Assessment of Pleural Effusion by Means of Imaging Modalities

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Introduction

Pleural effusion is the fluid collection in the pleural cavity between the parietal and visceral pleura. It is caused by parenchymal diseases such as inflammatory disorders or infection. Pleural effusion can be diagnosed using imaging modalities such as X-ray, computed tomography (CT) scan, ultrasound, and magnetic resonance imaging (MRI). MRI is rarely performed to investigate pleural effusion due to motion artifacts and has a poor spatial resolution. Benign and malignant pleural effusion can be diagnosed using an X-ray, CT scan, or ultrasound. Pleural effusion volume can be measured by using ultrasound. This article reviews the feasibility of investigating pleural effusion and fluid drainage in medical imaging and compares to find the best modality for its diagnosis.  

Characteristics of Pleural Effusion

The normal amount of pleural fluid in the right and left pleural space is 8.4 ± 4.3mL, and in non-smoker individuals, the total pleural fluid per kilogram of body mass is 0.26 ± 0.1 mL/kg. Formulas have been proposed for the quantification of pleural fluid volume under ultrasound guidance. Pleural fluid is identified by dynamic signs such as a change in echo-free space during the respiratory cycle, compressed lungs, or atelectatic and swirling motion in the echo-free space.
Quantify Pleural Effusion

The left side image shows that the ultrasound probe is placed at the level of mid-thorax for measuring the cross-sectional area of PE, and the right-side image shows right lung two-dimensional computed tomography (2D CT) reconstruction in one of the patients who had PE. The thin arrows (blue) indicate the PE length \( L \), and the dashed line (red) indicates the intercostal gap where the cross-sectional area \( A \) of PE was measured. Then the length of each paravertebral intercostal gap was measured (Fig. 1).

Calculation of Pleural Effusion Volume

The patient was positioned in supine. The pleural cavity was visualized in the axial plane by placing the probe in each paravertebral intercostal space. The probe was slid posteriorly to visualize the pleural cavity. The length of PE \( L_{us} \) was determined by measuring the distance between upper and lower paravertebral intercostal spaces where pleural effusion was noted. The frame where the pleural effusion was noted was frozen and the area of PE \( A_{us} \) was measured. The pleural effusion volume was calculated by multiplying \( L_{us} \) and \( A_{us} \) (Fig. 2 and Table 1).

Pleural Fluid-Thoracic Drainage

The patient’s position during the entire procedure was up to the sonographer’s choice but was generally supine to permit scanning of the lateral hemithorax. The possibility of thoracentesis was identified by a sonographic window where the fluid remained throughout the respiratory cycle. After identifying the suitable sonographic window, the angle of the sonoprobe was noticed, and the skin was marked where the needed depth of penetration was measured from the sonographic image. Under ultrasound guidance, site preparation, and thoracentesis were performed while maintaining the patient’s position. During the process, the placement of needle was along a safe penetration axis according to the sonographic image.

Diagnosis of Pleural Effusion

The initial step in diagnosing a pleural effusion is to identify whether it is a transudate or an exudate. When PE is an exudative effusion, additional diagnostic tests such as cytology, pleural biopsy, and sometimes thoracotomy can be performed to know a precise diagnosis and proper therapy for the pleural disease. On the other side, if the fluid is transudate, then therapeutic maneuvers performed for pleura are unnecessary and underlying diseases such as nephrosis, congestive heart failure, cirrhosis, or hypoproteinemia must be treated.

Pleural effusion can be identified by chest radiography. Pleural effusion can cause mediastinal shift away from the diseased side seen on chest X-ray. Mediastinal shift can be upper or lower shift. Tracheal shift indicates upper mediastinal shift, whereas a shift in the heart position shows lower mediastinal shift. The trachea and heart shift to the opposite side in conditions such as tuberculous PE and effusion caused by other infective diseases. In case of malignant PE, the tracheal and heart are seen to be centrally or shifted to the same side as the fluid. In moderate pleural effusions, there might be silhouette loss between the heart borders and hemidiaphragms on chest X-ray. On the chest PA radiograph, the presence of pleural fluid around 200 mL is abnormal. On a lateral chest radiograph, only 50 mL of pleural fluid that leads to costophrenic angle blunting is visible. Lateral films can help distinguish between pleural thickening and free fluid because free fluid gravitates to the most dependent area of the chest wall.

Ultrasound is more accurate in assessing pleural effusion volume and helps with thoracentesis than chest radiography. The pleural effusion was divided as echogenic or non-echogenic during the pre-procedure ultrasound. Echogenic pleural effusions were characterized as PE having

Fig. 1 Diagram depicting quantification of PE.

Fig. 2 Diagram showing PEV calculation.
Table 1 Standardized grading method for pleural effusions

<table>
<thead>
<tr>
<th>Grade</th>
<th>Illustration</th>
<th>Landmarks</th>
<th>Intercostal spaces</th>
</tr>
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<tbody>
<tr>
<td>Grade 1: minimum</td>
<td>Limited to costophrenic sinus</td>
<td>Partially evident diaphragmatic dome</td>
<td>Limited to costophrenic sinus</td>
</tr>
<tr>
<td>Grade 2: small</td>
<td>Partially involved lower lung lobe</td>
<td>Completely evident diaphragmatic dome</td>
<td>Intercoastal space 1</td>
</tr>
<tr>
<td>Grade 3: Small to medium</td>
<td>Partially collapsed lower lung lobe</td>
<td>Lower lung lobe partially atelectasis, pulmonary hilum not seen</td>
<td>Intercoastal space 2–3</td>
</tr>
<tr>
<td>Grade 4: medium</td>
<td>Completely collapsed lower lung lobe</td>
<td>Lower lung lobe atelectasis, pulmonary hilum is seen</td>
<td>Intercoastal space 3–4</td>
</tr>
<tr>
<td>Grade 5: large</td>
<td>Partially involved upper lung lobe</td>
<td>Lower lung lobe atelectasis, partially atelectasis of upper lung lobe</td>
<td>Intercoastal space four and more</td>
</tr>
<tr>
<td>Grade 6: massive</td>
<td>Fully collapsed lung</td>
<td>Hilum is wholly seen, Whole lung atelectasis.</td>
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Pleural Biopsy

Pleural biopsy is the most common method for obtaining diagnostic tissue that has been an accepted choice by patients and physicians due to its ease of use, particularly as an alternative to thoracoscopy in countries with limited healthcare resources. US-guided biopsy for thoracic lesions near the chest wall may be viable approach than CT-guided biopsy in terms of efficacy and safety.

Radiological Appearance

Benign Pleural Effusion

On chest X-ray, diffuse pleural thickening appears smooth and continuous pleural density that extends over at least 25% of the chest wall. The costophrenic angle is usually blunted, and laterally there is a slight increase in the radiographic density seen on the chest X-ray. The American Thoracic Society uses the presence of costophrenic angle blunting to differentiate it from widespread pleural plaque for diagnosis of the diffuse pleural thickness.

On ultrasound, most pleural collections are hypoechoic or anechoic collections demarcated by the lung echogenicity and visceral pleura. Pleural seapeat effusions are exudates, whereas hypoechoic effusions can be exudates or transudates, and pleural thickening can be seen in the depths.

On CT scan, diffuse visceral pleural thickening is characterized as a continuous sheet of pleural thickening that is more than 8 cm long, 5 cm wide, and 3 mm thick that can occur in pleural plaques. In contrast to pleural plaques, the diffuse pleural thickening borders are tapered.

Malignant Pleural Effusion

On chest X-ray, malignant pleural thickening typically appears irregular and nodular opacities can be seen in the lung perimeter. In 60% of cases, pleural effusions are seen as unilateral, and in 5% cases, bilateral pleural effusion.

On ultrasound, malignant solid pleural tumors appear as a homogenous well-delineated sheet-like lesion with breath > 1 cm in diameter. Pleural effusions with pleural nodularity and diaphragmatic thickness > 7 mm and parietal pleural thickness > 10 mm were found to have a high positive predictive value and specificity for underlying cancer in one of the studies.

On CT scan, parietal pleural thickening, mediastinal pleural thickening, nodular pleural thickening (>1 cm), and circumferential pleural thickening can be seen.

Conclusion

Pleural effusion can be diagnosed using imaging modalities such as chest radiograph, ultrasound, CT scan, and MRI. MRI has a limited role in diagnosing pleural effusion because of poor spatial resolution and motion artifacts. Ultrasound is a feasible imaging modality for diagnosing pleural effusion because there is no radiation involved. Also, it is the safest modality for pleural fluid drainage and biopsy as it provides...
real-time imaging with better efficacy and more safety to patients.

Conflict of Interest
None declared.

References
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