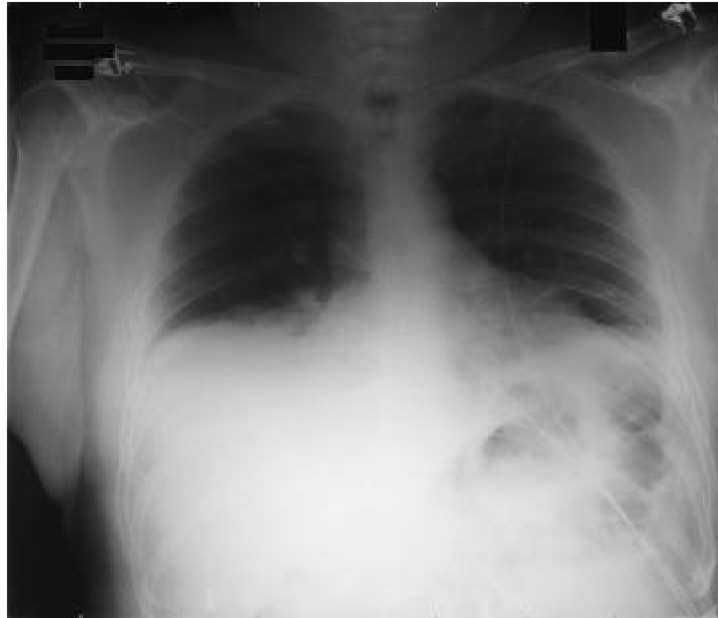
A Pain in the Chest



This is the radiograph of the chest of a 51 year old man who had been complaining of right sided chest pain into his right shoulder for 11 hours and haemoptysis for 8 hours.

His pain was worse on inspiration and movement. Mr M was admitted to ward 18 on 1/03/04 with the same symptoms, where an ETT, Troponin and VQ scan were carried out and were all negative. He was discharged home awaiting follow up appointment to see Dr W.

He was sent to CDU on the Non – Traumatic Chest Pain protocol. On arrival to CDU, his observations were stable. His respiratory rate was 22 bpm and his pain score was 10 out of 10

Later that morning he complained of severe right sided chest pain, radiating to his back and shoulder, worse on inspiration. The patient was finding it difficult to get his breath and to ease the pain.. Observations were unremarkable, his BP was slightly elevated. An ECG showed some changes, abnormal T waves in leads 11/111 and AVF. Diamorphine was given for pain relief. O2 therapy was increased to 10 litres and his observations were satisfactory. The ECG was repeated and there was nil acute. D/w Cardiology, repeat CXR (portable) requested. After review by Cardiology SHO, Respiratory SHO and in view of the under diagnosis and continuing pain, a CTPA would be requested to rule out PE. In the meantime, Tinzaparin would be commenced. D-dimer was less than 200 and Troponin 0.03.

What is the radiological diagnosis?

Click for answer

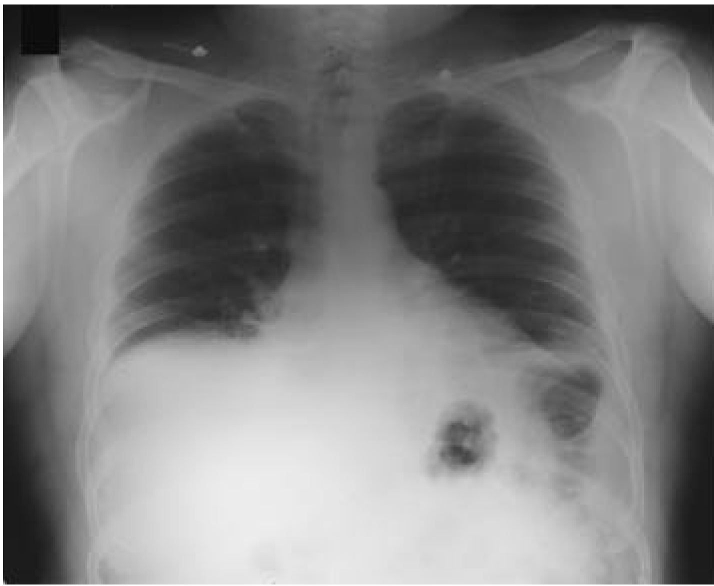
? Raised right hemidiaphragm, trachea deviated to right. ? shadow right base.

What is the diagnosis?

Click for answer

Answer: ? PE ? Atypical pneumonia

How would you manage this patient?



Click for answer

In view of ? underlying cause and no diagnosis from previous admission 3 weeks ago, the patient should be admitted to respiratory medicine for further investigations. The patient was transferred to ward 39 that evening.

After admission to ward 39, the patient spiked a temperature @ 38.8 and was commenced on intravenous antibiotics for 48 hours, then changed to oral antibiotics for a further 48 hours. The CTPA was cancelled as it was felt that in view of the negative results of previous scans and the pyrexia, the suspicion of a PE was very low. The patient was closely monitored and within four days after admission to ward 39 his symptoms were improving. The chest pain was controlled with Co-codamol and Ibuprofen. He had no SOB and was mobilising around the ward. Patient was discharged home on the 28/04/04 with a follow up appointment in 6/52 to see Dr Muers.

Click here for the final diagnosis :-

Chest Pain secondary to Pleurisy secondary to RTI.

Key learning points

1. Always consider continuing chest pain particularly worse on inspiration, despite negative tests previously
2. CXR's should be reported on if they appear abnormal
3. Blood tests and other scans do not always show up PE if not done at the right time

References / Links

http://health.allrefer.com/health/atypical-pneumonia
http://www.2.jeffersonhospital.org
http://www.nlm.nih.gov/medlineplus/ency
http://www.emedicine.com
http://www.healthatoz.com
http://www.biomedcentral.com
http://www.lungusa.org/site
http://www.cnn.com/healthlibrary
http://www.intelihealth.com
http://bmj.bmjjournals.com
http://www.medfrien.com./pleurisy
http://www.studentbjm.com