

中文題目：胸部X光片正常之主動脈剝離個案

英文題目：Aortic dissection in a case of normal chest radiography finding

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摘要：

Case Presentation

A 76-year-old man with a history of old stroke with secondary parkinsonism was sent to our hospital for cold extremities with weak pulse in his four limbs noted in the nursing home. He presented to our hospital with normal vital signs. His limbs were cold with weak pulse, but no edema was noted. The laboratory examination revealed impaired renal function and lactic acidosis, but no leukocytosis or elevated C-reactive protein level was noted. Chest radiography showed cardiomegaly and torturous aorta with atherosclerotic change, while no change of the mild mediastinal widening as compared with the previous radiograph was noted.

He developed shock status rapidly. As the fluid resuscitation with 2500 ml of normal saline did not restore his blood pressure, vasopressor infusion was started. Bedside ultrasonography revealed unremarkable liver and kidneys, and no intra-abdominal fluid accumulation was noted. Significant difference of the blood pressure in his in four limbs was noted. Computed tomography revealed type A aortic dissection involving aortic root through descending aorta and pericardial effusion. A cardiovascular surgeon suggested surgical intervention. The patient's family declined the suggestion due to his old age and the high mortality rate. The patient had persistent shock status with progressive bradycardia under supportive care. He died of cardiac tamponade with pulseless electrical activity on the next day.

Discussion

Acute aortic dissection is uncommon, but complications develop rapidly and the outcome is often fatal. The typical presentation is characterized by acute onset of severe pain. Chest radiography is the initial image for the patients presenting at emergency department. While chest radiography may be helpful for the diagnosis of aortic dissection, a substantial number of patients did not have evidence of widened mediastinum or abnormal aortic contour.

In our patient, typical clinical findings of aortic dissection, such as chest pain and hypertension, are absent, and no typical findings of aortic dissection on chest radiograph, such as mediastinal widening, was noted. His shock status, however, persisted despite aggressive fluid resuscitation and vasopressor administration. Therefore, aortic dissection was considered as one of the possible causes of his profound shock. As highly clinical suspicion of aortic dissection is considered, further examination such as chest CT or transesophageal echocardiography should be performed for the early diagnosis.

In conclusion, because of the low sensitivity of chest radiography for aortic disease, aortic dissection should not be excluded based on normal chest radiograph. Aortic dissection should still be considered as the shock status persisted despite aggressive fluid resuscitation and vasopressor administration.