課程主題摘要

主講題目	臨床病理討論會(CPC)
摘要內容	A 28-year-old woman was transferred to the intensive care unit (ICU) of this hospital because of progressive respiratory failure. She had a history of exercise-induced asthma, for which she had briefly used inhaled albuterol as a teenager. On pulmonary-function testing performed, the spirometry results and lung volumes were normal, but the diffusing capacity of the lungs for carbon monoxide was severely reduced. Computed tomography (CT) of the chest, performed without the administration of contrast material, showed diffuse, centrilobular, nodular ground-glass opacities in both lungs with mild enlargement of several mediastinal lymph nodes. The findings were thought to be indicative of hypersensitivity pneumonitis. Transthoracic echocardiography reportedly showed a small left ventricle with normal function, a markedly dilated and hypokinetic right ventricle, and interventricular septal compression. 3-year history of exertional dyspnea presented with severe hypoxemia and right heart failure that had been caused by rapidly progressive pulmonary hypertension. Determining the underlying cause of this patient’s pulmonary hypertension is a critical first step toward building a differential diagnosis.