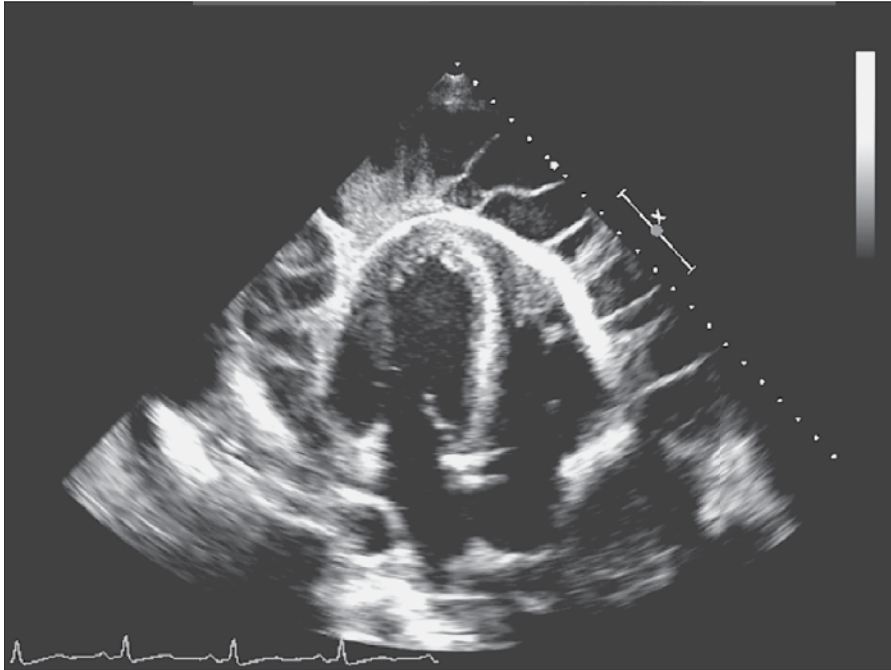


IMAGES IN CLINICAL MEDICINE

Lindsey R. Baden, M.D., *Editor*

Uremic Pericarditis



Imran Khan, M.B., B.S.
Charles McCreery, M.D.

St. Vincent's University Hospital
Dublin, Ireland

A 36-YEAR-OLD MAN WHO WAS AN ACTIVE USER OF ILLICIT INTRAVENOUS DRUGS WAS ADMITTED TO THE hospital with acute renal failure. He had been feeling generally unwell for the preceding 6 months. He was short of breath at rest, and his heart rate was 108 beats per minute and his blood pressure 140/80 mm Hg. He also had generalized edema and a pericardial rub. Laboratory assessment revealed a white-cell count of 25,400 cells per cubic millimeter, a blood urea nitrogen level of 102 mg per deciliter (37 mmol per liter), a creatinine level of 4.5 mg per deciliter (398 μ mol per liter), and an albumin level of 1.1 g per deciliter. He also had a positive test result for hepatitis C virus and proteinuria in the nephrotic range. Blood cultures grew *Staphylococcus aureus*. Examination of a renal-biopsy specimen revealed crescentic glomerulonephritis, and echocardiography showed a pericardial effusion with fibrinous strands traversing the pericardial space, without signs of cardiac tamponade (see the video). A pericardial window was created to allow drainage of a hemorrhagic pericardial effusion. Entry into the pericardial space revealed multiple adhesions and loculations that were typical of fibrinous pericarditis. Examination of a pericardial-biopsy specimen revealed acute inflammation of fibrous tissue, with no evidence of cancer or granuloma. The results of microbiologic studies were unrevealing. The pericarditis was presumed to be a result of uremia. Dialysis was initiated after diagnosis, and the patient ultimately died from complications of his illness.

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