ORIGINAL RESEARCH PAPER
Volume-8 | Issue-11 | November - 2019 | PRINT ISSN No. 2277 - 8179 | DOI : 10.36106/ijsr
INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH

ADENOCARCINOMA OF LUNG PRESENTING AS NON RESOLVING PNEUMONIA – A CASE REPORT

General Medicine

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KEYWORDS

• INTRODUCTION

Non Resolving Pneumonia is defined as a slow or delayed resolution of clinical symptoms or radiographic opacities despite adequate course of antibiotic therapy.

Non resolving pneumonia is observed as a result of inappropriate antimicrobial therapy, super infection, inadequate host response, obstruction, empyema, non infectious processes, or recurrent infection. Several conditions can be responsible for non-resolving pulmonary infiltrates. This case highlights a noninfectious cause that mimic infectious pneumonia.

• CASE REPORT

A 42-year-old female patient came to department with 4 to 6 weeks history of fever, cough with expectoration, dyspnea on exertion and left sided chest pain. She had already taken antibiotics from private clinic for left sided opacity. Her worsening of dyspnea and chest pain with progressive weight loss prompted her to the department. There was documented history of 6 kg weight loss in last 3 months.

Patient had similar episode of illness 8 months back & treated with Antibiotics considering the diagnosis of Bilateral Pneumonitis. At that time sputum AFB and CBNAAT was negative. Soon after that patient was put on Anti tuberculous treatment by private clinician after BAL Fluid gene expert showed Mycobacterium tuberculosis (detected : very low). However AFB Culture by BACTEC MGIT 320 showed No growth after 3 weeks.

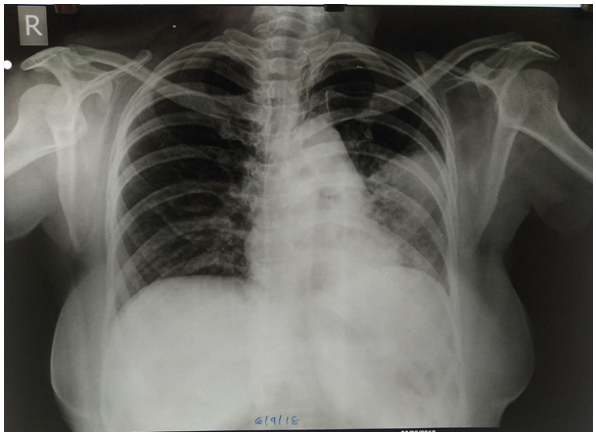
Patient was not having any comorbidities and there was no any significant family history.

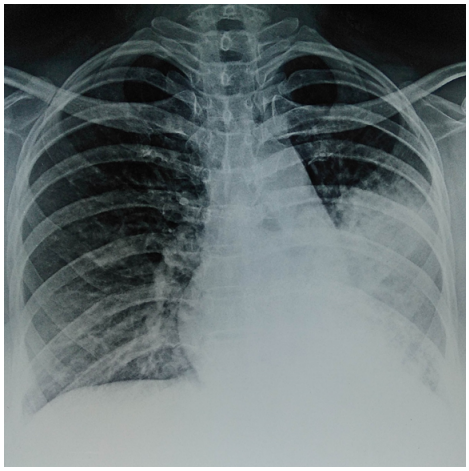
• EXAMINATION

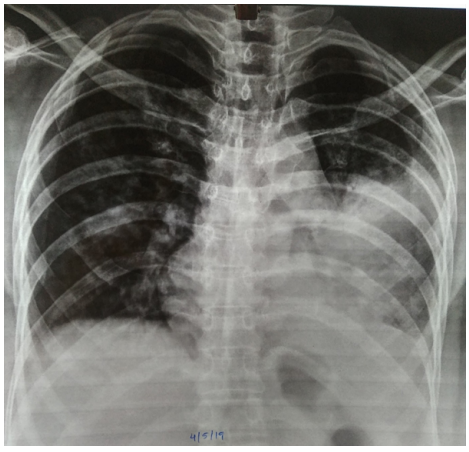
Patient was hemodynamically stable, febrile on touch, digital clubbing of grade 2 was there. On Auscultation reduced breath sound in left inter and infra scapular region. There were no any palpable cervical or axillary lymphnodes.

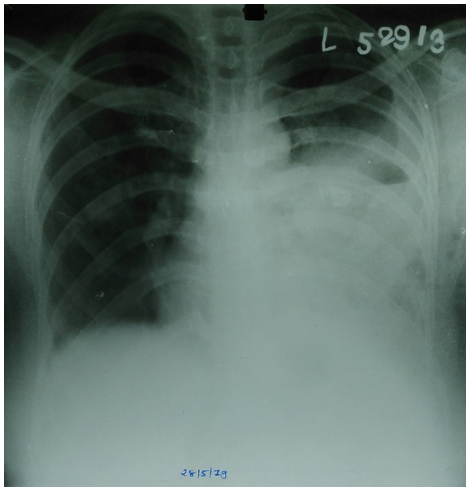
• INVESTIGATIONS , DIAGNOSIS AND MANAGEMENT

Chest radiograph demonstrated left middle and lower zone ill-defined soft tissue opacity with obliteration of left CP Angle.



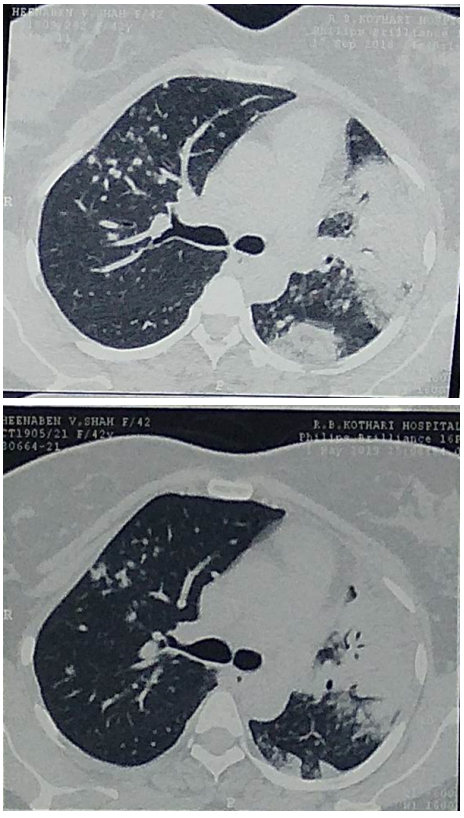






Hematological examinations including CBC, Coagulation profile, renal and liver function tests all within normal range. Blood culture was negative.

CECT of September 2018 was showing well demarcated segmental consolidation involving the left upper lobe, left lingual and left lower lobe with few enlarged pre and paratracheal nodes overall suggestive of possibility of Koch's etiology with endobronchial spread of infection. However at that time Sputum AFB were negative.



Repeat CECT in May 2019 showed no significant changes as compared to previous CT. It showed multifocal infective consolidation involving left lung with multiple small well defined nodules scattered diffusely in both lung fields with few enlarged mediastinal lymphnodes overall findings were suggestive of atypical / fungal pneumonitis or tuberculosis with endobronchial spread of infection.

USG suggested about 8×6 cm of loculated collection with possibility of developing Lung abscess with the depth of approx. 4 cm with underlying consolidation in left middle and lower lobe & left sided minimal pleural effusion.

Diagnostic Video bronchoscopy via nasal route done at earlier institute was suggested non endoluminal pathology. Culture and sensitivity report of BAL fluid showed scanty growth of Methicillin Resistant Staphylococcus Aureus (MRSA) which was only sensitive to linezolid, vancomycin and rifampicin. Fluid biochemistry revealed polymorphic picture. Gene expert for both sputum and BAL fluid was negative for M.TB & No malignant cells seen in sputum cytology. BAL fungal culture was negative. ANCA Profile was negative.

• CLINICAL SUSPICION

Initial differential diagnosis included BOOP (Bronchiolitis obliterans organizing pneumonia) or Broncho Alveolar Malignancy.

Later on patient underwent CT guided lung biopsy from left lung mass like consolidation which showed Adenocarcinoma with lepidic pattern. Tumour masker (CEA – Carcino Embryonic Antigen) was borderline raised. Patient was referred to oncologist. She is now on chemotherapy for the same.

• DISCUSSION AND CONCLUSION

Pulmonary neoplasms are one of the noninfectious causes of Febrile Pneumonitis Syndrome. Patients with persistent symptoms and pulmonary infiltrates, despite higher antibiotics require diagnostic re-evaluation and the clinician should include lung cancer as a differential diagnosis. Pulmonary Neoplasm is estimated to account for 1-8% of "Pneumonia Mimics" in most series.

The likelihood of noninfectious etiologies of pulmonary disease increases if the gram-stained smear and culture of sputum are unrevealing, if the initial response to empiric antimicrobial therapy proves unsatisfactory, or if radiographic findings are atypical.

Thus Careful assessment and timely interventions could lead to early therapeutic intervention and ultimately better outcomes.

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