CLINICAL PRACTICE

Clinical Images

Missing the Tree for the Forest: A Case of Secondary Spontaneous Pneumothorax

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Figure 1 Chest x-ray revealing a large left apical bleb (1), stable fungal infection (2) and new pneumothorax (3).

A 67-year-old woman presented with four weeks of gradually worsening exertional dyspnea, post-tussive right-sided chest pressure, intermittent foot swelling and drenching night sweats. She had a history of sarcoidosis, aspergilloma and recently completed several courses of

Figure 2 Baseline computerized tomography displays a large left apical bleb (1) and fungal infection (2).

antibiotics for repeated pneumonia. A chest x-ray (Fig. 1) demonstrated a pre-existing left apical bleb (1), stable fungal infection (2) and new moderate right-sided pneumothorax (3). Her prior coronal computerized tomography (CT) (Fig. 2) is included for comparison. She was treated with a temporary chest tube and did well with symptomatic improvement.

Secondary spontaneous pneumothorax (SSP) occurs in the context of underlying lung disease and frequently requires urgent management due to limited cardiopulmonary reserve.¹ Compared to primary spontaneous pneumothorax, secondary cases occur later in life¹ and portend poor outcomes with up to a fourfold increase in mortality for patients with chronic obstructive pulmonary disease.² Recurrence is seen in up to 50% of patients with SSP² and should prompt pulmonary consultation for consideration of a preventive intervention such as pleurodesis after the first presentation.^{2,3} This patient was discharged with outpatient evaluation for lung transplant. She was subsequently re-admitted with recurrent pneumothorax and is

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undergoing expedited inpatient evaluation for transplantation (pleurodesis would preclude transplant).

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