Patient #083

Chief Complaint: This 58 year old black woman presented with shortness of breath.

History of Present Illness: The patient had a history of hypertension and had had three weeks of intermittent left sided chest pain. The pain radiated to the back and improved when she leaned forward. There was no change with exertion. Pains lasted for approximately one minute. She also complained of increasing shortness of breath over the previous month. She became dyspneic performing minimum household chores. She denied orthopnea, PND or lower extremity edema. She had an occasional nonproductive cough. She had been seen by a local doctor prior to admission, found to be hypertensive and started on treatment. She complained of night sweats and fever over the previous week but had no weight loss.

Past Medical History: Her medications on admission included verapamil 180 mg p.o. q.d., benazepril 10 mg p.o. q.d. and furosemide 20 mg q.d. She had previous trauma to the right eye resulting in blindness. She had a total abdominal hysterectomy and bilateral oophorectomy in the 1970's.

Social History: She smoked for ten years, but not any during the previous twenty years. She drinks one beer every six months. She works in the home and lives with her husband.

Physical Examination: Her pulse was 90, blood pressure 159/107, temperature 38.3^{o}C and respiratory rate, 22. She had mild tachypnea at rest but was in no apparent distress. Her pupils were equally round and reactive to light. The TM's were normal. Her mucus membranes were moist. The right cornea was opacified. There was no thyromegaly. Jugular venous pulsations were visible at 8 cm. There was no adenopathy. There were no breast masses. The first and second heart sounds were normal. There was an S4 and a II/VI systolic ejection murmur. There were no rubs. The lungs were clear to auscultation and percussion. The bowel sounds were normal. The abdomen was soft and non-tender with no masses, or organomegaly. The stool was guaiac negative. The pulses were strong and equal bilaterally. There was no cyanosis or edema. The neurologic exam was normal.

Laboratory:

			Normal
CBC	Hct	28	*38-47 %*
	Hgb	8.7	*12.3-15.7 g/dl.*
	MCV	76	*81-97 fl*
	RDW	15.1	*12-15 %*
	WBC	8.1	*4-12 X $10^{9/L}$*
	Neut	74	*40-70 %*
	lymph's	18	*20-50 %*
	mono	6	*2-10 %*
	platelet count	472	*150-440 X 10^{9}/l*
Chemistries	sodium	142	*135-145 mmol/l*
	potassium	3.9	*3.5-5.0 mmol/l*
	chloride	99	*100-111 mmol/l*
	CO2	26	*24-30 mmol/l*
	creatinine	1.2	*0.6-1.2 mg/dl*
	BUN	17	*8-20 mg/dl*
	bilirubin, total	.4	*0-1.2 mg/dl*
	AST (SGOT)	116	*9-26 U/L*
	ALT (SGPT)	91	*7-30 U/L*
	LDH	371	*108-215 U/L*
	ALP	168	*39-117 U/L*
	GGT	71	*5-39 U/L*
	PT	11.7	*10-13 sec.*
	APTT	30.9	*21.5-31.9 sec.*
	Serum iron	23	*35-165 ug/dl*
	TIBC	286	*320-550 mcg/dl*
	% saturation	8	*20-45%*

Urinalysis: trace protein, no blood, 1+ nitrites. 3-7 WBC's, no RBC's, 10-15 squamous epithelial cells, and 3+ bacteria.

Chest X-ray: globular cardiomegaly with small left pleural effusion and sub-segmental atelectasis or scarring in the right costophrenic angle. Loculated fissural fluid in the left mid lung zone. No overt congestive heart failure.

EKG: small Q waves in the inferior leads. No ST segment or T wave abnormalities. Voltage within normal limits.

On the second hospital day the patient underwent an echocardiogram that showed a large pericardial effusion. Pericardiocentesis was performed and 800 cc of blood tinged serous fluid was withdrawn. The fluid had 58,250 RBC's/ mm^3 and 3,750 nucleated cells per mm^3. There were 78% neutrophils, 5% lymphocytes, 11% monos, 1% eos and 5% other. There were no malignant cells identified in the pericardial fluid. After drainage of the pericardial effusion the patient was noted to have a I/VI blowing diastolic murmur at the left sternal border. A urine culture showed greater than 100,000 E coli. Blood cultures and pericardial fluid cultures were negative.