeks,progressive.
- h/o bilateral lower limb swelling since 2 weeks,insidious onset,progressive.
- Chest pain since 1 day, located in the central part of the chest, radiating to neck, heavy in nature, no relieving factors.
- Associated with palpitations, sweating.
- Followed by an episode of syncope , regained consciousness within 2 mins, no h/o seizure activity.
- h/o SOB+.
- No h/o fever, headache, cough, trauma.

- Past history:

-h/o repeated similar complaints in past-admitted for same.

- k/c/o bronchial asthma,hypereosinophilia

- No h/o DM,HT, CAD, TB, EPILEPSY

- FAMILY HISTORY

-nil significant

diet-mixed

appetite-adequate

habits-nil

no significant weight loss

GENERAL EXAMINATION

- Patient is conscious, oriented, well built and well nourished.
- On examination-no pallor , icterus , cyanosis , clubbing, oedema, JVP-raised with absent a wave,kussmaul sign+
- VITALS

  PR-140bpm,irregularly irregular, low volume,

  normal character of vessel wall

  apex pulse defecit-20

  BP- 100/60mmof Hg, left arm, supine position,

  RR-20cycles/min, abdomino thoracic, normal pattern

  Temp : 98.6 degrees Fahrenheit

  SpO2 : 97% at room air

CVS

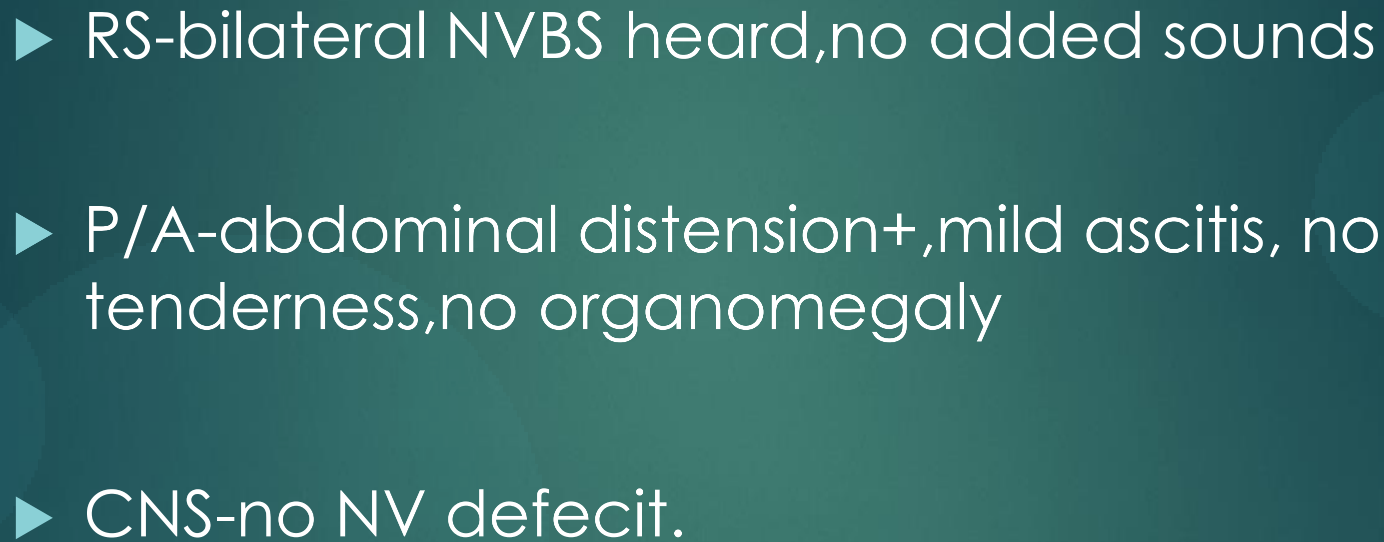
- Inspection : no chest deformity seen, apical impulse not visible.
- Palpation : apical impulse not felt. No parasternal heave, no thrills.
- Auscultation :

Mitral : Variable S1, normal S2, S4+, no murmurs

Tricuspid : Variable S1, short systolic murmur +,grade 2/6,soft.

Aortic : S1,variable,s2 +, no murmur

Pulmonary : S1,Variable,s2+, no murmur



RS-bilateral NVBS heard,no added sounds
P/A-abdominal distension+,mild ascitis, no tenderness,no organomegaly
CNS-no NV defecit.

PROVISIONAL DIAGNOSIS

- AF FOR EVALUATION

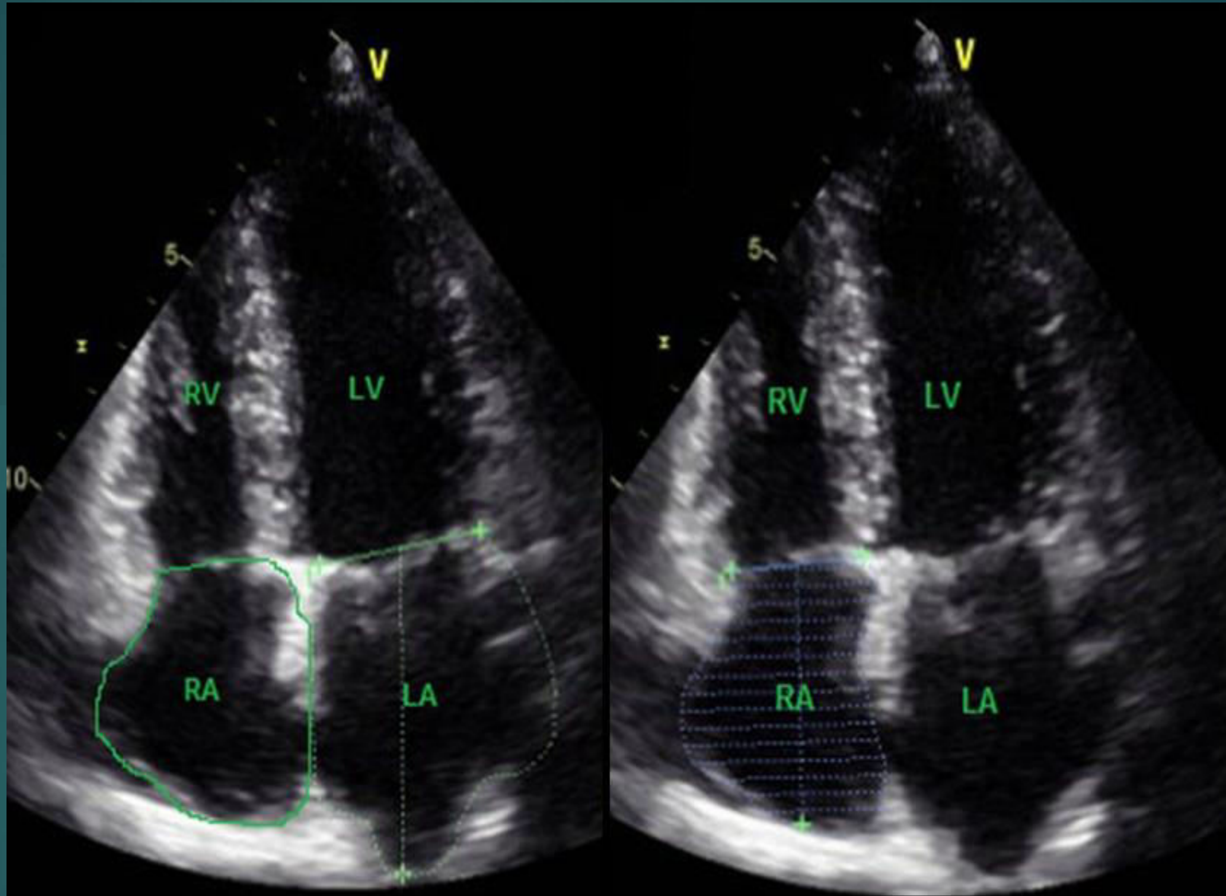
- CBP : Hb : 11 gm%, TLC : 9,200/cu.mm, Plts : 1,50,000/cu.mm
- CUE : WNL
- RFT : Urea : 30mg%, Creatinine : 1.0 mg%
- LFT : WNL
- S. electrolytes : Na : 142 meq/l, K : 4.1 meq/l

Cl : 100 meq/l

- RBS : 135 mg/dl
- AEC-1650/Cumm

- CK-MB : WNL, Troponin I : Negative
- CXR PA : normal
- ECG : Suggestive of Atrial fibrillation with fast ventricular response with low voltage complex.
- 2D ECHO : Biatrial enlargement present,b/l concentric hypertrophy of both ventricles,moderate PAH

EF-53%,diastolic dysfunction.intact ias,ivs.



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TREATMENT

- Tab verapamil 80mg tid
- Tab race 5mg od
- Tab dytor 10mg bd
- Tab ecospirin 150mg od
- Patient was referred to higher centre for further evaluation.

FINAL DIAGNOSIS

- Restrictive cardiomyopathy with AF

CASE 3

- AGE:32YRS
- SEX:FEMALE
- OCCUPATION:HOUSEWIFE
- TOWN : NALGONDA

CHIEF COMPLAINTS

- Breathlessness since 10 days
- b/l lower limb swelling since 1week
- Facial puffiness since 1week
- Chest pain since 3 days
- 1 episode of syncopal attack-1day back

History of presenting illness

- Patient is a known case of RHD since 15yrs,on treatment
- Apparently asymptomatic 10days back. Presented with breathlessness-progressed from grade II to grade IV (NYHA)
- Associated with orthopnoea and PND.
- Developed swelling of both feet, pitting type, associated with facial puffiness.

- H/o chest pain since 3 days,retrosternal, dull aching type, non radiating, associated with palpitations.
- h/o one syncopal attack 1 day back, while working at her home, Regained consciousness after 1-2 minutes. No h/o seizures.
- No h/o cough, expectoration, wheeze.
- No h/o fever

PAST HISTORY

- Patient was diagnosed with rheumatic heart disease 15 years ago, was on irregular treatment. She had similar episodes in the past.
- No h/o HTN, DM, IHD, CVA, TB.
- Underwent tubectomy 4 years ago.

- PERSONAL HISTORY :

Mixed diet

Normal appetite.

Bowel/bladder : Normal

Sleep : disturbed

No habits, addictions

- MARITAL HISTORY :

Married since 6 years. Non consanguineous.

Para – 1, living – 1, uneventful pregnancy. No h/o abortions.

- FAMILY HISTORY :

Nil significant

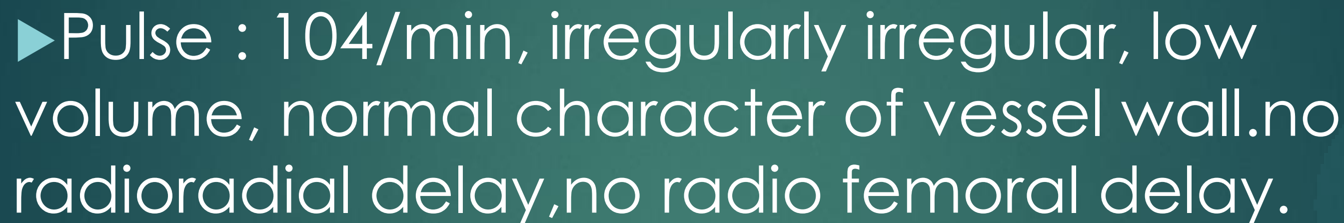
- DRUG HISTORY :

Was on Inj. Penidure 12 lakh unit (IM) once in 21 days x 10 years, discontinued thereafter.

- Tab Lasix 20mg BD
- Tab met XL 12.5mg od irregular treatment

General Physical Examination

- Patient is conscious, oriented, coherent, dyspnoeic.
- Thin built and moderately nourished.
- Pallor +, pedal edema + (pitting type), No icterus, cyanosis, clubbing.
- Temperature : 98.6 degrees Fahrenheit.
- No signs of infective endocarditis
- No cutaneous manifestations of RF.



- Pulse : 104/min, irregularly irregular, low volume, normal character of vessel wall.no radioradial delay,no radio femoral delay.

Apex pulse defecit-12

- BP : 100/70 mm Hg, left arm supine position.
- RR : 25 cycles/min, thoraco abdominal, normal pattern.
- SPO2 : 89% at room air, 96% with 6 litres of O2.

Systemic examination

CVS :

Inspection – Pectus carinatum +, Apical impulse seen in left 5th ICS, 1 cm lateral to mid clavicular line. No visible parasternal heave,no epigastric pulsations. JVP- raised with absent a wave.

Palpation – Inspectory findings confirmed. Tapping apical impulse,palpable p2, No parasternal heave, diastolic thrill present over apex.

- Auscultation :

  Mitral : variable S1,normal s2,diastolic murmur,localized,rough rumbling in mitral area,best heard in expiration in left lateral recumbent position with the bell, with no pre systolic accentuation.no gallop,no click,no radiation.

  Tricuspid :S1 , S2+ with PSM(functional TR)

  Aortic: normal

  pulmonary:S1,loud s2(p2)with diastolic murmur of PAH

- RS- BAE+,
  - B/L basal fine late inspiratory crepitations+
- P/A-soft,tender hepatomegaly+
  bowel sounds +
- CNS- No FND

PROVISIONAL DIAGNOSIS

- CHRONIC RHEUMATIC HEART DISEASE

SEVERE MITRAL STENOSIS WITH ATRIAL FIBRILLATION

WITH CONGESTIVE HEART FAILURE

WITH NO FEATURES OF INFECTIVE ENDOCARDITIS

INVESTIGATIONS

- CBP : Hb : 9.4 gm%, TLC : 7000/cu.mm, Plts : 200000/cu.mm
- CUE : WNL
- RFT : Urea : 26 mg%, Creatinine : 0.8 mg%
- LFT : WNL
- S. electrolytes : Na : 138 meq/l, K : 4.4 meq/l
- Cl : 101 meq/l
- RBS : 88 mg/dl
- T3,T4,TSH-WNL

- CK-MB : WNL, Troponin I : Negative
- CXR PA : cardiomegaly +
- ECG : Suggestive of Atrial fibrillation with fast ventricular response
- 2D ECHO : EF:40%

  Severe MS with mild MR

  moderateTR+,PAH

  Left atrial dimension-5cm

  mitral valve orifice area-1.0cm

  no calcifications,vegetations

  No LA thrombus,no RWMA

TREATMENT

- Inj Lasix 20mg iv,BD
- Inj ceftriaxone 1gm iv,BD
- Inj pantop 40mg iv,OD
- Tab Met XL 25mg OD
- Tab Warfarin 2mg OD
- Tb digoxin 0.125mg OD 5/7
- Tab orofer xt bd
- Treatment was continued for 2 weeks and symptomatically improved.

FINAL DIAGNOSIS

- chronic RHD with severe MS with mild MR

  With moderate TR,PAH.

  with AF with CHF

  no features of infective endocarditis

THANK YOU