Control Number: 26

Abstract Category: Clinical Case Challenge in Cardio-Oncology

Title: Constrictive Pericarditis Due to Tuberculous Etiology in Active Lymphoproliferative Disease: A Clinical Case Challenge

ABSTRACT BODY

Background and Purpose

Oncology patient are susceptible to develop a Pericardial Diseases (PD) which complications may be related to some cancer, chemotherapy, radiotherapy and opportunistic infections. However, Constrictive Pericarditis (CP) is present in 4% of these cases.

Case Description and Outcomes

Female, 26 years-old, without comorbidities, diagnosed with Hodgkin Disease, triggered progressive dyspnea associated with orthopnea. Cardiac tamponade by Transthoracic Echocardiography (TTE) with signs of restriction to ventricular filling was evidenced, and the patient underwent emergency relief pericardiocentesis. Serous fluid and biopsy compatible with nonspecific granulomatous inflammatory tissue, initiating the chemotherapy with Dacarbazine, Doxorubicin and Vimblastine. TTE performed showed no pericardial effusion. After the final cycle, she started with daily afternoon fever and dyspnea with detection of moderate pericardial effusion without restriction, moderate pleural effusion and febrile neutropenia. 18-FDP-PET/CT ruled out recurrence of pericardial lymphoproliferative disease and suggest acute pericarditis (AP). Cardiac Magnetic Resonance (CMR) was performed and confirmed AP. Colchicine and prednisone was prescribed. In outpatient return, she related fever and dyspnea. TTE showed right atrial thrombus and long-term catheter, and a new CMR revealed 3 moving images in the right atrium, close to the central venous catheter, in tricuspid supravalvular topography and demonstrated significant thickening / fibrosis of pericardial leaflets, especially parietal, measuring up to 0.6 cm, suggestive of CP. Hypotheses Thrombus are raised and anticoagulation treatment was started. New 18-FDP-PET/CT ruled out hematologic recurrence and right pleural uptake. Pleural biopsy revealed a tuberculoid-type chronic granulomatous inflammatory process and the treatment was initiated.

Discussion

This case demonstrates that different etiologies of PD may be present in the same patient. Although lymphoma is a frequent cause, other diagnoses should always be ruled out in these patients, especially in patients with pericardial effusions which do not respond to chemotherapy or that develop complications (cardiac tamponade and CP).

References

Adler AC, Cestero C. Symptomatic pericardial effusion in Hodgkin´s lymphoma: a rare occurrence. Case report and review of the literature. Tumori. 2012;98(2):50e-2e

Image 1