A rare cause of non-cardiogenic pulmonary edema
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Learning Objectives
- Identify patients with noncardiogenic pulmonary edema secondary to nephrotic syndrome (NS).
- Describe the management of a patient with noncardiogenic pulmonary edema secondary to NS.

Case Presentation:
A 37 year old man with a past medical history of diabetes mellitus type II, hypertension, and dyslipidemia, who presented with dyspnea, orthopnea, and non-productive cough for two days. He had been developing progressive abdominal distention and lower extremity (LE) swelling for three weeks prior to admission. He denies any chest pain, fevers, or chills.

Hospital Course:
- He appeared uncomfortable and hypoxic and had abdominal distention with bilateral LE edema.
- initial laboratory tests revealed BUN of 33, creatinine of 1.8, bicarbonate of 34, and albumin of 2.1.
- His random urine protein-to-creatinine ratio was 8.36 g.
- He had normal C3 and C4 levels.
- Chronic hepatitis panel, HIV, anti-GBM Ab, ANCA, ANA, anti-dsDNA, and RF were negative.
- EKG showed sinus rhythm, and echocardiogram revealed normal systolic and diastolic function with ejection fraction of 55-60%.
- Chest x-ray was consistent with volume overload and pulmonary edema.
- Kidney ultrasound was unremarkable.
- His kidney biopsy confirmed diabetic nephropathy as a cause of his nephrotic syndrome.
- He was diuresed with furosemide and metolazone and had a significant improvement of his volume status.
- The patient was subsequently weaned off room air following diuresis.

References