A correctable cause of lung collapse in an adolescent with severe scoliosis causing compression of the bronchial tree

Pierre Goussard,1 Robert Gie,2 Savvas Andronikou,3 Pieter Rousseau Fourie4

1Department of Paediatrics, Stellenbosch University, Cape Town, South Africa
2Department of Child Health and Pediatrics, Stellenbosch University, Cape Town, South Africa
3Department of Radiology, University of the Witwatersrand, Johannesburg, South Africa
4Department of Critical Care and Anaesthesia, Stellenbosch University, Cape Town, South Africa

Correspondence to Dr Pierre Goussard, pgouss@sun.ac.za

DESCRIPTION
A 17-year-old boy with known severe cerebral palsy presented with cough, fever and shortness of breath. He was a spastic quadriplegic with muscle weakness, severe scoliosis and poor cough which made it difficult for him to clear respiratory secretions. He presented with acute pneumonia which resulted in progressive respiratory failure requiring intubation and ventilation. The initial plain chest radiograph (figure 1A) demonstrated severe scoliosis and mediastinum shift to the right. On following the airways an abrupt cut-off of bronchus intermedius at the level where it crossed the vertebral column was seen. This resulted in a collapse of the right middle and lower lobes, further compromising the respiratory compromise. On X-ray, the curve measured 107° according to the Cobb method.

Fibre-optic bronchoscopy demonstrated compression of the bronchus intermedius from the posterior with an almost complete occlusion of the bronchus intermedius. The left bronchial tree was normal. A chest CT scan (figure 2A,B) confirmed the narrow chest (decreased diameter between the anterior thoracic wall and the vertebral bodies), a mediastinum shifted to the right and a compressed bronchus intermedius. As a result of the scoliosis, the bronchus intermedius had a horizontal rather than vertical orientation, with the bronchus narrowing caused by stretching of the bronchus across the vertebral body. The collapsed right middle and lower lobes are clearly visible. Bronchial lavage and chest physiotherapy failed to resolve the collapsed lobes. The patient underwent a long posterior correction with fusion, instrumentation from the level of T2 to the pelvis and multiple osteotomies for the severe scoliosis and had an uncomplicated postoperative course. Spinal radiographs (figure 1B) obtained postoperatively demonstrated that the collapsed lobes had re-expanded.

Respiratory compromise is a well-recognised complication of children with cerebral palsy. Most
recurrent chest infections are ascribed to repeated aspiration. Severe scoliosis leads to chest wall deformity which further decreases lung function and increases the risk of lower respiratory tract infections. Torsion of the large airways in children with lordoscoliosis may lead to bronchial compression. This problem is possibly more common than previously recognised and may be the explanation for the higher incidence of empyema and lung abscesses in these children. Ventilation to the lung and clearance of secretions can be re-established if the thoracic lordoscoliosis is successfully surgically repaired.

**Learning points**

- Torsion of the large airways in children with lordoscoliosis may lead to bronchial compression.
- Bronchial compression may improve if surgery is performed for thoracic lordoscoliosis.
- Children with cerebral palsy and thoracic lordoscoliosis are at high risk for respiratory complications.

**REFERENCES**