

Clinical Image

Bilateral Spontaneous Pneumothorax in an Intravenous Drug Abuser

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Clinical Image

A 29 years old male who has an addiction of injecting and sniffing heroin over 4 years, presented with complaints of progressive shortness of breath over three months time and dry cough which has increased over the last five days. No history of bronchial asthma or any chronic lung disease was reported. He denied history of trauma. At the time of arrival in Emergency Room (ER), he was afebrile with BP of 95/60 mmHg, PR 86/min regular, RR 24/min, peripheral oxygen saturation of 96% with supplementation of nasal prongs. Respiratory examination revealed bilateral hyper resonant note with barely audible breath sounds. The rest of the examination was normal. His blood gas analysis revealed pH 7.34, bicarbonate 30 mmol/l, pCO₂ 56 mmHg. 2D Echocardiography did not show any vegetation or valvular abnormality. Chest X-Ray revealed bilateral Pneumothorax (PTX) for which immediately chest tubes were inserted. Subsequently, High-Resolution Computed Tomography (HRCT) Chest was done (Figure 1), which confirmed the findings. A diagnosis of bilateral spontaneous PTX was made with possibility of underlying talcosis as an etiology as suggested by history of sniffing heroin. Simultaneous occurrence of bilateral pneumothorax is a rare entity, seen in up to 1.9% cases of spontaneous pneumothorax [1]. Various risk factors include smoking, male sex, intravenous drug abusers, chronic lung diseases and immunocompromised status [2]. Patients with pulmonary talcosis mainly present with progressive exertional dyspnea [3]. Treatment of acute talcosis is usually supportive in addition to steroids. Permanently damaged lungs in chronic cases are best treated with lung transplant [4].

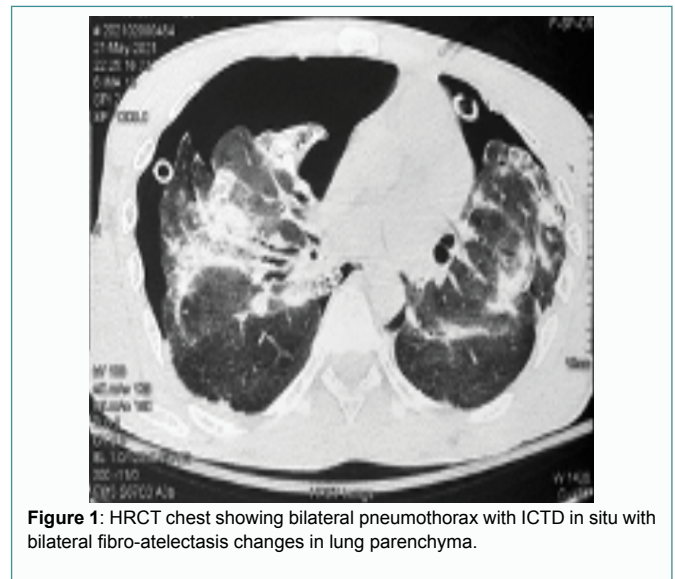


Figure 1: HRCT chest showing bilateral pneumothorax with ICTD in situ with bilateral fibro-atelectasis changes in lung parenchyma.

Keywords: Pneumothorax; Intravenous drug abuser

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