Cardiac Tamponade with Community-acquired Methicillin-resistant *Staphylococcus aureus* Pericarditis

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Ao: aorta, EFS: echo-free space, LA: left atrium, LV: left ventricle, RV: right ventricle

Picture 1.

A 60-year-old man with non-small cell lung cancer who was not receiving any treatment was referred to Kinki-Chuo Chest Medical Center due to a disturbance of consciousness, a high-grade fever and refractory hypotension. Chest computed tomography showed a large pericardial effusion, and an echocardiogram revealed tamponade caused by circumferential fluid accumulation in the pericardium (Picture 1). Urgent pericardiocentesis yielded 650 mL of purulent fluid that grew methicillin-resistant *Staphylococcus aureus* (MRSA); however, no malignant cells were detected (Picture 2). The patient's condition improved following pericardiocentesis and the administration of intravenous vancomycin. He denied any history of previous hospitalization, nursing home residency or surgical procedures. Moreover, the MRSA identified in the present case was sensitive to minocycline, clindamycin and trimethoprim/sulfamethoxazole. This sensitivity pattern is consistent with that of community-acquired MRSA.

Cardiac tamponade caused by MRSA pericarditis is an uncommon but potentially life-threatening illness (1, 2). To our knowledge, this is the second case of community-

Picture 2.

acquired MRSA pericarditis reported in the English literature. This entity can be misdiagnosed as pericarditis carcinomatosa, especially in cancer patients. Careful attention should therefore be paid when diagnosing pericardial effusion in cancer patients.

The authors state that they have no Conflict of Interest (COI).

References

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