Please find below the results of your literature search request.

If you would like the full text of any of the abstracts included, or would like a further search completed on this topic, please let us know.

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**Literature search results**

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<th>Pleuritic chest pain and pleurisy</th>
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<tr>
<td>Search completed by:</td>
<td>Richard Bridgen</td>
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**Search details**

Pleuritic chest pain and pleurisy

**Resources searched**

NHS Evidence; National Library for Health; Cochrane Library; TRIP database; CINAHL; EMBASE; MEDLINE, Google Scholar; Google Advanced Search

**Database search terms**

Pleurisy; exp PLEURISY; pleuropneumonia; “pleuritic pain”; CHEST PAIN; PAIN; pain; pleuritic; “chest pain”

**Google search string**

"pleuritic chest pain" pleurisy (guidelines OR guidance OR evidence OR policy OR meta-analysis OR "systematic review") 2000..2010 -book

**Summary**

The search request was rather broad, and so there is quite a lot of research and documents for you. Unfortunately this also means that I am not able to summarise further.

**Guidelines**

**British Thoracic Society**

Investigation of a unilateral pleural effusion in adults 2010

1. Approximately 75% of patients with pulmonary embolism and pleural effusion have a history of pleuritic pain

2. Only perform diagnostic aspiration if the patient is febrile, complains of pleuritic chest pain or the effusion is very large. Most settle spontaneously.

**Guidelines for the Management of Pleural Infection in Children** 2005

1. Pleuritic pain is often present, sometimes accompanied by headaches and referred abdominal pain. Pleuritic pain may interfere with deep breathing and affect the child’s willingness to cough, so analgesia should be used to keep the child comfortable.

**Management of a Malignant Pleural Effusion** 2010
1. Pleuritic chest pain and fever are the most common side effects of sclerosant administration.

2. Talc slurry is usually well tolerated and pleuritic chest pain and mild fever are the most common side effects observed.

**TRIP Answers**

How often is severe chest wall pain and tenderness associated with pleurisy and/or pneumonia in the absence of physical signs of introthoracic problems? 2008

We found no guidelines or studies indicating the reliability/positive predictive value of severe chest wall pain and tenderness as symptoms, in the absence of physical signs of introthoracic problems, in diagnosing pleurisy and ruling out other more serious conditions.

**Evidence-based reviews**

None found.

**Published research**

1. Reinforcing a medical hypothesis with a new question: is there a subgroup of shrinking lungs syndrome that is induced by pleurisy in systemic lupus erythematosus and is this subgroup marked by anti-Ro/SSA?

Author(s): Souza Neves F, da Silva TH, Paviani G, Fontes Zimmermann A, de Castro GR, Alves Pereira I

Citation: Clinical Rheumatology, July 2010, vol./is. 29/7(777-9), 0770-3198;1434-9949 (2010 Jul)

Publication Date: July 2010

Abstract: Shrinking lungs syndrome (SLS) is a rare entity associated with autoimmune diseases and its underlying pathogenesis is still unclear. We describe a series of seven consecutive cases of SLS in systemic lupus erythematosus, all of them with serositis and six (85.7%) with anti-Ro/SSA antibodies. Our findings reinforce the hypothesis that SLS may be, in some cases, a consequence of diaphragmatic restriction due to pleuritic pain, and we suggest anti-Ro/SSA as a marker of this subgroup of SLS.

Source: MEDLINE

2. Diagnosis of pleuritic chest pain query PE: beware of dissecting thoracic aneurysm of aorta.

Author(s): Taylor RC, Vedutla TS, Myint PK, Meenakshisundaram S

Citation: International Journal of Cardiology, April 2010, vol./is. 140/3(e56-8), 0167-5273;1874-1754 (2010 Apr 30)

Publication Date: April 2010

Source: MEDLINE

3. An unusual cause of pleuritic chest pain on a CT pulmonary angiogram.

Author(s): O'Brien J, Barrett S, Torreggiani W

Citation: Jbr-Btr: Organe de la Societe Royale Belge de Radiologie, March 2010, vol./is. 93/2(112), 0302-7430;0302-7430 (2010 Mar-Apr)
4. **Respiratory chest pain: diagnosis and treatment.**

**Author(s):** Brims FJ, Davies HE, Lee YC

**Citation:** Medical Clinics of North America, March 2010, vol./is. 94/2(217-32), 0025-7125;1557-9859 (2010 Mar)

**Abstract:** Chest pain from respiratory causes is a common complaint and may indicate the presence of a serious or even life-threatening pathologic condition. Most chest pains are the result of irritation or inflammation of the parietal pleura, as the visceral pleura is insensate, although pain may arise from direct malignant invasion or trauma to the chest wall. Rapid recognition with appropriate understanding of the anatomy and physiology of chest pain from respiratory causes is vital to ensure timely and appropriate therapy.

**Source:** MEDLINE

5. **Clinical profile and treatment outcome of tubercular pleurisy in pediatric age group using DOTS strategy.**

**Author(s):** Sharma S, Sarin R, Khalid UK, Singla N, Sharma PP, Behera D

**Citation:** Indian Journal of Tuberculosis, October 2009, vol./is. 56/4(191-200), 0019-5707;0019-5707 (2009 Oct)

**Abstract:** BACKGROUND: A significant proportion of global tuberculosis (TB) caseload is contributed by children. Management of pediatric TB especially EPTB is challenging. The present study was designed to study demographic, clinical profile and treatment outcome of DOTS strategy for pediatric tubercular pleurisy. AIM: To study the efficacy of DOTS strategy. METHODS: Retrospective analysis of 106 TB pleurisy children treated with DOTS. RESULTS: Mean age was 10.8 years (median age 12.2 years) with more females (51.9%) than males (48.1%) chi1(2) = 0.15; P = 0.698 (NS). In the age group of 0-5, 6-10 and 11-14 years, there were 15.1%, 30.2% and 54.7% patients respectively. Fever was the commonest symptom (98.1%) followed by cough (77.4%) and chest pain (55.7%). History of contact could be elicited only in 2/3rd of cases unilateral effusion (61.3%) was commonest, followed by empyema (22.6%), massive effusion and broncho-pleural fistula each in 13.2% cases respectively. Bilateral effusion was seen in 3.8% cases only. Conventional methods (mantoux, radiograph, ultrasound, pleural aspiration) and minimal invasive surgical techniques, percutaneous pleural biopsy were done to arrive at the diagnosis. Diagnosis was made by X-ray Chest in 92.5%, exudative pleural fluid (100%) predominantly lymphocytic in 85.8%, positive AFB smear and culture in 4.7 and 5.7% cases respectively. Category I, II and III was started on 35.9%, 2.8% and 61.3% patients respectively. Overall treatment completion rate was 94.3%, 4.7% default rate, 0.9% failure rate and no deaths. CONCLUSION: The study confirms early detection by simple tests and ensuring complete treatment using DOTS strategy.

**Source:** MEDLINE

6. **Association of the shrinking lung syndrome in systemic lupus erythematosus with pleurisy: a systematic review.**

**Author(s):** Toya SP, Tzelepis GE

**Citation:** Indian Journal of Tuberculosis, October 2009, vol./is. 56/4(191-200), 0019-5707;0019-5707 (2009 Oct)

**Abstract:** BACKGROUND: A significant proportion of global tuberculosis (TB) caseload is contributed by children. Management of pediatric TB especially EPTB is challenging. The present study was designed to study demographic, clinical profile and treatment outcome of DOTS strategy for pediatric tubercular pleurisy. AIM: To study the efficacy of DOTS strategy. METHODS: Retrospective analysis of 106 TB pleurisy children treated with DOTS. RESULTS: Mean age was 10.8 years (median age 12.2 years) with more females (51.9%) than males (48.1%) chi1(2) = 0.15; P = 0.698 (NS). In the age group of 0-5, 6-10 and 11-14 years, there were 15.1%, 30.2% and 54.7% patients respectively. Fever was the commonest symptom (98.1%) followed by cough (77.4%) and chest pain (55.7%). History of contact could be elicited only in 2/3rd of cases unilateral effusion (61.3%) was commonest, followed by empyema (22.6%), massive effusion and broncho-pleural fistula each in 13.2% cases respectively. Bilateral effusion was seen in 3.8% cases only. Conventional methods (mantoux, radiograph, ultrasound, pleural aspiration) and minimal invasive surgical techniques, percutaneous pleural biopsy were done to arrive at the diagnosis. Diagnosis was made by X-ray Chest in 92.5%, exudative pleural fluid (100%) predominantly lymphocytic in 85.8%, positive AFB smear and culture in 4.7 and 5.7% cases respectively. Category I, II and III was started on 35.9%, 2.8% and 61.3% patients respectively. Overall treatment completion rate was 94.3%, 4.7% default rate, 0.9% failure rate and no deaths. CONCLUSION: The study confirms early detection by simple tests and ensuring complete treatment using DOTS strategy.

**Source:** MEDLINE
OBJECTIVES: To report 2 patients with systemic lupus erythematosus and typical shrinking lung syndrome (SLS) in which pleuritic chest pain was the predominant symptom. In addition, to record the prevalence of pleuritic chest pain in all reported cases of patients with SLS and diaphragmatic dysfunction. METHODS: We conducted a comprehensive search of the English literature to record the association of pleurisy and SLS in all reported cases using the MEDLINE database from 1965 to present. RESULTS: Of the 77 patients with SLS reported in the literature, 50 (65%) patients had pleuritic chest pain at the time of evaluation. Treatment with anti-inflammatory agents improved symptoms in the majority of cases. CONCLUSIONS: Pleuritic inflammation and pain may have an important role in the pathogenesis of SLS. A possible mechanism linking pleural inflammation and diaphragm dysfunction may be via a reflex inhibition of diaphragmatic activation.

Source: MEDLINE

7. Gender differences in presentation and diagnosis of chest pain in primary care.

Author(s): Bosner S, Haasenritter J, Hani MA, Keller H, Sonnichsen AC, Karatolios K, Schaefer JR, Baum E, Donner-Banzhoff N

Citation: BMC Family Practice, 2009, vol./is. 10/(79), 1471-2296;1471-2296 (2009)

Abstract: BACKGROUND: Chest pain is a common complaint and reason for consultation in primary care. Research related to gender differences in regard to Coronary Heart Disease (CHD) has been mainly conducted in hospital but not in primary care settings. We aimed to analyse gender differences in aetiology and clinical characteristics of chest pain and to provide gender related symptoms and signs associated with CHD. METHODS: We included 1212 consecutive patients with chest pain aged 35 years and older attending 74 general practitioners (GPs). GPs recorded symptoms and findings of each patient and provided follow up information. An independent interdisciplinary reference panel reviewed clinical data of every patient and decided about the aetiology of chest pain at the time of patient recruitment. Multivariable regression analysis was performed to identify clinical predictors that help to rule in or out CHD in women and men. RESULTS: Women showed more psychogenic disorders (women 11.2%, men 7.3%, p = 0.02), men suffered more from CHD (women 13.0%, men 17.2%, p = 0.04), trauma (women 1.8%, men 5.1%, p < 0.001) and pneumonia/pleurisy (women 1.3%, men 3.0%, p = 0.04) Men showed significantly more often chest pain localised on the right side of the chest (women 9.1%, men 25.0%, p = 0.01). For both genders known clinical vascular disease, pain worse with exercise and age were associated positively with CHD. In women pain duration above one hour was associated positively with CHD, while shorter pain durations showed an association with CHD in men. In women negative associations were found for stinging pain and in men for pain depending on inspiration and localised muscle tension. CONCLUSIONS: We found gender differences in regard to aetiology, selected clinical characteristics and association of symptoms and signs with CHD in patients presenting with chest pain in a primary care setting. Further research is necessary to elucidate whether these differences would support recommendations for different diagnostic approaches for CHD according to a patient's gender.

Source: MEDLINE

Full Text: Available in fulltext at BioMedCentral
8. Diagnosis of radio-occult pulmonary conditions by real-time chest ultrasonography in patients with pleuritic pain.

Author(s): Volpicelli G, Caramello V, Cardinale L, Cravino M

Citation: Ultrasound in Medicine & Biology, November 2008, vol./is. 34/11(1717-23), 0301-5629;1879-291X (2008 Nov)

Publication Date: November 2008

Abstract: The evaluation of pleuritic pain in the emergency department (ED) presents a considerable challenge for the attending physician. Chest radiography (CXR) is a basic test, but its sensitivity is low, and often more sophisticated imaging techniques are needed. Our aim is to assess the diagnostic value of bedside B-mode lung ultrasound (LUS) in the visualization of radio-occult pulmonary lesions. Forty-nine patients complaining of pleuritic pain with negative CXR were prospectively studied by LUS. Detection of at least one of the following sonographic signs in the painful thoracic area was considered diagnostic: (i) the absence of pleural sliding; (ii) the focal alveolar-interstitial syndrome (AIS), defined by multiple artifacts B-line; (iii) the peripheral alveolar consolidation (PAC), defined by hypoechoic subpleural images; and (iv) the pleural disruption with thickening and irregularity of the line, with or without localized effusion. The final diagnoses were confirmed by spiral CT scanning (n = 12) and follow-up (n = 37). Final diagnoses were chest wall pain (n = 30), pleuropneumonia (n = 14), pulmonary embolism (n = 4), lung metastasis (n = 1). In 18 patients of the group with pulmonary conditions, LUS showed signs of pleurisy. They were PAC (n = 12), AIS (n = 17), pleural disruption (n = 17). If any sign is considered, the sensitivity of LUS in the diagnosis of radio-occult lesions was 94.7%, specificity was 96.7%, positive and negative predictive values were 94.7% and 96.7%, respectively, and accuracy was 95.9%. In patients with pleuritic pain of unknown cause, real-time LUS enables the diagnosis of radio-occult lung and pleural lesions.

Source: MEDLINE

9. Pleuritis and pleural effusion as the initial presentation of systemic lupus erythematosus in a 23-year-old woman.

Author(s): Wan KS

Citation: Rheumatology International, October 2008, vol./is. 28/12(1257-60), 0172-8172;0172-8172 (2008 Oct)

Publication Date: October 2008

Abstract: Systemic lupus erythematosus (SLE) is a chronic inflammatory autoimmune disorder that primarily affects women and may affect any organ system. Pleural inflammation is a common feature of SLE; however, as an initial presentation in SLE is rare. The author report the case of a 23-year-old woman with chest pain, dyspnea and without fever for 1 week. On physical examination, fine crackles were heard and vocal fremitus was decreased at the base of the left-side of lung. Patient had no symptoms/signs that can meet the SLE criteria; however, immunological workup showed positive response of ANA-speckle, anti-dsDNA, and anti-ENA in patient serum and pleural fluid. Lupus pleuritis with effusions was confirmed by the above investigation. A 1-month course of oral prednisolone-combined oral methotretate was beneficial in relieving the pleuritis and pleural effusions.

Source: MEDLINE

Full Text:
10. Clinical implications of unexpandable lung due to pleural disease.

Author(s): Doelken P

Citation: American Journal of the Medical Sciences, January 2008, vol./is. 335/1(21-5), 0002-9629;0002-9629 (2008 Jan)

Publication Date: January 2008

Abstract: Unexpandable lung due to pleural disease may manifest itself as a hydropneumothorax after pleural drainage procedure or as an inability to completely drain a pleural effusion due to chest pain. The condition is a mechanical complication of a variety of pleural disorders. Of these, malignant lung entrapment and inflammatory lung entrapment are considered complications of active pleural disease, and management is primarily dependent on the nature of the active process. Trapped lung is a sequela of remote inflammation of the pleural space. Trapped lung is usually asymptomatic but may be the cause of dyspnea in some patients. The only available treatment of symptomatic trapped lung is surgical decortication. Surgical decortication should only be considered after other causes of dyspnea have been excluded.

Source: MEDLINE

11. [Case of tuberculous pleurisy with eosinophilic pleural effusion and hematological eosinophilia].

Author(s): Kato E, Yamada N, Sugiura T

Citation: Kekkaku, May 2007, vol./is. 82/5(481-5), 0022-9776;0022-9776 (2007 May)

Publication Date: May 2007

Abstract: A 30-year-old man suffered from a chest-pain on his left side and was also having a low-grade fever though he actually neglected these symptoms for a while. Later, he was referred to our hospital due to the detection of chest abnormal shadows through the mass examination of chest X-ray taken on 18th October, 2005. His chest X-ray showed bilateral pleural effusion and it was confirmed that the right pleural effusion was encapsulated by his chest CT. The patient's hematological examination performed during his initial visit, showed an increased level of WBC with blood eosinophilia. He also had a puncture of pleural effusion at the time of admission to the center. Moreover, pleural effusion on both sides was exudative and elevations of ADA and eosinophil count as well were traced. In the patient's right pleural effusion, mycobacterium tuberculosis direct (MTD) test was positive. As there were no findings suggesting collagen disease, malignancy, parasite infection, and other complications, he was diagnosed as tuberculous pleurisy with eosinophilic pleural effusion and blood eosinophilia. He was treated with four antitubercular agents, namely, INH, RFP, EB and PZA. As the result, his pleural effusion and blood eosinophil counts were decreased along with an improvement in inflammatory reaction. The most common conditions associated with eosinophilic pleural effusion are described as malignancy, collagen disease, paragonimiasis, drug induced pleurisy, asbestosis, pneumothorax, and trauma, while there are only a few reports about such eosinophilic pleural effusion caused by tuberculous pleurisy. In this case, he also showed blood eosinophilia. Based on these findings, we finally came to the conclusion that the case is a very rare and significantly unique case of eosinophilic pleurisy with blood eosinophilia.

Source: MEDLINE

12. Pleurisy.
Abstract: Pleuritic chest pain is a common presenting symptom and has many causes, which range from life-threatening to benign, self-limited conditions. Pulmonary embolism is the most common potentially life-threatening cause, found in 5 to 20 percent of patients who present to the emergency department with pleuritic pain. Other clinically significant conditions that may cause pleuritic pain include pericarditis, pneumonia, myocardial infarction, and pneumothorax. Patients should be evaluated appropriately for these conditions before an alternative diagnosis is made. History, physical examination, and chest radiography are recommended for all patients with pleuritic chest pain. Electrocardiography is helpful, especially if there is clinical suspicion of myocardial infarction, pulmonary embolism, or pericarditis. When these other significant causes of pleuritic pain have been excluded, the diagnosis of pleurisy can be made. There are numerous causes of pleurisy, with viral pleurisy among the most common. Other etiologies may be evaluated through additional diagnostic testing in selected patients. Treatment of pleurisy typically consists of pain management with nonsteroidal anti-inflammatory drugs, as well as specific treatments targeted at the underlying cause.

Source: MEDLINE

Full Text:

Available in fulltext at EBSCO Host


Author(s): Mangiapan G, Van Koningsveld M, Maitre B

Citation: Revue du Praticien, March 2007, vol./is. 57/5(489-500), 0035-2640;0035-2640 (2007 Mar 15)

Publication Date: March 2007

Abstract: Pleurisy is a common syndrome revealing or complicating numerous diseases. It is suspected on dyspnea or chest pain, with or without dullness to percussion. Diagnosis is confirmed almost always by chest roentgenogram but CT scan and echography can help in case of small pleural effusion. Etiologic research is based on pleural fluid analysis. The dosages of protein and LDH separate transudate from exsudate. Cellular differential count and bacterial and mycobacterial culture must systematically be performed. Other pleural analysis are discussed when specific illness are suspected. In case of exsudative pleural effusion, histological examination of pleural tissue sample is often necessary. Despite the etiological search, some pleurisy remains without specific diagnosis and necessitate a prolonged follow up with sometimes repeated thoracocentesis or biopsy. Treatment of pleurisy is based on the treatment of the underlying disease and the evacuation of pleural fluid.

Source: MEDLINE


Author(s): Baade LM, Herrington RW

Citation: Annals of Emergency Medicine, July 2006, vol./is. 48/1(106-7; author reply 107),
15. Identifying pleuritic chest pain.

Author(s): Wright J, Hogg K, Mackway-Jones K

Citation: Emergency Nurse, June 2006, vol./is. 14/3(22-4), 1354-5752;1354-5752 (2006 Jun)

Publication Date: June 2006

Source: MEDLINE

Full Text:
Available in fulltext at EBSCO Host
Available in print at Pilgrim Hospital Staff Library

16. Management of malignant pleural effusion by multimodality treatment including the use of paclitaxel administered by 24-hour intrathoracic infusion for patients with carcinomatous pleuritis.

Author(s): Ohta Y, Shimizu Y, Matsumoto I, Watanabe G

Citation: Journal of Experimental & Clinical Cancer Research, March 2006, vol./is. 25/1(15-9), 0392-9078;0392-9078 (2006 Mar)

Publication Date: March 2006

Abstract: For successful intrapleural chemotherapy, intrapleural drug activity should be maintained for as long as possible. This interim report presents the results of treatment with paclitaxel administered by 24-hour intrathoracic infusion as an adjunct to selective surgical management and/or systemic chemotherapy for controlling malignant pleural effusion. Thirteen patients with carcinomatous pleuritis were enrolled in the study between October 2001 and September 2004. The sites of primary disease were the lung in 12 patients and the breast in one patient. Paclitaxel (120 mg/m2) was administered by 24-hour intrathoracic infusion. Seven patients underwent elective surgical treatment and 11 patients received adjuvant systemic chemotherapy. Mild toxicity occurred in 7 cases, and chest pain and neutropenia were dominant. During a median follow-up period of 9 months (range, 2-33 months), malignant effusion was controlled successfully in 11 patients (84.6%). The multimodality treatment, including the use of paclitaxel, in this manner merits further investigation for possible intervention for malignant pleural effusion originating in lung and breast neoplasms.

Source: MEDLINE

17. What's causing your patient's chest pain?.

Author(s): Pope BB
18. A male with pleuritic chest pain, dry cough, progressive dyspnoea, and weight loss.

Author(s): Barber CM, Aung T, Suvarna SK, Moloney ED

Citation: Respiration, 2006, vol./is. 73/4(571-3), 0025-7931;0025-7931 (2006)

Publication Date: 2006

Source: MEDLINE

Full Text:

Available in fulltext at EBSCO Host

19. Respiratory dead space measurement in the investigation of pulmonary embolism in outpatients with pleuritic chest pain.

Author(s): Hogg K, Dawson D, Tabor T, Tabor B, Mackway-Jones K

Citation: Chest, October 2005, vol./is. 128/4(2195-202), 0012-3692;0012-3692 (2005 Oct)

Publication Date: October 2005

Abstract: STUDY OBJECTIVES: Pleuritic chest pain is a common presenting condition in the emergency department. A noninvasive bedside rule out test for pulmonary embolism would aid investigating this patient group. Our study aimed to compare the clinical utility of three methods for calculating respiratory dead space in the diagnosis of pulmonary embolism in outpatients with pleuritic chest pain. DESIGN: Prospective diagnostic study. SETTING: Large city-center emergency department. PATIENTS: Between February 2002 and June 2003, 425 patients presenting to the emergency department with pleuritic chest pain were prospectively recruited. INTERVENTION: Data collection for respiratory dead space was performed in the emergency department by two researchers. The respiratory dead space fraction was calculated independently using three different methods. All patients underwent an independent reference standard diagnostic algorithm to establish the presence or absence of pulmonary embolism. Those with a low modified Wells clinical probability and a normal quantitative d-dimer finding were discharged home. All others followed a reference standard protocol using Prospective Investigation of Pulmonary Embolism Diagnosis-interpreted ventilation/perfusion scanning, CT pulmonary angiography, and digital subtraction pulmonary angiography. All patients were followed up clinically for 3 months. MEASUREMENTS AND RESULTS: For the Bohr calculation, the area under the receiver operating characteristic curve was 0.62 (95% confidence interval [CI], 0.51 to 0.73), the Enghoff calculation was 0.66 (95% CI, 0.55 to 0.77), and the capillary sample Enghoff was 0.62 (95% CI, 0.49 to 0.65). The optimum Bohr cutoff value
gave 100.0% sensitivity (95% CI, 84.5 to 100%) but a low specificity of 22.7% (95% CI, 18.8 to 27.2%). The optimum cutoff points for Enghoff and capillary Enghoff calculations gave sensitivities of 95.3% (95% CI, 77.3 to 99.2%) and 94.4% (95% CI, 74.2 to 99.0%), respectively, with poor specificity. CONCLUSIONS: Respiratory dead space analysis does not perform well as a stand-alone diagnostic test for pulmonary embolism in outpatients presenting with pleuritic chest pain.

Source: MEDLINE

Full Text:
Available in fulltext at Highwire Press
Available in print at Grantham Hospital Staff Library

20. The emergency department utility of Simplify D-dimer to exclude pulmonary embolism in patients with pleuritic chest pain.

Author(s): Hogg K, Dawson D, Mackway-Jones K

Citation: Annals of Emergency Medicine, October 2005, vol./is. 46/4(305-10), 0196-0644;1097-6760 (2005 Oct)

Publication Date: October 2005

Abstract: STUDY OBJECTIVE: Pleuritic chest pain is a common presenting complaint in the emergency department (ED) and a symptom of pulmonary embolism. Patients with pleuritic chest pain would benefit from a simple and rapid way of screening for pulmonary embolism. The aim of this study is to assess the utility of Simplify D-dimer as a rule-out tool for pulmonary embolism in ED patients with pleuritic chest pain. METHODS: This was a prospective diagnostic study in a large city-center ED. Four hundred twenty-five patients with pleuritic chest pain were prospectively recruited between February 2002 and June 2003. Simplify D-dimer testing was performed on each patient in the ED. All patients followed an independent reference standard diagnostic algorithm for pulmonary embolism. Each patient was followed up clinically for 3 months. RESULTS: The calculated sensitivity of Simplify D-dimer for pulmonary embolism was 81.8% (95% confidence interval [CI] 61.4% to 92.7%), and specificity was 74.2% (95% CI 69.6% to 78.4%). The negative predictive value was 98.6% (95% CI 96.6% to 99.6%), positive predictive value 15.0% (95% CI 9.1% to 22.7%), negative likelihood ratio 0.25 (95% CI 0.10 to 0.52) and positive likelihood ratio 3.17 (95% CI 2.30 to 3.97). The study cohort pretest probability was 5.3%. A negative Simplify result reduced the posttest probability to 1.3% (95% CI 0.5% to 3.4%). CONCLUSION: The Simplify D-dimer is not sufficiently sensitive to exclude the diagnosis of pulmonary embolism in all patients presenting to the ED with pleuritic chest pain.

Source: MEDLINE

Full Text:
Available in print at Pilgrim Hospital Staff Library

21. Pleuritic chest pain: A systematic approach to investigation

Author(s): Worsnop C., Pierce R.

Citation: Medicine Today, March 2005, vol./is. 6/3(53-60), 1443-430X (Mar 2005)

Publication Date: March 2005
Abstract: * Establish a diagnosis when a patient presents with pleuritic chest pain - do not just treat with analgesics. * The diagnosis of pulmonary embolism is important but can be difficult to make, so investigations such as CT pulmonary angiography and nuclear medicine V/Q scans are usually necessary. These tests need to be interpreted in the context of the clinical situation. * If the patient is also short of breath, assess his or her oxygen requirements. * Consider a CT scan if there is a suspicion of cancer in the chest. * The sudden onset of pleuritic chest pain may be caused by a pneumothorax; a chest x-ray with expiratory views is needed to make this diagnosis.

Source: EMBASE

22. Accumulator BET: A traumatic pleuritic chest pain

Author(s): Hogg K., Brown G., Mackway-Jones K.

Citation: Emergency Medicine Journal, July 2003, vol./is. 20/4(372), 1351-0622 (Jul 2003)

Publication Date: July 2003

Source: EMBASE

Full Text:

Available in fulltext at Highwire Press

23. Pleuritic chest pain and hypoxia - A diagnostic dilemma (multiple letters)

Author(s): McGavigan A., Sinharay R.

Citation: British Journal of Cardiology, November 2002, vol./is. 9/10(588-589), 0969-6113 (Nov 2002)

Publication Date: November 2002

Source: EMBASE

24. Pleuritic chest pain and hypoxia - A diagnostic dilemma

Author(s): Mahadeva S., Sahay P., Lewis R.V.

Citation: British Journal of Cardiology, September 2002, vol./is. 9/8(478-480), 0969-6113 (Sep 2002)

Publication Date: September 2002

Source: EMBASE

25. Pleuritic chest pain: Infection, infarction or musculoskeletal?

Author(s): Gill S., Pope A.

Citation: CPD Journal Acute Medicine, 2002, vol./is. 1/2(64-66), 1476-5063 (2002)

Publication Date: 2002

Abstract: A 52 year old patient, originally thought to have musculoskeletal chest pain was found to have features consistent with infective pleurisy on initial blood tests and chest x-
ray, with a negative d-dimer indicating a low likelihood of pulmonary embolism. Two weeks later he represented with continued symptoms and investigations revealed extensive pulmonary emboli, which were thought to have developed after his initial presentation.

Source: EMBASE

26. [A clinical study of tuberculous pleurisy].


Citation: Kansenshogaku Zasshi - Journal of the Japanese Association for Infectious Diseases, January 2002, vol./is. 76/1(18-22), 0387-5911;0387-5911 (2002 Jan)

Publication Date: January 2002

Abstract: A clinical study of 38 patients (28 men and 10 women) with tuberculous pleurisy was conducted. The age of these patients ranged from 19 to 92 years, with an average age of 48.9 years. In 30 patients, the chief complaint was fever, and other common complaints included chest pain, dyspnea, and coughing. Bacillus tuberculosis was found in the pleural fluid of 7.9% of the patients. Tuberculous pleurisy was diagnosed histologically, based on pleural biopsy, in 23.7% of the patients. The diagnosis rate of pleural biopsy was 47.4%. There were no significant differences in results of blood and pleural fluid tests between idiopathic pleurisy and concomitant pleurisy, but the tuberculin skin test was positive in only 50% of the patients with concomitant pleurisy. The tendency was that the longer the time period between symptom onset and first examination, the greater the pleural fluid retention. The diagnosis rate of pleural biopsy was influenced by the severity of pleural fluid retention. A thoracic cavity drain was inserted for continuous drainage in 15 patients, and every patient underwent INH + RFP-based chemotherapy. Tuberculous pleurisy is an important disease among patients with pleural fluid retention, thus clinicians need to know how to treat this disease.

Source: MEDLINE

27. Successful management of pleuritic pain with thoracic paravertebral block.

Author(s): Paniagua P, Catala E, Villar Landeira JM

Citation: Regional Anesthesia & Pain Medicine, November 2000, vol./is. 25/6(651-3), 1098-7339;1098-7339 (2000 Nov-Dec)

Publication Date: November 2000

Abstract: BACKGROUND AND OBJECTIVES: Thoracic paravertebral block (TPVB) is a unilateral analgesic technique that has been advocated in both acute and chronic thoracic and abdominal pain. Other blocks such as interpleural and epidural can be effectively used in pleuritic pain. This report illustrates that TPVB could also be effective for this kind of pain. METHODS: A 45-year-old man with acute pancreatitis was referred to the critical care unit 11 days after emergency admission with severe left pleural effusion and acute respiratory failure. His medical history revealed hypertension and chronic obstructive pulmonary disease (COPD); in addition, he was a heavy drinker and smoker. A pleuritic pain that only slightly improved with nonopioid analgesics and opioids resulted in the patient's increasing inability to eliminate bronchial secretions. In an attempt to avoid endotracheal intubation, the pain unit recommended a continuous paravertebral block. The block was performed at T9 on the left side. An initial bolus of 15 mL bupivacaine 0.25% was administered and a continuous infusion, initially at 5 mL/h, was increased up to 10 mL/h to achieve the desired analgesic effect. RESULTS: After the block the verbal analogue scale decreased from 9 to 3, and this level of pain relief was maintained until the end of the treatment 48 hours after the block. The patient improved and was discharged to the ward without the need for endotracheal intubation. CONCLUSIONS: This case report supports the notion that, in practice, the paravertebral block could be an effective and safe alternative to relief of
pleuritic pain.

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28. The postpericardiotomy syndrome as a cause of pleurisy in rehabilitation patients.

Author(s): Kelly BM, Nicholas JJ, Chhablani R, Kavinsky CJ

Citation: Archives of Physical Medicine & Rehabilitation, April 2000, vol./is. 81/4(517-8), 0003-9993;0003-9993 (2000 Apr)

Publication Date: April 2000

Abstract: Pleuritic chest pain in patients on a rehabilitation unit may be caused by several conditions. We report 2 cases of postpericardiotomy syndrome (PPS) as a cause of pleuritic pain. PPS occurs in 10% to 40% of patients who have coronary bypass or valve replacement surgery. The syndrome is characterized by fever, chest pain, and a pericardial or pleural friction rub. Its etiology is believed to be viral or immunologic. The syndrome can be a diagnostic challenge, and an increase in length of hospitalization because of it has been documented. Identified risk factors for PPS include age, use of prednisone, and a history of pericarditis. A higher incidence has been reported from May through July. Many patients undergo a battery of expensive procedures before PPS is diagnosed. The pain is sharp, associated with deep inspiration, and changes with position. Pleural effusions may be present and tend to occur bilaterally. Pericardial effusions are a documented complication. A pericardial or pleural rub may be present and is often transient. Serial auscultation is important. Laboratory work provides clues with a mild leukocytosis and an elevated erythrocyte sedimentation rate. However, this does not provide the definitive diagnosis. Cardiac enzymes are not reliably related to the syndrome. An electrocardiogram will show changes similar to those associated with pericarditis. The patient may have a fever, but it is rarely higher than 102.5 degrees F. Complications include pericardial effusions, arrhythmias, premature bypass graft closure, and cardiac tamponade. Treatment consists of a 10-day course of nonsteroidal anti-inflammatory drugs.

Source: MEDLINE

29. Clinical management. Investigation and management of patients with pleuritic chest pain presenting to the accident and emergency department.

Author(s): Jones K, Raghuram A

Citation: Journal of Accident & Emergency Medicine, 01 January 1999, vol./is. 16/1(55-59), 13510622

Publication Date: 01 January 1999

Abstract: The assessment of a patient with pleuritic chest pain calls for a high degree of clinical acumen and a high degree of suspicion that the diagnosis might be pulmonary embolism. This area is one of the most difficult in A&E medicine (and indeed chest medicine). One error is to "think the best" when considering the diagnosis in such patients but experience soon teaches to "think PE" and diagnose less serious conditions only when pulmonary embolism has been excluded. A key consideration is the presence of risk factors. Because the diagnosis is difficult, there should be no hesitation in requesting a senior opinion or referring to the inpatient medical team. We have produced an algorithm (fig 1) for the investigation and management of pleuritic chest pain as discussed in this article. Three questions relating to this article are: (1) Can pulmonary embolism be the diagnosis in a patient with pleuritic chest pain but a normal chest radiograph, ECG, and
arterial blood gases? (2) What is the chest radiograph abnormality which is most likely to alert you to the possibility of pulmonary embolism? (3) What percentage of patients with a low clinical suspicion of pulmonary embolism but a high probability V/Q scan will have pulmonary embolism demonstrated on pulmonary angiography? The three key references are The PIOPED Investigators, Dalen, and Fennerty.

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