

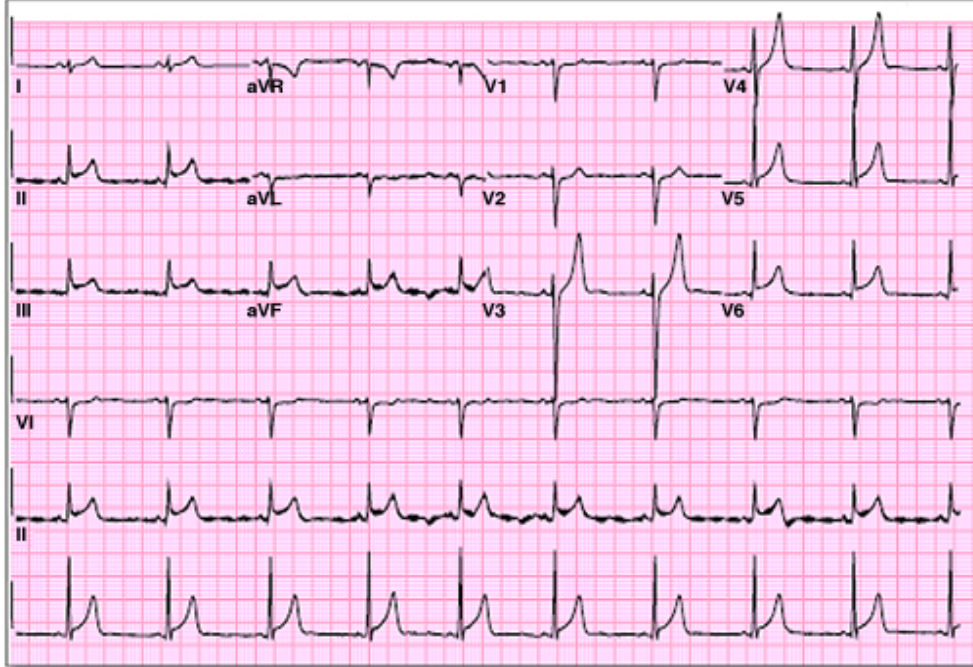
HOLY C.O.W.!

IT'S...

**Clinical Question of the Week #3
July 14th, 2008 through July 21st, 2008**

Please e-mail your answers to Kuo, Tim, Wendy, or Kevin (klian@mednet.ucla.edu; tprovias@mednet.ucla.edu; wsimon@mednet.ucla.edu; kbreger@mednet.ucla.edu) by 0800 on Monday, July 21st, 2008. The resident or intern with the most correct answers at the end of each month will receive a prize!

Case: A 22 year old male without past medical history presented to the ED after being awakened from sleep several hours prior by constant, pressure-like substernal chest pain associated with dyspnea and diaphoresis. He denied palpitations, swelling, or orthopnea, and had never had these symptoms before. History was negative for illicit drug use, alcohol, smoking, or herbal medication use. Review of systems was notable for a recent viral upper respiratory infection. Vital signs revealed BP 115/70, HR 70, RR 12, and oxygen saturation 99% on room air. Physical examination was notable for mild bibasilar crackles on lung auscultation and a normal cardiac examination including normal left ventricular impulse, normal S1/S2 sounds, no murmurs, clicks, rubs, or gallops, no bruits, and normal jugular venous pressure. Laboratory evaluation was notable for elevated CK total of 400 U, CKMB 60 ng/ml, and Troponin-I of 4.0 ng/ml, rising to 11.0 ng/ml six hours later. Other laboratory values including CBC, chemistries, urinalysis, and urine toxicology screen were unremarkable. EKG is shown below. Echocardiogram revealed mildly depressed LVEF of approximately 45% and a small effusion without any evidence of RV compression.



Questions:

1. What is the diagnosis?
2. How often does one see elevated cardiac enzymes with this diagnosis?
3. What is the standard initial workup (i.e. basic labs, other studies) to evaluate a patient with this presentation?
4. What is the management?