Chronic Cough as the Presenting Symptom of Oculopharyngeal Muscular Dystrophy*

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A patient had chronic, persistent cough as the presenting symptom of the neuromuscular disorder oculopharyngeal dystrophy (OPD). The presence of a significant smoking history initially resulted in the cough incorrectly being attributed to COPD. By using a systematic diagnostic approach, the correct etiology was determined. (Chest 1989; 95:921-922)

Although chronic persistent cough is a frequent diagnostic and therapeutic problem, it has been shown that a systematic diagnostic approach is successful in identifying the specific cause of chronic cough in almost all cases. Furthermoe, treatment directed at this underlying etiology, if available, is almost always effective. In the vast majority of cases, the etiology is a primary respiratory disorder, usually in the form of either an upper or lower airway disorder. Although respiratory disorders account for the vast majority of cases, chronic cough may also be the result of a number of other disorders which only effect the respiratory tract secondarily. Included in the differential diagnosis are disorders such as gastroesophageal reflux and congestive heart failure.

A case is reported in which chronic cough was the presenting complaint of a neuromuscular disorder (ie, OPD). To our knowledge, there are no previous reports of a neuromuscular disorder presenting with the sole complaint of cough. By pursing a systematic diagnostic approach, the correct diagnosis was made.

CASE REPORT

A 76-year-old woman was referred to the Pulmonary Clinic at the University of Massachusetts Medical Center for further evaluation of a chief complaint of chronic, persistent cough of seven years' duration. Her family physician had attributed it to COPD, based on her 60 pack-year history of cigarette smoking. Despite stopping smoking, the cough had persisted and had actually worsened over the past seven years. Other than chronic cough, she otherwise felt well and specifically denied dyspnea or other respiratory symptoms. Pulmonary function tests (PFTs) had never been performed. Her past history revealed that a sister had developed some sort of swallowing difficulty beginning at about age 50.

On physical examination, lung auscultation revealed normal breath sounds without wheezes or crackles. Neurologic examination disclosed hypernasal speech, difficulty with swallowing, and excessive salivation and drooling. The gag reflex was slightly decreased. Muscle strength was normal except for mild weakness of neck flexors, deltoids, biceps, triceps, and hip flexors. Gait, coordination,

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Figure 1. Deltoid muscle biopsy showing cluster of small angulated fibers. One fiber contains a rimmed vacuole (arrow) (Gomori trichrome, original magnification × 500).

Figure 2. Deltoid muscle biopsy showing ragged red fiber (Gomori trichrome, original magnification × 900).

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Blunt Chest Trauma*

Extrapercardial Cardiac Tamponade by a Mediastinal Hematoma

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Mediastinal hematoma resulting from blunt chest trauma can cause compression of the right ventricle and extrapericardial cardiac tamponade. The diagnosis in this instance was aided by conventional two-dimensional echocardiography in addition to hemodynamic measurements. The atypical aspects of this form of cardiac tamponade are discussed.

(Chest 1989; 95:922-24)

Cardiac tamponade may result from a variety of intrapericardial or extrapericardial sources of compression of the heart and great vessels. Postoperative tamponade following open-heart surgery is a well-known entity caused by either hemorrhage within the pericardial sac or by mediastinal hematoma formation.¹ Mediastinal hematoma has been reported in association with cardiac tamponade in several clinical settings, including nonaortic mediastinal hemorrhage from cervical spine fractures,² aortic and carotid aneurysmal rupture,³ mediastinal and cardiac penetrating trauma,⁴ perforation of mediastinal structures from subclavian vein catheterization,⁵ and in one case of blunt trauma to the anterior chest wall.⁶

Our institution is a major primary and tertiary referral center for blunt trauma, and many of these patients suffer severe blunt injury to the chest. In this paper, we present the unusual observation of an anterior mediastinal hematoma resulting from blunt chest trauma which caused extrapericardial cardiac tamponade. The diagnosis was made with the aid of conventional two-dimensional echocardiography in addition to hemodynamic parameters and roentgenographic findings.

CASE REPORT

A 57-year-old man was involved in a head-on motor vehicle accident, sustaining multiple rib fractures, bilateral hemopneumothoraces, a liver fracture, and several small mesenteric avulsions. He was wearing a seat-belt with a shoulder-harness at the time of the accident which left a distinctive ecchymotic band from the left shoulder to the right iliac crest across the anterior chest wall. In addition to the shoulder harness injury, a steering-wheel chest contusion was suspected. Bilateral chest tubes were placed to decompress the hemopneumothoraces, and oral intubation was required with mechanical ventilation for respiratory support. A subsequent chest roentgenogram revealed a widened mediastinum with a blunted cardiac apex consistent with mediastinal hematoma (Fig 1). An aortic arch arteriogram was normal, and the patient was observed after laparotomy in the Surgical Intensive Care Unit.

On arrival to the Surgical Intensive Care Unit, the blood pressure

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