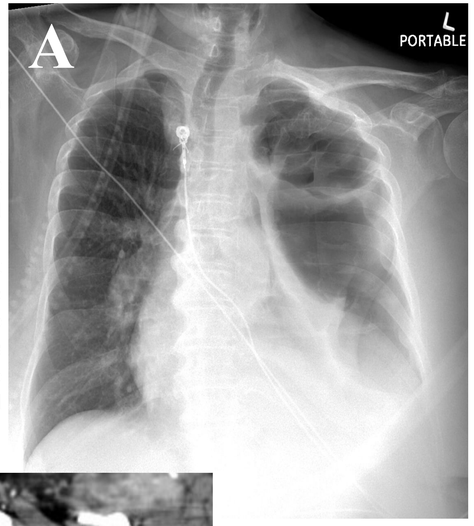
Tension pneumothorax in an elderly Jehovah's Witness secondary to colopleural fistula complicating a splenic flexure mass

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FIGURES



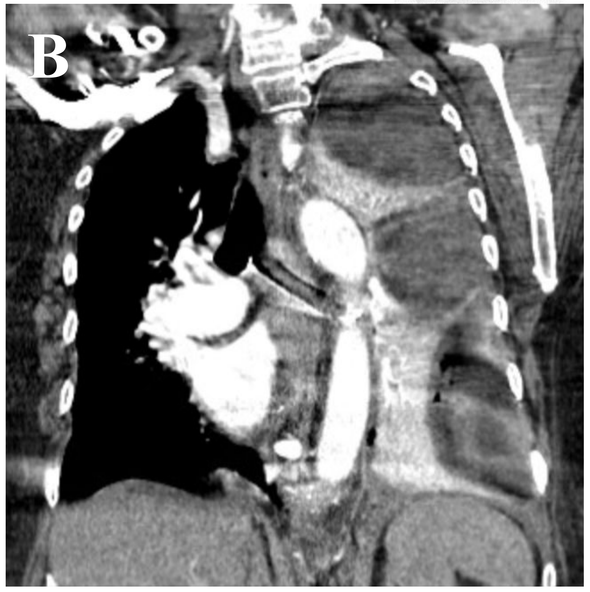


Figure 1. A) CXR with large cystic foci of air superiorly. Laterally, the basilar regions are collapsed, lung parenchyma and mediastinum displaced to the right. **B)** CT chest shows multiloculated left hydropneumothoraces, compressive atelectasis of the left lung and mediastinal shift to the right. **C)** CT abdomen/pelvis with oral contrast demonstrates the fistula at the splenic flexure of the colon connecting to the left pleural space. Some small pockets of free air at the splenic flexure whose wall appears low attenuating and lobulated.

INTRODUCTION

Tension pneumothorax (PTX) resulting from a colopleural fistula (CPF) is extremely rare with most case reports focusing on the presentation of CPFs with empyema or PTX.[1,2] This case highlights the exceptional occurrence of tension PTX due to a CPF.

CASE DESCRIPTION

A 76-year-old Jehovah's Witness female presented with sepsis and acute respiratory distress. She had no abdominal pain or peritonitis, and her previous colonoscopy was 8 years prior. Laboratory tests revealed leukocytosis (37,000/μL), anemia (hemoglobin 7.3 g/dL), and elevated lactate (6.4 mmol/L). Imaging (Figure 1) showed left tension PTX, left empyema, and air at the splenic flexure. A left chest pigtail was placed and drained air and purulent, feculent fluid. The patient was resuscitated, and started on broad-spectrum antibiotics. Repeat imaging with oral contrast showed findings that were consistent with perforated malignancy (Figure 1C). A laparoscopic diverting transverse loop colostomy was performed, and subsequent biopsy was consistent with adenocarcinoma. Anemia improved to 12 g/dL, left chest pigtail was removed, and she was discharged to a subacute rehabilitation center with hematology/oncology outpatient follow-up.

DISCUSSION

Although colorectal cancer perforations typically present with abdominal symptoms and peritonitis, this case underscores the rarity of CPFs and highlights the importance of broad differentials in patients with acute respiratory symptoms and unexplained anemia, including malignancy.

CONCLUSION

While CPFs secondary to perforated colorectal masses, although rare, should be considered in patients presenting with left tension hydropneumothoraces particularly when accompanied by chronic anemia and weight loss.

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FIGURES

