

# Letter to Editor regarding “Unusual Presentation of Spontaneous Chylothorax”

Anjali Rachel Varghese<sup>1</sup>, Atul Jindal<sup>2</sup>

Received on: 31 August 2022; Accepted on: 03 September 2022; Published on: 31 October 2022

**Keywords:** Chylothorax, Chylous pleural fluid, Octreotide, Pleural fluid lactate dehydrogenase.

*Indian Journal of Critical Care Medicine* (2022): 10.5005/jp-journals-10071-24353

We read with great attention the case report titled “An Unusual Presentation of Spontaneous Chylothorax” by Kaul et al.<sup>1</sup> We commend the authors on the interesting case but we would like to express some of our observations.

This case was regarding a 3-year-old male child presenting with bilateral scrotal swelling and diagnosed with bilateral chylothorax as an incidental finding. As per the case report, the intercostal drain (ICD) tube was inserted bilaterally to drain the collection and we observed that no drain output was documented till the 13th day of illness while the pleural fluid absolute lymphocyte counts and protein levels were measured. Hence some clarification is required to clear the ambiguity.

Usually, lactate dehydrogenase (LDH) level in the chyle is low, and the range remains similar to a transudate. An elevated LDH level should alert us regarding any other alternative cause for the pleural effusion in addition to a chyle leak.<sup>2</sup> So, pleural fluid LDH should be measured as it can aid in discerning other etiologies.

For chylothorax with less chest tube drainage, conservative management with pleural fluid drainage, diet modification, and treatment with a somatostatin analog can be considered. Somatostatin as well as Octreotide which is a synthetic somatostatin analog, in combination with diet has been effective in reducing the accumulation of chylous pleural effusion thus preventing unnecessary surgical management. Octreotide is usually given as a Continuous intravenous infusion with a maximum dose of 6 mg/day or as a subcutaneous injection with a dose of 50–100 µg every 8th hour. So, in this case, octreotide or somatostatin could have been added as part of the medical management.

According to the article by Riley and Atay<sup>3</sup>, those patients with ICD output of more than 10 mL/kg/day on a postoperative day 5, ICD output for more than 2 weeks, or deteriorating nutritional status are considered to have failed conservative therapy and surgical management should be considered. In this case, the drain output was persistent till day 21 as documented and the patient was discharged with an ICD tube *in situ*. Persistent drainage of pleural fluid can result in significant malnutrition and loss of immunoglobulin, hence increasing the risk of infections. So,

<sup>1,2</sup>Department of Pediatrics, All India Institute of Medical Sciences, Raipur, Chhattisgarh, India

**Corresponding Author:** Atul Jindal, Phone: +91 8224014667, e-mail: dratuljindal@gmail.com

**How to cite this article:** Varghese AR, Jindal A. Letter to Editor regarding “Unusual Presentation of Spontaneous Chylothorax”. *Indian J Crit Care Med* 2022;26(11):1225.

**Source of support:** Nil

**Conflict of interest:** None

ideally, pleural fluid drainage should not exceed 14 consecutive days.<sup>4</sup> We feel that the surgical intervention could have been an earlier decision that could have prevented the secondary bacterial infection in the second episode.

Idiopathic causes constitute about 10% of all chylothorax, out of which the majority turned out to be due to undiagnosed malignancy. Hence, such patients should be under regular follow-up so that they can be promptly detected and treated on time.

## ORCID

Anjali Rachel Varghese  <https://orcid.org/0000-0003-1231-1087>

Atul Jindal  <https://orcid.org/0000-0002-0504-1077>

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