A Startling Response to Flecainide

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Give It a Shot(Put): Teenage Baseball Player With Elbow Pain
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Mentor: Jason Meredith
Program: Family Medicine
Type: Case Report

Background: In young athletes, particularly those performing repetitive overhead motions, significant stress is placed on still-developing elbow structures. We present a case of a young baseball player with medial elbow pain.

Case: A 14-year-old right-hand-dominant male presented to clinic during spring baseball season for evaluation of sharp right medial elbow pain. He first experienced the pain 6 weeks prior after attempting to throw a shot put in an overhand pitching motion. Since onset, his pain had lingered when participating in baseball activities, initially only with throwing but began occurring with hitting as well. The pain improved with a few days' rest but immediately returned with resumption of baseball activities. Examination demonstrated tenderness to palpation over the medial epicondyle and ulnar collateral ligament (UCL). A full range of motion was present. Pain was present with resisted pronation/supination and valgus stressing. The Milking maneuver was negative. Plain films demonstrated widening of the medial epicondyle apophysis. The patient completed 6 weeks of complete restriction of throwing and hitting, followed by a graded return to throwing program and physical therapy. He successfully returned to baseball activities. Patient consent was obtained to use this case for educational purposes.

A Startling Response to Flecainide
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Mentor: John L. Smith
Program: Family Medicine
Type: Case Report

Background: Flecainide is a class 1c antiarrhythmic that has off label uses for premature ventricular contractions (PVCs) with grade G evidence. Listed adverse reactions include a <1% incidence of speech disturbance or twitching.

Case: A 38-year-old female with reported history of Wolff-Parkinson-White syndrome ( WPW) presented in clinic to establish care. She was referred to cardiology for confirmation of diagnosis and subsequently underwent ablation of her accessory conduction pathway. Five days later, she presented to the emergency department for shortness of breath and chest pain. She was admitted for workup, observation, and left heart catheterization. Her workup was negative for acute abnormalities and she was discharged. Two days later, she followed up in cardiology clinic with persistent chest pain and dyspnea, and was re-admitted for right heart catheterization (RHC). During RHC, she was found to have frequent PVCs in a bigeminy pattern, which were most prominent when the patient was placed in a wedge position. That night, Flecainide was initiated to treat the symptomatic PVCs. Early the following morning, a rapid response was called due to uncontrollable spontaneous vocal outbursts, stuttering, facial tics, and involuntary movements. Over the following three days, an extensive neurologic workup proved negative. Vocal and motor tics persisted despite initiation of an antipsychotic medication. Finally, Flecainide was discontinued and her symptoms markedly improved within 24 hours. She was transitioned to propranolol with no recurrence of either cardiac or neurologic symptoms. Patient consent was obtained to use this case for educational purposes.

No Rest, All Play: A Case of Pediatric Foot Pain
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Mentor: T. Jason Meredith
Program: Family Medicine
Type: Case Report

Background: Bone stress injuries account for up to 10-20% of sports medicine visits. Stress reactions have imaging evidence of trauma such as bone marrow edema, but lack the cortical break seen in stress fractures.

Case: An 11-year-old male athlete presented to clinic with one month of right foot pain. Patient was playing multiple sports simultaneously. He denied acute injury.

Bone stress injuries occur along a continuum; thus, early identification leads to improved outcomes as certain locations may progress to fracture. This case highlights the importance of early identification of bone stress injuries within a pediatric patient.

Patient was pain free at rest but endorsed medial and anterior right foot pain that was particularly worse with running or jumping. Exam was notable for pain with palpation over the navicular bone and significant discomfort with the tuning fork test on the navicular bone. Plain films were unremarkable. MRI demonstrated patchy bony marrow edema throughout the fore and midfoot suggestive of a diffuse multisite stress reaction. Management included a