Mycoplasma Infection Mimicking Hypersensitivity Pneumonitis

To the Editor:

Mycoplasma pneumoniae infection is a common cause of community-acquired pneumonia. It may cause a dry cough, dyspnea, and an interstitial infiltrate on chest radiography. Hypersensitivity pneumonitis may present with similar symptoms and radiologic features.

We recently cared for a 46-year-old ex-smoker who presented with dyspnea, a dry cough, and malaise of 3 weeks' duration. Treatment with amoxicillin had failed to improve his condition. Six months previously he had obtained a budgerigar, which he kept in his kitchen. On physical examination he looked relatively well, was afebrile, and had bilateral fine inspiratory crepitations. There were no other findings. A chest radiograph and computed tomographic scan revealed a bilateral patchy reticulonodular pattern. Findings from a full blood examination were normal. His PaO₂ while breathing air was 58 mm Hg. Fiberoptic bronchoscopy, transbronchial biopsy, and bronchoalveolar lavage revealed mild nonspecific interstitial inflammatory changes and marked lymphocytosis in the lavage fluid (49 percent of cells obtained). Precipitins for budgerigar extract were negative. His atypical pneumonia serology later showed the presence of anti-Mycoplasma IgM. A diagnosis of resolving Mycoplasma pneumonitis was made.

Despite a computerized search of the literature, we were unable to find any previous reports of bronchoalveolar lavage findings following Mycoplasma infection. Our finding of marked lymphocytosis in resolving Mycoplasma pneumonitis is important because it alerts clinicians to the possibility of confusing this infection with other relatively common conditions (hypersensitivity pneumonitis, in our case) that are associated with lavage lymphocytosis. It also emphasizes the need to exclude atypical infections in any patient presenting with a subacute illness associated with physical examination and radiologic findings suggestive of pneumonitis.

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REFERENCES

Pulmonary Artery Perforation Caused by a Flow-directed Balloon-tipped Catheter

To the Editor:

Pulmonary artery perforation caused by a flow-directed balloon-tipped catheter is the most dreaded complication of right heart catheterization and hemodynamic monitoring. This complication has been reported in about 0.1 to 0.2 percent of patients. However, it is believed to be more common, as many of these cases go unreported. We recently encountered a fatal case of pulmonary artery perforation despite strict observation of the guidelines for safe use of these balloon-tipped pulmonary artery catheters.

A 90-year-old white woman with ischemic cardiomyopathy and cancer of the uterus was admitted for a hysterectomy. To monitor hemodynamic parameters during and after the hysterectomy, a balloon-tipped catheter was passed into the pulmonary artery without any difficulty. After obtaining a proximal pulmonary artery wedge position under fluoroscopy, the balloon was deflated. Hemodynamic parameters following catheterization were as follows: right atrial pressure, 10 mm Hg; right ventricular pressure, 50/10 mm Hg; pulmonary artery pressure, 50/34 mm Hg; pulmonary capillary wedge pressure, 24 mm Hg. The catheter was secured in place, and the wedge position of the catheter tip was confirmed by inflating the balloon with a full 1.5-cm³ inflation volume. Before the second wedge of the balloon, it was confirmed that the distal-tip waveform reflected the pulmonary artery pattern. Approximately 5 min after insertion of the pulmonary artery catheter, hemoptysis was seen. An immediate wedge angiogram revealed extravasation of dye into the lung parenchyma. The patient died subsequently, due to massive hemoptysis in the catheterization laboratory despite all resuscitative efforts. Postmortem examination with dissection of the pulmonary artery revealed no apparent tear, although the entire lower lobe of the right lung was hemorrhagic (Fig 1).

The risk factors for catheter-induced pulmonary artery perforation include pulmonary arterial hypertension, advanced age, and recent cardiopulmonary bypass. Hemoptysis is the telltale sign of this complication. Diagnostic evaluation can be obtained by a wedge angiogram using 5 to 10 ml of contrast dye. However, a wedge angiogram could be traumatic and could further worsen a pulmonary arterial hemorrhage. A fiberoptic bronchoscope could be helpful in locating the area of bleeding in the airway. If a small amount of hemoptysis is present, observation is all that is necessary.

Figure 1. Postmortem examination with pulmonary artery dissection shows distal migration of the catheter with no apparent tear in the pulmonary artery supplying the lower lobe of the right lung.

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