

# A 38-Year-Old Man With a 2-Month History of Fever, Cough, Palpitations, and Weight Loss



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**CASE PRESENTATION:** A 38-year-old man of Indian origin, who migrated to Greece 13 years prior to presentation, was admitted to our hospital with a 2-month history of nonprogressive, intermittent (mostly evening), low-grade (up to 38.5°C) fever, accompanied by night sweats, dry cough, mild dyspnea on exertion (modified Medical Research Council Dyspnea Scale grade 1), anorexia, fatigue, and weight loss of 10 kg. He also experienced continuous palpitations, which were regular, not associated with chest pain or dizziness, and aggravated on exertion. He had not taken any medication for his condition, except for antipyretic agents, nor had he sought medical advice. He was a nonsmoker, had a history of past alcohol dependence, and had been hospitalized twice for acute pancreatitis due to hypertriglyceridemia. He had also been diagnosed with diabetes mellitus, presumably poorly controlled because he mentioned not taking any medication or having regular follow-up. CHEST 2018; 154(4):e101-e105

## Physical Examination Findings

Upon admission, the patient had a temperature of 38°C, heart rate of 130 beats/min, and normal BP, respiratory rate, and oxygen saturation. Physical examination revealed reduced breath sounds with dullness to percussion in both lower lung fields and a pleural friction rub on the right side. On cardiac examination, S1 and S2 were present with no additional sounds or murmurs; the patient's heart rhythm was regular. He had no signs of lymphadenopathy, clubbing, orthopnea, jugular venous distention, or peripheral edema.

## Diagnostic Studies

The patient's initial laboratory test results revealed hyperglycemia (198 mg/dL), mild hyponatremia (130 mmol/L), hypoalbuminemia (3.2 g/dL), and

elevated C-reactive protein levels at 92.6 mg/L (normal < 3 mg/L). His thyroid function and troponin levels were within normal limits, whereas his glycosylated hemoglobin level was 8.3% (normal < 6%), indicating poor glycemic control. His chest radiograph depicted blunting of the costophrenic angles, suggestive of bilateral pleural effusions. His ECG was notable only for sinus tachycardia. His tuberculin skin test result was 20 mm. A diagnostic thoracentesis showed characteristics of lymphocytic exudate (cell count 1,570/μL, 98% lymphocytes, lactate dehydrogenase 386 U/L, and total protein 5.56 g/dL) with elevated levels of adenosine deaminase (88.7 U/L) and negative acid-fast bacilli (AFB) stain, culture for aerobes and anaerobes, and cytologic examination for malignancy. A chest CT scan revealed bilateral pleural effusions and a cavitary

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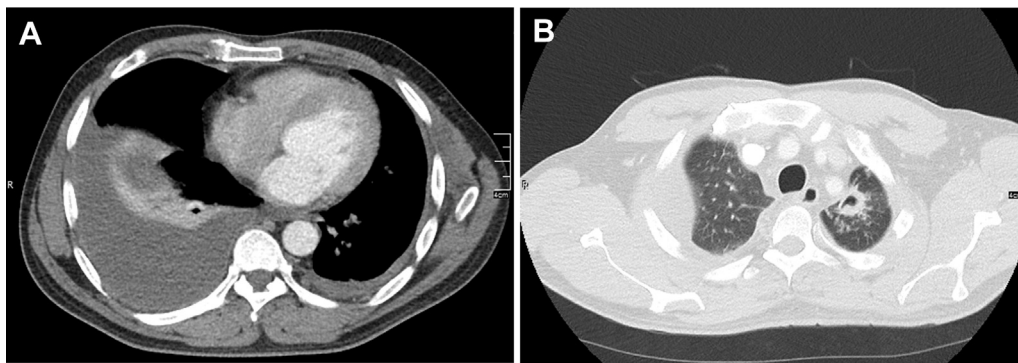


Figure 1 – Chest CT scan showing (A) bilateral pleural effusions and (B) a cavitary lesion in the apicoposterior segment of the left upper lobe.

lesion in the left upper lobe accompanied by “tree-in-bud” consolidation (Fig 1). His serologic test result was negative for HIV, and AFB stains were negative in the gastric aspirate, sputum, and BAL samples.

During the patient’s hospitalization, he experienced an episode of paroxysmal supraventricular tachycardia of sudden onset (Fig 2A) that required conversion with adenosine. The echocardiogram revealed an enlarged left ventricle with global hypokinesia (Video 1) and severe systolic dysfunction with an ejection fraction of 30%; left ventricular (LV) end-systolic and end-diastolic

dimensions were 52 and 62 mm, respectively (Fig 2B). His brain natriuretic peptide levels were normal. A subsequent cardiac MRI depicted LV dilation and the presence of linear and nodular areas in the subepicardial and mid-wall layers of the interventricular septum and the inferior and lateral wall of the left ventricle, exhibiting high signal in the T2 images and delayed enhancement following intravascular injection of gadolinium (Figs 2C, 2D). A further diagnostic evaluation with immunoassays was positive only for old Epstein-Barr virus and herpes simplex virus infections, indicated by elevated IgG antibodies.

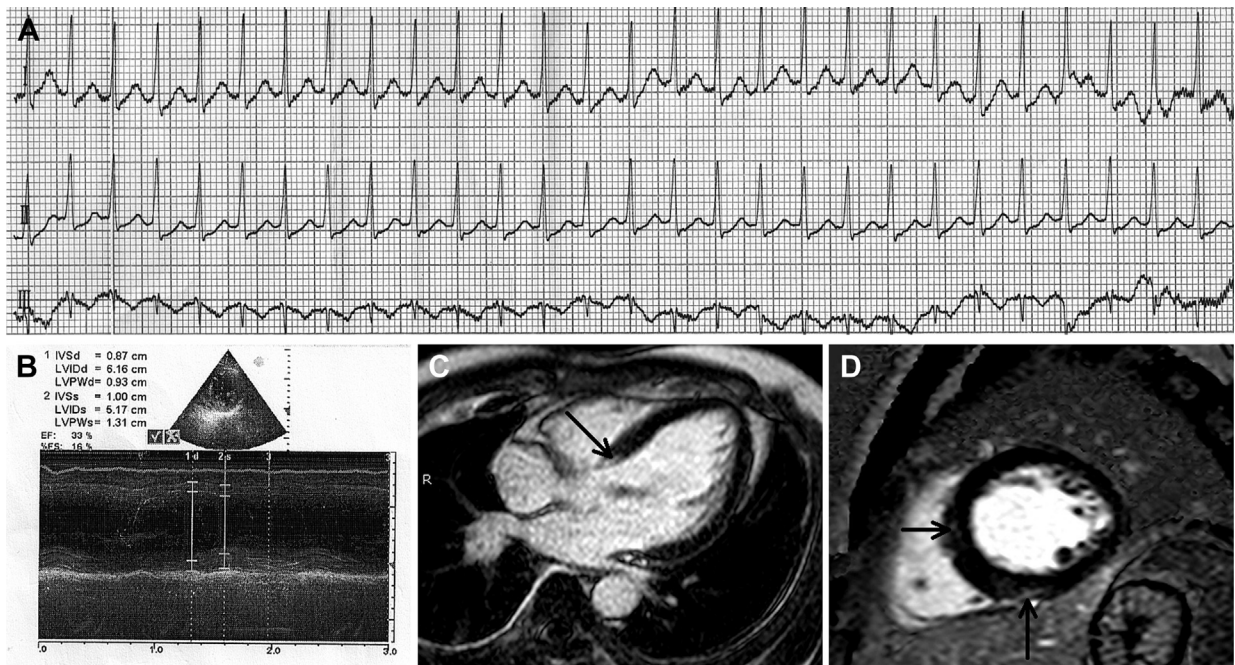


Figure 2 – A, ECG leads I, II, and III during an episode of paroxysmal supraventricular tachycardia (190 beats/min). B, Assessment of left ventricular ejection fraction via echocardiography. Cardiac MRI late gadolinium-enhanced phase-sensitive inversion recovery images, (C) four-chamber view and (D) two-chamber view. The imaging revealed multiple linear and nodular enhancing lesions in the inferior and septal left ventricular wall (arrows), suggesting the presence of myocardial inflammation or fibrosis.

*What is the diagnosis?*

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