Extended Abstract

Journal of Pulmonology and Clinical Research

2020
Vol. 1, Iss. 1

# The international debate on Perplexing transudative pleural effusions – not anymore: an interesting case series

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Pleural effusion is a common clinical scenario with varied etiology. The etiology of pleural effusion is mostly established by pleural fluid examination for biochemistry, microbiology and cytology. If the etiology is still not determined then a pleural biopsy is done. Till recently this was done with an Abram's or Cope's pleural biopsy needle. However, this being a blind procedure the diagnosis could not be established in 20-25% cases. Medical thoracoscopy or pleuroscopy, though not a relatively new procedure but appears to be the ideal investigation under the circumstances. The procedure consists of a single 7-10 mm incision, port inserted in the pleural space under conscious sedation with direct visualization of the entire pleural space along with biopsies of the affected site and drainage of entire pleural fluid, in a 20-30 min sitting, with results as high as 92-100%. It is a state of the art procedure done by pulmonologists cutting down the cost alongside providing a diagnostic as well as symptomatic relief to the patient. Patients presenting with shortness of breath, cough and chest-x-ray s/o pleural effusion, which when tapped is non-decisive of infective etiology, malignancy or tuberculosis (lymphocytic exudates with normal, borderline or very high ADA levels). Over here we would like to present a series of interesting cases where the diagnosis could only be made possible only with the help of thoracoscopy in these transudative effusions though done strictly in concordance with the ERS guidelines for pleural effusion. Hence, "A high yield with early targeted therapy with a better response and a better future

**Note:** This work is partly presented at 11th Annual Congress on Pulmonology & Respiratory Medicine | March 18-19, held at Amsterdam, Netherlands