Case report of simultaneous presentation of pulmonary embolism and pericardial effusion following an oncological esophagectomy

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A B S T R A C T

INTRODUCTION: This is the first reported case of simultaneous presentation of pulmonary embolism and pericardial effusion following esophagectomy. This case illustrates a diagnostic and therapeutic challenge exemplifying the difficulties arising from complex anticoagulant considerations in esophageal cancer.

PATIENT CASE: A 72 year old male undergoes an oncological esophageal resection. Postoperatively the patient develops pulmonary embolism for which he is treated with Rivaroxaban. After starting Rivaroxaban the patient develops a large pericardial effusion.

DISCUSSION: We suspect that the treatment of pulmonary embolism with Rivaroxaban had a causative role in the development of pericardial effusion. Based on literature we suspect that chemoradiotherapy increased susceptibility.

CONCLUSION: Diagnosis and treatment of simultaneous pulmonary embolism and pericardial effusion remains a challenge. Special consideration should be taken when using Rivaroxaban in esophageal cancer patients; this should always be conducted in consultation with a coagulation specialist.

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1. Introduction

Esophageal cancer (EC) is a serious diagnosis with high morbidity and mortality. Treatment involves chemoradiotherapy and esophageal resection. This is a complex procedure with a high risk of complications [1].

We present a case of a 72-year-old male with progressive chest pain (CP) and shortness of breath (SoB) following an uncomplicated esophagectomy in a University Medical Center in the Netherlands. The symptoms were initially attributed to a massive pulmonary embolism (PE) for which Rivaroxaban was started. Six days after, a pericardial effusion (Pce) was seen on CT alongside the PE.

This is the first reported case of the simultaneous presentation of PE and Pce following esophagectomy. This case illustrates a diagnostic and therapeutic challenges, exemplifying the difficulties arising from complex anticoagulant considerations in EC.

The case is presented according to SCARE criteria [2].

2. Presentation of case

A 72 year-old Caucasian male (Table 1) was diagnosed with distal esophageal squamous cell carcinoma (ct2N1M0) for which he received carboplatin/paclitaxel chemoradiotherapy. After 5 cycles, positron emission tomography showed complete response to therapy. Due to the aggressive nature of the cancer, an esophagectomy was indicated. Twelve weeks after the last chemoradiotherapy session the patient underwent a robot-assisted minimally-invasive esophagectomy with intra-thoracic anastomosis. Procedure was executed by two experienced GI surgeons.

On postoperative day (POD) 2 the patient developed SoB and CP. This was initially deemed reflective of recent post-operative status, however a progression in symptoms warranted additional imaging. A CT on POD 6 showed bilateral PE (left being segmental) with infarction of the right lower lobe and bilateral consolidations suggestive of pneumonia (Fig. 2). Therapeutic fraxiparine 2dd1 7600IE and antibiotics were immediately administered.

On POD7 the patient became acutely dyspneic requiring admission to the intensive care with acute respiratory failure secondary to PE and pneumonia. ECG showed atrial flutter. In the blood, a doubling of CRP (350 mg/L) with leukocytes of 15.50 × 10^9/L and stable hemoglobin were observed (Fig. 1). Optiflow and amiodarone were started, after which respiratory status improved and the arrhythmia converted to sinus rhythm. The patient was transferred back to the surgical ward where he continued to recuperate.

On POD13 the patient was switched to Rivaroxaban 2dd15 mg (Fig. 1), as this was deemed a better treatment for the arrhythmia and PE. Due to anxiety quetiapine 1dd12.5 mg, and lorazepam 1dd10 mg were also initiated.

Despite treatment, symptoms of SoB and CP continued to progress. Elevated CRP of 100 mg/L and leukocytes of 13.0 × 10^9/L suggested the symptoms were due to the PE and pneumonia. On
POD17 a hypotensive episode (94/68 mmHg) with a regular heart rate of 96bpm was observed. X-thorax showed bilateral pleural fluid and an enlarged heart. On CT a massive PCE was seen with pleural fluid, bilateral consolidations, and mediastinal air pockets suggestive of an anastomotic leakage (AL) (Fig. 2). A transthoracic echocardiogram showed substantial pericardial fluid with no signs of imminent tamponade. Rivaroxaban was stopped, and via pericardiacentesis 1150 mL of fluid was aspirated from the pericardium.

Fig. 1. Vital signs, laboratory findings and anticoagulation scheme during postoperative admission; CRP: C-Reactive Protein.  
Addendum 1: Clinical course.
Table 1
Patient Characteristics.

<table>
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<th>Baseline characteristics</th>
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<th>2004/09</th>
<th>2016</th>
<th>2019/03</th>
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<tr>
<td>Age</td>
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<td>Race</td>
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<td>Medical History</td>
<td>Myocardial infarction</td>
<td>Peripheral T-Cell Non-Hodgkin Lymphoma</td>
<td>Recurrence T-cell Non-Hodgkin Lymphoma</td>
<td>Colon carcinoma, pT3N0M0</td>
<td>Esophageal cancer, cT2N1M0</td>
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<td>2001</td>
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<tr>
<td>Medication</td>
<td>Lorazepam 1 mg once a day</td>
<td>Rosuvastatin 5 mg once a day</td>
<td>Carbasalate calcium 100 mg powder once a day</td>
<td>Perindopril 2 mg once a day</td>
<td>Neoadjuvant chemoradiation (carboplatin/paclitaxel)</td>
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<td>Allergies</td>
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<td>Alcohol: Yes, 6 glasses of alcohol per week</td>
<td>Drugs: Never</td>
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<td>Social Context</td>
<td>Marital status: Married</td>
<td>Employment: Manager wholesale glass company: retired</td>
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</table>

Pathological assessment of the fluid showed blood without malignant cells. A cytogram showed erythrocytes, a few leucocytes, no bacteria nor other microorganisms. Therapeutic fraxiparine was resumed 8 h post-pericardiocentesis. Intravenous antibiotics were administered in treatment of the lung consolidations. A small defect at the anastomosis was gastroscopically confirmed, and treated conservatively with antibiotics and nihil by mouth.

Following pericardiocentesis the CP and SoB symptoms improved. X-thorax showed reduced heart contours and pleural fluid. ECG showed sinus rhythm. Laboratory workup showed normalization of infection parameters. The patient was observed for another 5 days without complications before he was discharged from hospital.

3. Discussion and conclusion

This is the first reported case of the simultaneous presentation of PE and PCE following esophagectomy. The case poses diagnostic and therapeutic challenges arising from complex anticoagulation considerations.

There are few reported cases of PCE following an esophagectomy [3,4]. This procedure requires the surgeon to work in close proximity to the pericardium in order to dissect and prepare the esophageal tissue for resection. Surgical trauma may precipitate the development of a PCE shortly following surgery. In our case, the PCE was diagnosed on POD20, suggesting that surgical trauma played no direct role in its development.

A systematic review by Pabba et al. [5] presents 7 cases of concurrent PE and PCE in cancer patients, with PCE deemed secondary to malignancy based on cytological fluid analyses. In our case, cytological and pathology results showed no malignant cells. Another common cause of PCE is infection. We found no evidence of elevated white blood cells or microorganisms in cytology, suggesting an alternative cause of PCE.

Our patient received preoperative chemoradiotherapy. Several observational studies on the incidence of PCE following chemoradiotherapy for EC report an incidence of 27.7–57.0% with a median onset of 5.3–12 months following the last chemoradiotherapy session [6,7]. In our case, the PCE was diagnosed approximately 15 weeks after the last chemoradiotherapy session, suggesting that the chemoradiotherapy may have played a role in the development of PCE.

Considering the timeline, SoB and CP symptoms worsened one day after the start of Rivaroxaban. At this time, we see a downward trend in hemoglobin levels - possibly indicating an active bleed. The fact that the patient did not develop a cardiac tamponade despite having almost 1200 mL of blood in the pericardium, suggests that the blood accumulated slowly. Together this draws suspicion towards Rivaroxaban as the PCE-cause. A case series by Cinelli et al. (2019) [8] presents three cases of direct oral anticoagulant (DOAC)-induced PCE in oncologic patients. All three cases showed malignant cells in fluid cytology, suggesting that this may have played a causative role rather than Rivaroxaban.

The current standard of treatment for PE is therapeutic low molecular weight heparin (LMWH). Studies within the general population presented DOACs as an appropriate, patient friendly alternative to LMWH for the treatment of Venous Thromboembolism (VTE). Although encouraging, these studies underrepresented oncologic patients [9]. Two recent randomized controlled trials looked at the effectiveness of DOACs compared to LMWH for the treatment of VTE in cancer patients [10,11]. They showed a decreased incidence of recurrent VTE, with an increased risk of bleeding amongst the DOAC group. This risk was primarily observed in upper gastrointestinal malignancies, with emphasis on esophageal and gastric cancer. Within the esophageal group, bleeding was only noted in unresected esophageal tumors.


