IMAGES IN EMERGENCY MEDICINE

Fluid on the chest

A 29-year-old man was referred from clinic complaining of worsening dyspnoea, chest pain and weight loss for 1 month. He was HIV positive on antiretroviral medication.

On arrival in our emergency department he was markedly dyspnoeic with a respiratory rate of 42 breaths per minute. Pulse rate was 150 and blood pressure was 90/52 mm Hg. He had muffled heart sounds and dilated neck veins. A plain chest radiograph (figure 1) showed a massively dilated, globular heart. Bedside ultrasound confirmed a large pericardial effusion with radiological evidence of cardiac tamponade.

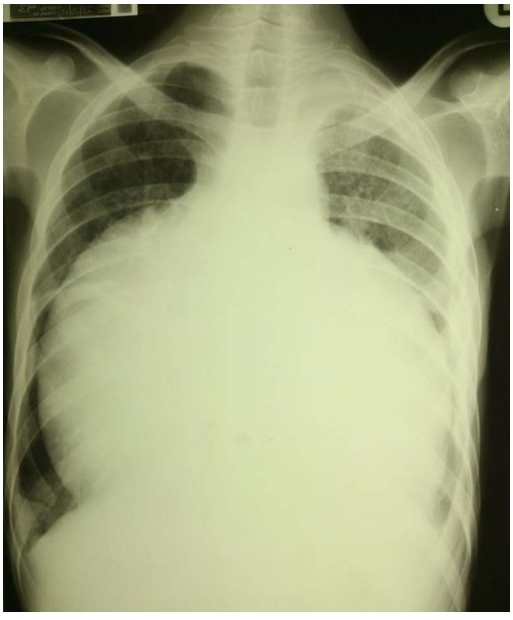

Figure 1 Plain chest radiograph showing a massive, globular heart secondary to a tuberculous pericardial effusion.

Urgent pericardiocentesis was performed and blood-stained fluid obtained. His clinical condition stabilised and he was admitted to the ward with a pericardial drain in situ. Over the next 24 h, 1900 mL of pericardial fluid was drained. Biochemistry showed an exudative effusion. He was started on steroids and antituberculous therapy for a presumed tuberculous pericarditis and discharged from the ward 2 weeks later.

Pericardial disease is a common manifestation of cardiovascular disease in patients with AIDS. Although rare in developed countries, tuberculosis is the commonest cause of pericarditis in Africa.[1] Regardless of aetiology, if tamponade occurs, immediate drainage is required in the emergency department.

Hazel Morrison, John Gilbert, Will Loughborough, Seelan Pillay

Emergency Department, Stanger Hospital, Stanger, KwaZulu- Natal, South Africa

Correspondence to Dr Hazel Morrison, Emergency Department, Stanger Hospital, Corner of King Shaka and Patterson Street, Stanger, KwaZulu-Natal, South Africa, hazelmorrison@doctors.org.uk

Contributors HM wrote and submitted the article. HM, JG and WL planned and edited the article. WL gained patient consent. JG obtained imaging. SP helped edit the article and is the overall guarantor.

Competing interests None.

Patient consent Obtained.

Ethics approval

Provenance and peer review Not commissioned; internally peer reviewed.

To cite Morrison H, Gilbert J, Loughborough W, *et al*. *Emerg Med J* 2014;**31**:407.

Accepted 21 August 2013
Published Online First 12 September 2013

Emerg Med J 2014;**31**:407. doi:10.1136/emermed-2013-203129

REFERENCE

1 Mayosi BM, Burgess LJ, Doubell AF. Tuberculous pericarditis. *Circulation* 2005;112:3608–16.