

中文題目:年邁體衰臥床老人肺積膿非手術處理之成功案例

英文題目: Challenges about febrile, feeble dystrophic demobilized soldier to perplex for diagnose and give treatment: a tough question

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ABSTRACT

Parapneumonic effusions existed in 20 to 40% of patients who are hospitalized for pneumonia. The mortality rate in patients with a parapneumonic effusion is higher than that in patients with pneumonia without parapneumonic effusion. mortality is due to delayed management of the parapneumonic effusion. Characteristics of these patients concerned about invasive procedure would be necessary for its resolution include the following: an effusion occupying more than of the hemithorax or once effusion is loculated and in the form of creamy colloid state

Key words: parapneumonic effusion , empyema, CT ,

INTRODUCTION

Febrile and weakness even cachexia old man make tremendous challenges for medical staff to handle and management. I describe how we successfully treat a veteran for organized lung empyema and rescued him from the hell and let him safely go home.

CASE REPORT

A 86 years old gentleman came for help in chest clinics as for fever ,short of breath. He presented with complaints of persisten chest pain with spit mucoid yellowish sputum and dyspneic at last 2 days. He was known to have hypertension and COPD for many years. Important clinical findings were as follows; The elderly man had a weight of 40 kg ,height of 168 cm. He was dyspneic on room air; SPO₂93%.Blood pressure was 82/50 mmHg, Body temperature was 36.1C. Laboratory investigations revealed WBC 9100 with left shift (segment 82%) Hb:9.1 elevated CRP:10.6 his serum creatinine 1.35 mg/dl and .For pulmonary cardiovascular evaluation : Troponin-I ;0.02 ; NT-proBNP : 1655

On chest auscultation breath sound were reduced on both side.

ECG showed Af with RVR

His chest x-ray revealed bil lateral whole lung infiltration with Rt leural effusion.

It was planned to conduct sono- guided thoracocentesis for pleural effusion aspiration and drainage but due to gray scale picture and whole sonography picture make whole ultrasound picture micmic of liver parenchyma and narrow window for evaluation of chest tapping make me failure of first trial .So CT guided large bore 18Fr lone needle aspiration and drainage with success tapping of Rt empyema about 20 cc bloody effusion sent for analysis .Immediately after those measures, the patient developed smoothly and fever and SOB subsided. His general condition was secured with these measures . After 21 days of aggressive care the patient regained healthy status which was managed by nutritional support antibiotics and inhalation therapy . The hazard was to ferry patient was discharge later.

. No any complication included pneumothorax or hemothorax and infection implied any in patients We suggest the following 2 strategies:

1. In high risk patient by age and nutritional status and mentality with poor performance which requires according to specific subjects then high order image study such as CT; color Doppler scan were appropriately prescript
2. Skillfully to explain such invasive measures about sufferers and their relatives about benefits and advantage. We were lucky to save the fortune's favorite through best choice.
3. Discussion

Bed ridden and malnutritional status has been associated with increased susceptibility to acute infections, including those of the lower respiratory tract include pleural infection . Dementia influence all about the control of the swallowing , impaired respiratory muscle function and airway secretion exportation, increases the chance of aspiration With multiple comorbidity also were important for these sickness groups Alternate explanations for our findings include the possibility that dependent side Right parapneumonic effusion in organization phase resembling liver parenchyma sonographic picture with difficult differentiation. Several authors have found that ultrasound lacks specificity in differentiating solid part or cystic areas in the pleural cavity and is poor about predicting the nature of the fluid or whether or not it is infected. The appearances of empyema on ultrasound represent different stages of the disease process. Anechoic or hypo-echoic, non-septated fluid precedes by hyperechoic fluid then later on septation or loculation developed. This may correlate with progression of empyema from exudative to fibrinopurulent stage whiling increasing fibrin deposition causes formation of septation and loculation in the pleural fluid and peel on the pleural surface. Septation or loculation and thickening of the pleura were easy to assess on ultrasonography.

Empyema in fibropurulent stage usually presented as homogeneously echogenic pleural fluid on ultrasound, but also hemorrhagic effusion. Echogenic pleural fluid was caused by cellular elements such as RBC, leucocytes, fat droplets, or air bubbles and ultrasound cannot differentiate between these. For reasons of anesthesia and surgery risk exam table , limited echocardiography window , all above restrictions confined our manipulation measures in affirm accurate intervention measures .Nevertheless, our results together with those of conventional impressions suggest that tube or simple aspiration about pleural infectious disease without questioning the effects of relief in the burden of illness in chronic debiliated people deserve contemplation over every systemic illness