# CONTEXT 1

Title: "BEG\_\_Large posterior vaginal cyst in pregnancy\_\_END"99

Context: "Summary\n\nA 20 - year - old primigravida presented in labour with a BEG\_\_mass\_\_END protruding from her BEG\_\_vagina during uterine contractions\_\_END .\nThe BEG\_\_mass\_\_END was a BEG\_\_large tense cyst\_\_END measuring 8 \u00d7 8 cm arising from the posterior vaginal wall .\nThe BEG\_\_cyst\_\_END was present since puberty but increased in size during pregnancy .\nIt collapsed following BEG\_\_aspiration\_\_END and uneventful vaginal delivery was conducted .\nFollowing delivery , the BEG\_\_cyst\_\_END was excised and vaginal wall repaired .\nOn histopathology the BEG\_\_cyst\_\_END was identified as a BEG\_\_M\u00fcllerian cyst\_\_END .\nThe patient recovered and remained BEG\_\_asymptomatic\_\_END on follow - up .\n\nBackground\n\nBEG\_\_Cystic lesions of the vagina\_\_END are uncommon and usually reported to occur in the third and fourth decades of life .\nNumerous case reports exist where BEG\_\_vaginal cysts\_\_END presented as a BEG\_\_prolapsing mass per vaginum\_\_END or rarely as BEG\_\_cystoceles\_\_END or BEG\_\_enteroceles\_\_END .\nHowever , only a few have reported BEG\_\_vaginal cysts\_\_END encountered during pregnancy and labour .\n1 This case report presents a rare case of a BEG\_\_large posterior vaginal wall cyst\_\_END in a labouring woman where the BEG\_\_delivery\_\_END was conducted vaginally , uneventfully , following BEG\_\_aspiration of the cyst\_\_END along with BEG\_\_cyst excision\_\_END and BEG\_\_vaginal repair\_\_END in the same sitting .\n\nCase presentation\n\nA 20 - year - old unbooked primigravida with full - term pregnancy , BEG\_\_labour pains\_\_END and BEG\_ \_leaking\_\_END per vaginum for 6 h , presented with a BEG\_\_mass\_\_END protruding from her vagina since the onset of BEG\_\_strong labour pains\_\_END .\nThe BEG\_\_mass\_\_END was pinkish in colour , hen 's egg sized and protruded only during BEG\_\_uterine contractions\_\_END ( figure 1 ) .\nDetailed history of the patient revealed that she had first noticed the BEG\_\_mass\_\_END inside the vagina 8 years earlier .\nThe BEG\_\_mass\_\_END was pea sized and BEG\_\_asymptomatic\_\_END at that time .\nThe patient 's menstrual cycles remained normal and there was no symptom of BEG\_\_dyspareunia\_\_END .\nThe BEG\_\_mass\_\_END gradually increased in size during pregnancy .\nThere was no history of BEG\_\_associated bladder or bowel disturbances\_\_END .\nThe BEG\_\_mass\_\_END did not increase on straining or lifting heavy weights .\nThere was no history of any BEG\_\_pelvic trauma\_\_END , and no BEG\_\_urological\_\_END or BEG\_\_gynaecological procedures\_\_END .\nThe patient was well built with stable vitals .\nOn BEG\_\_abdominal examination\_\_END , the uterus corresponded to term pregnancy with BEG\_\_cephalic presentation\_\_END .\nBEG\_\_Uterine contractions\_\_END lasting 10 \u2013 20 s every 5 min were recorded .\nThe BEG\_\_fetal heart rate\_\_END was 144 bpm .\nThe BEG\_\_cardiotocograph\_\_END was reactive .\nOn BEG\_\_local examination\_\_END , an BEG\_\_8 \u00d7 8 cm pink cystic mass\_\_END was seen protruding from the vagina during BEG\_\_uterine contractions\_\_END and receding completely in between the contractions ( figure 1 ) .\nOn per BEG\_\_speculum examination\_\_END the BEG\_\_mass\_\_END was seen arising from the posterior vaginal wall .\nIt was mobile and well demarcated with BEG\_\_blood vessels\_\_END running over its smooth surface .\nThe BEG\_\_mass\_\_END extended from just below the level of cervix to 2 cm inside the introitus .\nOn BEG\_\_palpation\_\_END , the BEG\_\_mass\_\_END was found to be BEG\_\_tense cystic and non-tender\_\_END with no BEG\_\_cough impulse\_\_END .\nFurther on per BEG\_\_vaginum examination\_\_END , the cervix was found to be 7 cm dilated and fully effaced .\nStation was at \u2212 2 and membranes were absent with clear leaking per vaginum .\nThe pelvis was assessed and found to be normal .\n\nDifferential diagnosis\n\nThe BEG\_\_mass\_\_END was provisionally diagnosed as BEG\_\_posterior vaginal wall cyst\_\_END , probably epidermal inclusion or M\u00fcllerian .\nOther differentials such as BEG\_\_rectocele\_\_END and BEG\_\_enterocele\_\_END were ruled out on BEG\_\_examination\_\_END .\nBEG\_\_Rectocele\_\_END was ruled out as on BEG\_\_rectal examination\_\_END the BEG\_\_cyst\_\_END wall was felt separate from the rectal wall .\nBEG\_\_Enterocele\_\_END was ruled out by the absence of BEG\_\_cough impulse\_\_END .\nSimilarly , possibility of the BEG\_\_cyst\_\_END being a BEG\_\_Bartholin 's\_\_END or BEG\_\_Gartner 's cyst\_\_END was ruled out as it was located in posterior vagina , BEG\_\_whereas Bartholin 's cysts\_\_END arise laterally medial to the labia minora and BEG\_\_Gartner 's cysts\_\_END are present anteriorly or anterolaterally in the vaginal wall .\n\nBEG\_\_Treatment\_\_END\n\nThe patient was planned for normal vaginal delivery .\nThe BEG\_\_cyst\_\_END was punctured and around 50 mL of clear yellowish fluid aspirated following which the BEG\_\_cyst collapsed\_\_END ( figure 2 ) .\nLabour was then augmented with BEG\_\_oxytocin\_\_END .\nBEG\_\_Episiotomy\_\_END was performed to assist vaginal delivery taking care not to involve the BEG\_\_cyst lining\_\_END .\nA baby boy weighing 3 kg was born uneventfully .\nPlacenta and membranes were expelled .\nUnder BEG\_\_local anaesthesia\_\_END , the BEG\_\_collapsed cyst\_\_END and BEG\_\_excess vaginal mucosa\_\_END were excised ( figure 3 ) .\nFollowing this , the vaginal mucosa was approximated with BEG\_\_continuous running absorbable sutures\_\_END .\nBEG\_\_Episiotomy\_\_END was closed in layers ( figure 4 ) .\nBEG\_\_Haemostasis\_\_END was attained .\nThe patient made an uneventful recovery , was followed up for 3 months and remained BEG\_\_asymptomatic\_\_END .\nOn histopathology , the BEG\_\_excised cyst\_\_END wall was lined by BEG\_\_mucin secreting tall columnar cells characteristic of M\u00fcllerian cysts\_\_END .\n\nOutcome and follow - up\n\nDiscussion\n\nThe prevalence of BEG\_\_vaginal cysts\_\_END has been estimated to be 1 in 200 , but this number is an underestimate as most BEG\_\_vaginal cysts\_\_END are not reported .\nBEG\_\_Vaginal cysts\_\_END have been classified according to the histology of BEG\_\_cyst lining\_\_END as BEG\_\_epidermal inclusion cysts\_\_END , embryonic ( M\u00fcllerian or BEG\_\_Gartner 's cysts\_\_END ) and BEG\_\_urothelial cysts .\nM\u00fcllerian cysts\_\_END are the commonest BEG\_\_congenital cysts of the vagina varying in size\_\_END from 1 to 7 cm .\nThey usually occur singly in the anterolateral vaginal wall , although a BEG\_\_few multifocal M\u00fcllerian cysts\_\_END have been reported .\nBEG\_\_M\u00fcllerian cysts\_\_END arise at the level of the cervix and usually present as BEG\_\_prolapsing masses\_\_END ;\nrarely they may extend anteriorly as BEG\_\_cystoceles\_\_END or posteriorly as BEG\_\_enteroceles\_\_END .\n5 \u2013 9 BEG\_\_Large vaginal cysts\_\_END are anticipated to cause BEG\_\_obstruction\_\_END to vaginal delivery .\nThe increase in size of BEG\_\_vaginal cysts\_\_END during pregnancy , as seen in the present case , can be hypothesised to be due to increased vascular supply during pregnancy .\nA few case reports of BEG\_\_vaginal cysts\_\_END complicating pregnancy have been presented .\nFischer , in 1912 , used forceps to assist vaginal delivery in a pregnancy complicated by a BEG\_\_large posterior vaginal wall cyst\_\_END .\nHowever , Frank , in 1915 , performed a BEG\_\_caesarean section\_\_END in a pregnancy complicated by a BEG\_\_large Gartner 's cyst\_\_END .\nRashmi et al reported a case in 2005 where BEG\_\_caesarean section\_\_END was performed in a pregnancy complicated by a BEG\_\_vaginal M\u00fcllerian cyst\_\_END presenting as a BEG\_\_prolapsing mass per vaginum\_\_END , to avoid BEG\_\_difficulty in vaginal delivery\_\_END .\nThus the present case is novel in the sense that it describes an uneventful vaginal delivery in pregnancy complicated by a BEG\_\_previously undiagnosed large posterior vaginal M\u00fcllerian cyst\_\_END by collapsing the BEG\_\_cyst\_\_END through BEG\_\_aspiration\_\_END .\nAlso , BEG\_\_excision\_\_END of the BEG\_\_collapsed cyst\_\_END and BEG\_\_repair\_\_END of posterior vaginal wall were undertaken immediately postdelivery just prior to BEG\_\_episiotomy repair\_\_END .

Questions:

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| query:"@placeholder are uncommon and are classified according to the lining epithelium of the BEG\_\_cyst\_\_END into BEG\_\_epithelial inclusion cysts\_\_END , embryonic ( M\u00fcllerian and Gartner 's ) BEG\_\_cysts\_\_END and BEG\_\_urothelial cysts\_\_END. | [{"answers":[{"text":"Vaginal wall cysts","origin":"dataset","sem\_type":"problem","cui":"C0750099"},{"text":"VAGINAL WALL CYST","origin":"UMLS","sem\_type":"problem","cui":"C0750099"},{"text":"cysts vaginal wall","origin":"UMLS","sem\_type":"problem","cui":"C0750099"},{"text":"vaginal wall cyst","origin":"UMLS","sem\_type":"problem","cui":"C0750099"}] | The text “Vaginal cysts” with origin “dataset” is mentioned in the context. |
| ","query":"BEG\_\_M\u00fcllerian cysts\_\_END are the commonest @placeholder and the usual location is anterolateral vaginal wall, but rarely they present posteriorly. | [{"text":"congenital cysts of the vagina","origin":"dataset","sem\_type":"problem","cui":"C0241619"},{"text":"VAGINAL CYST","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"Cyst of vagina (disorder)","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"cysts vaginal","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"vaginal cyst (physical finding)","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"vagina cyst","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"Cyst of the Vagina","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"vagina; cyst","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"Vaginal cysts","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"cyst vagina","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"vaginal cyst","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"Vaginal Cyst","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"cysts vagina","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"cyst vaginal","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"Cyst of Vagina","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"Vaginal cyst","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"cyst of vagina","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"cyst of vagina (diagnosis)","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"Cyst of vagina","origin":"UMLS","sem\_type":"problem","cui":"C0241619"},{"text":"cyst; vagina","origin":"UMLS","sem\_type":"problem","cui":"C0241619"}] | The text BEG\_\_congenital cysts of the vagina varying in size\_\_ENN with origin “dataset” is mentioned in the context |
| "query":"Uneventful vaginal delivery can be anticipated even in the presence of a @placeholder by aspiration of the BEG\_\_cyst\_\_END . | [{"text":"large posterior vaginal wall cyst","origin":"dataset","sem\_type":"problem","cui":"C0750099"},{"text":"VAGINAL WALL CYST","origin":"UMLS","sem\_type":"problem","cui":"C0750099"},{"text":"cysts vaginal wall","origin":"UMLS","sem\_type":"problem","cui":"C0750099"},{"text":"vaginal wall cyst","origin":"UMLS","sem\_type":"problem","cui":"C0750099"}] | The text BEG\_\_large posterior vaginal wall cyst\_\_END with origin “dataset” is mentioned in the context. |

# CONTEXT 2

Title: "Non-compaction of the left ventricle and BEG\_\_associated ventricular septal defect\_\_END"

Context: "Summary\n\nA case report of a 28 - year - old patient , who presented with BEG\_\_symptoms\_\_END and signs of BEG\_\_congestive heart failure\_\_END and had clinical signs of BEG\_\_ventricular septal defect\_\_END as well .\nOn BEG\_\_further work - up echocardiogram\_\_END showed BEG\_\_non-compaction of the left ventricle\_\_END with BEG\_\_severe left ventricular systolic dysfunction\_\_END and a BEG\_\_ventricular septal defect\_\_END .\nHe was treated with BEG\_\_standard treatment\_\_END of BEG\_\_heart failure\_\_END and is doing well .\n\nBackground\n\nLeft ventricular non-compaction ( LVNC ) also called BEG\_\_hypertrabeculation syndrome or spongy myocardium\_\_END is a BEG\_\_rare disorder\_\_END .\nIt is classified as a BEG\_\_primary genetic cardiomyopathy\_\_END by the American Heart Association ( AHA ) .\nIsolated LVNC can be either sporadic or familial and very rarely can occur as a BEG\_\_transient phenomenon during myocarditis\_\_END .\nThe prevalence of LVNC in the general population is not known but a review from Switzerland identified 34 cases within 15 years , which represented 0.014 % of BEG\_\_echocardiographic studies\_\_END done over a 15 - year period .\n2 This may be an underestimate , since improved echocardiographic image quality and BEG\_\_increasing awareness of this rare disorder\_\_END will likely lead to enhanced recognition .\nNon-compacted myocardium is occasionally found BEG\_\_accompanying other congenital cardiac anomalies\_\_END such as BEG\_\_ventricular septal defect\_\_END ( VSD ) .\n\nOur case report is a very rare clinical entity that will enhance awareness about its echocardiographic recognition .\n\nCase presentation\n\nA 28 - year - old man with no BEG\_\_known comorbids\_\_END presented in clinic with complaints of BEG\_\_breathlessness\_\_END , BEG\_\_swelling of feet\_\_END and BEG\_\_palpitations\_\_END for 6 months .\nHe had BEG\_\_exertional breathlessness\_\_END which had progressed and he was getting BEG\_\_short of breath\_\_END on just walking for approximately 5 min .\nHe had BEG\_\_paroxysmal nocturnal dyspnoea\_\_END for 4 months and BEG\_\_orthopnoea\_\_END for last 2 weeks .\nHe complained of BEG\_\_occasional palpitations\_\_END which had become more frequent for 1 week .\nHe denied BEG\_\_chest pain\_\_END , BEG\_\_fever\_\_END or BEG\_\_flu - like symptoms\_\_END and had no history of BEG\_\_heart problems\_\_END .\nHis family history was negative for BEG\_\_premature coronary artery disease\_\_END , BEG\_\_heart failure\_\_END , BEG\_\_hypertension\_\_END , BEG\_\_diabetes mellitus\_\_END and BEG\_\_sudden cardiac death\_\_END ( SCD ) .\n\nOn BEG\_\_examination\_\_END , he was a young man lying comfortably in bed with a BEG\_\_pulse\_\_END of 110 beats / min regular , BEG\_\_blood pressure\_\_END of 125 / 80 mm Hg , BEG\_\_raised jugular venous pressure\_\_END and BEG\_\_pitting pedal oedema\_\_END .\nApex beat was palpable in sixth intercostal space in anterior axillary line with no BEG\_\_thrills\_\_END or BEG\_\_parasternal heave\_\_END .\nA BEG\_\_pansystolic murmur\_\_END was BEG\_\_audible at lower - left sternal edge\_\_END .\nBEG\_\_Bilateral crackles\_\_END were BEG\_\_audible at the lung bases\_\_END but no BEG\_\_cyanosis\_\_END or BEG\_\_clubbing\_\_END was present .\nClinical impression of BEG\_\_decompensated heart failure\_\_END and BEG\_\_VSD\_\_END was made .\nBEG\_\_Treatment\_\_END was started with BEG\_\_diuretics\_\_END , BEG\_\_low - dose carvedilol\_\_END and BEG\_\_candesartan\_\_END .\n\nInvestigations\n\nBEG\_\_Echocardiogram\_\_END showed BEG\_\_spongiform cardiomyopathy\_\_END with BEG\_\_severe LV systolic dysfunction\_\_END ( BEG\_\_LV ejection fraction\_\_END , BEG\_\_LVEF\_\_END approximately 20 % ) and BEG\_\_global hypokinesia\_\_END .\nA BEG\_\_small perimembranous VSD\_\_END was seen measuring 5 mm with BEG\_\_left to right shunt\_\_END , a BEG\_\_peak gradient\_\_END of 60 mm Hg and QP : BEG\_\_QS ratio\_\_END of 1.3 ( BEG\_\_restrictive VSD\_\_END ) .\nBEG\_\_Right ventricular systolic function\_\_END was normal .\nThere was BEG\_\_grade III LV diastolic dysfunction\_\_END and a BEG\_\_retracted posterior mitral valve leaflet\_\_END with BEG\_\_moderate eccentric mitral regurgitation\_\_END .\nBEG\_\_Holter monitor\_\_END done for BEG\_\_palpitations\_\_END showed BEG\_\_sinus tachycardia\_\_END correlating with time of BEG\_\_symptoms\_\_END recorded in patient 's diary .\nThe rest of baseline reports were normal .\n\nOutcome and follow - up\n\nThe patient was seen in the clinic for follow - up .\nBEG\_\_Spironolactone\_\_END and BEG\_\_aspirin\_\_END were added , doses of BEG\_\_carvedilol\_\_END , BEG\_\_furosemide\_\_END and BEG\_\_candesartan\_\_END were optimised and the patient was counselled regarding need for an BEG\_\_implantable cardiac defibrillator\_\_END ( ICD ) for primary prevention of BEG\_\_SCD\_\_END .\nSix months following diagnosis , the patient has remained stable on BEG\_\_medical treatment\_\_END .\n\nDiscussion\n\nLVNC is a BEG\_\_rare cardiac disorder\_\_END , classified as a BEG\_\_primary genetic cardiomyopathy\_\_END by the AHA .\nThe European Society of Cardiology classified LVNC as an BEG\_\_unclassified cardiomyopathy\_\_END .\nLVNC is characterised by an BEG\_\_altered ventricular myocardium containing trabeculae\_\_END and deep intertrabecular recesses resulting in BEG\_\_thickened myocardium\_\_END with two layers consisting of non-compacted and compacted myocardium .\nAlso having direct communication between the LV cavity and the deep intratrabecular recesses , which are filled with blood from the LV cavity without connection to the epicardial coronary arteries ( figure 1 ) .\nNon-compacted myocardium is occasionally found accompanying other BEG\_\_congenital cardiac disorders\_\_END , like BEG\_\_bicuspid aortic valve\_\_END , aorta - to - LV tunnel , BEG\_\_Ebstein 's anomaly\_\_END , congenitally corrected transposition , BEG\_\_hypoplastic left heart syndrome\_\_END and BEG\_\_isomerism of the left atrial\_\_END appendage .\nNon-compacted myocardium has also been seen in patients with BEG\_\_atrial and VSDs\_\_END as was the case in our patient , patent ductus arteriosus5 and in cardiomyopathies due to BEG\_\_neuromuscular disorders\_\_END .\nBEG\_\_LVNC\_\_END can occur in BEG\_\_genetic syndromes\_\_END and BEG\_\_metabolic diseases\_\_END including BEG\_\_Charcot - Marie - Tooth disease 1A\_\_END , BEG\_\_Barth syndrome\_\_END and BEG\_\_Melnick - Needles syndrome\_\_END , as well as BEG\_\_nail - patella syndrome\_\_END .\nIt has been postulated that LVNC may be due to BEG\_\_intrauterine arrest of compaction of the loose interwoven meshwork\_\_END or pronounced hypertrabeculation may be due to BEG\_\_altered regulation in cell proliferation\_\_END , differentiation and maturation during BEG\_\_LV wall formation\_\_END .\n6 The prevalence of LVNC in the general population is not known but has been described among patients undergoing BEG\_\_echocardiographic studies\_\_END .\nA review from Switzerland identified 34 cases within 15 years , which represented 0.014 % of echocardiograms that were performed .\n7 This may be an underestimation , since improved echocardiographic image quality and BEG\_\_increasing awareness of LVNC\_\_END will perhaps lead to BEG\_\_enhanced recognition of LVNC\_\_END .\nBEG\_\_LVNC\_\_END can be either sporadic or familial .\nIn various reports , 12 \u2013 50 % of patients with LVNC had a family history positive of this condition .\nMutations have been identified in at least nine genes in LVNC patients including genes encoding LIM domain - BEG\_\_binding protein\_\_END 3 ( LDB3 ) , \u03b1 - dystrobrenin ( DTNA ) , BEG\_\_tafazzin\_\_END ( TAZ ) , BEG\_\_lamin A / C ( LMNA ) , \u03b2 - myosin heavy chain ( MYH7\_\_END ) , \u03b1 - BEG\_\_cardiac actin\_\_END ( ACTC ) , BEG\_\_cardiac troponin T\_\_END ( TNNT2 ) , BEG\_\_SCN5A\_\_END and BEG\_\_tropomyosin\_\_END 1 ( TPM1 ) .\nThe main clinical presentations of LVNC are BEG\_\_congestive cardiac failure\_\_END , BEG\_\_atrial and ventricular arrhythmias\_\_END and BEG\_\_thromboembolic events\_\_END including BEG\_\_stroke\_\_END .\nThe BEG\_\_ECG\_\_END is usually abnormal but there are no BEG\_\_characteristic changes .\nECG abnormalities\_\_END that can be seen include right or BEG\_\_left bundle branch block\_\_END , BEG\_\_fascicular block\_\_END , BEG\_\_atrial fibrillation\_\_END ( BEG\_\_AF )\_\_END and BEG\_\_ventricular tachycardia\_\_END .\n\nBEG\_\_Echocardiographic image , left parasternal short - axis view\_\_END at apical level .\n\nThe diagnosis of BEG\_\_LVNC\_\_END is usually established by BEG\_\_echocardiography\_\_END .\nBEG\_\_Cardiovascular MRI\_\_END , BEG\_\_cardiac CT\_\_END and BEG\_\_left ventriculography\_\_END are BEG\_\_other imaging modalities\_\_END that may be diagnostic or raise the initial clinical suspicion .\nBEG\_\_Echocardiography\_\_END has been utilised both to establish the diagnosis and as an aid during patient follow - up .\nHowever , there is no universally accepted definition of BEG\_\_LVNC\_\_END .\nProposed echocardiographic criteria for BEG\_\_LVNC\_\_END are based on BEG\_\_observations\_\_END from different centres .\nJenni et al proposed the criteria which included : ( 1 ) a BEG\_\_thickened LV wall\_\_END consisting of two layers : a thin compacted epicardial layer ; and a BEG\_\_markedly thickened endocardial layer\_\_END with BEG\_\_numerous prominent trabeculations\_\_END and deep recesses with a maximum ratio of non-compacted to compacted myocardium & gt ; 2 : 1 at end - systole in the parasternal short - BEG\_\_axis view\_\_END , ( 2 ) BEG\_\_colour Doppler\_\_END evidence of flow within the deep inter- BEG\_\_trabecular recesses\_\_END and ( 3 ) BEG\_\_prominent trabecular meshwork in the LV apex\_\_END or BEG\_\_midventricular segments of the inferior and lateral wall\_\_END .\nAll three echocardiographic criteria are required for diagnosis and the criteria are assessed in the parasternal short - BEG\_\_axis views\_\_END at base , mid - and apical levels .\nOther findings that can be seen on BEG\_\_echocardiography\_\_END include BEG\_\_reduced global LV systolic function\_\_END , BEG\_\_diastolic dysfunction\_\_END , BEG\_\_LV thrombi\_\_END and BEG\_\_abnormal papillary muscle structure\_\_END ( figures 2 and 3 ) .\n\nBEG\_\_Echocardiographic image\_\_END , BEG\_\_left parasternal short - axis view at midleft ventricular cavity level\_\_END with BEG\_\_colour Doppler\_\_END .\n\nThe BEG\_\_echocardiographic image of isolated LVNC\_\_END can be very heterogeneous including BEG\_\_dilated forms\_\_END , BEG\_\_hypertrophic variant\_\_END and BEG\_\_restrictive types\_\_END ( figures 4 and 5 ) .\nPublished series have found that LVNC is linked with high rates of BEG\_\_morbidity\_\_END and BEG\_\_mortality in adults\_\_END .\nIn a BEG\_\_study\_\_END of 34 patients ( mean age 42 ) the probability of survival free of BEG\_\_death\_\_END or BEG\_\_heart transplantation\_\_END at 5 years was 58 % .\n\nBEG\_\_Echocardiographic image\_\_END with BEG\_\_continuous wave Doppler\_\_END showing BEG\_\_pressure gradient across the ventricular septal defect\_\_END .\n\nHowever , this BEG\_\_study population\_\_END represents a group of severely affected patients with a poor prognosis but hopefully with the increasing awareness of BEG\_\_LVNC\_\_END , more subtle forms in BEG\_\_minimally symptomatic patients\_\_END or severe forms in asymptomatic patients will be detected , which may change the prognosis .\nClinical data on BEG\_\_treatment\_\_END of LVNC are limited , and there is no BEG\_\_specific therapy\_\_END for BEG\_\_LVNC\_\_END .\nMedical management depends on clinical manifestations , BEG\_\_LVEF\_\_END , the presence or absence of BEG\_\_arrhythmias\_\_END and perceived risk of BEG\_\_thromboembolism\_\_END .\nLVNC patients with reduced BEG\_\_LVEF\_\_END , BEG\_\_heart failure\_\_END and BEG\_\_asymptomatic systolic dysfunction\_\_END are treated according to standard guidelines .\nLVNC patients with or without BEG\_\_AF\_\_END are at high risk for BEG\_\_thromboembolism\_\_END .\nIn addition , given the BEG\_\_high thromboembolic risk\_\_END , BEG\_\_chronic anticoagulation therapy\_\_END is recommended in patients with BEG\_\_LVNC\_\_END and BEG\_\_AF\_\_END who do not otherwise have an indication for BEG\_\_anticoagulation\_\_END .\nBEG\_\_Anticoagulation\_\_END is also recommended in patients with BEG\_\_LVNC\_\_END without BEG\_\_AF\_\_END with BEG\_\_LVEF\_\_END & lt ; 40 % .\nLVNC patients should be advised to refrain from competitive endurance sports or weight lifting .\nLVNC patients should receive BEG\_\_ICD therapy\_\_END according to standard indications for BEG\_\_ICD therapy\_\_END in patients with BEG\_\_non-ischaemic cardiomyopathy\_\_END .\nPatients with BEG\_\_LVNC\_\_END who have BEG\_\_end - stage heart failure\_\_END are candidates for BEG\_\_cardiac transplantation evaluation\_\_END ."}

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# CONTEXT 3

Title:"BEG\_\_Kikuchi - Fujimoto disease\_\_END : an unusual cause of BEG\_\_neck swelling in pregnancy\_\_END"

Context: "Summary\n\nBEG\_\_Kikuchi - Fujimoto disease\_\_END ( KFD ) is an unusual cause of BEG\_\_lymphadenopathy\_\_END and BEG\_\_fever\_\_END .\nPregnancy associated with BEG\_\_KFD\_\_END presents as a diagnostic dilemma for BEG\_\_clinicians\_\_END .\nThe diagnosis can be confirmed with BEG\_\_invasive biopsies\_\_END or BEG\_\_non-invasive gene analysis\_\_END .\nWe report a case of a 24 - year - old woman at 18 weeks \u2019 gestation with a BEG\_\_neck lump\_\_END and histologically confirmed KFD .\n\nBackground\n\nBEG\_\_Kikuchi - Fujimoto disease\_\_END ( KFD ) is a rare cause of BEG\_\_acute lymphadenitis in pregnancy\_\_END .\nIt is reported to be self - limiting with BEG\_\_unilateral cervical lymphadenopathy\_\_END .\nThe presentation commonly raises suspicion for BEG\_\_lymphoma\_\_END , BEG\_\_tuberculosis\_\_END and BEG\_\_systemic lupus erythematosus\_\_END ( BEG\_\_SLE\_\_END ) . Diagnosis is confirmed by BEG\_\_excision biopsy\_\_END , which shows BEG\_\_histiocytic necrotising lymphadenitis\_\_END .\nOnly nine cases of histologically confirmed KFD are reported in pregnancy so far .\nWe present a case of a pregnant woman with histologically confirmed KFD .\n\nCase presentation\n\nA 24 - year - old woman at 18 weeks \u2019 gestation presented to the ear , nose and throat ( ENT ) clinic with a 3 - week history of BEG\_\_progressively enlarging\_\_END and BEG\_\_tender right anterior triangle neck swelling\_\_END and BEG\_\_associated intermittent fever\_\_END .\nShe had no BEG\_\_significant medical history\_\_END .\nBEG\_\_Physical examination\_\_END revealed a BEG\_\_firm 3 \u00d7 2 cm neck swelling\_\_END suspicious for BEG\_\_lymphadenopathy at level II of the right neck\_\_END .\nThe site was BEG\_\_erythematous\_\_END and BEG\_\_tender\_\_END on BEG\_\_palpation\_\_END .\nNo other area with BEG\_\_lymphadenopathy\_\_END was noted .\nBEG\_\_Cardiovascular and abdominal examinations\_\_END were unremarkable .\nThe BEG\_\_patient 's vital signs\_\_END were within normal limits .\n\nInvestigations\n\nBEG\_\_Initial investigation\_\_END contained BEG\_\_full blood count\_\_END , BEG\_\_urea and electrolytes\_\_END , BEG\_\_liver function tests\_\_END , BEG\_\_serum lactate dehydrogenase\_\_END and BEG\_\_C reactive protein\_\_END , which were all normal .\nA BEG\_\_monospot test\_\_END was carried out and was negative .\nBEG\_\_Erythrocyte sedimentation rate\_\_END was raised at 29 mm / h .\n\nIg G and Ig M antibodies for BEG\_\_cytomegalovirus\_\_END ( CMV ) were positive but BEG\_\_CMV IgG avidity\_\_END was BEG\_\_high\_\_END and also the BEG\_\_CMV viral load\_\_END was negative .\nBEG\_\_Toxoplasma IgG\_\_END was positive and BEG\_\_IgM\_\_END was negative .\nBEG\_\_Urine and blood cultures\_\_END showed no BEG\_\_growth\_\_END after 48 h .\nAn BEG\_\_intradermal Mantoux test\_\_END was negative .\nBEG\_\_HIV screen\_\_END was performed on the patient and it was negative .\n\nBEG\_\_Ultrasound scan of the neck\_\_END confirmed the presence of a BEG\_\_3 cm single lymph node in the right side of the neck\_\_END .\nThe thyroid and parathyroid glands were normal .\nBEG\_\_Chest X-ray\_\_END ( with BEG\_\_abdominal shield\_\_END ) showed normal cardiopulmonary markings .\n\nBEG\_\_Fine - needle aspirate of the lymph node\_\_END showed BEG\_\_non-specific acute - on - chronic inflammatory cells\_\_END .\nAt high power , a BEG\_\_single necrotic cell\_\_END noted was suspicious for BEG\_\_lymphoma\_\_END ( figure 1 ) .\nBEG\_\_Microscopy\_\_END and BEG\_\_culture\_\_END were negative for BEG\_\_bacteria\_\_END , including for BEG\_\_acid - fast bacilli\_\_END .\n\nBEG\_\_Fine - needle aspiration cytology\_\_END showing BEG\_\_necrotic cell in the background of lymphocytes\_\_END .\n\nBEG\_\_As lymphoma\_\_END was a possible differential diagnosis , the case was discussed in a multidisciplinary meeting and it was decided to perform an BEG\_\_urgent open biopsy\_\_END .\n\nBEG\_\_Final histological studies\_\_END showed BEG\_\_numerous apoptotic bodies\_\_END in the background of histiocytes .\nNo BEG\_\_granuloma\_\_END or BEG\_\_inclusion bodies\_\_END were seen .\nBEG\_\_Immunohistochemistry studies\_\_END showed a BEG\_\_prominent T - lymphocytic background\_\_END with BEG\_\_occasional B lymphocytes\_\_END .\nBEG\_\_CD68 stain\_\_END confirmed a histiocyte - rich background .\nBEG\_\_EBER stain\_\_END for BEG\_\_Epstein - Barr virus\_\_END ( EBV ) was negative .\nOverall features suggested BEG\_\_histiocytic necrotising lymphadenitis\_\_END , which was compatible with BEG\_\_Kikuchi lymphadenitis\_\_END ( figure 2 ) .\n\nDifferential diagnosis\n\nBEG\_\_Treatment\_\_END\n\nBEG\_\_Empirical antibiotic treatment\_\_END with BEG\_\_penicillin\_\_END was dispensed .\nThe patient also received BEG\_\_paracetamol\_\_END for BEG\_\_fever\_\_END and BEG\_\_pain\_\_END .\nDuring the course of her hospital stay , the obstetricians regularly assessed fetal well - being .\n\nOutcome and follow - up\n\nThe patient was discharged on BEG\_\_paracetamol treatment\_\_END .\nShe was seen 2 weeks later in the ENT outpatient department and the BEG\_\_swelling\_\_END had abated .\nObstetricians had also followed her up and the patient recently had a normal delivery of a healthy baby with no BEG\_\_complications\_\_END .\n\nDiscussion\n\nKFD was initially described in Japan by two separate authors , Kikuchi and Fujimoto , at almost the same period in 1972 .\nThe aetiology of this BEG\_\_disease\_\_END is unknown .\nIt is a self - BEG\_\_limiting lymphadenitis\_\_END predominantly affecting the cervical lymph nodes .\nIt was initially believed to be more common in the Asian female population , but current evidence states that the male to female ratio is reported at 1 : 1.4 A recently published case report and review of published work on nine cases of KFD in pregnancy has shown a better outcome in maternal as well as fetal health .\nSo far , there are 10 KFD cases associated with pregnancy published .\nThe common clinical manifestation was BEG\_\_fever\_\_END with BEG\_\_isolated cervical lymphadenopathy\_\_END noted in seven of the 10 case reports .\nOthers had BEG\_\_fever\_\_END with BEG\_\_isolated sub maxillary , supraclavicular and mesenteric lymphadenopathy\_\_END .\n\nDiagnosing KFD is a challenging task , particularly in a pregnant patient .\nBEG\_\_Radiological imaging\_\_END and BEG\_\_empirical treatments\_\_END such as with BEG\_\_antibiotics\_\_END , BEG\_\_steroids\_\_END and BEG\_\_immunoglobulin\_\_END are restricted due to pregnancy .\nBEG\_\_CMV IgG\_\_END and BEG\_\_IgM\_\_END were found to be BEG\_\_positive\_\_END in this patient , however , BEG\_\_perinatal studies\_\_END have showed that the BEG\_\_CMV avidity test\_\_END does not necessarily correlate with BEG\_\_CMV in the amniotic\_\_END fluid .\nTests for BEG\_\_SLE\_\_END ( eg , BEG\_\_antinuclear antibody )\_\_END were not performed in this patient .\nThe BEG\_\_latest series\_\_END from BEG\_\_Taiwan supports\_\_END this , as it has shown that only 1 % of 195 cases were associated with BEG\_\_SLE\_\_END .\n\nThe comprehensive review on KFD published in the American Journal for Clinical Pathology has discussed in detail , about the cause and BEG\_\_pathogenesis of KFD\_\_END .\nThe positive serology with BEG\_\_Yersinia enterocolitica\_\_END and Toxoplasma gondii are not sufficient to confirm the association of these BEG\_\_diseases\_\_END with BEG\_\_KFD\_\_END .\nThe BEG\_\_histological lymphadenitis\_\_END presented with these BEG\_\_infections\_\_END is different from BEG\_\_KFD\_\_END .\nIn addition , the article also discusses and draws the conclusion that there is no convincing laboratory evidence associating BEG\_\_KFD\_\_END with BEG\_\_EBV\_\_END , human herpesvirus 6 ( BEG\_\_HHV - 6\_\_END ) , BEG\_\_HHV\_\_END - 8 , BEG\_\_human T - lymphotropic virus type\_\_END 1 , BEG\_\_parvovirus B19\_\_END , BEG\_\_herpes simplex\_\_END or BEG\_\_CMV .3\_\_END\n\nThere are reports on upcoming non-invasive diagnostic methods for BEG\_\_KFD\_\_END , such as the use of microarray analysis of BEG\_\_peripheral blood mononuclear cells\_\_END ( PBMCs ) , which entails a BEG\_\_study\_\_END of BEG\_\_peripheral mononuclear cell genes\_\_END specifically expressed in these patients by examining the whole transcriptome using PBMC microarray analysis .\nHowever , the definitive diagnosis of KDF is still confirmed mainly by BEG\_\_histological examination of lymph node biopsy\_\_END .\n\nThere are cases reported regarding BEG\_\_intravenous immunoglobulin treatment\_\_END with a combination of BEG\_\_corticosteroids\_\_END in case of BEG\_\_airway compromise in severe\_\_END KFD .\nDubois et al10 reported that BEG\_\_KFD\_\_END has shown no impact on pregnancy , delivery or BEG\_\_infancy\_\_END .\n\nIt is worth noting that the differential diagnosis includes BEG\_\_lymphoma\_\_END , so early diagnosis is essential , especially taking into account the gestational age , as this can affect the treatment options available to the patient , such as option for early delivery or for BEG\_\_radiotherapy\_\_END with BEG\_\_abdominal shield\_\_END .\nAs our patient was in the second trimester of pregnancy , another option may have been to postpone the BEG\_\_chemotherapy\_\_END until BEG\_\_induction of labour\_\_END .\n11 , 12\n\nFrom our experience , we found that BEG\_\_antibiotic therapy\_\_END did not improve the outcome .\nHowever , BEG\_\_supportive therapy\_\_END with BEG\_\_fluids\_\_END and antifevers provided symptomatic relief to the patient .\nBEG\_\_Full diagnostic work up\_\_END to exclude other possible BEG\_\_differential diagnoses\_\_END and multidisciplinary team input , as were provided in this case , can assist in diagnosing KFD in such a patient .\n\nA multidisciplinary approach in management is crucial in ensuring prompt and appropriate diagnosis for these patients .\n\nBEG\_\_Patient 's perspective\_\_END\n\nWe were initially BEG\_\_anxious\_\_END and concerned about the BEG\_\_swelling in the neck\_\_END with BEG\_\_fever\_\_END during our early part of the pregnancy .\nAs all other young couples do , we searched the internet and the results were even more worrying , such as it could be a BEG\_\_lymphoma\_\_END .\nAfter all the investigations and explanations from the doctors we were a bit relieved .\nHowever , until she delivered the baby we were very cautious .\nThe overall outcome was good from our perspective ;\nhowever , waiting for the BEG\_\_biopsy\_\_END and investigation results were extremely stressful times for the pregnant patient and our family ."}

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| Query | Answers | Reasons |
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# CONTEXT 4

title: "BEG\_\_Serum creatine kinase elevation\_\_END associated with BEG\_\_olanzapine treatment\_\_END"

context:"Summary\n\nOn 2 May 2008 , a 25 - year - old male patient on BEG\_\_olanzapine\_\_END 15 mg developed BEG\_\_mild central chest pain\_\_END , and BEG\_\_blood tests\_\_END revealed a BEG\_\_high creatine kinase ( CK ) value\_\_END at 1016 iu / l .\nBEG\_\_Troponin\_\_END , BEG\_\_CK - MB , CK\_\_END : BEG\_\_MB ratio\_\_END , BEG\_\_full blood count ( FBC ) , urea and electrolytes ( U & amp ; E ) , C reactive protein\_\_END ( BEG\_\_CRP )\_\_END and BEG\_\_glucose\_\_END were all normal .\nBEG\_\_Liver enzymes\_\_END were marginally raised : BEG\_\_alanine aminotransferase\_\_END ( ALT ) 91 iu / l , \u03b3 - BEG\_\_glutamyl transferase\_\_END ( GGT ) 46 iu / l , BEG\_\_alkaline phosphatase\_\_END ( ALP ) 137 iu / l .\nThe BEG\_\_ECG\_\_END was normal and the BEG\_\_chest pain\_\_END later resolved and was thought likely to be due to BEG\_\_costochondritis\_\_END .\nA BEG\_\_repeat blood test\_\_END on 7 May revealed BEG\_\_further elevation of CK\_\_END at 1391 iu / l and BEG\_\_olanzapine\_\_END was stopped .\nBEG\_\_CK\_\_END continued to rise : 19 May 2857 iu / l , 20 May 3285 iu / l , and 22 May 3646 iu / l .\nOn 30 May BEG\_\_CK\_\_END dropped to 708 iu / l , on 20 June it was 593 iu / l , and on 30 June BEG\_\_CK\_\_END was 343 iu / l .\nThe patient was started on BEG\_\_amisulpiride\_\_END on 15 July and BEG\_\_CK\_\_END began to rise again : on 18 July it was 445 iu / l and on 31 July BEG\_\_CK\_\_END was 480 iu / l , at which time the BEG\_\_medication\_\_END was stopped .\nThe patient did not have any signs or symptoms of BEG\_\_physical disorder\_\_END on this occasion .\n\nWe have never seen a patient develop BEG\_\_such high CK values\_\_END in the absence of any BEG\_\_clinical or other significant laboratory abnormalities\_\_END .\nWe can rule out exercise as the cause as he attends an inpatient unit and we are aware that his exercise has been light to moderate at most ;\nalso , he stopped exercising at our request on 7 May 2008 , yet BEG\_\_CK\_\_END continued to rise .\nThere is no clinical indication of other causes of BEG\_\_elevated CK\_\_END such as BEG\_\_myositis\_\_END , and BEG\_\_CK - MB\_\_END and BEG\_\_CK - MB\_\_END : BEG\_\_CK ratio\_\_END were normal throughout , so it was not cardiac in origin .\nWe believe BEG\_\_olanzapine\_\_END caused the BEG\_\_elevated CK value\_\_END .\nWhen the patient was rechallenged with BEG\_\_amisulpiride\_\_END on 15 May his BEG\_\_CK\_\_END again rose and the BEG\_\_medication\_\_END therefore had to be stopped .\nThere are three similar cases that have been reported in the past when patients on BEG\_\_second generation antipsychotics\_\_END developed BEG\_\_CK elevation\_\_END in the absence of BEG\_\_other clinical or laboratory abnormalities\_\_END .\nWe therefore believe this is an important finding to report .\n\nCASE PRESENTATION\n\nA 25 - year - old male patient being treated with BEG\_\_olanzapine\_\_END , 15 mg once daily , developed BEG\_\_chest pain\_\_END on 2 May 2008 and BEG\_\_blood tests\_\_END revealed a BEG\_\_high creatine kinase ( CK ) value\_\_END of 1016 iu / l .\nThe BEG\_\_ECG\_\_END was normal and the BEG\_\_chest pain\_\_END later resolved the same day .\nOn 7 May the BEG\_\_CK value\_\_END had further increased to 1391 iu / l and the BEG\_\_olanzapine\_\_END was stopped .\nOn the same day , BEG\_\_troponin\_\_END , BEG\_\_CK - MB\_\_END , BEG\_\_CK - MB\_\_END : BEG\_\_CK ratio\_\_END , BEG\_\_full blood count ( FBC ) , urea and electrolytes ( U & amp ; E ) , C reactive protein\_\_END ( BEG\_\_CRP )\_\_END and BEG\_\_glucose\_\_END were all within normal range .\nBEG\_\_Liver enzymes\_\_END were marginally raised : BEG\_\_alanine aminotransferase\_\_END ( ALT ) 91 iu / l , \u03b3 - BEG\_\_glutamyl transferase\_\_END ( GGT ) 46 iu / l , BEG\_\_alkaline phosphatase\_\_END ( ALP ) 137 iu / l .\nThe patient had been doing light exercise but stopped at our request on 7 May .\nBEG\_\_CK\_\_END continued to rise : 19 May 2857 iu / l , 20 May 3285 iu / l , and 22 May 3646 iu / l .\nBEG\_\_CK values\_\_END subsequently began to fall : 26 May 1832 iu / l , 30 May 708 iu / l , 20 June 593 iu / l , 30 June 343 iu / l .\nBEG\_\_Other blood tests\_\_END on all the above mentioned dates , including FBC , U & amp ; E , BEG\_\_glucose\_\_END , BEG\_\_CRP\_\_END , BEG\_\_CK - MB\_\_END and BEG\_\_CK - MB\_\_END : BEG\_\_CK ratio\_\_END , were normal throughout .\nBEG\_\_ALT\_\_END , BEG\_\_GGT\_\_END and BEG\_\_ALP\_\_END continued to be marginally raised through all the BEG\_\_blood tests\_\_END .\nHowever , BEG\_\_ALT\_\_END and BEG\_\_GGT\_\_END were raised in a test done before the BEG\_\_raised CK\_\_END , on 3 December 2007 : BEG\_\_ALT\_\_END 81 iu / l , BEG\_\_GGT\_\_END 44 iu / l .\nAfter stopping BEG\_\_olanzapine\_\_END , the patient \u2019 s mental state deteriorated with BEG\_\_increasing paranoia\_\_END and we therefore decided to try another BEG\_\_antipsychotic\_\_END , BEG\_\_amisulpiride\_\_END 200 mg orally twice daily , which was started on 15 July 2008 .\nThe BEG\_\_CK value\_\_END rose again : on 18 July it was 445 iu / l and on 31 July it was 480 iu / l , at which time the BEG\_\_amisulpiride\_\_END was stopped on advice from the medical team and pharmacy .\nThe patient had no BEG\_\_physical complaints\_\_END and a BEG\_\_physical examination\_\_END revealed no BEG\_\_abnormalities\_\_END .\nBEG\_\_Blood pressure\_\_END , BEG\_\_pulse rate\_\_END , BEG\_\_respiratory rate\_\_END and BEG\_\_temperature readings\_\_END were done twice daily since starting the BEG\_\_amisulpiride\_\_END and all were normal .\n\nDIFFERENTIAL DIAGNOSIS\n\nBEG\_\_TREATMENT\_\_END\n\nThe patient was admitted to our medium secure forensic service from prison on 19 November 2007 .\nHe was not on any BEG\_\_medication\_\_END until we started him on BEG\_\_olanzapine\_\_END on 28 December 2007 at a dose of 10 mg orally at night , which was increased on 11 January 2008 to 15 mg orally at night .\nIt was further increased to 20 mg on 16 January and reduced back to 15 mg on 19 March as the patient complained of BEG\_\_drowsiness\_\_END on the higher dose .\nHe has not been treated with any BEG\_\_other medications\_\_END during his current admission since 19 November 2007 .\nHe has not been on any BEG\_\_medication\_\_END since the BEG\_\_olanzapine\_\_END was stopped on 7 May 2008 until he was started on BEG\_\_amisulpiride\_\_END 200 mg twice daily on 15 July 2008 .\n\nOUTCOME AND FOLLOW - UP\n\nDISCUSSION\n\nThere have been three similar cases reported in the past1 \u2013 3 in which individuals developed BEG\_\_very high creatine kinase\_\_END ( CK ) while on BEG\_\_olanzapine\_\_END in the absence of BEG\_\_other abnormalities\_\_END .\nOur case was very similar to those reported in that we could find no physical cause for the BEG\_\_CK rise\_\_END .\nWe believe the BEG\_\_rise in CK\_\_END was associated with the BEG\_\_olanzapine treatment\_\_END .\nHowever , we could not find a similar case in which the BEG\_\_CK\_\_END continued to rise for a period of 2 weeks ( 7 \u2013 22 May 2008 ) after discontinuation of the BEG\_\_drug\_\_END , but we believe this may have been a BEG\_\_residual effect\_\_END of the BEG\_\_olanzapine\_\_END .\nBEG\_\_Olanzapine\_\_END has a half life of 21 \u2013 54 h but the BEG\_\_longer pharmacokinetic effects\_\_END and plasma clearance vary from one individual to another and can last up to 2 weeks after discontinuation , which could explain the continued rise in BEG\_\_CK\_\_END for 2 weeks following 7 May when the BEG\_\_drug\_\_END was stopped .\nThe BEG\_\_high CK\_\_END made us initially very concerned that the patient may have been developing BEG\_\_neuroleptic malignant syndrome\_\_END ( NMS ) .\nHowever , he never developed any BEG\_\_physical features of NMS\_\_END .\nThere are a number of case reports since 1998 associating BEG\_\_olanzapine\_\_END with BEG\_\_NMS\_\_END .\nHowever , there are only three studies indicating BEG\_\_high CK developing\_\_END with BEG\_\_olanzapine\_\_END .\nSome BEG\_\_case studies\_\_END have identified an BEG\_\_atypical presentation of NMS\_\_END with BEG\_\_olanzapine\_\_END , presenting with just one or two features of BEG\_\_NMS\_\_END .\nIt will be important for clinicians to be aware that BEG\_\_olanzapine\_\_END can cause BEG\_\_notably elevated CK\_\_END .\nIt is possible that there may be an association between the BEG\_\_high elevation in CK\_\_END seen with BEG\_\_olanzapine treatment\_\_END and BEG\_\_NMS\_\_END or BEG\_\_other disorders\_\_END such as BEG\_\_dystonia\_\_END , although if there is a relationship between these , it has yet to be clearly established ."}

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| Query | Answers | Reasons |
| "query":"BEG\_\_Olanzapine\_\_END and BEG\_\_other second generation antipsychotics\_\_END such as amisulpiride may cause @placeholder in BEG\_\_creatine kinase\_\_END in certain individuals . | [{"text":"elevation","origin":"dataset","sem\_type":"problem","cui":"C0175643"},{"text":"Medical Elevators","origin":"UMLS","sem\_type":"problem","cui":"C0175643"},{"text":"elevators","origin":"UMLS","sem\_type":"problem","cui":"C0175643"},{"text":"ELEVATOR","origin":"UMLS","sem\_type":"problem","cui":"C0175643"},{"text":"elevator","origin":"UMLS","sem\_type":"problem","cui":"C0175643"},{"text":"medical elevators","origin":"UMLS","sem\_type":"problem","cui":"C0175643"},{"text":"Elevators","origin":"UMLS","sem\_type":"problem","cui":"C0175643"}] | The text BEG\_\_high creatine kinase (CK) value\_\_END with origin “dataset” is mentioned in the context. “Elevation” comes from combining the information of Olanzapine and amisulpiride. |
| "query":"It is possible the BEG\_\_CK elevation\_\_END may represent a prelude to BEG\_\_neuroleptic malignant syndrome\_\_END or BEG\_\_another disorder\_\_END such as @placeholder , but this is at present unclear as we were not able to find any BEG\_\_other clinical and laboratory abnormalities\_\_END ." | [{"text":"dystonia","origin":"dataset","sem\_type":"problem","cui":"C0013421"},{"text":"abnormal muscle twitching or contraction","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"Dystonia, Muscle","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"Muscle Dystonia","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"dystonia (physical finding)","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"DYSTONIA","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"involuntary twisting movements","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"dystonic movements","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"dystonia was noted","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"[X]Dystonia, unspecified","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"Dystonic movements","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"dystonias","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"Dystonias","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"Dystonia (finding)","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"Dystonia","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"involuntary twisting movements (symptom)","origin":"UMLS","sem\_type":"problem","cui":"C0013421"},{"text":"Dystonia, unspecified","origin":"UMLS","sem\_type":"problem","cui":"C0013421"}],"id":"bcr.06.2008.0040.11","query":"It is possible the BEG\_\_CK elevation\_\_END may represent a prelude to BEG\_\_neuroleptic malignant syndrome\_\_END or BEG\_\_another disorder\_\_END such as @placeholder , but this is at present unclear as we were not able to find any BEG\_\_other clinical and laboratory abnormalities\_\_END ."},{"answers":[{"text":"other clinical and laboratory abnormalities","origin":"dataset","sem\_type":"problem","cui":"C1401681"},{"text":"clinical; findings abnormal (not laboratory)","origin":"UMLS","sem\_type":"problem","cui":"C1401681"}] | The text BEG\_\_dystonia\_\_END with origin “dataset” is mentioned in the context. |
| "query":"It is possible the BEG\_\_CK elevation\_\_END may represent a prelude to BEG\_\_neuroleptic malignant syndrome\_\_END or BEG\_\_another disorder\_\_END such as BEG\_\_dystonia\_\_END , but this is at present unclear as we were not able to find any @placeholder ."} | [{"text":"other clinical and laboratory abnormalities","origin":"dataset","sem\_type":"problem","cui":"C1401681"},{"text":"clinical; findings abnormal (not laboratory)","origin":"UMLS","sem\_type":"problem","cui":"C1401681"}] | The text “other clinical and laboratory abnormalities” with origin “dataset” is mentioned in the context. |

# CONTEXT 5

Title: "BEG\_\_Psoas muscle pyogenic abscess\_\_END in association with BEG\_\_infected hip arthroplasty\_\_END : a rare case of simultaneous bilateral presentation"

Context: "Summary\n\nSimultaneous bilateral presentation of BEG\_\_psoas abscess\_\_END with BEG\_\_prosthetic joint involvement\_\_END is extremely rare .\nA 68 - year - old woman presented to us with BEG\_\_bilateral dull aching groin pain\_\_END of 6 months \u2019 duration , which flared up in the past month , associated with BEG\_\_pyrexial symptoms\_\_END .\nShe had undergone BEG\_\_bilateral hip replacements\_\_END in the past with uneventful recovery .\nBEG\_\_MRI\_\_END showed BEG\_\_bilateral psoas muscle collection in communication with the hip joints\_\_END .\nBEG\_\_Preoperative hip aspirate\_\_END demonstrated BEG\_\_frank pus\_\_END with positivity on BEG\_\_Gram stain\_\_END and BEG\_\_radiographs\_\_END confirmed prosthetic loosening of bilateral hips .\nThe patient subsequently underwent BEG\_\_two - stage revision arthroplasty of both infected hip implants\_\_END .\nAt 5 - year follow - up , the patient remains BEG\_\_asymptomatic\_\_END with good functional outcome and no BEG\_\_recurrence\_\_END on BEG\_\_serial MRI\_\_END .\n\nBackground\n\nBEG\_\_Psoas abscess\_\_END is characterised by BEG\_\_pus within the psoas muscle\_\_END .\nIts incidence is about 0.4 / 100 000 in the UK .\nThis condition may be either primary or secondary .\nFrom an aetiological point of view , although the cause of a BEG\_\_primary abscess\_\_END may be unknown , it is most likely due to BEG\_\_haematogenous\_\_END or lymphatic dissemination from a distant and BEG\_\_occult infective focus\_\_END .\nNevertheless , BEG\_\_HIV\_\_END , BEG\_\_diabetes mellitus\_\_END , intravenous drug abuse , BEG\_\_renal failure\_\_END and other conditions of BEG\_\_immune suppression\_\_END , may all predispose the occurrence of a BEG\_\_primary abscess\_\_END .\n\nOn the other hand , in a BEG\_\_secondary abscess\_\_END , the BEG\_\_contamination\_\_END usually comes directly from adjacent tissues infected .\nSpecifically , an BEG\_\_abscess of the psoas muscle\_\_END may be associated with BEG\_\_Crohn 's disease\_\_END , BEG\_\_appendicitis\_\_END , BEG\_\_diverticulitis\_\_END , BEG\_\_ulcerative colitis\_\_END , BEG\_\_urinary tract infections\_\_END , BEG\_\_spondylodiscitis\_\_END or an BEG\_\_infection\_\_END of the sacroiliac joint .\n\nBEG\_\_Symptoms\_\_END are often subtle and non-specific , making the diagnosis difficult and delayed .\nThere is some evidence that BEG\_\_septic hip arthritis\_\_END may be associated with an BEG\_\_abscess of the psoas muscle4\_\_END \u2013 6 or following BEG\_\_hip arthroplasty\_\_END .\n7 \u2013 10\n\nSimultaneous bilateral presentation of BEG\_\_psoas abscess\_\_END with BEG\_\_prosthetic joint involvement\_\_END is unreported in the literature .\n\nWe report a case of a BEG\_\_bilateral psoas abscess\_\_END presentation likely secondary to BEG\_\_concomitant prosthetic hip joint involvement\_\_END , management and outcome .\n\nCase presentation\n\nA 68 - year - old woman presented with a 6 - month history of BEG\_\_bilateral groin pain\_\_END .\nShe presented with BEG\_\_constitutional symptoms\_\_END , including BEG\_\_fever\_\_END , BEG\_\_weight loss\_\_END , BEG\_\_night sweats\_\_END , all worsened in the past month .\nBEG\_\_Masses\_\_END were palpable on either side of the groin .\nShe underwent BEG\_\_total hip arthroplasty of the left side\_\_END in 1996 , and of the right side in 2007 .\nThe patient also had a history of BEG\_\_pulmonary tuberculosis\_\_END , successfully treated in 1975 with BEG\_\_isoniazid\_\_END and BEG\_\_rifampicin\_\_END .\n\nInvestigations\n\nBEG\_\_Clinical examination\_\_END to detect any focus of BEG\_\_infection\_\_END was negative .\nBEG\_\_Abdominal ultrasound\_\_END was negative .\nHaemocultures were sterile .\nBEG\_\_Serum infective markers\_\_END were raised .\nBEG\_\_Erythrocyte sedimentation rate\_\_END was 66 mm / h ( 0 \u2013 29 ) , BEG\_\_PCR\_\_END was 156 mg / L ( 0 \u2013 6.00 ) and BEG\_\_white cell count\_\_END was 15.18 \u00d7 109 / L ( 4.40 \u2013 11 ) .\nBEG\_\_Blood and urine cultures\_\_END were negative .\nThe patient was immunocompetent .\nBEG\_\_Chest radiograph\_\_END was normal .\n\nBEG\_\_Hip radiographs\_\_END demonstrated BEG\_\_lucencies along both the acetabulum\_\_END that were suggestive of BEG\_\_loosening\_\_END ( figure 1 ) .\nBEG\_\_MRI of the lumbar spine\_\_END excluded BEG\_\_intervertebral discitis\_\_END .\n\nBEG\_\_MRI coronal section of the pelvis\_\_END showing a BEG\_\_bilateral abscess of the psoas muscle in communication with the hip\_\_END ( orange arrows highlight the abscesses and BEG\_\_blue arrows\_\_END show communications with the joints ) .\n\nBEG\_\_MRI axial section of the pelvis\_\_END showing a BEG\_\_bilateral abscess of the psoas muscle in communication with the hip\_\_END ( orange arrows highlight the abscesses and BEG\_\_blue arrows\_\_END show communications with the joints ) .\n\nA BEG\_\_joint aspiration of both the hip joints\_\_END was carried out before proceeding with BEG\_\_surgery\_\_END .\nBEG\_\_Cultures\_\_END were sent for aerobic and BEG\_\_anaerobic bacteria\_\_END , and , due to the BEG\_\_pervious tuberculosis infection\_\_END , BEG\_\_acid - fast bacilli stain\_\_END and BEG\_\_Lowenstein culture\_\_END were used .\n\nBEG\_\_Treatment\_\_END\n\nA BEG\_\_two - stage revision procedure\_\_END was undertaken bilaterally at an interval of 10 days .\nWe used a lateral direct approach ( Hardinge 's approach ) for both hips , which had been the previous access for primary .\nThe BEG\_\_implants\_\_END were loose and it was easier to remove both BEG\_\_femoral and acetabular components\_\_END .\nAfter the BEG\_\_removal\_\_END of the cup and due to BEG\_\_anterior acetabulum deficiency\_\_END , the access to the iliac muscle was easier .\nThe purulent material was drained from the bursa of the psoas and hip joint .\nAfter BEG\_\_thorough exploration\_\_END and BEG\_\_debridement\_\_END , we used a BEG\_\_static Gentamycin - impregnated hand - made spacer\_\_END .\nBEG\_\_Significant bone loss\_\_END was found on the anterior wall of both hip joints .\n\nTen days later , the same procedure was undertaken on the other joint : a BEG\_\_massive collection\_\_END of BEG\_\_pus\_\_END was drained , the BEG\_\_prosthesis\_\_END was removed and an BEG\_\_antibiotic loaded spacer\_\_END was implanted .\n\nBEG\_\_Culture\_\_END grew BEG\_\_Streptococcus anginosus species\_\_END in the samples from both hips .\nThe patient was started on BEG\_\_intravenous antibiotic therapy\_\_END ( BEG\_\_ceftriaxone sodium\_\_END ) for 6 weeks .\n\nIn the interval period , BEG\_\_serial testing\_\_END for BEG\_\_infective markers\_\_END was carried out , which showed a BEG\_\_declining trend\_\_END .\nThe patient was treated on BEG\_\_antibiotics\_\_END for 6 weeks .\nTwo weeks later both hips were aspirated with negative BEG\_\_cultures\_\_END .\nBEG\_\_Repeat MRI\_\_END showed resolution of the BEG\_\_abscess\_\_END .\n\nThe patient was taken up for a BEG\_\_staged total hip replacement\_\_END with an interval of 2 weeks .\n\nThe acetabulum on both sides showed BEG\_\_significant bone loss\_\_END medially and hence cages were used with BEG\_\_cementless cup fixation\_\_END .\nLong uncemented stems were implanted on the femoral side .\n\nOutcome and follow - up\n\nThe patient had an uneventful postop recovery .\n\nAt the most recent follow - up at 5 years , the patient continued to be BEG\_\_asymptomatic\_\_END .\nShe had good functional range of movements at both the hips with a BEG\_\_Harris Hip Score\_\_END of 77.85 on the right and 77.2 on the left , with normal radiographs ( figure 4 ) and good functional outcome .\n\nDiscussion\n\nMynter reported the first case of BEG\_\_abscess of the psoas muscle\_\_END , referred to as BEG\_\_psoitis\_\_END , in 1881 .\nBEG\_\_Typical symptoms\_\_END are BEG\_\_back pain\_\_END , BEG\_\_fever\_\_END and BEG\_\_limp\_\_END , 2 present only in 30 % of patients , 2 but general symptoms may mask this condition , delaying diagnosis and BEG\_\_management\_\_END .\n\nBEG\_\_Staphylococcus aureus\_\_END is the main cause of BEG\_\_abscess\_\_END , with an BEG\_\_increased incidence of methicillan resistant S. aureus\_\_END over the past few years2 .\nThe presentation of this case is unusual .\nS. Anginosus was isolated , a BEG\_\_pathogen\_\_END normally present in the oral cavity and gastrointestinal tract .\nIt can cause BEG\_\_local abscesses\_\_END , BEG\_\_endocarditis\_\_END , BEG\_\_osteomyelitis\_\_END , BEG\_\_septic arthritis\_\_END and BEG\_\_septic shock\_\_END .\n11\n\nWe speculate that the BEG\_\_psoas infection\_\_END was likely secondary .\nThe association between BEG\_\_psoas abscess\_\_END and BEG\_\_hip infection\_\_END may be better explained assessing the anatomical features of the iliopsoas bursa , a synovial structure that lies between the tendon insertion of the psoas muscle and its BEG\_\_insertion site\_\_END , the lesser trochanter .\nAs showed in a BEG\_\_cadaveric study\_\_END , the BEG\_\_infection\_\_END could come from the bursa itself , given its communication with the hip joint .\nOn the right side , the BEG\_\_infection\_\_END could have spread through BEG\_\_bone fissures\_\_END present within the acetabulum , due to the BEG\_\_screw penetrating within the pelvis\_\_END .\nAnother explanation to the BEG\_\_bilateral infection\_\_END would be the BEG\_\_formation of a pseudocapsule around the hip\_\_END , secondary to a BEG\_\_primary arthroplasty of the hip\_\_END .\nThis pseudocapsule may have easily communicated with the adjacent bursa of the psoas , allowing the BEG\_\_infection to spread to the ipsilateral hip joint\_\_END .\n\nIn a BEG\_\_retrospective study\_\_END , Dauchy et al9 found a BEG\_\_psoas abscess\_\_END in 12 % of patients admitted with BEG\_\_prosthetic hip infection\_\_END .\nIn BEG\_\_another study\_\_END , 10 7 of 214 patients assessed at BEG\_\_CT\_\_END for BEG\_\_hip infection\_\_END after BEG\_\_hip arthroplasty\_\_END also presented a BEG\_\_psoas abscess\_\_END .\n\nA BEG\_\_CT scan\_\_END with soft tissue window is the standard for BEG\_\_assessment\_\_END of the location , size and extent of the BEG\_\_abscess\_\_END in 80 \u2013 100 % of patients , 6 but BEG\_\_MRI\_\_END is more sensitive .\n2 To the best of our knowledge , there is no evidence in the literature of a case of BEG\_\_bilateral abscess of the psoas muscle\_\_END associated with BEG\_\_bilateral hip infection\_\_END after BEG\_\_hip arthroplasty\_\_END caused by S. anginosus .\nThe incidence of BEG\_\_periprosthetic deep infection\_\_END is 0.3 \u2013 1.7 % .\nIts management is challenging , 12 and remains controversial .\n13 The gold standard is BEG\_\_two - stage revision surgery\_\_END , with BEG\_\_eradication of the infection\_\_END in more that 90 % of patients .\nBased on the algorithm of management by Zimmerli et al , 15 we performed a BEG\_\_two stage re-implantation bilaterally\_\_END .\nIn this instance , the use of the BEG\_\_antibiotic - loaded cement spacer\_\_END and BEG\_\_specific systemic antibiotic therapy\_\_END was decisive ."

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| Query | Answers | Reasons |
| "query":"Simultaneous presentation of @placeholder with BEG\_\_prosthetic joint infection\_\_END is extremely rare . | [{"answers":[{"text":"bilateral psoas abscess","origin":"dataset","sem\_type":"problem","cui":"C0085222"},{"text":"psoas abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Abscesses, Iliopsoas","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"iliopsoas abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Pyogenic Iliopsoas Abscesses","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Iliopsoas Abscess, Pyogenic","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Iliopsoas abscess (disorder)","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Psoas Abscess [Disease/Finding]","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"psoas; abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Pyogenic Iliopsoas Abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"psoas abscess (diagnosis)","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"psoas abscesses","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Psoas abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Abscess, Iliopsoas","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"PSOAS MUSCLE ABSCESS","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Iliopsoas Abscesses, Pyogenic","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Abscesses, Pyogenic Iliopsoas","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Iliopsoas Abscesses","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Abscesses, Psoas","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Iliopsoas Abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Abscess, Pyogenic Iliopsoas","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Iliopsoas abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Psoas Abscesses","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"PSOAS ABSCESS","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"psoas muscle abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Psoas muscle abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Abscess, Psoas","origin":"UMLS","sem\_type":"problem","cui":"C0085222"},{"text":"Psoas Abscess","origin":"UMLS","sem\_type":"problem","cui":"C0085222"}] | The text BEG\_\_psoas abscess\_\_END with origin “dataset” is mentioned in the context |
| "query":"Simultaneous presentation of BEG\_\_bilateral psoas abscess\_\_END with @placeholder is extremely rare . | [{"text":"prosthetic joint infection","origin":"dataset","sem\_type":"problem","cui":"C0410808"},{"text":"infection due to internal joint prosthesis","origin":"UMLS","sem\_type":"problem","cui":"C0410808"},{"text":"infections joints prosthetic","origin":"UMLS","sem\_type":"problem","cui":"C0410808"},{"text":"infection due to an internal joint prosthesis","origin":"UMLS","sem\_type":"problem","cui":"C0410808"},{"text":"infection due to internal joint prosthesis (diagnosis)","origin":"UMLS","sem\_type":"problem","cui":"C0410808"},{"text":"Prosthetic joint infection (disorder)","origin":"UMLS","sem\_type":"problem","cui":"C0410808"},{"text":"Prosthetic joint infection","origin":"UMLS","sem\_type":"problem","cui":"C0410808"},{"text":"Infected arthroplasty","origin":"UMLS","sem\_type":"problem","cui":"C0410808"},{"text":"Infected joint prosthesis","origin":"UMLS","sem\_type":"problem","cui":"C0410808"},{"text":"infections joint prosthetic","origin":"UMLS","sem\_type":"problem","cui":"C0410808"}] | The text BEG\_\_prosthetic joint involvement\_\_END with origin “dataset” is mentioned in the context |
| "query":"BEG\_\_Streptococcus anginosus\_\_END is an uncommon cause of @placeholder and is usually isolated from the BEG\_\_oral and gastrointestinal tract\_\_END ."} | [{"text":"joint infection","origin":"dataset","sem\_type":"problem","cui":"C0157749"},{"text":"infection joints","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"infectious joint disease","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"[X]Infectious arthropathies (disorder)","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Infectious disorder of joint","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Infectious arthropathies","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"arthropathy associated with infections","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Arthropathy associated with infections","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Infectious disorder of joint (disorder)","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"infections joint","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Joint Infection","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Arthropathy related to infection (disorder)","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Arthropathy associated with infection (disorder)","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"infection joint","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Arthropathy related infection","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Infectious arthropathy, NOS","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"infections joints","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"[X]Infectious arthropathies","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Infectious arthropathies (M00-M02)","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"infectious arthropathy","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Arthropathy related to infection","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Infectious arthropathy","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"arthropathy associated with infections (diagnosis)","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Arthropathy associated with infection","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Infection-associated arthritis, NOS","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Arthropathy associated with infection, NOS","origin":"UMLS","sem\_type":"problem","cui":"C0157749"},{"text":"Joint infection","origin":"UMLS","sem\_type":"problem","cui":"C0157749"}] | The text “joint infection” with origin “dataset” is mentioned in the context. Should co-relate with “presentation is unusual”. Additional knowledge required that BEG\_\_septic arthritis\_\_END is a joint infection. |

# CONTEXT 6

Title: "BEG\_\_Crescent - shaped extensive pericardial calcification\_\_END"

Context: "Description\n\nA 65 - year - old man presented with BEG\_\_symptoms\_\_END of BEG\_\_angina\_\_END at rest .\nOn BEG\_\_evaluation\_\_END , his BEG\_\_ECG\_\_END showed BEG\_\_T wave inversion\_\_END in the anterior leads .\nBEG\_\_Troponin T\_\_END was BEG\_\_elevated\_\_END .\nBEG\_\_Echocardiography\_\_END revealed that the apex and anterior wall of the left ventricle was BEG\_\_hypokinetic\_\_END with normal left ventricular function .\nBEG\_\_Fluoroscopy\_\_END during the BEG\_\_angiogram\_\_END revealed a BEG\_\_stunning image\_\_END of BEG\_\_crescent - shaped extensive pericardial calcification along the right atrium and right ventricle\_\_END ( figure 1 , video 1 ) .\nAn BEG\_\_extensive crescent - shaped calcification\_\_END was noted ( figure 2 , video 2 ) .\nExtension into the diaphragmatic surface was seen in the lateral view ( video 3 ) .\nThe BEG\_\_coronary angiogram\_\_END revealed a BEG\_\_triple vessel disease\_\_END .\nHe was evaluated for BEG\_\_pericardial calcification\_\_END .\nBEG\_\_CT of the chest\_\_END showed BEG\_\_dense pericardial calcification along the right atrium , right ventricle\_\_END and atrioventricular groove ( figure 3 ) .\nThe patient did not give a history of having BEG\_\_tuberculosis\_\_END in the past .\nBEG\_\_Echocardiography\_\_END was reviewed , which showed that there was no BEG\_\_significant respiratory variation in mitral and tricuspid inflow velocities\_\_END ( figures 4 and 5 ) .\nBEG\_\_Tissue Doppler velocities\_\_END were normal ( figures 6 and 7 ) .\nHence , BEG\_\_constrictive pericarditis\_\_END was ruled out .\nThere was no evidence of BEG\_\_hypercalcaemia\_\_END or BEG\_\_parathyroid abnormality\_\_END .\n\nBEG\_\_AP view\_\_END showing BEG\_\_extensive calcification along right atrium and right ventricle\_\_END .\n\nVideo 2\n\nBEG\_\_AP Caudal view\_\_END showing BEG\_\_crescent shaped calcification in the pericardium\_\_END .\n\nVideo 3\n\nBEG\_\_Iateral view\_\_END showing BEG\_\_extensive calcification in right atrium , right ventricle and diaphragmatic surface\_\_END .\n\nThe most common cause for BEG\_\_pericardial calcification\_\_END is BEG\_\_tuberculosis\_\_END .\nWhereas in the developed countries , common causes for the same is postsurgery , BEG\_\_trauma\_\_END , BEG\_\_uraemia\_\_END and BEG\_\_postradiation\_\_END and idiopathic .\n1 The atrioventricular groove is the most common site for BEG\_\_pericardial calcification\_\_END , along with involvement of the inferior and the diaphragmatic portions of the pericardium .\nBEG\_\_Pericardial calcification\_\_END is not pathognomonic of BEG\_\_constrictive pericarditis\_\_END .\nThirty to 70 % of patients with BEG\_\_constrictive pericarditis\_\_END have BEG\_\_pericardial calcification\_\_END .\n2 In our patient , in spite of having an BEG\_\_extensive pericardial calcification\_\_END , there was no evidence found of BEG\_\_constrictive pericarditis\_\_END on BEG\_\_echocardiography\_\_END ."

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| Query | Answers | Reasons |
| "query":"@placeholder of the pericardium may occur in the absence of BEG\_\_constrictive pericarditis\_\_END . | [{"text":"Extensive calcification","origin":"dataset","sem\_type":"problem","cui":"C1533591"},{"text":"CALCIUM DEPOSIT","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"Calcium deposition, NOS","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"CALCIUM DEPOSITS","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"Deposition, calcium","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"Calcification","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"Calcium Depositions","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"Calcium deposits","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"Deposit calcium","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"mineralization","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"CALCIFIC","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"Mineralization, NOS","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"Calcification, NOS","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"Mineralization","origin":"UMLS","sem\_type":"problem","cui":"C1533591"},{"text":"DEPOSIT CALCIUM","origin":"UMLS","sem\_type":"problem","cui":"C1533591"}] | The text BEG\_\_extensive calcification along right atrium and right ventricle\_\_END with origin “dataset” is mentioned in the context. |
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