Pulmonary embolism presenting as adult respiratory distress syndrome—support for a hypothesis

ADRIAN J. WILLIAMS
M.B., M.R.C.P.

DAVID C. YAUCH
M.D.

STEPHEN N. FINBERG
D.O.

SILVERIO M. SANTIAGO JR
M.D.

H. KENNETH FISHER
M.D., F.A.C.P., F.C.C.P.

The Pulmonary Division, Department of Medicine VA Wadsworth Medical Center, Los Angeles, and University of California at Los Angeles, California 90073, U.S.A.

Summary
Adult respiratory distress syndrome (ARDS), or non-cardiogenic pulmonary oedema, has only rarely been associated with pulmonary embolism. In this case study the association is further documented and the occurrence of pulmonary oedema confined to unobstructed portions of the pulmonary capillary bed is illustrated.

Introduction
Adult respiratory distress syndrome (ARDS), or non-cardiogenic pulmonary oedema, has been well documented in animal experiments (Singer et al., 1957; Swenson, Lamas and Ring, 1965; Parmley, North and Ott, 1962) but is rare in man (Meth et al., 1975). A number of mechanisms have been proposed including the notion that major occlusions of the pulmonary vasculature may result in pulmonary hypertension with transmission of the high pulmonary arterial pressure to unobstructed portions of the pulmonary capillary bed (Robin et al., 1973). Nevertheless, this has not been demonstrated in man and the present case is presented in support of this hypothesis. The patient described here had angiographically documented pulmonary emboli and developed pulmonary oedema confined to unobstructed segments and in the presence of a normal pulmonary capillary 'wedge' pressure.

Case report
A 61-year-old man underwent radical excision of a malignant squamous cell tumour of the oropharynx. His past history was significant for myocardial infarcts in 1962 and 1965, and systemic arterial hypertension under treatment with hydralazine. The pre-operative chest radiograph was normal except for moderate cardiomegaly (cardiac diameter 16 cm) (Williams, 1977). The surgical procedure included a prophylactic tracheostomy with hemimandibulectomy, hemimaxilllectomy and radical neck dissection. His postoperative course was unremarkable for the next 72 hr but following transfer from the intensive care unit to the ward, the patient was found to be tachypnoeic and hypotensive (blood pressure 80/60 mmHg) with a heart rate of 150/min. Arterial blood gases breathing room air were abnormal: pH 7.32, PaO₂ 52 mmHg, PaCO₂ 28 mmHg. A chest radiograph (Fig. 1) revealed bilateral acinar shadows sparing both lower zones and consistent with pulmonary oedema. There was no increase in heart size. An electrocardiogram showed no change from the preoperative record apart from a sinus tachycardia. A diagnosis of pulmonary oedema was made and 80 mg of frusenide was administered intravenously, with a resulting diuresis of 2 litres over the next 2 hr. Nevertheless no improvement was apparent in the patient’s clinical status, arterial blood gases or chest radiograph. A flow-directed pulmonary artery catheter was inserted and the pulmonary artery pressure was found to be 25/5 mmHg, with a mean of 16 mmHg. The pulmonary capillary 'wedge' pressure was 3 mmHg.

Because of the confusing clinical and radiographic picture a pulmonary angiogram was performed (Fig. 2). This demonstrated intraluminal filling defects in arteries to both lower lobes coincident with the non-oedematous areas (Fig. 3). A diagnosis of pulmonary embolism was thus confirmed and anticoagulant therapy with intravenous heparin was instituted. The normal pulmonary cap-

0032-5473/82/0500-0290 $02.00 © 1982 The Fellowship of Postgraduate Medicine
illary 'wedge' pressure excluded left ventricular failure, and the radiographic abnormality was interpreted as non-cardiogenic pulmonary oedema. The patient was subsequently managed by fluid restriction and artificial ventilation. A fractional inspired O₂ concentration (F₁O₂) of 1·0 was initially required to maintain an arterial Po₂ of 50 mmHg, so that positive end expiratory pressure (PEEP) of 15 cm H₂O was gradually introduced. Over the next 48 hr oxygenation improved (together with the radiographic appearance), and the F₁O₂ was reduced to 0·4 and the level of PEEP to 10 cm H₂O. On this regime arterial blood gases were: Po₂ 59 mmHg; Pco₂ 35 mmHg; pH 7·44. Five days after respiratory failure had first developed broad-spectrum antibiotic coverage was begun for fever of uncertain source. One day later the patient suffered a cardiac arrest and could not be resuscitated. Permission for a post-mortem examination was denied.

**Discussion**

Pulmonary oedema is recognized as a complication of pulmonary embolism (Short, 1952; Felson, 1973) but usually occurs in those patients with left ventricular dysfunction (Yuceoglu et al., 1971) and in these individuals is thought to be due to left ventricular failure. Non-cardiogenic pulmonary oedema, or ARDS, occurs in a wide variety of clinical settings such as hypovolaemic shock, major trauma and septicaemia. It has been described as a complication of classic pulmonary thromboembolism by Windebank and Moran (1973), and in more detail in a case report by Meth et al. (1975), though in this instance no pulmonary capillary 'wedge' pressures were obtained. In the present case pulmonary embolism was documented by angiography and the normal capillary 'wedge' pressures exclude left ventricular
failure as a cause of the pulmonary oedema. Although it might be argued that therapy with frusemide early in the course of the respiratory failure had 'cured' any left ventricular failure that was present, it is noteworthy that the patient's clinical state did not improve. At no time was the 'wedge' pressure greater than 10 cm H₂O and it therefore seems clear that this was truly a case of non-cardiogenic pulmonary oedema or ARDS.

The case is interesting not only because this ARDS was associated with pulmonary embolism but also because the alveolar oedema was initially confined to areas not obstructed by clot. This has implications for any theory of pathogenesis. It has been proposed that the release of vasoactive substances from clots may lead directly to increased capillary permeability (Gurewich, Cohen and Thomas, 1968), or to vasoconstriction and an increased capillary hydrostatic pressure (Swenson, quoted by Robin, 1970); in addition, it is possible that fibrin microemboli may injure pulmonary capillaries (Saldeen 1976). All these possibilities would, of course, be expected to produce oedema 'downstream' of the obstruction. Another mechanism may be maldistribution of blood flow causing some areas of lung to be overperfused. In this instance, the unobstructed areas of the pulmonary circulation would be subjected to high regional pressures resulting in interstitial and alveolar oedema (Ohkuda et al., 1978).

Because the obstructed areas were unaffected by oedema in the present case, this hypothesis seems tenuous. The absence of overall pulmonary hypertension does not exclude the possibility since local pressures may have been transiently quite high. This case confirms that pulmonary embolism may be a cause of ARDS and that obstructed portions of the circulation may be spared.

References