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A RARE CASE OF PERICARDIAL EFFUSION DUE TO IV FLUIDS

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ABSTRACT

A 25-year-old female presented with fever, shortness of breath, and interscapular pain. Investigations revealed moderate pericardial effusion, pulmonary edema, and anemia. Managed conservatively due to financial constraints, she showed significant improvement after discharge on antibiotics. Follow-up confirmed resolution, highlighting the value of tailored care in managing idiopathic pericardial effusion.

KEYWORDS: Pericardial effusion, Pulmonary edema, Conservative management.

INTRODUCTION

Pericardial disease can be due to inflammatory neoplastic vascular.

Iatrogenic and Idiopathic

All other causes of pericardial effusion were excluded and this case was a part of iatrogenic or over enthusiastic treatment with IV fluids. It was admitted in our institute.

CASE REPORT

A 25 year old female patient with unremarkable medical history presented to the OPD setting with complaints of fever, shortness of breath, generalized weakness and left interscapular and infrascapular pain. For these complaints, she initially tried home remedies and alternative medicines and care at a local medical facility on outpatient basis. She then reports noticing no improvement in her condition and was brought to our tertiary care for further treatment.

She was having tachycardia and tachypnea. Physical examination revealed normocephalic head, clear sclear and conjunctiva with normal tongue. Patient is febrile, pulse - feeble, BP - 100/70, Respiratory rate - 26 breaths per min and

Spo2 - 93%; On Neurological exam she was Alert and oriented. Cranial nerves were grossly intact. Musculoskeletal system demonstrated full and active range of motion in all extremities on gross evaluation except some discomfort in between the shoulder blades.

Systemic examination

CV system: Tachycardia with heart sounds less pronounced

CN system: Higher mental functions were found normal

Per Abdomen: Soft, non tender, mildly distended, bowel sounds heard.

Respiratory system: Tachypnea.

Based on the clinical presentation, laboratory work up in the inpatient setting was suggested for further assessment and evaluation. After hospitalization, Blood investigations, 2D ECHO, ECG, and plain chest X ray was done.

Chest X Ray revealed water bottle heart, ECG showed low voltage complexes, CBP showed moderate anemia with Hb - 9.1Gms% and RBC - 3.3 million/cumm. CT scan of chest confirmed moderate pericardial effusion; pulmonary edema in the left lung lower lobe and right lung upper and lower lobe - likely pulmonary edema; Right sided mild pericardial effusion with mild ascites and mild gall bladder wall edema. ESR was elevated i.e. 120 mm/hr. 2D ECHO reported large pericardial effusion. Other investigations like urine test, widal test and serum electrolytes were non significant. She denied SLE profile.

In the interim, She was started on conservative management as per treatment protocols. Final diagnosis of Pulmonary edema, Overzealous treatment with IV Fluids and Idiopathic pericardial effusion was made. Cardiologists opinion was taken in view of pericardial effusion and was advised pericardiocentesis. Patient denied to stay in the hospital and undergo the procedure due to financial constraints. Patient was not given any steroids or ATT. The patient was hemodynamically stable and discharged on Tab. Levoflox 500mg once a day x 7 days along with multivitamins and was advised followup thereafter. After one week, she was seen in OPD, Patient was asymptomatic, afebrile, vitals - stable, No SOB. She reported dramatic and gradual improvement. ECG and 2D ECHO were repeated for confirmation and were obtained unremarkable.

CONCLUSION

A commonest cause of pericardial effusion was excluded and this case was considered to be due to overzealous iv fluids administration.

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