A case of lung volume reduction surgery with decortication for a septic patient in respiratory failure

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**Abstract**

**Introduction:** Decortication and lung volume reduction surgery are both major operations and each has its independent risk of morbidity and mortality.

**Case Report:** We present the case of a 41 year old gentleman with left sided empyema and giant bullae of the upper lobe with an active air leak that was transferred to our tertiary referral centre for further management. We performed emergency left thoracotomy, decorticated the left lower lobe with extensive lung volume reduction surgery of the upper lobe. Patient’s respiratory status significantly improved along with excellent radiological results.

**Conclusion:** Our case demonstrates that a combination of complex procedures is feasible with excellent outcomes.

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1. Background

Secondary spontaneous pneumothorax is a pneumothorax that occurs as a complication of underlying lung disease [1,2]. In the treatment of this condition, pleurodesis is commonly achieved by either pleurectomy or chemical pleurodesis. An endoscopic stapler can be used to resect bullae or blebs most of the time.

Thoracic empyema is defined as pus in the pleural space. Debridement and decortication is carried out in multiloculated empyemas that fail to resolve with antibiotics and chest tube drainage.

Bullae are defined as sharply demarcated, air-filled spaces within the parenchyma of the lung, measuring one centimetre or greater in distended diameter, which are formed as a result of the destructive process of emphysema or alpha-1 antitrypsin deficiency [3].

Giant Bullous disease was first described by Burke et al. in 1937 as a case of Vanishing Lung Syndrome [4] which was characterised by unilateral or bilateral asymmetric upper lobe involvement with the formation of multiple bullae [9]. It can be challenging to differentiate from a pneumothorax which has a similar picture on a plain chest radiograph [10] which may lead to misdiagnosis and mismanagement.

Decortication and lung volume reduction surgery are both major operations and each has its independent risk of morbidity and mortality.

2. Case presentation

A 41 year old gentleman presented to the Emergency Department of a General Hospital complaining of sudden onset left sided chest pain. He has no past medical or surgical history. He is a smoker with a 25 pack year history.

Chest radiograph was reported as a large left sided pneumothorax. This was treated with insertion of a 28 Fr chest drain. Due to the acute presentation with significant respiratory sepsis, it was not possible to perform valid pulmonary function tests on this patient. During his hospital stay, he continued to have a significant air leak and his lung failed to re-expand fully.

On day 7 of admission, he spiked a temperature of 38.2 °C and became septic. His chest radiograph showed a left sided pleural effusion raising the suspicion of an empyema. Sampling of his pleural fluid was turbid looking with a pH of 6.96. He was subsequently referred to our tertiary referral centre on day 10 for further management (Fig. 1).

On arrival, the patient was severely dyspnoeic and febrile but otherwise haemodynamically stable. His physical examination was unremarkable apart for decreased air entry to the left lower zone which was dull to percussion.

Hb 12.7 g/dL, WCC 13.9 x 10^9/L, alpha-1 antitrypsin was negative.

CT thorax was performed and reported as a large loculated left sided hydropneumothorax with fluid in the base and large
pneumothorax locules/complex bullous lung disease compressing
the upper lobe. The right lung was normal. He was commenced on
broad spectrum antibiotics – Flucloxacillin, Vancomycin, and Pip-
eroicillin/Tazobactam – as per microbiology advice with minimal
improvement (Fig. 2).

We proceeded to perform emergency left posterolateral tho-
racotomy and decortication with lung volume reduction surgery.
Preoperative V/Q testing is not used as a routine preoperative
investigation at our institution and thus was not performed. His
operative findings showed multiple giant bullae in the upper lobe,
and a lower lobe with thick pleura that was decorticated. Note
that this patient’s preoperative flexible bronchoscopy was normal.
Due to significant bullous disease and adhesions due to the empyema,
it was considered too risky to perform a thoracoscopic debridement
on this patient.

Histopathology report of surgical samples contained a left apical
bullae measuring 4.7 × 2 × 1.5 cm and another left lung bullae mea-
suring 11.8 × 6.5 × 3 cm. Microscopic examination of these bullae
confirmed large airspaces lined by variably thickened but uniformly
fibrotic walls. Decorticated parietal pleura were also sent showing
fibrotic and thickened pleura with surface fibrin, mesothelial cell
hyperplasia and eosinphils with scattered lymphoid aggregates.
There was no evidence of malignancy.

Microbiological examination of the parietal pleura grew coag-
ulase negative staphylococcus bacteria and was negative for
acid-alcohol fast bacilli and for mycobacteria TB culture.

The patient’s respiratory status significantly improved along
with excellent radiological results. He was discharged on day 7 post
operatively. Postoperative pulmonary function tests were not per-
formed as the patient’s respiratory status was not compromised
(Fig. 3).

3. Methods

This case report has been reported in line with the CARE criteria
[11].

4. Discussion

Given the presenting history, we feel this patient’s left sided
chest pain could have been secondary to pleurisy from a developing
empyema rather than a pneumothorax. Initially, the operative plan
was to treat this patient’s empyema and perform a decortication.
Peri-operatively, the patient was difficult to ventilate secondary
to a massive air leak from the giant bullae; hence it was decided to
perform a lung volume reduction surgery.

Bullous lung disease is an uncommon cause of respiratory dis-
tress. In patients with severe emphysema, discrete emphysematosus
bullae have been shown to functionally impair pulmonary mechan-
s and result in diminished exercise capacity and even acute
respiratory distress [6]. Giant bullae refers to the enlargement of
one or more bullae to such a degree that they fill more than one
third of the hemithorax [3]. The disease usually afflicts young male
smokers and is characterised by large bullae in the upper lobes of
the lung [7].

A bulla results from destruction of the integrity of the alveolar
tissue [8] and leakage of air into the interstitium [9]. Giant bullae
are considered to be hard to rupture, because the rise in the internal
pressure in a bulla spreads in a horizontal direction and the bigger
the bulla, the less is the change of the pressure inside the bulla [8].

Bullae can produce signs and radiologic appearances of
pneumothorax and it is important to differentiate them

Fig. 1. PA chest radiograph showing a left sided pneumothorax and empyema with
dox with chest drain in situ.

Fig. 2. CT thorax showing a large left sided hydropneumothorax and giant bullae.
Right lung was normal.

Fig. 3. Post-operative chest radiograph prior to discharge.
before treatment. The differentiation between giant bulla and pneumothorax can be very difficult and often leads to inaccurate diagnosis and management [5].

The role of CT scan in the diagnosis of pneumothorax in the presence of bullous lung disease is vital as it can avoid unnecessary chest drain insertion. High resolution computed tomography (HRCT) plays an important role in characterising the degree and distribution of emphysema, providing information necessary for operative planning in symptomatic individuals. HRCT is often used to assist in the final diagnosis of Giant Bullous disease as it has been shown to have significant correlation (r=0.94) with pathologic grade on resected lung specimens [7].

The NETT trial showed that patients most likely to benefit from lung volume reduction surgery have heterogeneously distributed emphysema involving the upper lung zones predominantly. Lung volume reduction surgery increases the chance of improved exercise capacity but does not confer a survival advantage over medical therapy. Survival benefit was limited to patients with predominantly upper lobe emphysema and a low baseline exercise capacity. Functional benefits were noted in patients with predominantly upper lobe emphysema and a high baseline exercise capacity and in patients with non-upper lobe emphysema and a low baseline exercise capacity [10].

5. Conclusion

Our case demonstrates the feasibility of achieving an excellent overall outcome with a combination of complex procedures.

Conflicts of interest

No conflicts of interest.

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Ethical approval

None.

Author contribution

All authors contributed in the study design, writing of the paper, and final approval of the case report.

Consent

Written informed consent was obtained from the patient for publication of this case report and any accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

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