inflammatory myofibroblastic tumour might become locally invasive and involve adjacent structures, surgical resection is the treatment of choice (Thistlethwaite et al, 2011). Patients who are unable to have complete surgical resection should receive glucocorticoids, radiotherapy or chemotherapy. Inflammatory myofibroblastic tumour reactivation after initial resection has been reported (Weinberg et al, 1987). **BJHM**

Cunha BA, Lortholary O, Cunha CB (2015) Fever of unknown origin: a clinical approach. *Am J Med* **128**(10): 1138.e1–1138.e15. https://doi.org/10.1016/j.amjmed.2015.06.001

Lewis JT, Gaffney RL, Casey MB, Farrell MA, Morice WG, Macon WR (2003) Inflammatory pseudotumor of the spleen associated with a clonal Epstein-Barr virus genome. Case report and review of the literature. *Am J Clin Pathol* **120**(1): 56–61. https://doi.org/10.1309/BUWNMG5RV4D09YYH

Melloni G, Carretta A, Ciriaco P et al (2005) Inflammatory pseudotumor of the lung in adults. *Ann Thorac Surg* **79**(2): 426–432. https://doi.org/10.1016/j.athoracsur.2004.07.077

Petersdorf RG, Beeson PB (1961) Fever of unexplained origin: report on 100 cases. *Medicine* **40**(1): 1–30. https://doi.org/10.1097/00005792-196102000-00001

Thistlethwaite PA, Renner J, Duhamel D, Makani S, Lin GY, Jamieson SW, Harrell J (2011) Surgical management of endobronchial inflammatory myofibroblastic tumors. *Ann Thoracic Surg* **91**(2): 367–372. https://doi.org/10.1016/j.athoracsur.2010.09.017

Weinberg PB, Bromberg PA, Askin FB (1987) "Recurrence" of a plasma cell granuloma 11 years after initial resection. *South Med J* **80**(5): 519–521.

LEARNING POINTS

- Although self-limited febrile processes commonly end without aetiological diagnosis, further investigation is needed when systemic involvement is detected or they can recur.
- For patients who are able to have complete resection, surgery is the treatment of choice.

Acute dyspnoea in a paraplegic man

A 72-year-old paraplegic man presented with acute dyspnoea (oxygen saturations (in air) of 79%). Examination revealed raised jugular venous pressure and bilateral leg swelling. Initial arterial blood gas measurements indicated type 1 respiratory failure. D-dimer level was elevated at 5.64 ng/ml.

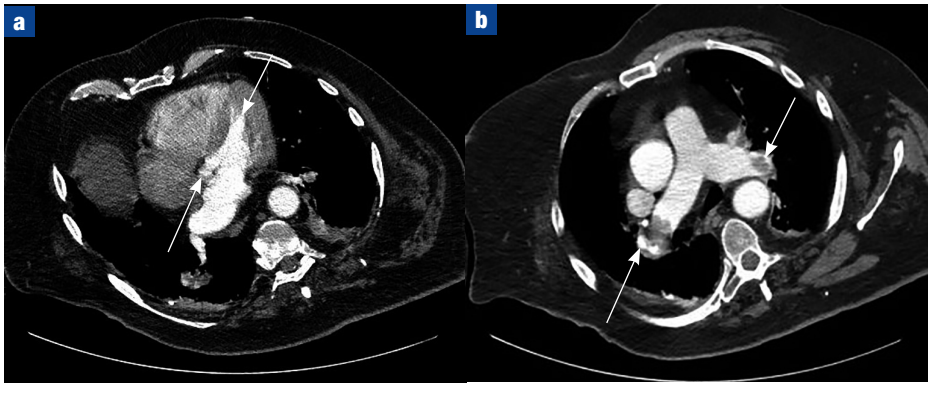
Computed tomography pulmonary angiogram (*Figure 1*) showed right ventricular dilatation and displacement of the interventricular septum, suggesting right heart strain secondary to bilateral large pulmonary emboli. Transthoracic echocardiogram showed severely impaired and dilated right ventricular and pulmonary artery systolic pressure >40 mmHg (i.e. pulmonary hypertension); a unifying diagnosis of cor pulmonale. No regional wall abnormalities were identified and therefore McConnell's sign, i.e. akinesia of the mid-right ventricular wall with apical sparing in a patient with an acute pulmonary emboli (Matthews and McLaughlin, 2008), was not present.

Embolic disease increases pulmonary resistance and right ventricular afterload through obstruction and vasoconstriction. Consequently, the interventricular septum deviates toward the left ventricle in diastole. Right ventricular wall tension increases and may result in myocardial ischaemia. Right ventricular failure in the presence of acute pulmonary emboli carries high mortality (Piazza and Goldhaber, 2005). Hence early recognition is crucial and treatment involves therapeutic anticoagulation and restoring oxygenation. **BJHM**

Matthews JC, McLaughlin V (2008) Acute right ventricular failure in the setting of acute pulmonary embolism or chronic pulmonary hypertension: a detailed review of the pathophysiology, diagnosis, and management. *Curr Cardiol Rev* **4**(1): 49–59. https://doi.org/10.2174/157340308783565384

Piazza G, Goldhaber SZ (2005) The acutely decompensated right ventricle: pathways for diagnosis and management. *Chest* **128**(3): 1836–1852. https://doi.org/10.1378/chest.128.3.1836

Figure 1. a. Computed tomography pulmonary angiogram demonstrating bowing of the cardiac septum (arrows) and a dilated right ventricle suggestive of acute right heart strain. **b.** Bilateral emboli in the left and right pulmonary arteries (arrows) with co-existing pulmonary hypertension.



Dr Timothy Shao Ern Tan, Foundation Year 1 Doctor in Cardiology, Department of Cardiology, Royal Preston Hospital, Lancashire Teaching Hospitals NHS Foundation Trust, Preston PR2 9HT

Dr Saad Ahmad, Specialty Registrar in Cardiology, Department of Cardiology, Royal Preston Hospital, Lancashire Teaching Hospitals NHS Foundation Trust, Preston

Correspondence to: Dr TSE Tan (timothy.tan.shao.ern@doctors.org.uk)