Case Presentation: Other studies

- CXR: Bibasilar subsegmental atelectasis or scarring, possible small bilateral pleural effusions, prominent cardiac silhouette
- EKG: Sinus rhythm, LAD and non-specific T wave abnormalities in the lateral leads, ventricular bigeminy
Summary statement and Differential diagnosis

- 84 y/o M with a PMHx of HLD and last negative stress in 2009, ED, ampullary mass s/p ERCP and removal with negative pathology, inflammatory polyarthritis arthritis and GERD with Shatzki’s ring s/p dilation 2009 who presents with shortness of breath, chest pain and fevers to 102 who on physical exam shows an abnormal breathing pattern, JVP wnl, normal cardiac exam, crackle in the lower 1/3 of the lung fields, trace BLE edema and other testing pertinent for an enlarged cardiac silhouette on CXR.
Case Presentation: Differential Diagnosis

- Pulmonary embolus
- Acute Coronary Syndrome
- Community Acquired Bacterial Pneumonia with parapneumonic effusion
- Influenza pneumonia
- Acute Congestive Heart Failure
- Pericardial Effusion
- Pericarditis
- Systemic Lupus Erythematosus
- Aortic Dissection
- Pulmonary Infarction
- Esophageal rupture (Boerhaave’s syndrome)
- Reactivation TB
Case Presentation: Work up

- What diagnostic tests would you order next?
Case Presentation: Work up Part 2

- Troponin, CK-MB
- TSH
- Lyme Titer
- TTE or TEE
- Pulsus paradoxus
- CTA of the chest
- TSH
- Influenza A/B swab
- HIV
- RF, ESR, CRP, ANA, Complements
- Bronchoscopy with BAL and biopsy
Troponin: Negative X 3
CRP 136.8, ESR 29
Lyme Ab: negative
Legionella: antigen negative
TSH: 7.580
Influenza swab not done
Case Presentation: Further Work up

- A diagnostic test was ordered.....
CPC: Diagnostics Exams

- Dr. Joe Kannam, MD
Case Presentation: Follow up

- Patient was transferred to BIDMC, were pulsus was noted to be 20 and he received a pericardiocentesis where 520 cc of hay colored fluid was removed, TTE showed resolution.
- Fluid showed: WBC’s 3550 with 85% polys and 5% lymphs, path negative for malignant cells, numerous neutrophils and reactive mesothial cells.
- ANA was positive with a 1:160 titer (nucleolar) RF 21 (norm 10-14), quantiferon gold: indeterminate, CCP antibody: negative.
- Discharge on ibuprofen 600 TID X2 weeks and Colchicines 0.6 BID X 6 months, effusion presumed to be due to viral etiology.
- 4-5 days after discharge represented to PCP with los of energy, weakness, SOB and pleuritic CP, pursed lip breathing.
- TTE showed moderate-large sized effusion without tamponade (but abnormally pronounces respirophasic variation of ventricular outflow, early hemodynamic compromise), with evidence of pericardial thickening and consolidation with a WBC 23K and creatinine 1.48 (norm baseline) pulsus was 18.
Sent to BIDMC and was sent for a left anterior thoracotomy with pericardial window by thoracic surgery, 1L of pleural fluid was found in addition to a moderate sized fluid pocket posteriorly behind the LV up to the LA (loculated), 4X6 cm window was removed
- Pericardium showed pathology consistent with fibrinous pericarditis
- Pericardial fluid was negative for malignant cells and positive for lymphocytes
- Course complicated by pneumonia, small apical pneumothorax and SVT and atrial fibrillation
Outpatient Follow up

- Interval follow up by Cardiology shows complete resolution
- Complains of arthralgias, pending Rheumatology referral, completed 6 months course of Colchicine
Thank you!

- Questions?