A 63-year-old woman with no known cardiac history presented with a sudden onset of dyspnea requiring intubation and ventilatory support out of hospital.
She denied preceding symptoms of chest discomfort, palpitations, syncope or infection.
The patient was afebrile and normotensive, with a sinus tachycardia of 140 beats/min.
The cardiorespiratory examination was remarkable for an elevated jugular venous pressure at the angle of the jaw, a left-sided third heart sound and bibasilar crackles in both lung fields.
The complete blood cell count, electrolytes and cardiac biomarkers were within normal limits.
An initial electrocardiogram revealed ST depression in leads V2 to V6, suggestive of anterolateral ischemia (Figure 1).
A chest radiograph demonstrated pulmonary vascular congestion consistent with a diagnosis of pulmonary edema (Figure 2).
An echocardiographic examination revealed normal cardiac dimensions, normal wall motion and mild diastolic dysfunction with an early diastolic to late diastolic transmitral ratio of less than 1, prolonged deceleration time (250 ms) and a reduced early diastolic annular velocity of the lateral mitral valve annulus.
Following aggressive diuresis and requiring minimal ventilatory support, the patient was extubated one day following her initial presentation.
Within 1 h of extubation, the patient developed recurrent pulmonary edema clinically and radiographically, requiring mechanical ventilation.
Cardiac catheterization was performed and revealed normal coronary arteries.
On day 4 of the coronary care unit admission, the patient failed a repeat attempt at extubation.
A computed tomographic scan revealed a 4 cm × 9 cm multinodular goiter extending into the mediastinum and suspected associated tracheal stenosis (Figure 3).
With a diagnosis of NPPE secondary to an enlarged goiter, the patient underwent surgical intervention for a thyroidectomy.
Intraoperative bronchoscopy revealed tracheal stenosis of greater than 50%.
The postoperative course was uncomplicated, and three months following discharge, the patient returned to her previous activity level without subjective dyspnea.