Pyrexia of unknown origin presenting as Aortic Root dissection

Nilanka Mudithakumara[1*], Srijith Dahanayake[2]
1. Post Graduate Institute of Medicine, Sri Lanka
2. Base Hospital Siyambalanduwa, Sri Lanka
Correspondence to: Nilanka Mudithakumara
*Post Graduate Institute of Medicine, Sri Lanka.
Email: tmnilanka@gmail.com
DOI: 10.24911/SJEMed.12-2607

Introduction

Pyrexia of unknown origin (PUO) is a rare emergency presentation, and the origin of pyrexia is rarely found in the emergency department (ED) because it requires extensive blood, imaging, and other investigations to come to a diagnosis. Aortic root dissection is a rare presentation of PUO that could present as an unstable cardiac tamponade. Aortitis is a rare etiology of PUO as well. This case is a rare triple combination of PUO, present as an aortic root dissertation, with an etiology of aortitis.

Case Report

A 50-year-old previously healthy Sri Lankan male with a history of on-and-off fever for one month presented to a peripheral ED with dizziness was found to have low blood pressure of 86/52mmHg with a heart rate of around 120bpm, with audible heart sounds, no elevation of jugular venous pressure, and with other stable vital parameters. He had no fever on admission. Initial stabilization and sepsis hour-one bundle was activated, along with other investigations. The electrocardiogram showed small complexes with electric alternants raising a suspicion of cardiac tamponade.

The patient neither had radio radial delay, radio femoral delay, or discrepancy of bilateral upper limb blood pressures initially, nor chest or abdominal pain. No analgesics were required initially. The patient developed a severe (pain score 10/10) tearing interscapular pain in minutes, with the loss of left side radial pulse, and went into cardiac arrest before the ultrasound scan was switched on. With ongoing cardiopulmonary resuscitation, the sub-xiphoid window revealed a circumferential pericardial effusion of more than 5-6cm in size in the point-of-care Ultrasound. 400cc of unclotted pure blood was aspirated with ultrasound-guided pericardiocentesis. However, the patient succumbed to death, and the postmortem revealed features of aortitis and aortic root rupture leading to cardiac tamponade as the cause of death.

Conclusion

PUO may rarely present as aortic root dilatation. Subtle features of aortic dissection could be a warning sign of an impending catastrophic complication. Being vigilant of possible different pathologies and being aware of the existence of dual pathologies is the cornerstone to not miss a pathology.