Clinical case

Pneumomediastinum and diffuse alveolar pain. Severe interstitial pneumopathy due to dermatomyositis

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ABSTRACT

We have recently observed the case of a 36-year-old man with dermatomyositis of recent onset, who developed massive pneumomediastinum and subcutaneous emphysema at the onset of a progressive and severe pulmonary disease. Although there were no sign of parenchymal cysts, after the bronchoscopy it was possible to observe endobronchial necrotic injury, which was considered as the likely source of the air leak. He was treated with high dose of corticosteroids, cyclophosphamide and cyclosporin A that resulted in the disappearance of the pneumomediastinum and subcutaneous emphysema and the progressive improvement of both parenchymal lung disease and respiratory insufficiency, enabled us to progressively taper the dose of corticosteroids.

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Neumomediastino y daño alveolar difuso. Afección pulmonar severa por dermatomiositis

RESUMEN

Presentamos el caso de un varón de 36 años con dermatomiositis de reciente comienzo, que desarrolló neumomediastino y enfisema subcutáneo masivo al inicio de una neumopatía intersticial progresiva y severa. En el momento del diagnóstico no había imágenes parenquimatosas quísticas evidentes; sin embargo, la broncoscopia permitió evidenciar una lesión endobronquial de aspecto necrótico que se consideró como probable origen de la fuga aérea. El paciente se trató con corticoides a dosis altas, ciclofosfamida y ciclosporina A, con resolución del neumomediastinum y del enfisema subcutáneo. Con el tratamiento se observó una mejoría progresiva de la afección parenquimatoso pulmonar y de la insuficiencia respiratoria, lo que permitió la disminución progresiva de los corticoides.

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hemogram and an erythrocyte sedimentation rate of 20 mm for the first hour (normal, 0–10). Biochemistry determinations that included creatinphosphokinase (CPK), lactate dehydrogenase (LDH), aldolase, THS, proteinogram, immunoglobulin, complement, tumor markers, CRP, coagulation, and urine testing were normal. The immunology studies showed: ANA+ 1/320. The rest of the determinations, including anti-dsDNA, ENA, AMA, ASMA, ANCA, rheumatoid factor, and anticardiolipin were negative.

The patient was diagnosed with systemic lupus erythematosus (SLE) and treatment was begun with hydroxicloroquine 200 mg TID and prednisone 30 mg daily, with marked improvement of the skin lesions on the face and scalp, a reduction in hair loss and the constitutional symptoms.

He comes into the emergency room 6 months later presenting hoarseness, increase in the neck diameter and crepitus sensation. He referred neither previous trauma nor other respiratory or digestive symptoms. Upon physical examination he presented: fever (37.5°C); heart rate, 105 beats/min; normal respiratory rate and blood pressure (BP). Pulse oximetry showed normal oxygen saturation. No finger deformity or skin vasculopathy was seen. Skin lesions compatible with Gottron’s papules were found on the hands and elbows as well as subcutaneous emphysema on the face, neck, trunk and upper extremities. The rest of the examination showed no alterations. A chest x-ray and thoraco-abdominal computed tomography (CT) showed pneumomediastinum, pneumorrachis, extensive subcutaneous emphysema, a small bilateral apex pneumothorax, and bilateral mild lung parenchymal affection with a peripheral distribution (Figure 1). In addition, an esophagogram, bronchoscopy, electrocardiogram, and echocardiogram were performed and found normal. No functional lung study was performed due to the risk that the thoracic hyperpressure technique involved. A magnetic resonance (MR) of the pelvis and muscles showed bilateral, symmetric perifascial fluid affecting the semimembranosus, vastus lateralis, and rectus anteriors muscles, without evidence of muscle edema. An electromyogram (EMG) showed spontaneous, sporadic activity with motor unit potentials of myopathic aspect in the proximal muscles of the upper and lower extremities.

Conservative treatment based on 30 mg prednisone in a descending dose was installed. After reducing the dose of prednisone to 15 mg/day, the subcutaneous emphysema and fever (38.5–39°C) increased and there was a progressive gasometrical worsening, obliging treatment with cyclosporine A (CyA) at a dose of 5 mg/kg/day. After 1 month of combined therapy, the patient experimented slow but progressive improvement, both clinical and radiological, with disappearance of the emphysema and pneumomediastinum, as well as of the skin lesions and the muscle weakness.

After 9 months of immunosuppressive treatment (trimestral pulse CFM, CyA at a dose of 5 mg/kg/day and steroids in a diminishing dose), there was no recidivating pneumomediastinum, the patient remained stable and was able to walk again. Arterial blood gases showed PO2 60 mm Hg and PCO2 37 mm Hg, 91% oxygen saturation. Respiratory function tests revealed a restrictive pattern with a reduction in the lung diffusion of oxygen. There was extensive bilateral honeycombing on the (Figure 2), with the disappearance of the ground glass lesions. Because of the severity of the residual lung alterations and the stability of the radiological images, the patient was sent to a hospital of reference in order to evaluate lung transplantation.

Discussion

Spontaneous pneumomediastinum is a clinical entity of unknown origin and benign progression that affects young individuals and is resolved in a few days with conservative treatment. The most probable cause is the rupture of the alveolar walls caused by thoracic hyperpressure maneuvers, with the consequential escape of air into the interstitium and a further centripetal dissection along the bronchovascular sheaths until it reaches the mediastinum through the hyllum.
Occasionally, alveolar rupture can occur during an attack of asthma or as the result of a peripheral parenchymal affection of interstitial processes that lead to honeycombing. Among these latter cases, an association with dermatomyositis and polymyositis has been described, which in some cases can also be accompanied by necrotizing tracheobronchial lesions of a vasculitic nature that lead to perforation and constitute the origin of air leakage into the mediastinum.1

Dermatomyositis is a connective tissue disease with a predominant affection of the skin and muscles, although the lung is affected in 5%–40% of cases,1,2 in the form of interstitial lung disease (ILD),3,4 with 4 clinical forms, each with a different underlying histology:

- Asymptomatic, diagnosed only through radiological or functional studies.
- Cryptogenic organizing pneumonia (COP).
- Interstitial lung disease with slow progression and occasional exacerbation. The underlying histology is usually non-specific interstitial pneumonia (NSIP).
- Acute-subacute interstitial pneumonia, with a rapidly progressive deterioration, usually exhibiting a biopsy with a diffuse alveolar damage pattern (DAD).

Spontaneous pneumomediastinum is a rare complication of dermatomyositis,5 with an incidence of 2/100 000, but frequently accompanying those cases with a greater clinical aggressiveness. Eighty-eight per cent of cases are present in patients under 40 years of age and occasionally can be complicated with spontaneous pneumothorax.6 The profile of the patient at risk for the appearance of SP has been described. They are usually young,7 with recent-onset disease,8 interstitial lung disease,9 skin vasculopathy (nail infarcts, erosive/ulcerative lesions on the tip of the fingers),10 mild or no elevation of CPK,11 and receiving treatment with steroids.12 Our patient, with the exception of the skin vasculopathy, had all of these risk factors.

The presence of anti-Jo-1 antibodies increases the risk of interstitial lung disease in patients with dermatomyositis. This antibody is present in 20% of cases and in 70% of patients with interstitial lung disease; it is usually negative in amyopathic dermatomyositis, even though for most authors, the true cause would be a hypothetical weakening of interstitial lung tissue due to treatment with steroids,1 the poor prognosis faced by patients with dermatomyositis,14 interstitial lung disease and pneumomediastinum,15 control of disease activity is recommended with intense and early immunosuppressive treatment, in this case, intravenous CFM and oral CyA, after ruling out infectious causes and with a progressive reduction of steroids. Treatment in this case has been effective, with a resolution of the pneumomediastinum in 3 months and a clinical improvement at 5 months, corroborating the results of other studies.16

### Conclusions

The appearance of SP in a patient with a collagen-related disease must always alert the clinician to the possibility of dermatomyositis with severe lung parenchyma disease. In spite of the limited number of cases described and that in other studies the progression has been favorable, given the poor prognosis faced by patients with dermatomyositis, interstitial lung disease and pneumomediastinum, control of disease activity is recommended with intense and early immunosuppressive treatment, in this case, intravenous CFM and oral CyA, after ruling out infectious causes and with a progressive reduction of steroids. Treatment in this case has been effective, with a resolution of the pneumomediastinum in 3 months and a clinical improvement at 5 months, corroborating the results of other studies.
References


