An Interesting Case of Mediastinal Adenopathy

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Abstract

Mediastinal adenopathy in a dyspneic patient can be due to infective conditions like tuberculosis, lymphoreticular malignancies, sarcoidosis etc. Its occurrence in congestive heart failure is not commonly reported. The knowledge of this association is essential for the expeditious and correct management of the patients.

Keywords: Mediastinal Adenopathy; Congestive Heart Failure

Introduction

Even though Mediastinal adenopathy is not an uncommon sign of severe congestive heart failure, it is underreported. Its presence in CHF may lead to misdiagnosis. We present a case of congestive mediastinal adenopathy to emphasize the pattern of involvement to avoid unnecessary invasive procedures.

Case Report

A 55-years-old hypertensive male was admitted with acute breathlessness and dry cough for three days duration. He had history of orthopnea. He was not a diabetic, asthmatic or Coronary Artery Disease patient. He was a non-smoker and non-alcoholic. On examination bilateral basal crepitations were noted. His complete hemogram and metabolic blood work up were within normal limits. Chest x-ray showed bilateral blunted costo-phrenic angles and increased Cardio-thoracic ratio. CT Chest revealed bilateral interlobular septal thickening, bilateral moderate pleural effusion and significant mediastinal adenopathy (Figure 1-3). The right lower paratracheal [4R] and subcarinal nodes [7] were enlarged but hilar nodes were normal. His auto immune blood panel was negative. His echocardiogram revealed severe Left ventricular dysfunction with ejection fraction of 30%. The final diagnosis of cardiogenic pulmonary edema with congestive mediastinal adenopathy was arrived and he was treated with CPAP and diuretics. He improved well.

Figure 1
An Interesting Case of Mediastinal Adenopathy

Figure 2

Figure 3

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Discussion

The association of mediastinal adenopathy in acute volume overload conditions has been described in few studies and it is not associated with chronic cardiac failure, renal failure, or CAD without left ventricular dysfunction.

In 1998, Slanetz, et al. retrospectively analysed 46 patients with acute heart failure and identified 55% of them with hypertrophied mediastinal lymph nodes [1].

In 2004, Chabbert, et al. in a prospective study of 31 cases with heart failure demonstrated an average EF of 34% in patients with adenopathy versus 43% in those not having adenopathy [2].

Ngom, et al. demonstrated the pathology from mediastinoscopic biopsy as benign sinus histiocytosis [3].

Yousef R Shweiihat, et al. in the largest study of congestive adenopathy postulated that the increased volume of fluid passing through the lymphatic system during acute hypervolemic status leads to mediastinal nodal congestion and hypertrophy along with interstitial and alveolar edema. Enlargement of more than one mediastinal node in the presence of acute pulmonary edema or volume-related bilateral pleural effusion should probably need not be undergone invasive diagnosis procedures, especially if 4R station is involved. Isolated hilar adenopathy is almost never seen in volume overload.

Conclusion

This knowledge of distribution of congestive adenopathy will be helpful to promptly diagnose and treat without any iatrogenic complications [4].

Bibliography


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