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Images in emergency medicine

Haemoptysis from the pulmonary artery

Shih-Hung Tsai, Wei-Chou Chang, Shi-Jye Chu, Hsien-He Hsu

A 72-year-old woman presented because of cough with fresh blood for 3 days. She had a history of aortic dissection and underwent aortic arch reconstruction 12 years earlier. On arrival, her vital signs included blood pressure of 150/78 mm Hg and respiratory rate of 24 breathes/min. Physical examination revealed rales over the left hemithorax. Laboratory results included haemoglobin of 10.9 g/dl and platelet count of 113 000/μl. An oblique coronal reformatted image was performed by multislice computed tomography (MSCT) and demonstrated non-tapering distal branches of the left pulmonary artery with an adjacent area of ground-glass attenuation, indicating the culprit lesions (asterisk). The patient was treated conservatively and recovered uneventfully.

Most cases of haemoptysis (90%) originate from the bronchial circulation. MSCT angiography with a combination of multiplanar reformatted images can help identify the origins and courses of arteries that may be responsible for bleeding. Effective trans-arterial embolisation requires such knowledge, particularly for differentiating pulmonary, bronchial or non-bronchial systemic feeder vessels.¹

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Figure 1 An oblique coronal maximum intensity projection reformatted image, obtained with 64 multislice computed tomography, demonstrating non-tapering distal branches of the left pulmonary artery with an adjacent area of ground-glass attenuation, and indicating the culprit lesion (asterisk: the highest attenuation was 95 HU). Arrow, left main bronchus; Ao, aortic arch; LA, left atrium; P, left pulmonary artery.

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