Abstract

Pericardial effusion is characterized by abnormal collection of fluid within the pericardial space. It can be classified as mild, moderate and massive depending onthe extent of fluid accumulation and depending on the speed of fluid collection itmay give rise to symptoms relevant to pericardial effusion. Thus, massivepericardial effusion may give rise to cardiac tamponade in the acute setting.Commonest causes for massive pericardial effusion are malignancy, lymphoma,infections like tuberculosis and idiopathic cases where cause is unknown.

Although pericardial involvement is a serious complication in advanced solidorgan malignancies, lymphoma presenting as a massive pericardial effusion israre. Patients presenting with massive pericardial effusions always warrantsthorough investigation with minimal delay in diagnosis.

This is a case of massive pericardial effusion manifesting as the initialpresentation of lympho-plasmacytoid lymphoma in a Sri-Lankan female.

A 66- year-old previously healthy female, presented with sudden onset of rapidly progressive shortness of breath with associated tightening type retrosternal chest pain. On examination she was an averagely built female, who was dyspneic with arespiratory rate of 30/min and an on-air saturation of 93%. She washemodynamically stable with a blood pressure of 100/60mmHg, but wastachycardic with a heart rate of 120bpm. Her jugular venous pressure waselevated and heart sounds were muffled, there were no murmurs and the lungfields were clear. Her ECG showed small volume complexes with poor R waveprogression. Therefore, an urgent 2Dechocardiogram was performed whichrevealed a 25mm width massive pericardial effusion with encasement of all 4chambers, but pericardial wall thickening was not seen. Urgent pericardiocentesiswas performed and 450cc volume of pericardial fluid volume was removed in 2occasions. Her pericardial fluid full report was supportive of an exudate and thecytology, pericardial fluid culture and TB screening were negative.
Her basic investigations revealed anemia with significant leukocytosis withlymphocyte predominance and elevated inflammatory markers. She hadsignificant albumin to globulin ratio reversal and her blood picture revealedmultiple plasmacytoid lymphocytes with anemia probably secondary to irondeficiency. Her serum protein electrophoresis revealed an abnormal monoclonalband seen in the gamma region and the bone marrow biopsy was supportive of alympho-plasmacytoid lymphoma. Flow cytometry findings were consistent with amature B cell lymphoproliferative disorder: in keeping with Lymphoplasmacytoid lymphoma. Immunofixation was positive for a monoclonal band in the IgG kappa region. Autoimmune hemolytic anemia and possibility of amyloidosis was excluded. She underwent chemotherapy after the diagnosis of lympho-plasmacytoid lymphoma was made. During the course of chemotherapy, she passed away following an opportunistic infection