Shortness of breath as a disguise

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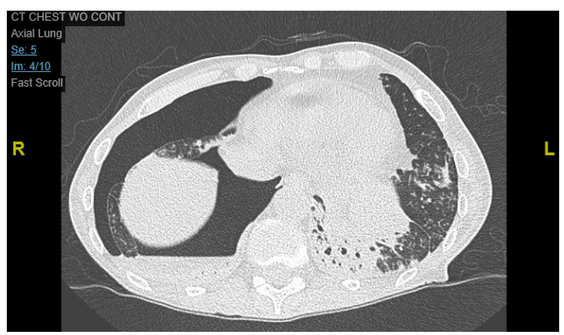
Introduction:

When the do-not-miss diagnosis is not cancer but instead recognition of the arch towards the end of life, careful communication and goal setting is key in order to allow intentional patient centered care coordination.

Case Description:

Initial Presentation

- **56-year-old male** with a **history of HIV** (undetectable viral load), squamous cell carcinoma (in remission)
- Presented with several months of **worsening severe shortness of breath** in the setting of **60 pounds of weight loss over a year**.
- Prior to admission he was **essentially immobile** and **wrote out his responses** due to how symptomatically short of breath he was.
- His primary care physician recommended that he present to the emergency room given concern for **suspicious findings on an outpatient CT chest.**
- He **appeared extremely cachectic**, as well as elderly beyond his stated age.

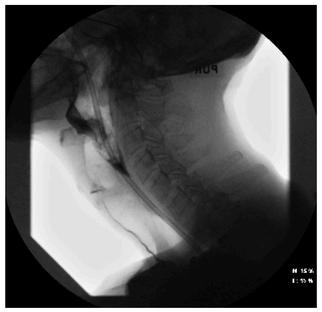


Right hydropneumothorax that was detected on CT Chest without contrast done prior to admission as screening for lung nodules given this patients extensive smoking history

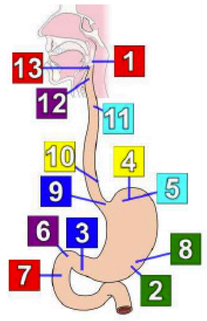
Hospital Course

- Once admitted, he was found to have a hydropneumothorax, as well as nodules suspicious for cancer.
- Work-up was done to rule out any possibility of opportunistic infections versus malignancy.
- Despite concerns for both, all imaging and lab work remained negative.
- Swallow studies were completed that showed his swallowing mechanics were essentially non-functional.
- It became clear that his hydropneumothorax was secondary to aspiration, due to his challenges swallowing.
- The transition to a liquid-based diet secondary to difficulty swallowing at home was likely the cause of his significant weight loss.

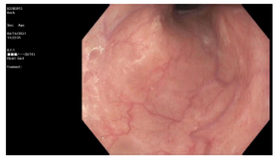
XR Pharyngogram showed aspiration with all types of consistencies



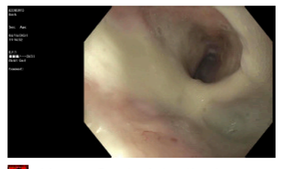
EGD Findings



Upper Gastrointestinal Tract



11 Upper Third of the Esophagus : Dilated



1 Upper Gastrointestinal Tract : Edema, laryngeal edema, pooling secretions

Discharge and Follow-up

- *PEG tube placement was declined*, and the patient requested to go home to meet his goals of care - *discharged him to home*, reassured by his close primary care follow up.
- Several months later, he *re-presented with failure to thrive, and was agreeable to a PEG tube* placement at that time.
- He discharged to home once again despite recommendations for skilled nursing home placement.
- In the last few weeks has become amenable to nursing home placement.

Discussion:

- Complete a full work-up for patients with high suspicion for causes of shortness of breath that might be related to acute infection, malignancy, or obstruction.
- The greater challenge may be when their suffering is found to be progressive and coalescing with the end of life.
- In order to respect patient autonomy medical intervention must be reconsidered, even if it risks possible later interventions to manage subsequent complications.
- acknowledgement of the emotional challenge of decision making in this space especially for patients without strong social support is key, in order to form a stronger patient-clinician relationships.
- Partnership with the patient, and effective communication with their primary care team can help the patient navigate this space.

Sources:
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