The Life-Changing Implications of Evaluation of Jugular Venous Pressure

To the Editor:

Correct evaluation of jugular venous pressure (JVP), in all its details,\textsuperscript{1} can be a matter of life-changing, if not life-saving, importance. The details that matter most include the precaution to relax the neck muscles, encapsulated in the warning “Do not turn the head”,\textsuperscript{1} which I have previously taken the opportunity to champion,\textsuperscript{2} notwithstanding prevailing received wisdom to the contrary.\textsuperscript{3} Also crucial to mitigating the risk of overlooking the presence of raised JVP is the invocation to flex the trunk “to whatever angle makes the wave form most obvious,”\textsuperscript{1} because that may be the diagnostic maneuver pivotal to generating the “right angle” for eliciting a raised JVP.\textsuperscript{4} In the latter report, that strategy was crucial to identification of constrictive pericarditis as the underlying (and eminently reversible) cause of ascites.\textsuperscript{4}

Sloppy terminology, exemplified by “JVP raised 2 cm,”\textsuperscript{5} has been an occasional unhappy by-product of undisciplined evaluation of JVP. To counteract that tendency, clinicians must adhere to the use of recognizable anatomic landmarks such as the angle of the sternum\textsuperscript{1} or, in the case of a markedly elevated JVP, the angle of the jaw; the latter a useful landmark when the height of the venous column is visible only when the patient is sitting bolt upright.\textsuperscript{6}

The final rhetorical exercise is to monitor the response of the JVP to a course of diuretic therapy. A JVP that remains markedly elevated despite a diuresis sufficiently vigorous to generate a significant degree of weight loss\textsuperscript{7} or hypovolemia\textsuperscript{8} is highly suggestive of a diagnosis of constrictive pericarditis,\textsuperscript{7,8} the latter an eminently reversible underlying cause of the syndrome of congestive heart failure.

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References