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FIT Clinical Decision Making

NECK PRESSURE AND SHORTNESS OF BREATH, IT IS TIME TO CALL THE SURGEON

Poster Contributions

Hall C

Sunday, March 30, 2014, 9:45 a.m.-10:30 a.m.

Session Title: FIT Clinical Decision Making: Heart Failure / Cardiomyopathies

Abstract Category: Pericardial Disease

Presentation Number: 1172-18

Authors: *M Chadi Alraies, Hiraad Yarmohammadi, Wael AlJaroudi, Allan Klein, University of Minnesota, Minneapolis, MN, USA***Background:** Pericarditis diagnosis and management can be challenging requiring surgical intervention even in young healthy individuals.**Case:** A 23-year-old lady presented with two months history of progressive neck pressure and dyspnea on exertion. She recalls having flu-like symptoms few months prior to her presentation and was treated with over-the-counter medications. She had two hospitalizations for increased shortness of breath for assumed bronchitis. On physical examination, she was tachycardic at 112 beats per min and she had elevated JVP 14-16 cm H₂O with sharp x and y descents, and pericardial rub.**Decision-making:** ECG showed sinus tachycardia. Laboratory workup showed elevated CRP and ESR. CT of the chest showed pericardial effusion. Echocardiogram revealed organized anterior pericardial effusion adjacent to the RV free wall that also appeared severely thickened with abnormal septal bounce and normal EF (60%). Cardiac MRI showed a large pericardial effusion compressing the right ventricle, mild pericardial thickening with circumferential pericardial enhancement consistent with effusive constrictive pericarditis. She was treated with indomethacin, colchicine and furosemide. Few weeks later, indomethacin was switched to aspirin and prednisone was initiated too due to worsening symptoms. Her symptoms improved slightly over a period of a month as well as her inflammatory markers ESR and CRP; however, she could not tolerate the prednisone and had recurrent symptoms of neck pressure and dyspnea on exertion with ongoing taper. Follow-up cardiac MRI showed no improvement. Extensive rheumatology and infectious worked up was negative. Due to limited options, azathioprine was started with minimal symptoms relief. At this point decision was made to undergo a total pericardiectomy. Surgical pathology showed organizing granulation tissue with neovascularization and mild fibroblastic proliferation. Her symptoms have resolved since surgery.**Conclusion:** Surgical pericardiectomy is virtually never required for the treatment of acute pericarditis. This case highlights the proper work up and medical treatment that should be attempted before considering invasive surgical therapy.