Acute Pneumonia in the Right Lower Lobe*

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This 35-year-old man was hospitalized with cough, purulent sputum, hemoptysis, and high fever of recent onset. Past medical history was unremarkable. Breath sounds were diminished over the right interscapular area and medium crepitations were heard on the same side. The WBC was 14,000/cm², with 80 percent polymorphonuclear leucocytes. A PA chest roentgenogram (Fig 1) was obtained on admission.

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Figure 1
Diagnosis: Primary Amebic Lung Abscess

Figure 1 shows a large homogenous opacity in the midzone of the right lung. On the lateral view, the lesion appeared confined to the superior segment of the right lower lobe.

A provisional diagnosis of acute bacterial pneumonia with possible lung abscess was made on the day of admission. Treatment with penicillin in high doses was started. On the third hospital day, bronchoscopy revealed purulent secretions coming from the orifice of the superior segmental bronchus of the right lower lobe. A biopsy taken from the inflamed bronchus showed trophozoites of Entamoeba histolytica. The diagnosis was further confirmed by a positive indirect hemagglutination reaction (1:2048 dilution).

Serum SGOT, SGPT, and alkaline phosphatase tests were normal. At no time during his hospital stay did physical examination reveal hepatic enlargement or tenderness over the right lower thorax.

His illness responded dramatically to combined emetine hydrochloride and chloroquine therapy. A repeat chest film taken seven days after admission (Fig 2) showed a large thick-walled abscess cavity with considerable resolution of the surrounding consolidation. Complete healing of the abscess took place less than four weeks after the specific chemotherapy was instituted.

Pleuropulmonary amebiasis is a common clinical problem in patients residing in the tropics. Usually it involves the right lower thoracic cavity, the infection arising in the liver, most commonly as an abscess, and extending through the diaphragm. When pulmonary amebiasis is recognized without obvious hepatic disease and at some distance from the diaphragm, hematogenous infection is presumed, with spread of E histolytica directly from colonic lesions via the hemorrhoidal veins. The pulmonary lesions may be seen in any lung segment on either side.

One unusual feature in the present case was localization of the pneumonia in the superior segment of the right lower lobe, a site more commonly involved in aspiration pneumonia. As there was no apparent liver disease and a clear space was seen radiologically between the diaphragm and the lung abscess, the pulmonary amebic abscess was assumed to be hematogenous. Sigmoidoscopy was, however, normal. Liver biopsy was not considered to be indicated. Spread of amebic infection from liver via a venous route could not be ruled out completely.

This case illustrates the need to include pulmonary amebiasis among the causes of acute suppurative pneumonia, in a patient from an endemic area.

REFERENCES