Dyspnea after CABG, What Do You Think: A Case Report

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Abstract

Diagnosis of iatrogenic pneumothorax is often delayed, which should make physicians and critical care nurses vigilant. A 55 year old man referred to the emergency unit with chief complain dyspnea one week after CABG. In pulmonary CT angiography, huge pneumothorax was presented in left lung. Patient underwent emergent chest tube insertion and discharged two days later in a good condition.

Keywords: CABG; CT angiography; Pneumothorax

Introduction

Post Coronary Artery Bypass Graft (CABG) surgery, pulmonary complications account for postoperative morbidity in many patients. These are occurred in 99.4% of CABG patients. Atelectasis, plural effusion and pneumonia were the most frequent complication post CABG [1]. Pneumothorax is an infrequent complication of cardiac surgery. It is more common if postoperative mechanical ventilation is prolonged or if high levels of PEEP is required.

A history of COPD (Chronic Obstructive Pulmonary Disease) and bronchitis were precursors of a postoperative pneumothorax.

Iatrogenic pneumothorax occurs most often following trans-thoracic needle biopsy (24%), subclavian vein catheterization (22%), thoracentesis (20%), transbronchial lung biopsy (10%), plural biopsy (8%) and positive pressure ventilation (7%) [2]. Diagnosis of iatrogenic pneumothorax is often delayed; therefore physicians and critical care nurses must be vigilant.

Case Report

A 55 years old man referred to the emergency unit of a general hospital with chief complain dyspnea. Dyspnea was started from one day before his referral, onset was gradual. It is not aggravated by exertion and he did not complain of chest pain or palpitations or cough, he underwent coronary artery bypass graft surgery about one week ago. He denied fever and chills and didn't have diabetes, but was hypertensive. He did not smoke at anytime.

His family history was positive for coronary disease but negative for asthma. Findings on physical examination were: an anxious, a febrile man who had sinus tachycardia, at the rate of 110 per minute, his blood pressure was 135/84 mmHg. He didn’t have respiratory distress. Jugular venous pressure was normal, and due to chest pain, he did not have good cooperation for examination of lung. Examination of the thorax revealed normal anteroposterior diameter, chest pain, he did not have good cooperation for examination of lung.

In a study of 315 patients who had CABG surgery at a large healthcare center risk factors for pulmonary complication were recorded: history of bronchitis and COPD were related to postoperative pneumothorax in most cases [3]; in another retrospective nine-year analysis of adult cardiac surgical procedures, twenty-one of 1463 patients suffered a postoperative pneumothorax for an overall incidence of 1.4% [4]. Although it is not frequent, but it must consider as a lung complication after CABG. Our patient did not present with the common symptoms and signs associated with huge pneumothorax however early identification of this fatal complication of CABG is critical to prevent morbidity and mortality of patients.

References


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