Refractory ascites due to ascites praecox

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A 14-year-old girl presented with gradually increasing abdominal distension for 6 months. She recently noticed mild breathlessness on exertion. Examination revealed a tense ascites with mild oedema of the lower limbs. Her jugular venous pulse (JVP) was not seen to be elevated in the supine or 45° position but was raised up to the ear lobes in sitting up position. A pericardial knock was heard on auscultation.

Lateral X-ray of the chest showed calcification of the pericardium (Figure 1). CT scan showed a circumferential calcification of the pericardium (Figure 2) along with massive ascites (Figure 3).

Figure 1. X-ray chest (lateral view)  Figure 2. CT scan of the chest

Figure 3. CT scan of the abdomen
Echocardiography findings were consistent with constrictive pericarditis. She underwent a pericardiectomy with complete resolution of symptoms. Tuberculosis was confirmed as the cause of chronic calcific constrictive pericarditis on the histologic sections of the pericardium postoperatively.

Ascites secondary to constrictive pericarditis typically occurs before the oedema of the lower limbs, unlike other cardiac causes. Hence it is referred to as ‘ascites praecox’. Abdominal signs such as hepatomegaly and ascites frequently over shadow the cardiac signs causing difficulty in diagnoses.

The most important physical sign in constrictive pericarditis is a raised JVP which is often missed as it is grossly elevated above the angle of the jaw. A sitting up position is preferred in such cases. The importance of making an accurate diagnosis lies in the fact that surgical intervention can provide complete relief of symptoms in these patients.

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