

**PP119 DOUBLE EDGE SWORD, A
RARE CASE OF MASSIVE
PULMONARY EMBOLISM WITH
THORACIC AORTIC DISSECTION**

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INTRODUCTION:

This case report describes a case of 41-year-old patient with massive PE with coincidental finding of thoracic aortic dissection.

CASE:

41-year-old male presented to our emergency department (ED) with 3-day history of dyspnea, productive cough with blood streaked sputum and episodes of syncope. He was intubated and mechanically ventilated for severe respiratory distress. Physical examination revealed signs of circulatory collapse, elevated jugular venous pressure and basal crackle. There was no clinical evidence of aortic dissection (AD) and deep vein thrombosis (DVT) of both lower limbs.

RESULT:

Mobile chest radiograph demonstrated widened mediastinum. Subcostal echocardiography view showed dilated right atrial chambers with inter-atrial septum bowing toward left atrial with the RA/LA ratio was less than 1. Urgent computed tomography pulmonary artery (CTPA), and angiogram of the thorax and abdomen revealed ascending aortic aneurysm with AD (Stanford A) and bilateral PE.

DISCUSSION :

Point Of Care Ultrasonography (POCUS) is typically performed at bedside, interpreted and integrated into care by emergency physicians in hemodynamic unstable PE patient. Acute PE may lead to right ventricular pressure overload and dysfunction, which are detectable by echocardiography. In this reported case, the findings of subcostal echocardiographic view were in consistent with elevated right ventricular afterload.

Immediate systemic thrombolysis without further diagnostic work-up is recommended in a highly unstable patient with echocardiography evidence of right ventricle dysfunction. However, AD is one of the absolute contraindication for systemic thrombolytic therapy, therefore it was not initiated in this reported case. Family members opted for medical therapy after the discussion with cardiathoracic team. Patient was admitted to CCU for continuation of medical therapy, which consist of parenteral anticoagulant. Fortunately, patient's condition improved and was discharged with outpatient CTC appointment.

Despite comprehensive literature search, we could not find similar case report to support the best treatment modality in such complex case.

CONCLUSION :

Even-though the principles of management of massive PE are prompt diagnosis and timely reperfusion therapy, clinician should actively sought for the contra-indication for therapy. This article demonstrates the importance of early involvement of multidisciplinary team in managing a complex illness pertaining to this case