A hemorrhagic pericardial effusion can be seen in up to as high as 12-25% of blunt chest trauma.\(^1\) An effusion large enough to cause cardiac tamponade occurs most commonly acutely after the injury. Nevertheless, the development of a clinically significant effusion can have a late presentation in rare cases. Etiology is most often thought to be secondary to a slow bleed after injury to pericardial vasculature that is not symptomatic at first or evident on initial echocardiogram.

A 52-year-old male presented to the hospital after sustaining a motor vehicle collision (MVC). Initial imaging revealed multiple injuries: displaced left rib 1-10 anterolateral and 1-12 posterior rib fractures, left lateral clavicle and left scapula fracture, mandibular fractures, and left-sided hemopneumothorax. He underwent chest tube placement and fixation of the clavicular and mandibular fractures. During the admission he was started on anticoagulation for a left upper limb deep vein thrombosis. On day 20 after initial MVC he developed significant dyspnea on exertion while working with physical therapy, with associated tachycardia and palpitations. Chest x-ray showed a globular contour of the heart. Stat echocardiography showed circumferential effusion that was suggestive of tamponade including right ventricular diastolic collapse (Fig. 1). Anticoagulation was stopped and pericardiocentesis was performed with 900cc of bloody fluid removed with improvement in both his symptoms and hemodynamics.

Clinicians should have a high index of suspicion for delayed cardiac tamponade following blunt chest trauma even up to a month after initial injury. Diagnosis is often not straightforward as symptoms can be non-specific like in this case in which the patient developed acute shortness of breath and tachycardia.

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**REFERENCES**


