Presenting symptoms of this 42-year-old man were left pleuritic pain and severe dyspnea while climbing stairs. He had a 2-year history of exertional dyspnea but had not sought medical advice. The patient's pulse was 123 beats per minute; respiratory rate, 45 breaths per minute; blood pressure, 80/45 mm Hg; and temperature, 37.3°C (99.1°F). Chest examination revealed hyperresonance with absence of breath sounds over the left hemithorax and wheezing over the right lung.

A chest film (A) showed left-sided tension pneumothorax with a collapsed left lung, and a shift of the trachea and mediastinum to the right. Left-sided tube thoracotomy was carried out, and the patient was placed on mechanical ventilation. The air leakage sealed after 4 days; ventilatory support was then discontinued, and the chest tube was removed.

A follow-up chest film revealed diffuse pulmonary parenchymal disease (B), and bronchoscopy was performed to determine the underlying pathologic process. No endobronchial lesions were seen. Transbronchial biopsy showed noncaseating epithelioid granulomas, which led to the diagnosis of sarcoidosis. All cultures were negative for pathogenic organisms. The patient received corticosteroid therapy, which resulted in clinical improvement, and he had no recurrent episodes of pneumothorax during the ensuing year. The association between pneumothorax and sarcoidosis was first described by Freiman in 1948, writes Dr Samer Alkhuja of Greenwich, Conn. Development of pneumothoraces in these cases is believed to be caused by rupture of a subpleural bleb or necrosis of a subpleural granuloma, resulting in a bronchopleural fistula. Pneumothorax may be the presenting manifestation of pulmonary sarcoidosis.

REFERENCE:

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