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CASE REPORT

DIAGNOSIS: BILHARZIAL PULMONARY HYPERTENSION WITH PULMONARY ARTERY ANEURYSMAL DILATATION

By
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52 years old male patient named K.A, works as a merchant, lives at Khafr El Sheikh Governorate,Egypt married with 3 offsprings.

The patient is a heay cigarette smoker (50 pack/year).

The patient presented to the Respiratory Intensive Care Unit (RICU) of Ain Shams University Hospital complaining of SOB of one month duration of gradual onset.

The patient reported past history of cardiac troubles of ten years duration & was on regular cardiac medications in the form of diuretics & positive inotropic drugs.

One month before admission, the patient's dyspnea shifted to be on mild exertion along with orthopnea. The condition was associated with bilateral lower & upper limb swelling with disturbed level of consciousness.

The patient sought medical advice and was admitted to the RICU for 12 days. During the hospital stay, the patient received treatment in the form of positive inotropic drugs, diuretics & liver support measures. Abdominal U/S was done & revealed moderate ascites, coarse cirrhotic liver with congested hepatic vein. Echocardiography showed evidence of cor pulmonale with massive pericardial effusion, pericardiocentesis was done, Echo cardiography revealed severe pulmonary hypertension with aneurysmal dilatation of the main pulmonary artery (measuring 11 cm) & its main branches, mild pericardial effusion with dilated right sided structures and severe TR.

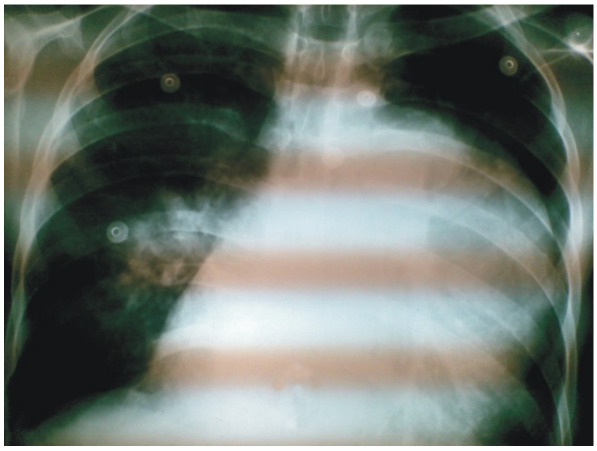
On admission to RICU, patient was conscious, alert, oriented to time, place & person, dyspneic, orthopneic, jaundiced, tachypneic (RR 26/min), blood pressure 100/70 mmHg, congested pulsating neck veins, bilateral upper & lower limb pitting oedema, lax calf muscles with no clinically palpable lymph nodes.

After 1 week, the patient was discharged from the ICU on positive inotropic drugs, diuretics, calcium channel blockers, sildinafil and liver support measures.

Local chest examination revealed diminished chest movement & tactile vocal fremitus over the left infraclavicular & mammary areas with bulge over the same areas, visible left parasternal pulsation & palpable left parasternal thrill. On percussion, there was stony dullness over the left infraclavicular & mammary areas. On auscultation, there was diminished intensity of

harsh vesicular breathing over the left infraclavicular & mammary areas with accentuated second heart sound over the pulmonary area & left parasternal diastolic murmur with maximum intensity over the pulmonary area.

Chest X ray:



(1)

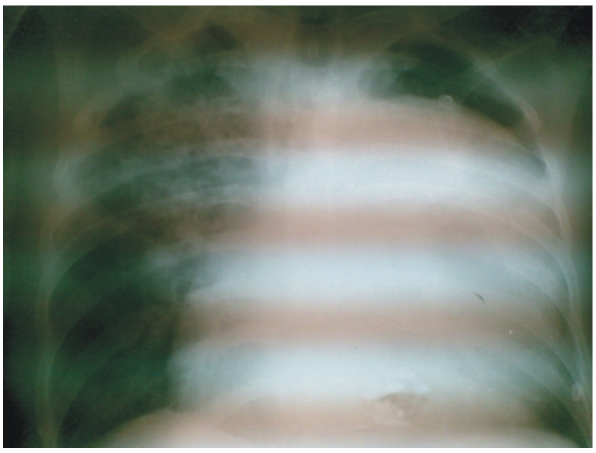
Arterial blood gases was done on room air: PH 7.55, PCO2 43, PO2 56, HCO3 26.5, ABE 3 & SO2 83%.

ECG showed sinus tachycardia, right bundle branch block & right axis deviation.

Laboratory investigations showed: albumin 2.9, total bilirubin 46, direct bilirubin 1.6, prothrombin time 21.2, INR 1.8 & platelet count 89,000.

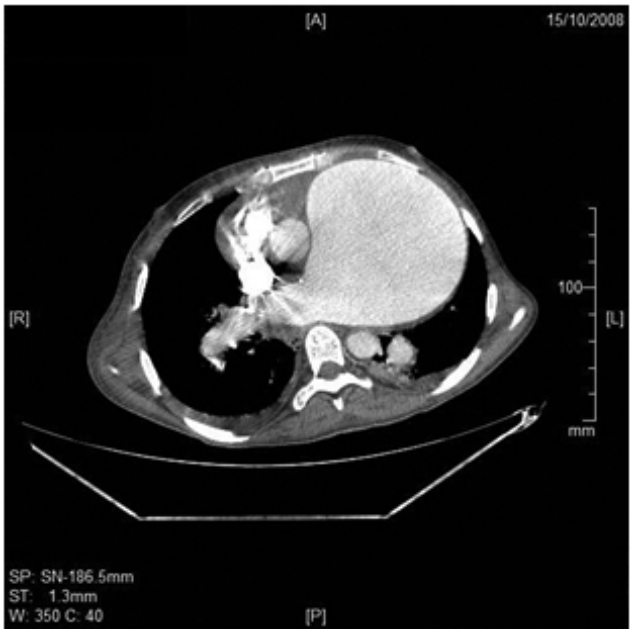
Pericardiocentesis revealed an exudative reaction and culture of the fluid was negative.

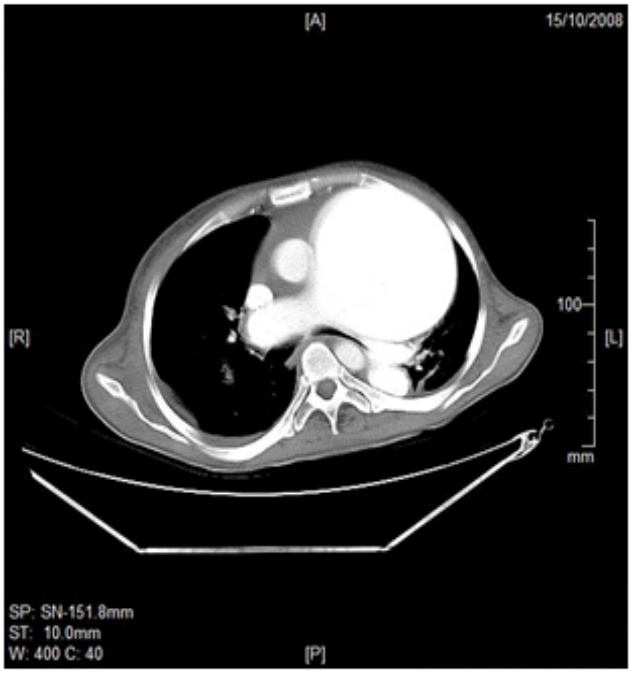
Follow up chest X ray was done.



(2)

Echocardiography revealed: EF 60 %, dilated right ventricle, paradoxical septal wall motion, moderate tricuspid regurge, RVSP 65 mmHg, aneurysmal dilatation of the pulmonary artery with estimated PAP 30 mmHg, dilated right atrium, minimal pericardial effusion & huge pleural effusion. CT scan of the chest with pulmonary angiography was done which showed pericardial effusion,mild bilateral pleural effusions, massive ascitis, bilharzial hepatic changes with secondary pulmonary hypertension (Ayerza's disease).

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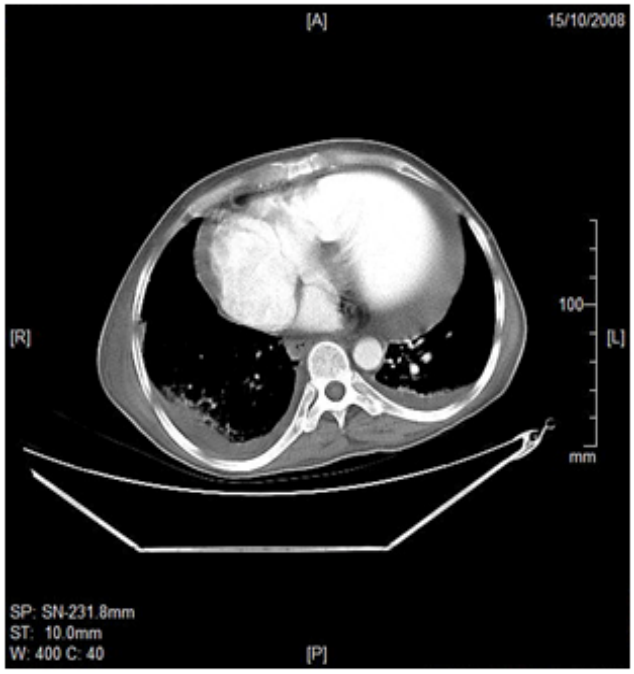
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