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Chronic Diaphragmatic Impairment with Kyphosis: Yielding to Pressure

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Clinical Image

A 90 year-old patient with a clinical diagnosis of COPD presented to an urban Canadian emergency department with a complaint of progressive dyspnea for two years despite multiple courses of bronchodilator, antibiotic, and prednisone therapy. Prior chest imaging had not been performed. The patient had a history of progressive functional decline, dyspnea at rest, non-productive cough with wheeze, and progressive height loss. A routine chest radiograph performed by

the Emergency Physician demonstrated a kyphotic spine with marked elevation of an intact left hemidiaphragm (Figure 1A), with migration of abdominal contents cranially into the left hemithorax. Cardiac deviation into the right hemithorax was associated with compressive atelectasis of the right lung, rightward tracheal deviation, and rightward migration of the descending aorta and cardiac apex (Figure 1 B). Diaphragmatic paralysis is an uncommon cause of dyspnea with a broad differential diagnosis. Potentially masquerading as obstructive airways disease, it requires imaging to exclude (Figure 2).

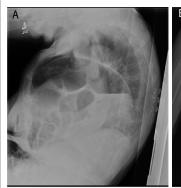




Figure 1A: Lateral Panel.

Figure 1B: PA Panel.



Figure 2: CXR ap and lat.

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