Clinics in Surgery

Short Communication
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Pneumopathy during Pregnancy

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Short Communication

A 31-years old female, with thrombogenic Leyden Factor V, who smoked 5 cigarettes/day from 15 to 25 years.

She started with right chest pain during the last three months of her first pregnancy delivering a normal baby in December 2013.

Two weeks after, she began with cough and mucous sputum.

Chest X-rays and PET-CT showed a tumor like lesion with a cavity in the anterior segment of Right Upper Lobe (Figure 1,2) and low metabolic activity in hilar adenopathies.

Bronchofiberscopy: No endobronchial lesions.

CT Fine Needle Biopsy: No neoplastic cells.

Chorionic Gonadotrophin and Alpha Fetoprotein were negative.

In June 2014 surgical exploration showed hard RUL tumor strongly attached to superior cava vein. Atypical segmentectomy of Anterior Segment with good margins and sampling of group 4 adenopathy was performed. Intraoperative and delayed Pathology showed chronic inflammation with acute suppurative areas.

Prolonged antibiotic treatment depending on cultures was indicated without good result (Figure 3).

New bronchoscopy with transbronchial biopsies (TBB) showed non-specific inflammation.

Local and general evolution went torpidly worse, even though different antibiotic schemes were instituted.

March 2015: Surgical re-exploration. Biopsies of small nodules in RLL and mediastinal pleura. The wedge biopsy of a strongly consolidated Middle Lobe got into a suppurative cavity that was drained through pneumonostomy (Figure 4).

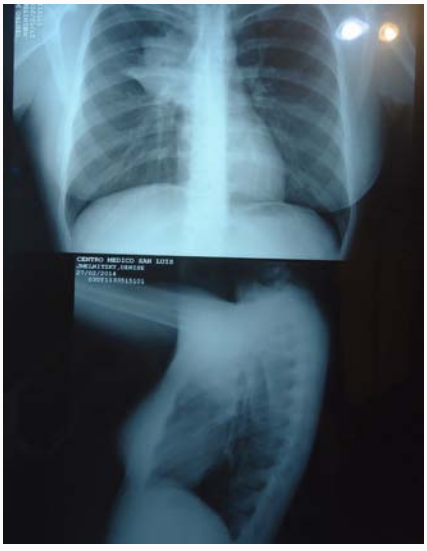

Figure 1: Initial Rx showing right upper lobe (RUL) opacity.

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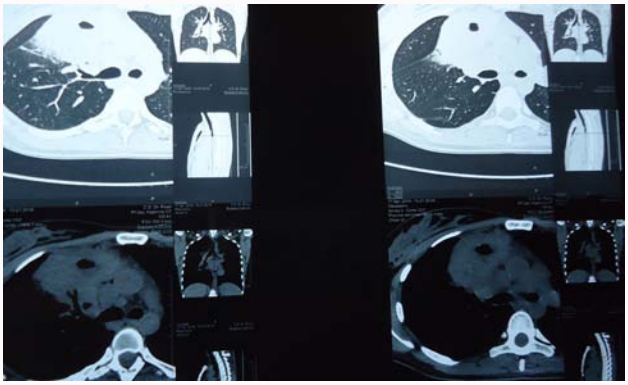

Figure 2: Initial CT scan shows a small cavity inside RUL lesion.

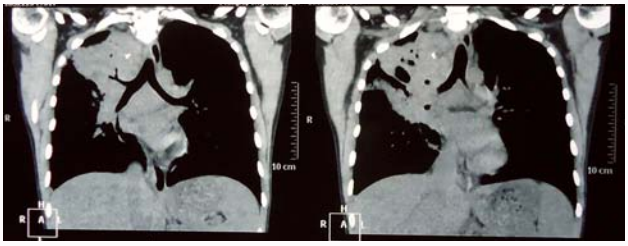

Figure 3: Lesion progression in spite of the first operation and antibiotic treatment.

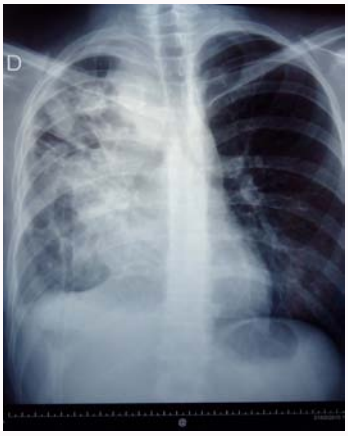

Figure 4: Pneumonostomy draining a large middle lobe cavity.

The patient did better while the cavity slowly got closed and drainage was thrown out.

Initially the pathological diagnosis didn't change and an international consultation was proposed. Material obtained through both surgical operations and bronchoscopies was sent to the Pathology Laboratory of the Cedars Sinai Medical Center in California.

No specific lesions were detected in all the previous samples, but Right Middle Lobe wedge resection was described as: "Lung with necrotizing pneumonia admixed with atypical lymphoid infiltrates consistent with Hodgkin lymphoma classical type" (Figure 5, and 6).

The Comment by the Pathologist was as follows: "The case is very difficult to classify as it shows extensive area of severe necrotizing pneumonia. However, the right middle lobe wedge resection specimen shows nodular areas with a relatively small number of large atypical cells that exhibit an immunophenotype consistent with Hodgkin lymphoma (CD30+, MUM+, CD20+, TARC +, PAX5 weakly +, CD45 -). The case was evaluated by our hematopathologist".

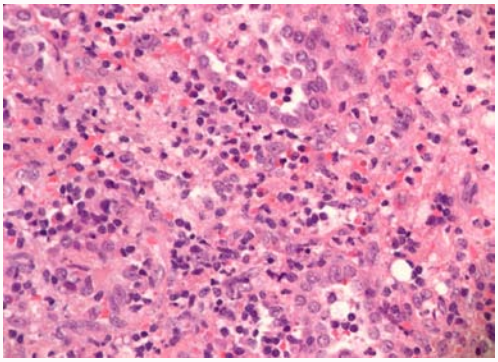

Figure 5: Atypical lung infiltrate with eosinophils and scattered large cells.

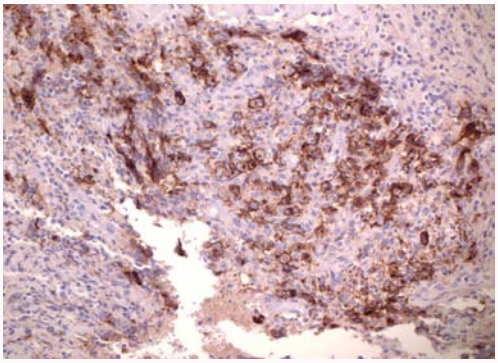

Figure 6: Immunostain showing that large cells are CD30 positive.

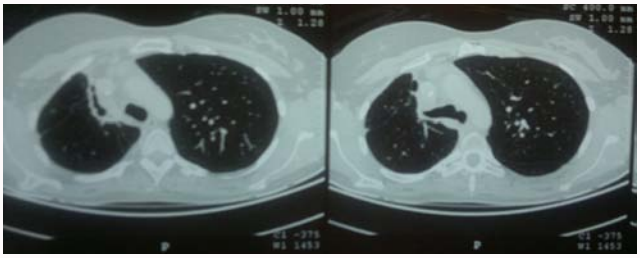

Figure 7: Reduced lesion after specific Hodgkin disease treatment.

The patient started specific treatment with good tolerance.

She remains free from the illness more than two years after. Small asymptomatic bronchiectasis remaining in RULobe (Figure 7).

Conclusion

Persistence and detailed work of surgeons and pathologists lead to life saving diagnosis and treatment in an unusually confusing case.