Constrictive Pericarditis: An Incidental Finding

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A 41-year-old male presented to medicine outpatient department for physical fitness to undergo hernioplasty. He gave history of breathlessness on exertion since 7 days without any cough, chest pain, or any other symptoms related to cardiovascular or respiratory system. His past, family, and personal history was not significant.

General examination revealed a low-volume pulse with an irregularly irregular rhythm. Systemic examination revealed decreased breath sounds over left mammary region.

Chest X-ray showed calcified pericardium, homogeneous airspace opacities in left lower zone, and bilateral small pleural effusion (Fig. 1). HRCT scan of thorax showed sequelae of old tuberculosis in both lungs, mild cardiomegaly with right and left atrium hypertrophy, and imaging evidence of constrictive pericarditis (Fig. 2). Two-dimensional (2D) echo showed pericardial thickening with abrupt anterior motion following atrial contraction with inspiratory septal shift (Fig. 3). Electrocardiogram (ECG) showed atrial fibrillation with rapid ventricular response with rightward axis and T-wave abnormalities (Fig. 4).

Constrictive pericarditis is the end stage of an inflammatory process involving the pericardium. Virtually any inflammatory process can cause constriction. In developed world, the cause is most commonly idiopathic, postsurgical, or radiation injury. Tuberculosis is the most common cause of constrictive pericarditis in developing countries.¹ Although constriction can follow an initial insult by as little as several months, it usually takes years to develop. The end result is dense fibrosis, often calcification, and adhesions of parietal and visceral pericardium.

The clinical presentation is usually dominated by signs and symptoms of right heart failure.² Cross-sectional imaging of computed tomography (CT) scan allows precise identification of pericardial thickening. Definitive diagnosis requires 2D echo and CT imaging.³ Management mainly involves treating the cause, salt restriction, and diuretics with surgical pericardiectomy being the treatment of choice.¹

In our case, the patient had no symptoms for a longer time and ultimately presented

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with breathlessness of grade-II New York Heart Association without any history of tuberculosis. The patient was referred to higher center for surgical intervention.

**Fig. 4:** Electrocardiogram (ECG) showing atrial fibrillation with rapid ventricular response with rightward axis and T-wave abnormalities

**REFERENCES**

