Intermittent Massive Hemoptysis

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71 year old male presented to the emergency department after experiencing sudden onset hemoptysis of cups of bright red blood. On arrival, he was hypoxemic requiring 2L nasal cannula to maintain his oxygen saturation above 90%. His blood pressure was 91/60, heart rate 125. He was pale appearing and had crackles throughout his lung fields. His hemoglobin was 7.4 down from a recent baseline of 10.4. Chest X-ray demonstrated bilateral opacification. This represented his fourth recurrence of hemoptysis over the past year. He initially presented in January 2019 with steaks of blood thought to be secondary to bronchitis. He was treated with a course of Zithromax and steroids. He presented again in March complaining of coughing up enough blood to coat several tissues. He underwent bronchoscopy which was unrevealing. He had a thoracic aortic aneurysm repair 30 years prior. In April 2019, routine CT imaging of his chest to follow up on his aneurysm repair found an incidental pulmonary embolism. He was sent to the emergency department where he was started on Eliquis and discharged. He developed massive hemoptysis after less than 24 hours of Eliquis therapy and was admitted to the medical intensive care unit where he underwent emergent bronchoscopy that was significant for clots and fresh blood in the airways bilaterally. Rheumatologic workup was negative. The Eliquis was stopped and an IVC filter was placed. He had no further hemoptysis and was discharged. During this presentation with hemoptysis; review of a CT angiogram of his chest revealed possible contrast enhancement adjacent to the aneurysm graft site. It was decided to proceed with bronchoscopy. Initial airway inspection failed to demonstrate any signs of hemorrhage. The pediatric scope was used to navigate to the apical segment of the superior segment of the left lower lobe. There, a small blind appearing bronchus was identified without any surrounding blood. A small aliquot of normal saline was pushed into the bronchus and pulsatile red blood returned. The bleeding stopped spontaneously and thoracic surgery and vascular surgery were consulted. The patient underwent TEVAR which demonstrated contrast extravasation at the distal aortic anastomotic site. Grafting was completed. The patient was brought back to the bronchoscopy suite where the same small bronchus was identified. Again, it was stented open with a small amount of normal saline but there was no pulsatile blood return. The patient was discharged in excellent condition to follow up as an outpatient.

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