



Case Presentation: Lung Transplant Evaluation for COVID-19 PNA and ARDS

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History

- 31F with no significant PMHx, at 28w5d gestation
 - Presented to an outside ED with 1 week of dry cough
 - Symptoms progressed to fever, SOB/DOE over preceding 48 hours

History (Cont)

- Found to be COVID-19 & Rapid Strep +ve
 - Increasing O₂ requirements: (7L NC -> 15L NRB)
- Started on Azithromycin and Betamethasone
- Transferred to Texas Children's Hospital (TCH) for peripartum care

History (Cont)

- At arrival to TCH, visibly dyspneic & tachypneic
 - WOB improved with transition to HFNC
 - Started on Ceftriaxone for Group A Strep pharyngitis
 - Treatment for COVID initiated:
 - Remdesivir
 - Convalescent plasma
 - Dexamethasone

History (Cont)

- HD #4:
 - Acute worsening in respiratory status → intubated
 - Urgent cesarean delivery at 29w2d
- Unable to be extubated post C-section with worsening hypoxemia
 - HD #14: Transferred to Baylor St. Luke's Medical Center (BSLMC)

Physical Exam – Arrival at BSLMC

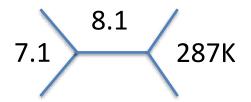
Vital Signs:

- T: 100.4F, HR: 89, BP: 99/55, RR 26 with 95% SaO2

Ventilator Settings:

- Mode: CMV, Vt: 300mL, RR: 26, PEEP: 9 cm H₂0; FiO₂: 60%
- $-P_{IP}$: 38 cm H₂O, P_{PIAT} : 37 cm H₂O, P/F: 267
- GEN: Intubated; Sedated on Hydromorphone & Propofol gtts, midazolam PRN
- CV: RRR, no murmur auscultated
- PULM: Coarse breath sounds bilaterally, symmetric chest rise
- ABD: C-section wound healing without erythema or exudates
- EXT: No appreciable pitting edema in BLE; DP/PT pulses palpable bilaterally

Initial Laboratory Values



CRP: 11.4

LDH: 834

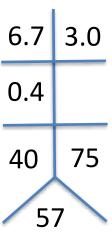
Ferritin: 132

132	95	5	2.1
4.6	29	0.5	4.7

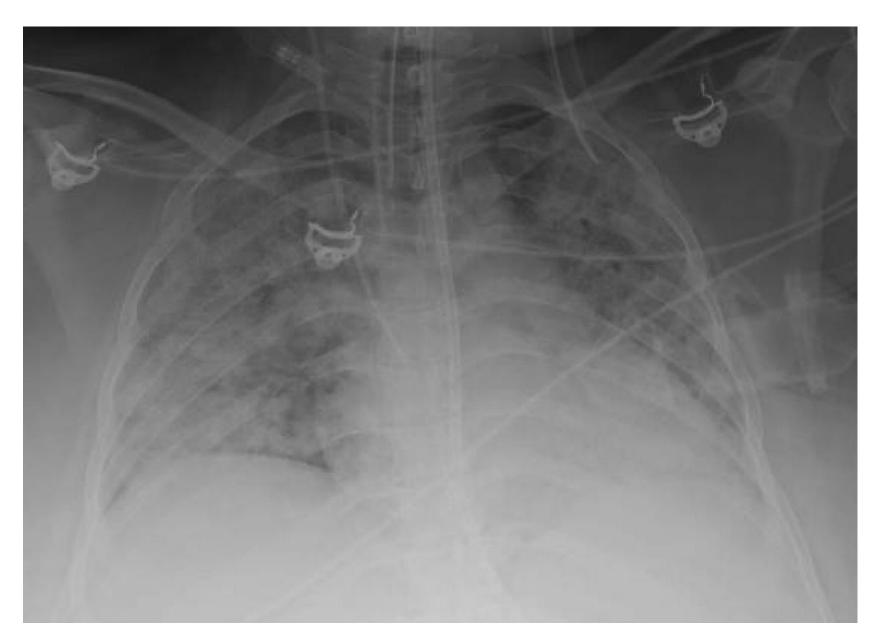
D-Dimer: 1.5

PCT: 0.05

Troponin: 0.01



Initial CXR



Hospital Course

- Worsening oxygenation;
 On inhaled
 Epoprostenol, deep
 sedation & paralytics.
- Proning initiated

HD #20

HD #25

Tracheostomy

- Given worsening hypoxemia and lung compliance, would you refer this patient for consideration of lung transplantation?
 - A. Yes
 - B. No
 - C. I do not know

Hospital Course

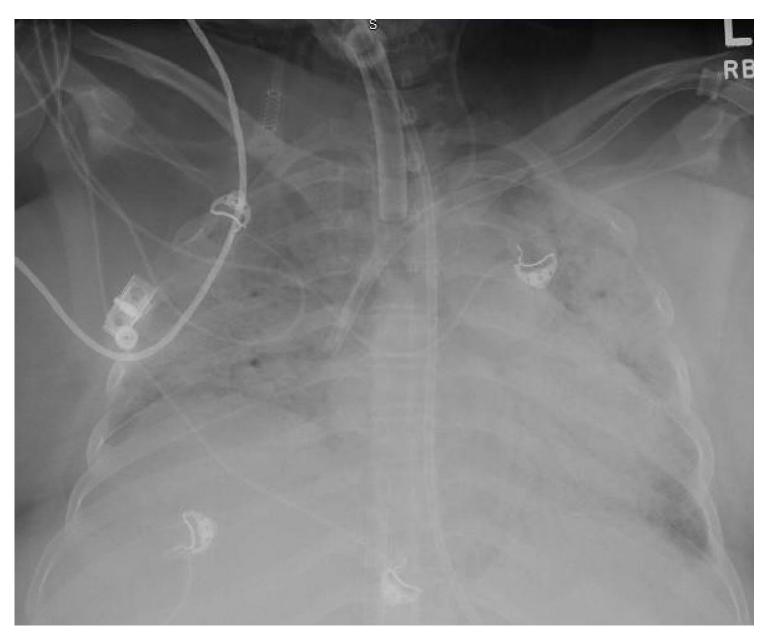
- LTx Service Consultation:
 - Prolonged MV w/ deep sedation & paralytics; Deconditioning preclude active listing
 - Given single organ dysfunction, stabilization with ECLS recommended
 - VV-EMCO cannulation (Rt FV inflow, Lt SCV outflow) as bridge to transplant vs recovery

HD #28

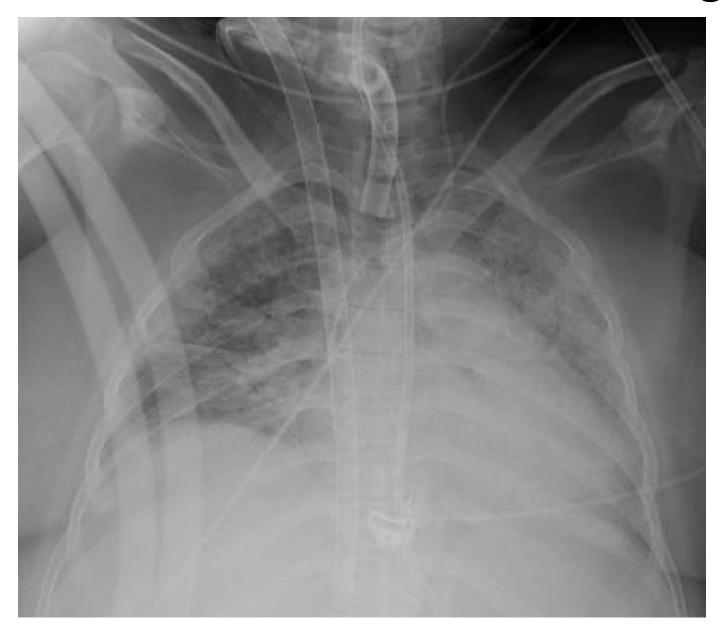
HD #36

- Weaned to Tracheostomy Collar
- RIJ Avalon cannula exchange for mobilization given prolonged ECMO needs

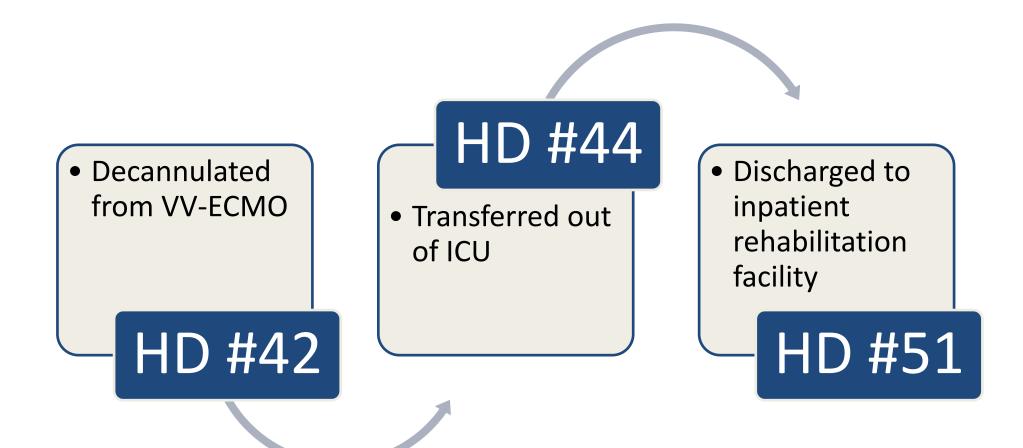
CXR at VV-ECMO Cannulation



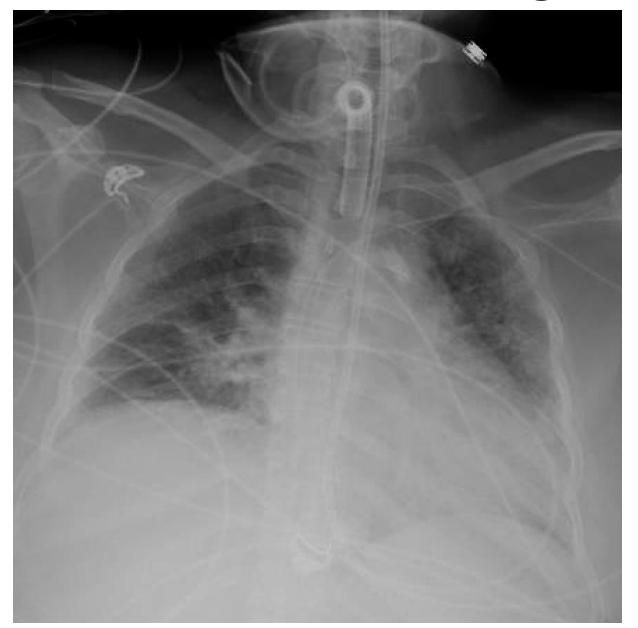
CXR at RIJ Avalon Cannula Exchange



Hospital Course



CXR Prior to Discharge



Discussion by: Dr. Amit Parulekar

