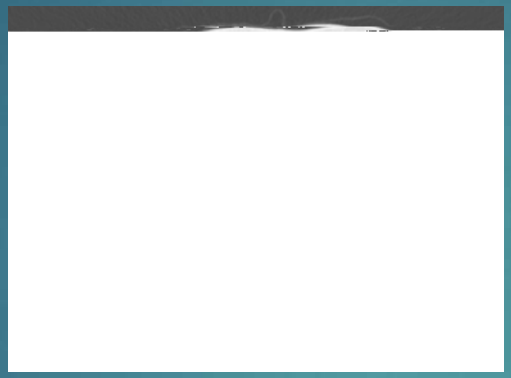
Background

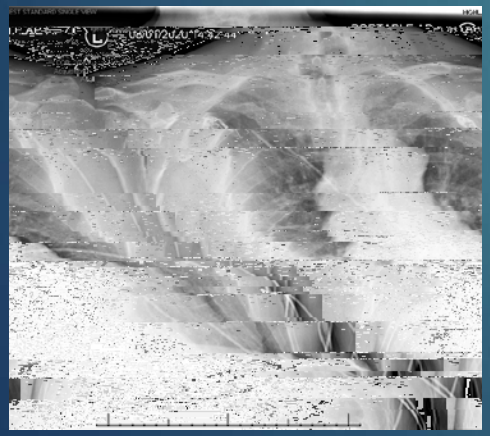
- Post-pericardiotomy syndrome (PPCS) occurs secondary to pericardial injury generally post-cardiac procedure (valve replacement, PCI, PPM, RF ablation)
- Occurs in a large percentage of patients (10-40%) who have undergone cardiothoracic surgery
- Frequently underdiagnosed because it is a clinical diagnosis which typically presents after patient discharge
- Contributes significantly to post-op morbidity, prolonged hospital stays, readmissions
- Presents with fever, pleuritic chest pain, pericardial rub, elevated c-reactive protein (CRP) and pericardial/pleural effusions.
- Unilateral pleural effusions are reported in a minority of patients with PPCS
- This is an unusual case of PPCS that presented with primarily pulmonary symptoms and a large R pleural effusion which was refractory to initial treatment and ultimately required therapeutic drainage

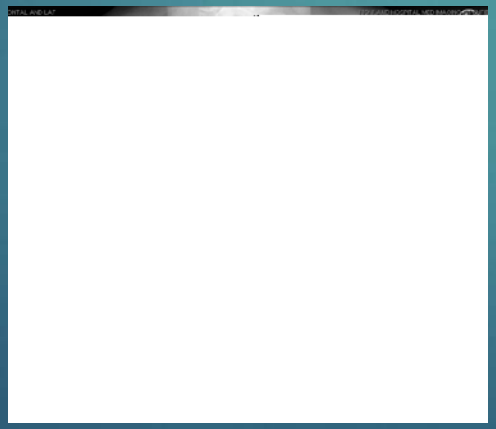
Case Presentation

A 65-year-old man with a 22-pack-year smoking history, severe aortic stenosis, and recent bioprosthetic aortic valve replacement presented with worsening dyspnea, productive cough, fever, and night sweats.

Clinical Course







Conclusions

- Post-cardiac injury syndrome:
  - PPCS
  - Post-MI syndrome (Dresser syndrome)
  - Post-traumatic pericarditis
- Characterized by pericarditis - pleuritic chest pain in >80% of patients
- Exudative pleural effusions observed in PPCS, but 85% are small and left-sided
- A unique case of PPCS in a patient who presented without chest pain and was found to have a predominantly large right-sided pleural effusion refractory to first-line treatment
- Diagnosis was complicated by a clinical picture suspicious for pneumonia versus malignancy
- Symptomatic improvement in this case was ultimately achieved with systemic glucocorticoid therapy and therapeutic thoracentesis