IMAGES IN EMERGENCY MEDICINE

Pulmonary involvement in Henoch–Schonlein purpura

A 72-year-old man presented to the emergency department with a 2-day history of fever and difficulty in breathing. His medical history included Henoch–Schonlein purpura treated with steroids, pulmonary tuberculosis treated with antimicrobials, and lobectomy of the right lung 30 years previously.

On presentation, his vital signs were as follows: blood pressure 120/80 mm Hg, heart rate 100 beats/min, oral temperature 38.2℃, respiratory rate 22/min, oxygen saturation 86% (on air). Lung auscultation showed crackles in bases bilaterally. The rest of the physical examination was unremarkable. Laboratory tests showed leucocytosis (11.69×10^3 U/l) and increased C reactive protein (11.1 mg/dl), without other abnormal values. Purified protein derivative test and sputum cultures for mycobacterium were negative. The patient underwent a computed tomography scan of the chest (fig 1), which showed ground-glass opacification compatible with interstitial pneumonia. He was treated successfully with antibiotics. Pulmonary involvement in Henoch–Schonlein purpura is rare, occurring more often in adults and commonly manifesting as diffuse alveolar haemorrhage and occasionally as usual interstitial pneumonia or interstitial fibrosis.[1]

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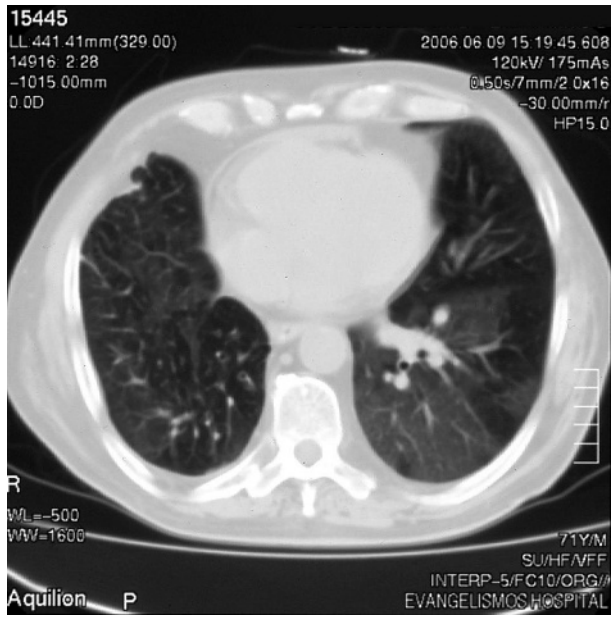

Figure 1 Chest computed tomography scan showing ground-glass opacification compatible with interstitial pneumonia.

Reference

1 **Nadrous HF**, Yu AC, Specks U, *et al.* Pulmonary involvement in Henoch-Schonlein purpura. *Mayo Clin Proc* 2004;**79**:1151–7.

Tramlines: pneumatosis intestinalis secondary to enterocolitis

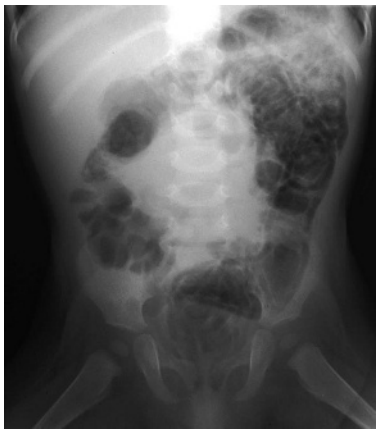

Figure 1 The abdominal radiograph shows the classical ''tramline'' pattern seen in pneumatosis intestinalis, created by gas trapped between layers of the bowel wall and most obvious here in the descending colon.

An 11-month-old boy presented acutely with a 3-day history of fever, vomiting and diarrhoea. A background of recent gastroenteritis among family members was noted. On admission, the patient was lethargic, dehydrated and had tachypnoea; general examination was otherwise unremarkable.

A provisional diagnosis of viral gastroenteritis was made. However, the tachypnoea prompted a venous blood gas examination, showing a metabolic acidosis that persisted despite fluid resuscitation and apparent clinical improvement. Suspecting intussusception, abdominal ultrasound and radiography were requested. The ultrasound was normal, but the plain radiograph (fig 1) showed the classical ''tramlines'' of intramural gas.

Pneumatosis intestinalis is generally viewed with foreboding by clinicians owing to its association with necrotising enterocolitis in neonates. However, outside the neonatal period, pneumatosis intestinalis is often seen in the context of enterocolitis secondary to infective gastroenteritis and has also been reported with various conditions including gastrointestinal dysmotility and inflammatory bowel disease. Conservative management is associated with a favourable conclusion in most cases; the presence of portal venous gas and acidosis may be indicative of a poorer outcome, however, with patients requiring aggressive intervention if bowel necrosis or perforation is suspected.[1]

Management in our patient was conservative, with bowel rest, intravenous fluids, antibiotics and observation for complications, notably perforation. The patient was discharged after 4 days, repeat abdominal film having shown minimal remaining intramural gas.

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REFERENCE

1 **Kurbegov AC**, Sondheimer JM. Pneumatosis intestinalis in non-neonatal pediatric patients. *Pediatrics*, 2001;**108**;402–6.