



Recurrent Dyspnea Following a Swollen Leg in a 46-Year-Old Man

Judith P. Post, MD; Hans M. Westgeest, MD; Jan D. Blankensteijn, MD, PhD; Bram van der Meijs, MD, PhD; Rob J. L. Klaassen, MD, PhD; Esther Nossent, MD; Katrien Grünberg, MD, PhD; Jan Buter, MD, PhD; and Erik H. Serné, MD, PhD

CHEST 2013; 144(4):1402–1405

A 46-year-old man with no notable medical history presented with a swollen left leg to the ED of a secondary care center. DVT and cellulitis were excluded, and he went home. Several days later, he returned with complaints of dyspnea during exertion, a dry cough, and bilateral lower limb edema. Physical examination showed signs of right-sided congestive heart failure. Subsequent diagnostic assessment excluded pulmonary embolism but demonstrated cephalization of pulmonary vessels, bilateral pleural effusion, hepatic congestion, and elevated N-terminal pro-brain natriuretic peptide levels. Cardiac evaluation demonstrated a normal ECG and no abnormalities on echocardiography, and right-sided heart catheterization was later performed. Meanwhile, the patient had responded well to the initiated loop diuretic with resolution of the dyspnea and pleural effusion. However, the swollen left leg persisted and became painful, which prevented him from going to work. Two months later, the lack of a satisfactory explanation for the clinical picture prompted referral to our tertiary care center.

Physical Examination Findings

A repeated full physical examination showed normal vital signs. Chest auscultation was normal without

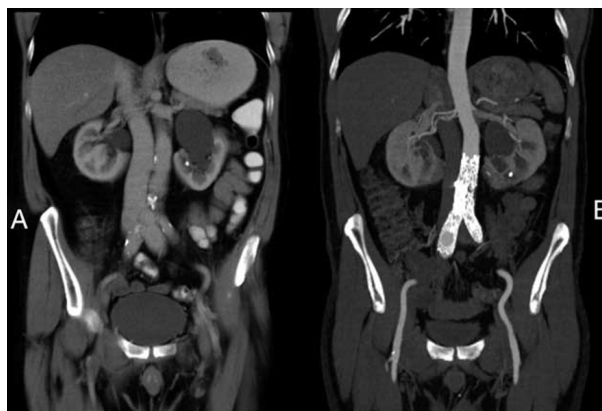


FIGURE 1. A, Abdominal CT scan revealing contrast in the vena cava during the arterial phase. B, Contrast in the vena cava during the arterial phase was no longer apparent after endovascular repair.

adventitious sounds. Abdominal examination revealed a distinct grade V/VI holosystolic machinery murmur in the umbilical region accompanied by a palpable thrill. The abdomen was nontender and without organomegaly. Examination of the extremities confirmed a swollen left leg with extensive distended collateral veins in the groin.

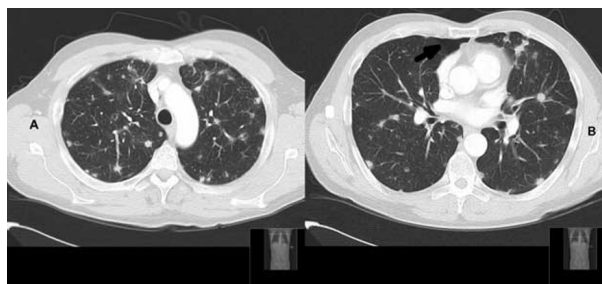


FIGURE 2. A, Chest CT scan revealing multiple bilateral variable-sized cavitating pulmonary nodules. B, Chest CT scan revealing a small asymptomatic pneumothorax (arrow).

Manuscript received February 18, 2013; revision accepted April 3, 2013.

Affiliations: From the Department of Internal Medicine (Drs Post and Serné), Department of Medical Oncology (Drs Westgeest and Buter), Department of Vascular Surgery (Dr Blankensteijn), Department of Radiology (Dr van der Meijs), Department of Pulmonary Medicine (Dr Nossent), and Department of Pathology (Dr Grünberg), VU University Medical Center, Amsterdam; and the Department of Internal Medicine (Dr Klaassen), Zaanse Medical Center, Zaandam, The Netherlands.

Correspondence to: Judith P. Post, MD, Department of Internal Medicine, VU University Medical Center, PO Box 7057, 1007 MB, Amsterdam, The Netherlands; e-mail: jp.post@vumc.nl.

© 2013 American College of Chest Physicians. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians. See online for more details. DOI: 10.1378/chest.13-0390

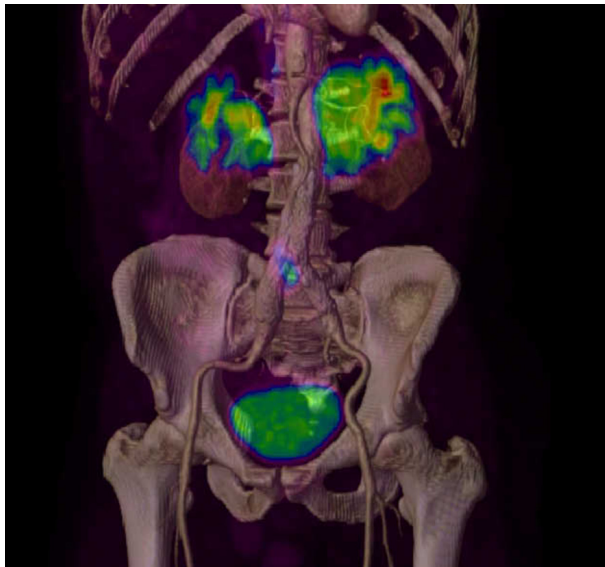


FIGURE 3. PET-CT scan.

Diagnostic Studies

Laboratory investigation revealed normal CBC count, basic chemistry panel, and urinalysis results. N-terminal pro-brain natriuretic peptide level was slightly elevated at 449 ng/L (normal level, < 121 ng/L).

Contrast angiography showed an aortocaval fistula. Abdominal CT scan revealed a dilated left iliac and femoral vein with varicose veins in the groin, mild atherosclerotic calcifications of the aortoiliac region, and an incidental horseshoe kidney, but no apparent cause of the fistula, in particular no aortic aneurysm or perivascular mass. It was decided to perform endovascular repair by placement of a bifurcated stent graft. During the procedure, angiography demonstrated complete cessation of fistula flow, and the massive backflow via arterialized veins resolved. Figure 1 shows CT angiography before and after endovascular repair. Three months later, after initial full recovery, the patient complained of recurrent dyspnea on exertion, a cough, and mild hemoptysis. Chest CT scan demonstrated multiple bilateral variable-sized cavitating nodules and a small asymptomatic pneumothorax (Fig 2). Routine blood test results were all normal and did not show signs of inflammation. Blood cultures showed no growth. An 18-fluorodeoxyglucose (FDG) PET-CT scan was ordered (Fig 3).

What is the diagnosis?

Download English Version:

<https://daneshyari.com/en/article/5955505>

Download Persian Version:

<https://daneshyari.com/article/5955505>

[Daneshyari.com](https://daneshyari.com)