Disclosures...

• I have no relevant financial relationships to disclose

Learning Objectives: At the conclusion of this presentation, the participant should be able to:

• <1> Discuss the common anginal-equivalents and atypical presentations for Acute Coronary Syndrome

• <2> Explain the key interventions for patients with Acute Cardiogenic Pulmonary Edema

• <3> Discuss some of the key cardiac diagnoses not to miss in an acute care setting and how to diagnose/treat them

Diagnosis ???
NO!!

Younger Patients (i.e. Under 45 years of age)
African American Patients
Younger patients
Atypical presentation
Incorrect interpretation of the EKG
Not getting a repeat EKG
• 61-year old male who presents with severe shortness of breath
  • It began 60 minutes ago and is progressively getting worse.

PMH: DM, HTN
• Meds: Insulin, Lisinopril
• Alleg: NKA
• SH: 1 ppd smoker; Social Etoh; Denies IDU
• PE: BP 200/100; P 110 R 32 T 98.4 SaO2=88% RA
  • Neck: (+) JVD
  • CV: Tachycardia w/reg rhythm and S3 w/o murmur/rub
  • Lungs: Coarse rales through all lung fields; subcostal retractions; accessory muscle use
  • Ext: 2+ pitting edema B/L LEs
What do you want to do now??

• Diagnostics??

• Therapeutics??

To Intubate or Not to Intubate....

• Are you and the patient up for the 60 minute challenge??

• Oxygen and NPPV (Bipap)

• Preload reduction (Nitroglycerin)
  • S/L Nitro and IV Nitro

• Afterload reduction (Lasix)
  • Will take some time to work

• Don’t forget the ACE inhibitor...
  • IV Vasotec (1.25 mg IV)
By 60 minutes post-interventions, you will find your patient like this:

![Patient Image]

You are working in an UC/ED/FP Office

- 23-year old male presents with 2 days of cough, fever and chest pain.
  - PMH / PSH: Denied
  - Meds: Denied
  - Alle: NKDA
  - SH: No Etoh/tob/idu
  - Vitals: BP 138/72 P 88 R 18 T 101 SaO2=98% RA
  - HEENT: WNL
  - Cv: RR w/o M/R/G
  - Lungs: CTA

What is your diagnosis/plan??

- 3 days later you get a call.......
  - Remember that 23-year old patient you saw 3 days ago in the ______??

JURY AWARD: $4.8 MILLION

- Diagnosis:
  - Acute cardiopulmonary arrest secondary to cardiomyopathy secondary to Viral Myocarditis

Viral myocarditis has been recognized as a cause of congestive heart failure for >50 years, but it is still a challenging disease to diagnose and treat. The history and clinical features are often nonspecific, and practical serological markers are not available during the acute phase of the disease. Even after proper diagnosis, no clinically proven treatment exists to inhibit the development of subsequent dilated cardiomyopathy (DCM) and, in some cases, death.

![Diagram of Myocardial Function]

Acute viral myocarditis
4/19/16

18-year old female presents with the above complaint

What else do you want to know??

What is your DDX??

What is your plan for her??

The prevalence of congenital LQTS is approximately 1 in 10,000

Approximately 4,000 deaths per year are attributed to LQTS

Including 30% of first-time cardiac events

LQTS is diagnosed more frequently in women (70% of cases)
If you are ever making the diagnosis of Acute STEMI

• The patient has any mental status changes or neurological deficits......

• ASSUME it is an Acute AORTIC DISSECTION until proven otherwise

• i.e. get a stat CTA of the chest

• Or at least let the interventional cardiologist know......

One Last Pearl.....

References:

- Moy, E et al. Missed diagnoses of acute myocardial infarction in the emergency department: variation by patient and facility characteristics. Diagnosis 2015; 2(1): 29–40