La neumonía por bacteremia septicá trajo a una mujer de 60 años de edad, con antecedentes de artritis de la mama, enfermedad del hígado y enfermedad de la vejiga. Fue hospitalizada por un cuadro febril de 3 días de evolución. La paciente presentó signos de shock inespecífico, y su estado hemodinámico se deterioró rápidamente. Se realizó ecocardiograma que mostró vegetaciones en la válvula mitral. La tomografía computarizada del tórax reveló una nódulo infiltrativo en el lóbulo inferior derecho, y la biopsia pulmonar confirmó la presencia de bacilos gram-negativos. Se inició tratamiento con antibióticos empíricos y realizó antibioticoterapia dirigida. La paciente experimentó una mejoría clínica significativa después de 7 días de tratamiento. Se concluyó que la neumonía por bacteremia septicá es una condición grave que requiere un tratamiento inmediato y a menudo requiere un cambio de antibióticos para asegurar la curación.
costal arch, and pulmonary consolidation with pleural effusion in the left lower lobe (Fig. 1). Findings were confirmed on both ultrasonography of the neck and bone scintigraphy. Ultrasound-guided fine needle aspiration and biopsy was performed, from which S. aureus was isolated. The strain was resistant to ampicillin, and susceptible to erythromycin, gentamicin, clindamycin, ciprofloxacin, levofloxacin, and cotrimoxazole. The same microorganism was isolated from the bronchoscopy samples. During admission, intravenous ciprofloxacin and amoxicillin–clavulanic acid were administered, in line with susceptibility results, and improvement was observed in clinical symptoms, radiological signs, and acute phase reactants. Drainage was not required. Treatment continued on an outpatient basis for another 40 days, with complete resolution of the syndrome.

SSA is exceptional and accounts for only 1%–9% of SA, and generally occurs in patients with debilitating risk factors and immunosuppression. It is also unusual to see the simultaneous development of SA in the acute period of an episode of pneumonia, as it tends to occur later. In our patient, the SSA was attributed to the bacteremic pneumonia, as the same microorganism was isolated. S. aureus pneumonia in a patient without risk factors is in itself exceptional. The clinical picture of SSA, in contrast to our case, is generally insidious, and presents with fever, pain in the shoulder, and edema and erythema in the sternoclavicular joint. The most widely used diagnostic test is ultrasound, although CT can identify the degree of bone destruction, and scintigraphy is used to delimit the inflammatory area and guide the biopsy and aspiration procedure. The definitive diagnosis depends on isolation of the microorganism. This will indicate the appropriate antibiotic therapy, which should continue for at least 4 weeks in the absence of complications. Surgical treatment is recommended in case of extensive osteomyelitis, abscesses, empyema, or mediastinitis.

In conclusion, pneumonia can unusually cause SA, and exceptionally SSA, and these entities may go unnoticed in the clinical context. As this process is potentially disabling and possibly fatal, etiologic diagnosis should not be delayed.

References


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Pediatric Interstitial Lung Disease: An Ongoing Challenge

La enfermedad pulmonar intersticial en el niño. Todavía hoy un reto diagnóstico

To the Editor,

Surfactant protein C deficiency causes interstitial lung disease (ILD) of varying severity. Diagnosis in children is complex, due to the rarity and heterogeneous clinical manifestations of this entity. We report a case of this disease that was initially incorrectly diagnosed.

Our patient was a boy, born at term, with no significant history. At the age of 14–15 months, he was admitted twice due to bronchiolitis caused by syncytial respiratory virus and bronchitis due to adenovirus. After the second admission, persistent tachypnea, respiratory failure, and bilateral infiltrates on chest X-ray were observed. Further examinations ruled out malformations, immunodeficiencies, pulmonary hypertension, and other infections. Bronchoalveolar lavage was performed: cell count was normal, with no eosinophilia, and negative Gram stain and microbial cultures. Lung computed tomography (CT) showed a diffuse ground glass pattern with hilar lymphadenopathies. Lung biopsy was performed by thoracoscopy. The specimen was sent to a reference laboratory, and the report described “changes associated with bronchiolitis obliterans”. The patient was discharged at the