ผศ.พญ.อาภัสสร วัฒนาศรมศิริ

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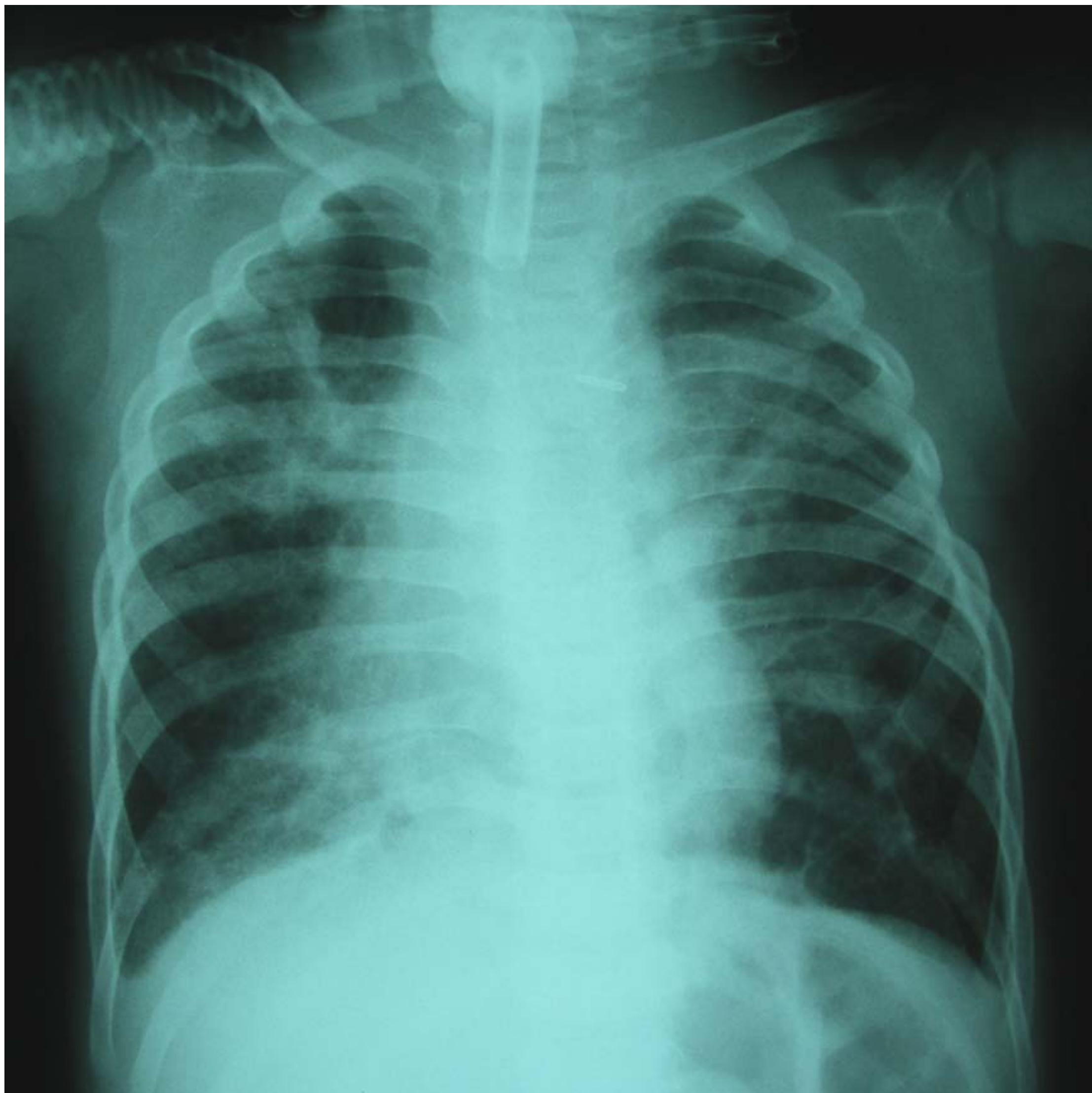
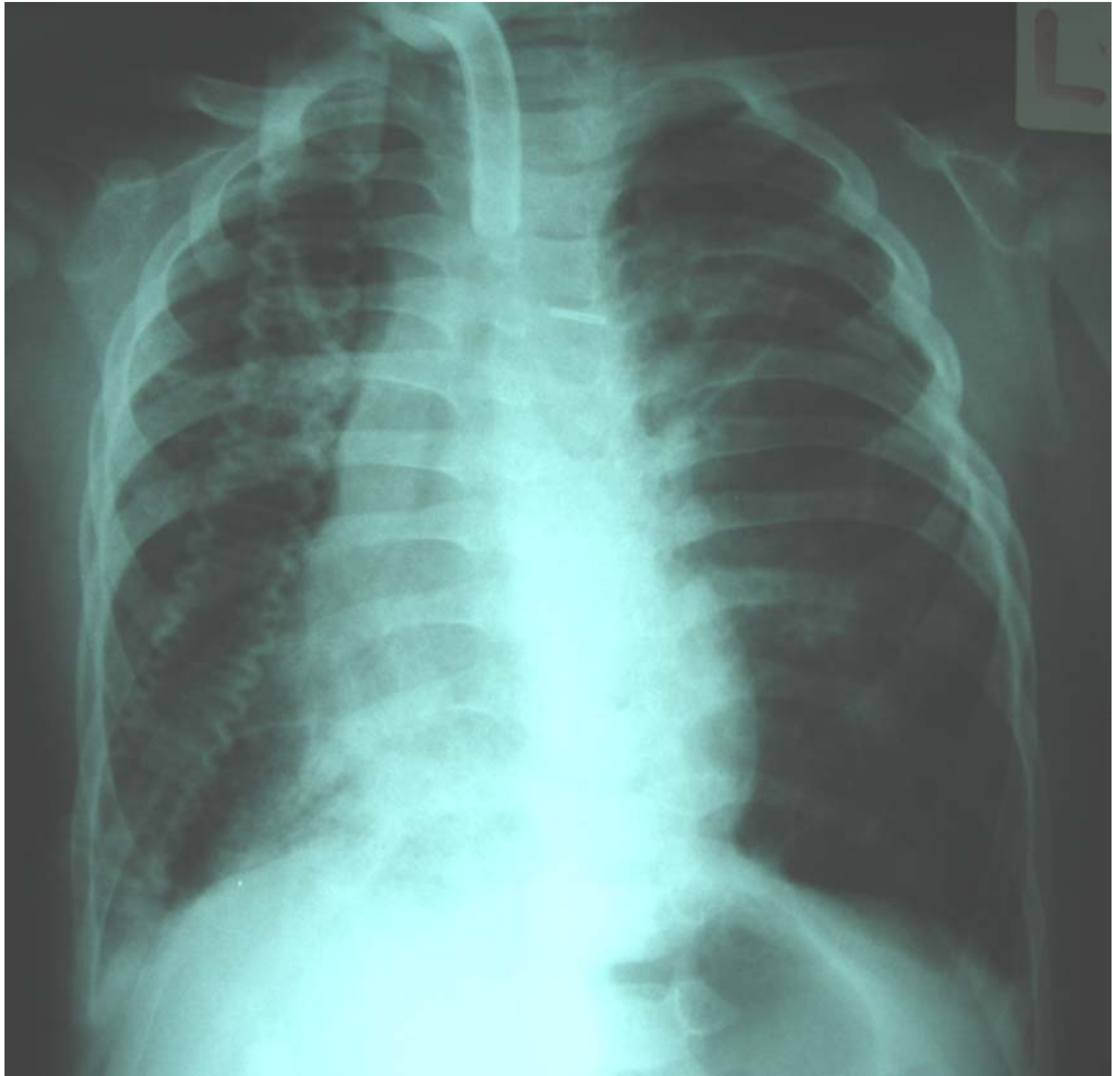
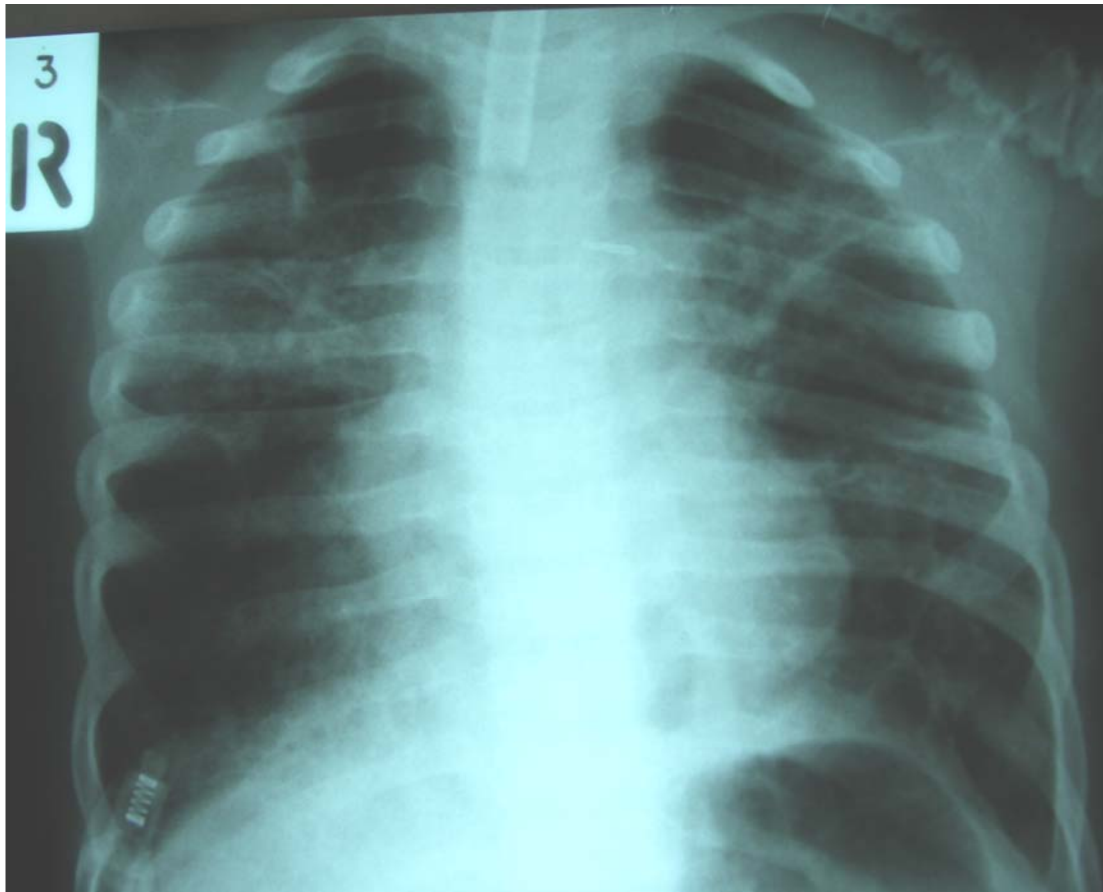


CHEST : PA upright (Feb)
Tracheostomy tube is in place.
Evidence of remote left lateral thoracotomy and PDA ligation.
Multiple patchy and reticular opacities of pneumonia are noted in both upper lobes and right lower lobe, predominant in central areas. Some linear opacities and hyperlucent areas scattered in both lungs, probable from fibrosis or plate atelectasis, with compensatory or obstructive emphysema.



(In Apirl), persistent or recurrent pneumonia in LUL and RLL are noted, while the opacity in RUL is much less with remained fibrosis or plate altectasis.
The chest is mildly rotated to the right, so mediastinal shift or not cannot be certained.
Bilateral pulmonary hyperinflation is pronounced with low and flat diaphragm.
The trachea and main bronchi are patent.



(In June):pneumonia in both upper lobes and left lower lobe are noted, also with (sub)segmental atelectasis or fibrosis, and hyperinflation.

<u>Opinion</u> :

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The patient has recurrent pneumonia.

(The patient may have past history of PDA which had been surgically treated.)

1 Aspiration pneumonia from GERD or swallowing dysfunction can be the cause of recurrent or persistent pneumonia, and should be further investigated. Other investigations for the cause of recurrent pneumonia are according to clinical information.

2.Underlying BPD cannot be excluded, and should be correlated with the patient's past history.

<u>Comment</u>

ผศ.พญ.อาภัสสร วัฒนาศรมศิริ

This patient has been admitted in the hospital since birth.He weighed 810gm at birth and has clinically and CXR compatible with BPD. He is ventilator dependent. These series of CXR are common findings. I'd like to remind that the second film showed inappropriate setting due to hyperinflation. Last CXR was taken due to desaturation in the old comfortable setting.He had no fever and nothing changed for the secretion.He denied chest PT and suction for few weeks.Our conclusion using both clinical and

CXR interpretation suggested atelectatic problem.We did aggressive aerosol and chest PT.He return to the previous setting in few days later.

Opinion

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The lung parenchyma in BPD may show focal abnormal aeration, atelectasis, fibrosis, and architectural distortion. Patients with BPD tend to have recurrent pneumonia.
It is usually difficult to differentiate between pneumonia or atelectasis or coexisting of both in the BPD lung. Clinical information is very necessary.