Late presentation of lung sequestration

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DESCRIPTION

A 35-year-old woman presented with a 4-month history of generalised body aches, fever, chills, pleuritic chest pain and cough productive of yellow sputum. She had history of multiple episodes of

pneumonia treated with oral antibiotics with no improvement. She had 20 pack-years smoking history on bronchodilators. Extensive work was conducted including a skin purified protein derivative test, sputum acid-fast bacilli and HIV antibodies, which were all negative. On examination, the chest was remarkable for crepitations over the right lower lung zone. The rest of her examination was unremarkable. A chest radiograph showed airspace opacity within the right lower chest zone (figure 1). Sputum culture grew *Streptococcus pneumoniae*. CT of the chest revealed multiple cavitary lesions with air fluid level supplied by an artery originating from the aorta (figure 2). These findings were consistent with intralobar pulmonary sequestration presenting with frequent pulmonary infections. The patient underwent a right-lower lobectomy and the histology report revealed an acute neutrophilic pneumonitis supplied by elastic artery with intimal fibrosis.

Figure 1 Chest radiograph showing airspace opacity within the right lower chest zone.

Figure 2 CT of the chest showing multiple cavitary lesions with air-fluid level supplied by an artery originating from the aorta (arrow).

Learning points

- ▶ Most patients with intralobar pulmonary sequestration (ILS) are asymptomatic.
- ▶ The diagnosis usually made after non-specific respiratory symptoms such as recurrent lobular pneumonia in the lower lung zones or haemoptysis.¹
- ▶ In 85% of ILS cases, the arterial supply is arising from the infradiaphragmatic aorta.
- ▶ Treatment is mainly surgical with lobectomy.²

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