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Isolated left ventricular tamponade in a patient with severe pulmonary hypertension due to chronic thromboembolisms: a case report

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A case presents a 37 years old patient who presented to emergency department with progression of dyspnea. Patient had a history of pulmonary hypertension due to chronic thromboembolism and known, repetitive thrombosis of both legs with both of them postthrombotically altered, especially left leg. During his emergency department workup he had a pulmonary angiography performed which showed evidence of old thromboembolism in right pulmonary main branch and circumferential pericardial effusion which was dominantly localized behind left ventricular posterior wall. Emergency echocardiography was performed which showed marked respiratory variations in mitral and aortic flow with mid to late diastolic left ventricular collapse. Also left ventricular cavity was severely reduced (EDD 29 mm) due to prominent interventricular septum (right ventricular pressure overload) and hyperkinetic posterior wall (pericardial effusion). There were no apparent signs of compression of right ventricular chambers. Clinically patient had no pulsus paradoxus and had an RR of 115/70 mmHg. Emergency pericardiocentesis was performed using subxiphoid approach. However, pericardiocentesis setting was challenging because patient also had ample of ascites which made orientation by aspiration impossible. Instead puncture was performed under fluoroscopy while slowly instilling the contrast until contrast was delievered intradiaphragmally. From there needle was advanced 3-4 mm into pericardial cavity and pigtail catheter was placed. A total of 2200 ml of milky pericardial fluid was removed during the following 48 hours (cytology – mixed type; triglycerides 1.9 mmol/L). Patient was initially treated with corticosteroids and colhicin, but had a relapse of pericardial effusion once drainage was stopped so re-pericardiocentesis was performed. This time a total of 7200 ml of pericardial fluid was drained so we opted for pericardial fenestration (into left pleural space). Unfortunately, patient died on the 8th postoperative day due to complications (developed subcutaneous emphysema at the place of insertion of thoracal drainage and developed respiratory, then refractory cardiac arrest).