

PP101 DID I COUGH OUT MY LUNG?

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INTRODUCTION:

Lung herniation via intercostal muscle wall defect is rare, occurring most commonly after external trauma, surgery or excessive intrathoracic pressure. We present a case of massive Subcutaneous Emphysema (SE), as a result of a rupture in the chest wall, with presence of lung herniation secondary to excessive, violent cough.

CASE REPORT:

A 64-year-old gentleman presented to us with history of face, neck and chest swelling for 5 days. He was a non-smoker and his past medical history was significant for Diabetes Mellitus and Hypertension. His presentation was preceded with 2-weeks history of productive, excessive cough. At presentation, he was not in respiratory distress. Physical examination revealed an extensive swelling over his jaw and neck, extending towards his left lower chest region; which on palpation, noted to be SE. Chest x-ray showed a classical ginkgo-leaf sign without any evidence of pneumothorax. CT-Thorax was performed which showed a left lung herniation through left 6th and 7th intercostals space wall defect associated with left hydropneumothorax, causing bilateral SE. Patient then underwent Left Video Assisted Thoracoscopic Surgery and chest wall defect repair.

DISCUSSION AND CONCLUSION

This is a presentation of a unique case of spontaneous lung herniation. The herniation is a possible result of an increase in intrathoracic pressure, which in this case is due to coughing. Lung herniation usually present with a painful bulge and can be concurrent with SE. The clinical diagnosis is usually confirmed by means of plain x-ray or computed tomography (CT). In Emergency setting, there is no urgent indication to perform indiscriminate insertion of chest tube for all SE without finding the root cause. In regard to the necessity of repairing the hernias, general indications include increase in size, pain, dyspnea and impending incarceration.