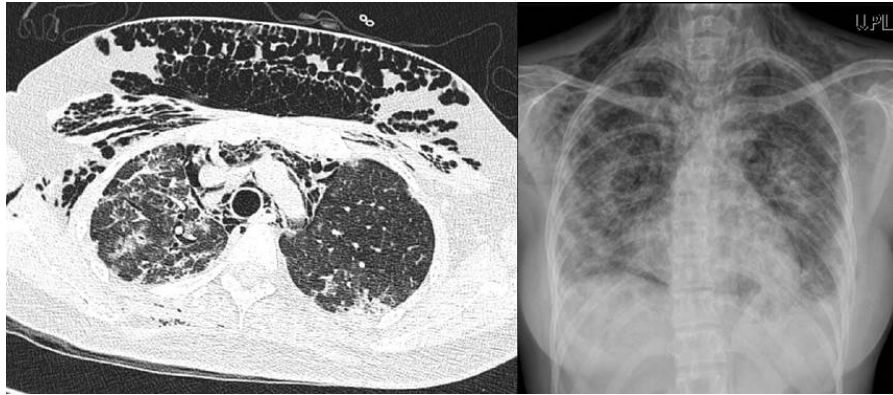


Recurrent pneumomediastinum and subcutaneous emphysema in systemic lupus erythematosus

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Recurrent pneumomediastinum and subcutaneous emphysema in systemic lupus erythematosus **Introduction:** spontaneous pneumomediastinum in systemic lupus erythematosus(SLE) patient is very rare case. We report a case of recurrent spontaneous pneumomediastinum and subcutaneous emphysema in a 26 year old woman with SLE. **Case:** A 26-year-old female patient, who had diagnosed with SLE complained of sudden neck pain, crepitus sound, and mild dyspnea. She previously had history of mediastinotomy, small bore catheter insertion due to recurrent pneumomediastinum. She showed tachypnea with tachycardia. Physical examination showed subcutaneous crepitus to the chest wall and neck. Total blood count and biochemical characteristics were not noticeable. Chest X-ray and CT scan(figure) showed subcutaneous emphysema and extensive pneumomediastinum in the lower neck and upper chest wall. This recurrent pneumomediastinum and subcutaneous emphysema is thought to result by alveolar rupture from interstitial fibrosis or pulmonary infarction caused by pulmonary vasculitis, which is often a feature of connective tissue disorders. Respiratory tract infection also had been described as a possible precipitating factor in some cases. Fasciotomy and high concentration oxygen been applied and patient recovered. **Conclusion:** In patients with SLE, recurrent pneumomediastinum and subcutaneous emphysema due to lung fibrosis may occur. Patients should be instructed and educated in advance, and the cough should be well controlled.



A case of Pulmonary tuberculosis presenting as a crazy-paving pattern on chest computed tomography

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Introduction: Crazy-paving pattern is diffuse ground glass appearance with superimposed interlobular septal thickening on chest computed tomography(CT). It can be observed in various diseases, but rarely in the tuberculosis. We report a case of pulmonary tuberculosis showing crazy-paving pattern on CT leading delay in diagnosis. **Case:** A 69-year-old man visited our emergency room(ER) complaining cough and dyspnea which had lasted for 3 weeks. He did not report fever, purulent sputum, or night sweat. His vital sign was normal. Laboratory findings revealed a normal complete blood count and CRP-level of 1.19 mg/dL. Chest X-ray showed lobar consolidation at right lower lung field(Fig.1). Antibiotics was prescribed with a diagnosis of pneumonia. He was referred to outpatient clinic after 1 week. Respiratory symptoms and abnormal infiltrates on Chest X-ray persisted. Chest CT scan showed consolidation and diffuse GGOs with crazy-paving pattern in RLL(Fig.4). Bronchoalveolar lavage (BAL) was done. BAL fluid analysis showed marked increase in lymphocytes (84 % of total WBCs, 706/mm³). AFB smear and M. tuberculosis PCR of BAL fluid was positive. He was diagnosed as pulmonary tuberculosis and anti-tuberculosis medication was started. After 2 months, dyspnea was improved and chest CT also showed decreased crazy-paving pattern(Fig.2,5). At the time of treatment completion, abnormal infiltrates on chest X-ray was disappeared(Fig.3) **Conclusion:** Tuberculosis should be considered in differential diagnosis of patients with crazy-paving pattern on chest CT scan.

