COMMUNICATIONS TO THE EDITOR

Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Specific permission to publish should be cited in a covering letter or appended as a postscript.

Community-Acquired Acinetobacter Pneumonia

To the Editor:

Acinetobacter calcoaceticus is a nonfermentative Gram-negative bacterium of increasing importance because of its ability to produce a wide variety of infections, including septicaemia, urinary tract infections, pneumonia and surgical wound infections. Although most infections occur in hospitalized patients, there are a few cases of community-acquired pneumonia. Recently, Rudin et al reported six of these cases and in a review the literature found only another six cases. We describe another case of pneumonia with bacteremia and shock that developed in the community.

CASE REPORT

A 32-year-old man was admitted on July 24, 1979 because of acute respiratory disease. His only previous hospitalization was in another hospital in March 1977 for septicaemia of E coli and pneumonia. After this, he was well except for occasional lumbosacral pain which irradiated to the legs. Results of outpatient physical, radiologic and laboratory examinations were normal, although a moderate elevation of erythrocyte sedimentation rate was noted. One month before admission to the Jimenez Diaz Foundation, he began to experience lumbosacral pain and was treated with phenylbutazone and methylprednisolone, 8 mg every other day. Three days before admission, he had developed fever, chills, malaise, generalized aches, cough, hemoptoic sputum and chest pain. He was afebrile (39°C), hypotensive (80/60 mm Hg), tachycardic and tachypnoeic. Inspiratory crackles and bronchial breath sounds were heard in both lower lung fields. Smooth hepatomegaly, 3 cm below the right costal margin, was noted. Leukocyte count was 3,600 with 55 percent polymorphonuclear leukocytes. Hemoglobin was 14 g/100 ml. An arterial blood sample taken shortly after admission revealed pH 7.46, Po2 53 mm Hg, Pco2 26 mm Hg, CO2H- 18 mEq/L. A chest x-ray film showed alveolar infiltrates in both lower lobes. A sputum specimen and three blood samples were taken for culture and therapy with oxygen, benzylpenicillin, gentamicin, albumin and dextran was started intravenously. The patient improved initially, but remained febrile and over the next hours he developed endotoxic shock, stupor and seizures and died 29 hours after hospitalization. Culture of sputum and three blood cultures taken in the emergency room were positive for Acinetobacter calcoaceticus.

DISCUSSION

Community acquired Acinetobacter calcoaceticus pneumonia is a fulminating disease with high mortality which occurs in patients with chronic disease, especially alcoholism. Patients present acutely ill with pulmonary infiltrates, hypoxemia, leukopenia and shock.

We do not know the underlying disease that led two years ago to the development of pneumonia and septicemia by E coli, in our patient to the persistence of elevated erythrocyte sedimentation rate and now to A calcoaceticus pneumonia, because we did not receive permission for postmortem examination, but it is probable that our patient was an altered host. It is also possible that methylprednisolone treatment helped in the development of infection.

Finally, we think that Acinetobacter calcoaceticus must be considered in the differential diagnosis of community acquired pneumonia in a presumed immunocompromised host.

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REFERENCES

1 Glew RH, Moellering RC, Kunz LJ. Infections with Acinetobacter calcoaceticus (Herella vaginicolus): clinical and laboratory studies. Medicine, 1977; 56:79-97

Middle Lobe Syndrome as an Unusual Presentation of Metastatic Osteogenic Sarcoma

To the Editor:

Eighteen months after rib resection for osteogenic sarcoma, a patient was admitted with right middle lobe syndrome. He succumbed two weeks later, after a fulminating downhill course. This is a most unusual presentation and complication of metastatic osteogenic sarcoma.

CASE REPORT

A 71-year-old man was admitted because of continuous cough, right-sided chest pain and a low grade fever, all of which began suddenly two weeks earlier. Eighteen months previously, he underwent resection of the right 10th rib for osteogenic sarcoma. Thereafter, he remained under regular surveillance at three-month intervals, without symptoms or signs of recurrence. On admission, physical examination revealed temperature of 38°C, marked dyspnoea and an area of dullness with coarse crepitations over the lower right chest. Laboratory examinations showed: ESR—90 mm in 1 hour; HB—12 g%; WBC—13,300/µm, with a normal differential count. Results of kidney and liver function tests were within normal limits. Chest x-ray film showed a large right pleural effusion; this was immediately drained through a pleural puncture. On repeated chest film, a dense infiltration of the right middle lobe was observed, a finding consistent with the diagnosis of pneumonia, and treatment with intravenous cephalothin, 8 g/day was started. His fever decreased and his general condition improved. However, the roentgenologic findings of infiltration of the right middle lobe remained unchanged. Bronchoscopic examination was performed, which showed only nonspecific inflammatory changes in the mucosa of the affected segment. Cytologic and bacterial examination of the endobronchial secretions and material taken by brush biopsy revealed no specific pathology. Similar examinations of the pleural fluid aspirated previously were

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also negative. One week after admission he was afebrile, symptomatically improved and was discharged. Two weeks thereafter, he was readmitted with recurrence of high fever (39°C), chills, chest pain and dyspnea. While the findings on physical examination were unchanged, the chest x-ray film showed the infiltration previously seen in the right middle lobe to be denser, with bulging of the interlobar fissure. An abscess formation was suspected, and antibiotic treatment with clindamycin commenced. His condition deteriorated rapidly, and 12 hours after readmission, he required ventilatory support with a Bennett respirator. A repeated chest x-ray film now showed infiltration of the entire right lung. The patient died two hours later, with a clinical picture of respiratory failure and shock.

At autopsy, the middle lobe of the right lung was found to be infiltrated by multiple metastatic tumors, one of which had invaded the right pulmonary artery producing massive infarction of the right lung. No metastases were detectable in any of the other lobes of the lungs, nor in other organs (Fig 1).

**COMMENT**

Multiple lung metastases are common findings in the natural history of osteogenic sarcoma, and are present in approximately 80 percent of patients dying of this disease. While a primary tumor of the lung occurs infrequently in the middle lobe, metastatic tumors tend to be scattered over two or more lobes. Therefore, bacterial pneumonia was considered to be the most likely cause of the right middle lobe syndrome. The autopsy findings, however, showed the right middle lobe to be almost replaced by metastatic tumor, with no evidence of metastases in the other lobes of either lung, nor in other organs.

This patient's course illustrates dramatically a characteristic feature of osteogenic sarcoma in that pulmonary metastases may appear long after radical excision of the primary tumor. A noteworthy aspect of this case was the unusual location of the pulmonary metastasis to a single lobe, and the massive infarction of the right lung due to tumor invasion of the right pulmonary artery.

**REFERENCE**


**Prolonged Cavitating Pneumonia in a Patient with Serologic Evidence of Legionnaires' Disease**

**To the Editor:**

Legionnaires' disease usually presents as an acute self-limiting illness. Little is known about the chronic manifestations of this infection. We describe a case of necrotizing pneumonia in a patient with serology indicating recent *Legionella pneumophila* infection.

**CASE REPORT**

A 73-year-old male smoker was admitted to hospital complaining of malaise and 5 kg weight loss over a six-week period. Four weeks prior to admission he developed an increase in dyspnea with a cough productive of purulent blood-stained sputum. He was on no medication. On physical examination he was febrile with right upper lobe consolidation. This was confirmed by chest roentgenograms, which also revealed multiple areas of cavitation (Fig 1). His white blood cell count was 23,900/cu mm, with 76 percent polymorphs, 12 percent lymphocytes, 1 percent monocytes and 11 percent band forms. The tuberculin skin test was negative at 5 TU. Culture of sputum showed *Pseudomonas fluorescens*. Sputum analysis for malignant cells and *Mycobacterium tuberculosis* was negative. Fiberoptic bronchoscopic examination was unrevealing. A diagnosis of aspiration pneumonia was made and the patient was treated with intravenous penicillin-G. Over the following week his general condition improved with return of his temperature and white blood cell count to normal. Results of acute phase serum indirect fluorescent antibody studies for Legionnaires' disease (CDC, Atlanta) returned after the patient's discharge were positive to a titer of 1/32. Convalescent phase serum was positive to a titer of 1/512.

**DISCUSSION**

Necrotizing pneumonia with abscess formation has recently been described as a complication of Legionnaires' disease, but only in the immunosuppressed or in patients with fulminating disease. However, we have been unable to find a report of a prolonged cavitating pneumonia in association with Legionnaires' disease.