

A 62-Year-Old Woman With Acute Respiratory Failure and a Painful Right Lower Limb



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CASE PRESENTATION: A 62-year-old woman with no medical history was admitted to the ED for fever, acute respiratory failure, and pain in the right lower limb. Three months prior to presentation, she had spent 45 days travelling through India and Thailand. She presented with no signs of traveler's disease such as fever or diarrhea during that trip. Two weeks following her return to France, the patient presented with an episode of bronchitis and received 5 days of treatment with cefixime (a third-generation cephalosporin). Despite this antibiotic treatment, her symptoms worsened and she developed, over the following 3 weeks, general weakness and arthralgia/myalgia. Due to the severity of hypoxemia, the patient was immediately transferred to the ICU. CHEST 2018; 154(4):e107-e111

Physical Examination Findings

The patient's hemodynamic examination revealed a heart rate of 115 beats/min and BP of 112/35 mm Hg. Her temperature was 38.5°C. Cardiac auscultation revealed a regular rhythm and a grade III/IV diastolic murmur. Her respiratory rate was 28 breaths/min, and her oxygen saturation was 96%, with 50% oxygen inspired fraction and 50 L/min gas flow. Urinary catheterization revealed oliguria with a urine output < 0.3 mL/kg/h over the first 4 h. Her abdomen was soft and not distended. The clinical examination revealed a cold, pale, and pulseless lower right limb, and the neurologic examination was significant for decreased cutaneous sensitivity in the same limb.

Diagnostic Studies

The patient's chest radiograph revealed bilateral pulmonary edema and right-sided pleural effusion (Fig 1). Transthoracic echocardiogram showed thickening of the aortic cusps (Fig 2A), preserved

biventricular morphology and function, mild pericardial effusion, and bilateral pleural effusions. The color Doppler examination showed severe aortic regurgitation (Fig 2B). Transesophageal echocardiography revealed a tricommissural aortic valve, with small vegetations on the three cusps (Video 1) and confirmed the severity of the aortic regurgitation (Video 2). CT angiography showed the presence of a thrombus in a preexisting right external iliac artery stenosis and confirmed the diagnosis of acute right lower limb ischemia (Fig 3).

Due to the severity of the patient's heart failure, urgent cardiac surgery involving an aortic valve replacement with a bioprosthesis was performed. Surgical inspection of the aortic valve revealed an unusual thrombotic aspect. Simultaneously, a femorofemoral crossover bypass graft was performed to restore right lower limb perfusion, and curative anticoagulation was started with IV unfractionated heparin. Results of all blood cultures

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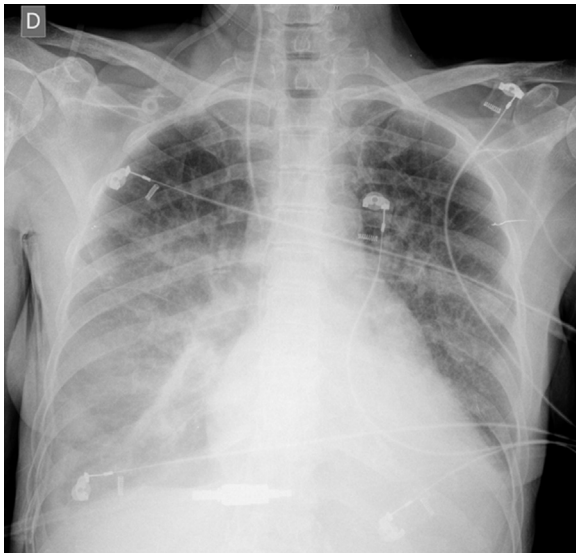


Figure 1 – Bilateral pulmonary edema and right-sided pleural effusion on the chest radiograph.

since the patient's hospital admission were negative. Moreover, results of all microbiologic investigations, including serology and serum polymerase chain reaction specific for rare causes of blood culture-negative infective endocarditis, were also negative. Pathologic examination of the resected aortic valve identified a preserved valvular structure and a thrombotic lesion, with aggregated platelets surrounded by fibrin (Fig 4). After stopping sedation, the patient woke up with complete right hemiplegia. The cerebral CT angiography revealed thrombosis of the left middle and right posterior cerebral arteries, with signs of established cerebral infarcts. Low hemoglobin levels (9.3 g/dL) and thrombocytopenia ($73,000 \text{ per mm}^3$) were found on the

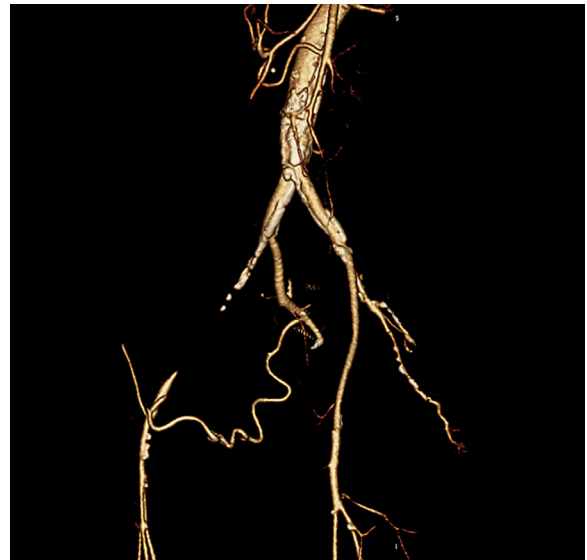


Figure 3 – Three-dimensional reconstruction of CT angiography (left anterior oblique view) showing the site of thrombosis in the right external iliac artery. Calcified aortic bifurcation and common iliac arteries are shown. Residual perfusion of the right femoral artery results from a branch of the internal iliac artery.

postoperative hemogram. Activated partial thromboplastin time was 81 s (normal value: 23-38 s), and the international normalized ratio was 1.43 (normal value: 0.9-1.2). Results of the anti-PF4 antibody test were negative. Autoimmune disorders were excluded by negative anti-nuclear, anti-double-stranded DNA and anti-neutrophil cytoplasmic antibodies. Immunologic assays for antiphospholipid syndrome, including IgG and IgM of anticardiolipin and anti- $\beta 2\text{GPI}$ antibodies, were also negative. No pathologic activation of complement was found (normal CH50).

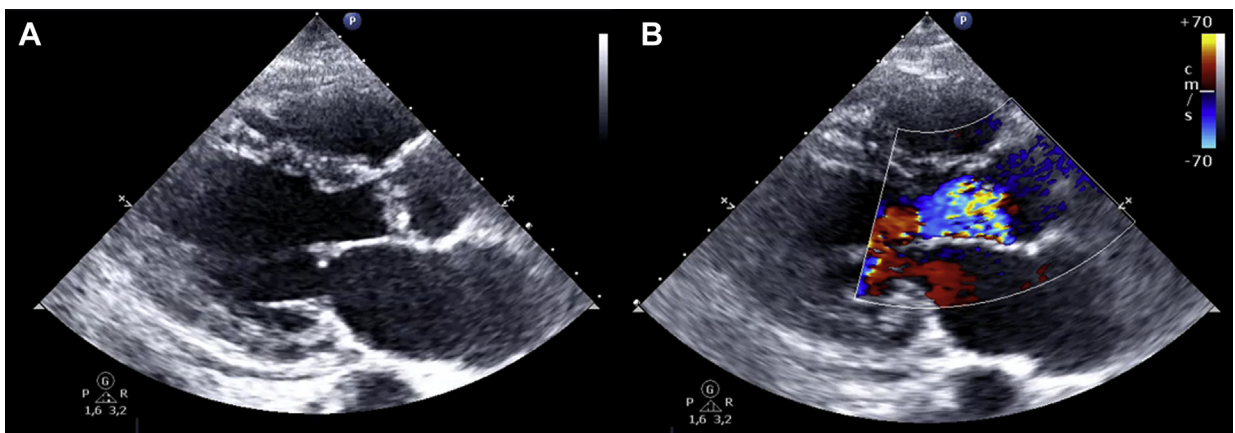


Figure 2 – Long-axis parasternal view with transthoracic echocardiography revealed (A) thickening of the aortic cusps and (B) severe aortic regurgitation with color Doppler imaging.

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