

THE WHITE ARMY

CVS Case Presentation

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Patient Details

Name: Mr XYZ

Age: 32 years Sex: Male

Address: Patia, Bhubaneswar

Occupation: Security Guard

SES: Lower Middle Class

Informant: Self

DOA: 4 October 2021

DOE: 11 October 2021

Chief Complaints

- . Unpleasant awareness of heart beat X 4 months
- . Breathlessness X 2 months

History of Presenting Illness

Unpleasant awareness of heart beat X 4 months

- Patient was apparently alright 4 months back. To begin with he noticed an unpleasant awareness of his own heart beat in the form of pounding sensations.
 - Sudden onset.
 - Initially on and off and now continuously for 2 weeks.
 - Irregular in nature.
 - No aggravating or relieving factors.
 - No history of loss of consciousness or chest pain
 - No history of polyuria.

Breathlessness X 2 months

- Insidious in onset
- Gradually progressive.
- Initially breathless on walking a distance of 500m but was able to carry out his day-to-day activities. But now over past 2 weeks it has progressed to the stage where he feels breathless even at rest.
- Orthopnea present.
- No history suggestive of PND.

- . History of fatigue present over past 3 months.
- . No history of chest pain or syncope.
- . No history of pedal edema, abdominal distension.
- . No history of weight loss, intolerance to heat/cold.
- . No history of cough, wheeze or hemoptysis.
- . No history of decreased urine output.

Past History

- Episode of fever and swelling of joints at 11 years
 - Was diagnosed to have a cardiac problem and was started on medications.
 - Does not recall the diagnosis.
- On routine follow-up,
- At 29 years of age, was advised surgery.
 - Patient unwilling to go ahead with it.
- No history of cyanotic/squatting episodes in childhood.
- No history of Hypertension, DM, hyperlipidemia, Thyroid disorder.

Family history

- No history of Congenital heart disease, IHD, obesity, DM, HTN, sudden cardiac death in the family.

Personal History

- Occupation: Security guard
- Diet: Non-Vegetarian
- Appetite: Normal
- Sleep: Disturbed Sleep
- Habits:
 - Consumes 30ml of whiskey daily at night.
 - No history of smoking or IV drug abuse.
- Bowel & Bladder: Regular and Normal

Medication History

• On Tab. Penicillin V 250mg BD

Summary

- Here is a 32 year old man with significant past history suggestive of rheumatic fever, on penicillin prophylaxis who presented with palpitations since 4 months and breathlessness since 2 months which is associated with orthopnea and fatigue. No associated history of chest pain, edema, syncope or hemoptysis. The most probable system involved would be the cardiovascular system.
- My provisional diagnosis is a valvular heart disease probably rheumatic in origin with features of left sided heart failure with arrhythmia probably Atrial fibrillation.

General Physical Examination

- The patient is conscious, co-operative and well oriented to time, place and person.
- Patient is dyspneic and tachypneic at rest.
- He is moderately built and moderately nourished.

Height: 170 cm

Weight: 65 kg

BMI: 22.5 kg/m²

- No pallor
- No Icterus
- No Cyanosis
- No Clubbing
- No Edema
- No lymphadenopathy

- No markers of rheumatic fever.
- No markers of Infective Endocarditis.
- No peripheral signs of AR.

Vitals

Pulse: 147 bpm, variable volume, irregular, Equally felt on both the sides,
No radio-radial or radio-femoral delay. Condition of the vessel wall
is normal. Peripheral pulses are palpable. No special character.
An apex pulse deficit of 17 is present.

Temperature: 101.9°F, measured orally

Respiratory Rate: 24/min, abdominothoracic

Blood Pressure: 100/70 mm Hg measured in the right upper arm in sitting position.

JVP: Not elevated

Systemic Examination

Inspection

- Chest wall shape/symmetry : No sternal or spinal deformities
- Position of trachea: Central
- Position of apex beat: Visible at the left 5th and 6th ICS 1cm lateral to the mid-clavicular line.
- Precordial bulge: Absent
- Engorged Veins: No
- Visible Pulsations: None
- Scars: None

Palpation

- Tracheal position is confirmed to be in the midline.
- Apex beat is palpated at the left fifth and sixth intercostal space 1cm lateral to the midclavicular line. It is hyperdynamic in character.
- A left parasternal heave of grade 2 is present
- A systolic thrill present at the apex.

Percussion deferred due to risk of dislodgement of clots.

Auscultation

• Mitral Area: S1 variable, S2 is heard. Murmur present.

- **Character / quality**: A soft musical blowing
- **Pitch / Timing**: High-pitched pansystolic murmur.
- **Intensity**: Grade IV , best heard with the diaphragm of the stethoscope.
- **Position of patient**: Patient is lying in the left lateral position with breath held in expiration.
- **Radiation**: Radiates towards the left axilla and inferior angle of scapula.
- **Maneuvers**: Louder when the patient is made to squat or after the handgrip.

- Tricuspid Area: • S1 and S2 heard.
 - No murmurs or added sounds.
- Aortic Area: • S1 and S2 heard.
 - No murmurs or added sounds
- Pulmonary Area: • S1 and S2 heard.
 - No murmurs or added sounds.

Examination of other Systems

GI Examination :

- Soft, non-tender abdomen.
- No organomegaly
- No Ascites

Respiratory System :

- Breath Sounds → Vesicular.
- No Rhonchi
- No Crepitations

Nervous System :

- Higher mental functions are normal.
- No focal neurological deficits.

Diagnosis

- A case of acquired valvular heart disease possibly rheumatic etiology involving the mitral valve in the form of chronic severe mitral regurgitation, now complicated with atrial fibrillation with rapid ventricular response and left heart failure with no signs of Infective Endocarditis.