CARDIOGENIC SHOCK
CASE PRESENTATION

PRESENTER:
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Clinical history

- NM a 42yr/F a known patient with rheumatic heart disease and heart failure was on po lasix 40mg ,spironolactone 25mg od ,warfarin 5mg and sacubitril –valsartan 49/51mg for over 3 years poor drug adherence .
- She was brought to A/E on 11th/10/2023 with 1 week history of progressive worsening shortness of breath , exertional dyspnea,palpitations ,dizziness , paroxysmal nocturnal dyspnea and lower limb swellings .
- She reported no symptoms of loss of consciousness or convulsions.

Primary survey

Airway	Patent Patient able to talk	
Breathing	Obvious respiratory distress with lower chest depression , RR 42b/m ,spo2 75% room air ,bilateral air entry, no crackles or rhonchi	Oxygen therapy 15litres/minute via NRM – spo2 96%
Circulation	cold extreamities, jugular venous distension , CRT>4sec HR 154b/m reduced volume irregular irregular Bp. 66/29mmgh MAP 49,distended jvp, Hs 1n 11 heard with loudest murmur at mitral	Iv fluids n/s 1 litre start Iv norepinephrine 60mcg/hr infusion Iv dobutamine 6mcg/mg titrate accordingly to effect MAP >65 Blood samples taken : CBC, RFTS, LFTS AND Serum electrolytes.

Disability	Alert GCS-15/15 pearl RBS 3.1mmol/l	
Exposure	Cold extremities Anuria for 24 hours Abdomen normal fullness no obvious abnormalities	Iv fluids n/s 1 liter start urethral catheterization inserted , sample for urinalysis and Rfts taken

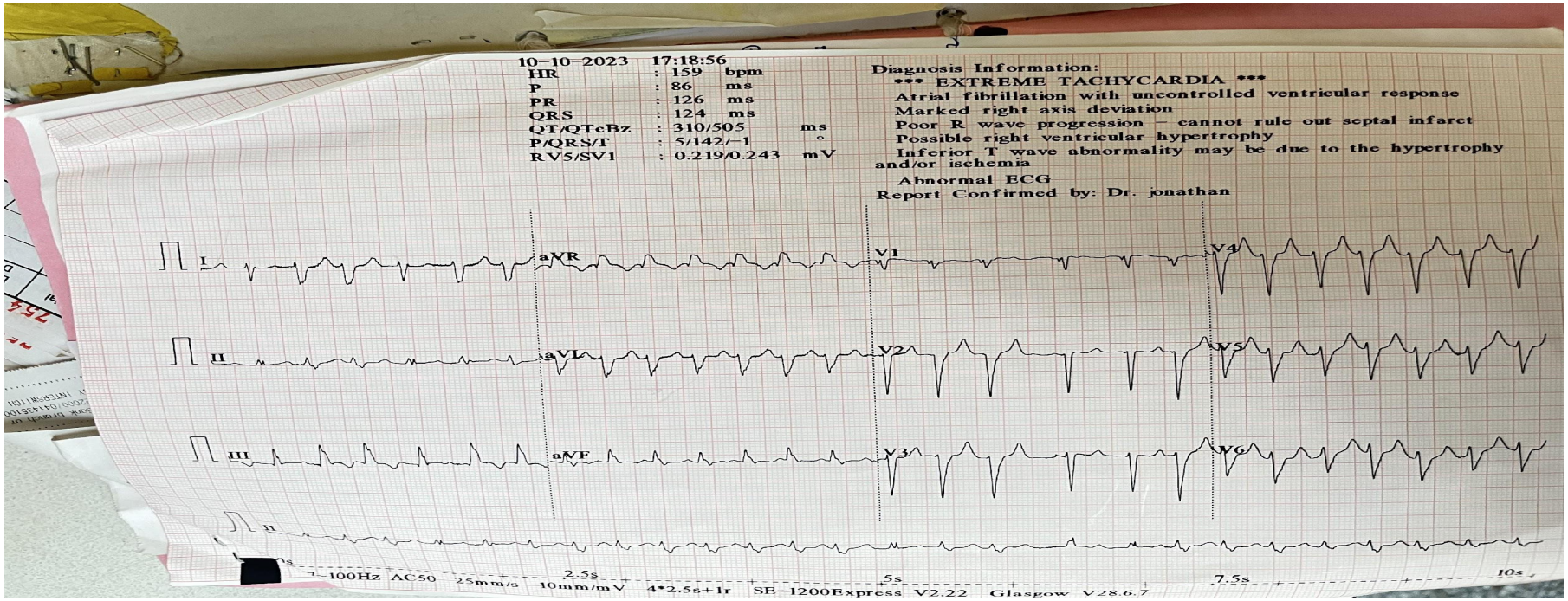
SAMPLE HISTORY

S	Signs and symptoms	Shortness of breath for 1/52 associated with palpitations , left sided dull chest pain , orthopnea , exertion dyspnea and lower limb swellings Anuria x 24 hours
A	Allergies	No known food or ay drug allergies
M	Medications	Po lasix 40mg ,spironolactone25mg,warfarin 5mg ,bisoprolol 5mg and sarcobitril /vasartan
P	Past medical History	Had 2 admissions at in past 1 month prior to admission On 12th-09 -2023 she was admitted at cardiology ward due to RHD with severe Afib and acute decompensated heart failure(ADHF) , discharged on 15th-09-2023 Readmitted on 25th -09-2023 at cardiology ward due to ADHF , severe A-Fib and acute AKI Discharged on 5th -10-2024 following marked improvement .
L	Last meal	Supper the previous night
E	EVENTS	No traumatic events or aura

Investigations

- ECG-features of Afib marked rt axis deviation,ventricular tachycardia -156
- Rfts –creatinine2.91(0.5-1.2)H, urea 49(7-18)H,k+6.68(3.6 -5.3)
- LFTS-elevated
- Cbc-WBC 21k/ul (3.2-9),neu 18.4(1.7 to 7.7) HB8.3g/dl PLT136
- Rbs -5.6mmol/l

ecg


10-10-2023 17:18:56
HR : 159 bpm
P : 86 ms
PR : 126 ms
QRS : 124 ms
QT/QTcBz : 310/505 ms
P/QRS/T : 5/142/-1 °
RV5/SV1 : 0.219/0.243 mV
Diagnosis Information:
*** EXTREME TACHYCARDIA ***
Atrial fibrillation with uncontrolled ventricular response
Marked right axis deviation
Poor R wave progression - cannot rule out septal infarct
Possible right ventricular hypertrophy
Inferior T wave abnormality may be due to the hypertrophy and/or ischemia
Abnormal ECG
Report Confirmed by: Dr. jonathan
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
II
2.5s
5s
7.5s
10s
25mm/s
10mm/mV
4*2.5s+1r
SR 1200Bxpress V2.22 Glasgow V28.6.7

Problem list

- A known RHD with severe A fib and ADHF
- Acute kidney injury with hyperkalemia
- Cardiogenic and septic shock

Treatment and follow up

- 12th/10/2023 : patient was transferred to medical HDU , still in cardiogenic shock with bps 65/38mmmgh pr 154b/m MAP 53 CRT >5sec ,RR 30b/m spo2 96% on 15/l of oxygen.still anuric ,GCS 15/15
- Ecg done and suggestive features of atria fibrillation
- The patient was sedated with iv ketamine 100mg iv and performed synchronised cardioversion at shock of 100j.normal sinus was sustained
- Patient arrested after 18 minutes with PEA, CPR initiated , given adrenaline boluses of 1mg every 5 minutes and endotracheal intubation . Sustained pulse VT defibrillation at 200j.
- Arrested 3 times .CPR was unsuccessful.

- Thank you