A 54-year-old woman was referred for evaluation of possible cor pulmonale based on the presence of dyspnea, chronic productive cough, and bilateral leg edema for 8 years. For about 8 years, her nails had been thick, brown-yellowish and would break easily. The nail grew very slowly and sometimes separated from its bed. The appearance of the nails did not change after 7 courses of antimycotic therapy. Physical examination was remarkable for dullness and decreased breath sounds at both lung bases. There was slight symmetric, nonpitting pretibial, ankle, and hand edema (Figure 1). All nails were brown-yellowish, thickened, excessively curved from side-to-side, and had transverse ridging. The lunulae were absent, and there was a distinct hump on the nails (Figure 1). Standard hematological and biochemical tests showed values within the normal ranges. Sinus radiographs revealed shadowing of both maxillary sinuses. The echocardiogram showed a small pericardial effusion (8 mm); there was no sign of constrictive pericarditis or pulmonary hypertension. The chest radiograph revealed bilateral pleural effusions with normal heart and pulmonary vasculature (Figure 2, top). Computed tomography demonstrated normal heart, great vessels and mediastinal structures, and bilateral pleural effusions. There were discrete changes suggestive of bronchiectasis in the left lower lobe. Thoracentesis revealed a clear, straw-colored nonviscous fluid with a protein content of 43.7 g/L. The concentration of glucose, lactic dehydrogenase, and amylase was normal. The white cell count was 5400/mm³ with a predominance of lymphocytes. No malignant cells were found and the culture was negative. The common causes of a transudate (cardiac failure, hepatic cirrhosis, nephropathy, myxedema, or hypoproteinemia) or exudate (lymphoma, metastatic disease, connective tissue disease, infection) were excluded. A diagnosis of pleural effusions secondary to yellow nail syndrome was made. No therapy was prescribed. A control chest radiograph after 7 weeks showed spontaneous reduction of both pleural effusions (Figure 2, bottom). Since the initial presentation the patient has been followed for 8 months and did not require thoracentesis. Chest radiographs have shown stable small pleural effusions.

The yellow nail syndrome is a triad of slow-growing dystrophic yellow nails, lymphedema, and pleural effusions, often associated with pericardial effusion, rhinosinusitis, and bronchiectasis. Our patient presented with most of these signs coexisting simultaneously. The etiology of this syndrome is obscure, although the pathogenesis seems to involve impaired lymphatic drainage. There is no known specific treatment. The pleural fluid often recurs after tapping; pleurodesis is sometimes helpful. This case illustrates the rather benign course of the syndrome over more than 8 years. The entity should be considered in the differential diagnosis of bilateral pleural effusions.
Figure 1. Photograph showing lympheledema of both legs and thickened, brown-yellowish dystrophic nails.

Figure 2. Top. Chest radiograph on admission, showing bilateral pleural effusions with normal heart and normal pulmonary vasculature. Bottom, Spontaneous reduction in both pleural effusions after 7 weeks.
Multiple Effusions and Lymphedema in the Yellow Nail Syndrome
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