Clinical Image

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Superior Vena Cava Syndrome

Deepak Kumar Pasupula[1*], Sudeep Kumar Siddappa Malleshappa[1] and Vikhyath Terla[2]

[1]University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania, USA

[2]Harlem Hospital Center, New York, New York, USA

[*]**Corresponding author:** Deepak Kumar Pasupula, University of Pittsburgh Medical Center, 9100 Babcock Blvd, Pittsburgh, Pennsylvania 15237, USA, Tel: 412-999-8606; E-mail: 84pdeepak@upmc.edu

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Image Article

A 49-year-old male with 68 pack-year history of smoking tobacco and 10 cannabis cigarettes per month for 29 years, presented with bilateral upper extremity swelling and right-sided chest pain (**Figure 1**). On examination, he had facial plethora (Panel A), distended jugular vein (Panel B), grade 4 digital clubbing (Panel C) with positive Schamroth's sign (Panel D), and distended superficial veins (Panel E). Computed tomography of the chest revealed a mass in posterior aspect of the right upper lobe (Panel F, arrow), and a necrotic nodal mass encasing and constricting the mid to lower portion of the superior vena cava (SVC) (Panel F & G, arrow). Diagnosed with small-cell lung carcinoma (SCLC) on biopsy. SCLC is second most common malignant cause for SVC syndrome. Severity of signs and symptoms reflects the degree and rate of SVC narrowing. Digital Clubbing is a common finding in lung cancer, but rarely due to SCLC. He was started on carboplatin and etoposide, after 2nd cycle he developed pancytopenia and acute respiratory distress syndrome. Considering overall clinical complexity, family opted for palliative management. He died in 6 weeks from the diagnosis.

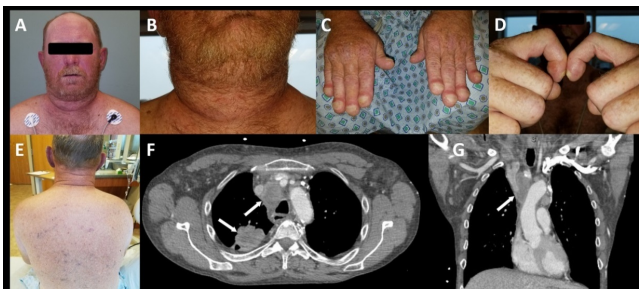

Figure 1 Facial plethora (Panel A), distended jugular vein (Panel B), grade 4 digital clubbing (Panel C) with positive Schamroth's sign (Panel D), and distended superficial veins (Panel E). Computed tomography of the chest revealed a mass in posterior aspect of the right upper lobe (Panel F, arrow) and a necrotic nodal mass encasing and constricting the mid to lower portion of the superior vena cava (SVC) (Panel F & G, arrow).