CHEST

An Unusual Case of Postpartum Dyspnea

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VIDEO

A 40-year-old South Asian woman was admitted in active labor at 38 weeks' gestation. She had an unremarkable medical history with routine prenatal care, negative HIV testing results, and an uneventful pregnancy. She received a Bacillus Calmette-Guérin vaccine during childhood and reportedly had a subsequent positive purified protein-derivative test result 1 year prior to conception. She never smoked and had seven normal term pregnancies.

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On her first postpartum day, after an uncomplicated delivery, she complained of mild central chest pain and dyspnea and was noted to be febrile at 38.3°C. She was empirically treated for suspected postpartum endometritis by the obstetric team. Initial workup results, including a portable chest roentgenogram (CXR), urine cultures, and blood cultures, were negative for other sources of infection. On postpartum day 3, she developed progressive dyspnea with two-pillow orthopnea and worsened central chest pain. She was hypotensive (BP, 80/40 mm Hg); tachycardic (heart rate, 120 beats/min); and tachypneic, with oxygen saturation via pulse oximetry of 97% on room air; with a worsening fever of 39.7°C. Examination findings included an elevation in her jugular venous pulsation, muffled heart sounds with a regular cardiac rhythm, radial pulsus alternans, and peripheral pitting leg edema. Lung examination revealed diminished bibasilar air entry, bronchial breath sounds, and bilateral crackles.

A CXR on day 3 showed a globular-shaped heart, small bilateral pleural effusions, Kerley B lines, and upper lobe and hilar vascular prominence (Fig 1A). An ECG showed sinus rhythm, low voltage QRS complexes in the inferior leads, and electrical alternans (Fig 1B). A bedside echocardiogram confirmed the presence of a large, circumferential, pericardial effusion that measured 3.2 cm in its largest dimension with $>25\%$ respiratory variation of transmitral flow (Fig 1C, Video 1). Strands and echogenic densities were noted in the pericardial fluid, suggesting an exudative process. The inferior vena cava was enlarged and lacked normal respiratory variation. An emergency pericardiocentesis was performed with the removal of 850 mL of serosanguinous pericardial fluid, which restored hemodynamic stability.

Pericardial fluid analysis was remarkable for a WBC count of 4,733 cells/μL with a lymphocyte predominance (91%) and an RBC count of $>70{,}000$ cells/μL. Cytologic evaluation revealed numerous small lymphocytes, rare reactive mesothelial cells, and fibrin. The lymphocyte analysis showed a mixed population of T (CD3 positive), and B (CD20 positive) cells with negative cyclin D1, consistent with a reactive non-neoplastic process. Periodic acid-Schiff, Gomori-Grocott methenamine silver, and gram stains were negative. A hematoxylin-and-eosin stain revealed a homogenous collection of lymphocytes (Fig 1D). Further biochemical analysis of the pericardial fluid confirmed our clinical suspicion.

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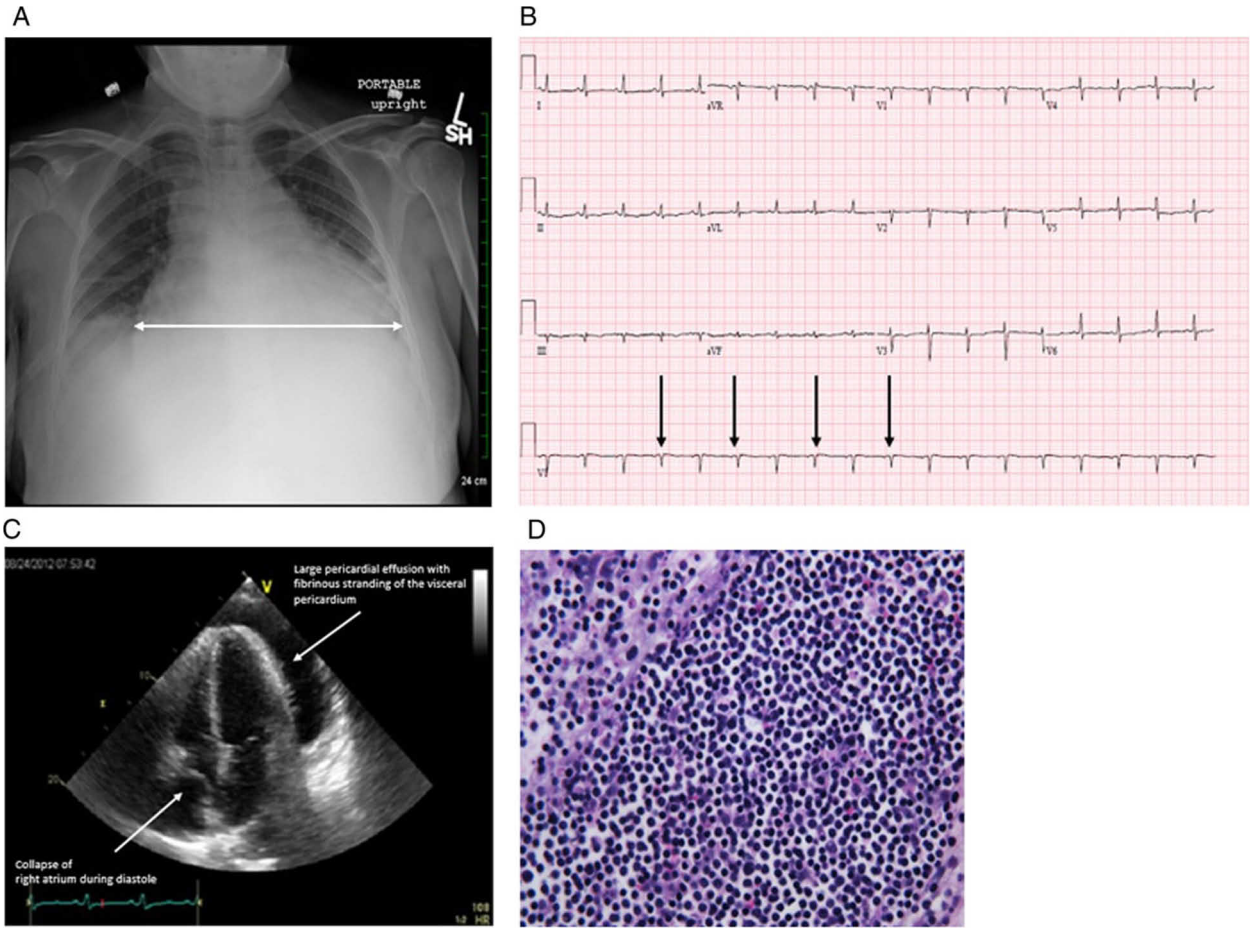

Figure 1 – *A, Portable erect chest roentgenogram showing a globular heart, moderate-sized bilateral pleural effusions, increased interstitial lung markings, and hilar prominence. B, ECG showing electrical alternans and low-voltage complexes in the inferior leads. C, Two-dimensional echocardiogram demonstrating large pericardial effusion measuring 3.2 cm at lateral wall of the left ventricle, 2.4 cm at the right atrium, and 3 cm anterior to the right ventricle free wall. Right ventricle and right atrium collapse was noted (Video 1). D, Hematoxylin-and-eosin-stained cytospin preparation of pericardial fluid revealing numerous reactive lymphocytes and few mesothelial cells (original magnification × 200).*

What is the diagnosis?

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