June 2014 Arizona Thoracic Society Notes

The June 2014 Arizona Thoracic Society meeting was held on Wednesday, 6/25/14 at the Bio5 building on the University of Arizona Medical Center campus in Tucson beginning at 5:30 PM. This was a dinner meeting with case presentations. There were about 33 in attendance representing the pulmonary, critical care, sleep, pathology and radiology communities.

Four cases were presented:

1. Eric Chase presented a 68 year old incarcerated man shortness of breath, chest pain and productive cough. The patient was a poor historian. He was supposed to be receiving morphine for back pain but this had been held. He also had a 45 pound weight loss over the past year. His PMH was positive for COPD, hypertension, congestive heart failure, chronic back pain and hepatitis C. Past surgical history included a back operation and some sort of chest operation. On physical examination he was tachypneic, tachycardic and multiple scars over his neck, back and chest including a median sternotomy scan. Subcutaneous emphysema was present. Laboratory evaluation was most remarkable for a lactate of 4.6 mg/dL. Chest x-ray revealed subcutaneous and mediastinal air, LLL consolidation, and a left pleural effusion. Thoracentesis of the pleural effusion showed a high amylase and a low pH. A chest tube was placed. Esophagram showed contrast draining through the left chest and chest tube. CT scan was consistent with a colonic interposition graft with a graft to pleural fistula. The patient was deemed to be a poor surgical candidate and a jejunostomy tube was placed.

2. Mohammad Dalabih presented a 72 year old woman with asthma who had no response to asthma medications. Spirometry was consistent with moderate restriction. A thoracic CT scan showed two small nodules along with mosaic attenuation. A lung wedge biopsy showed nonmalignant appearing cells with tumorlets and bronchitis. The cells were CD56 positive. A diagnosis of diffuse interstitial pulmonary neuroendocrine hyperplasia (DIPNECH). Dr. Dalabih reviewed DIPNECH which usually presents in middle aged women with symptoms of cough and dyspnea; obstructive abnormalities on pulmonary function testing; and radiographic imaging showing pulmonary nodules, ground-glass attenuation, and bronchiectasis. In general, the clinical course remains stable; however, progression to respiratory failure can occur. Long-term follow- up studies and the best treatment remains unknown. The April 2014 Pulmonary Case of the Month also presented a case of DIPNECH (1).

3. Mohammad Alzoubaidi presented the case of a 61 year old woman with right upper quadrant pain who was found to have a large liver lesion on abdominal CT scan. She suffered a cardiac arrest shortly after the CT scan and her hemoglobin decreased to 5.6 g/dL. Angiography revealed multiple pseudoaneursyms with the largest apparently bleeding. Coil embolization was

performed but a couple of days later her shock recurred. A repeat angiogram showed enlargement of the known pseudoaneursyms and several new ones. She was begun on corticosteroids for a presumed vasculitis. Unfortunately, she continued to bleed and died. Autopsy was consistent with fibromuscular dysplasia. Fibromuscular dysplasia is a non-atherosclerotic, non-inflammatory disease of the blood vessels resulting in constriction and dilatation (pseudoaneursyms) (2). The cause and best treatment are unknown.

4. John Bloom presented a 22 year old Somali man that grew up in India who came to the US about 15 months before presentation. He was relatively asymptomatic but was found to have supraclavicular adenopathy on a "wellness" physical examination. Biopsy of the lymph nodes was recommended but he refused. He presented about a month later with neck and back pain. Physical examination revealed by adenopathy and a fever of 38.2º C. His white blood cell count was 12,600 cells/μL. Thoracic CT showed a miliary pattern with vertebral destruction. Laminectomy with cord stabilization was performed. Biopsy was negative for acid fast bacilli but positive for GMS+ organisms consistent with coccidioidomycosis. A large cervical paraspinal abscess just below the skull was drained and a large mediastinal abscess was also seen on CT scan. Discussion ensued about whether drainage was appropriate for the mediastinal mass, but most thought not. The case illustrates that Valley Fever is common and in most chest differential diagnosis in the Southwest.

There being no further business the meeting was adjourned about 6:45 PM. There will be no meeting in July. The next meeting in Phoenix will be a case presentation conference on August 27, 6:30 PM at Scottsdale Shea Hospital.

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References

1. Wesselius LJ. April 2014 pulmonary case of the month: DIP-what? Southwest J Pulm Crit Care. 2014;8(4):195-203. [CrossRef]
2. Slovut DP, Olin JW. Fibromuscular dysplasia. N Engl J Med. 2004;350(18):1862-71. [CrossRef] [PubMed]