All prescription medications have favorable and unfavorable effects and treatment decisions must be based on whether the potential benefit outweighs the potential for harm. The CV benefits of antiplatelet drugs are over-whelmingly documented, especially for those with ACS or those who undergo PCI. Since their use is also clearly associated with an increased risk of GI bleeding, the challenge for healthcare providers is to determine which patients are more likely to benefit from the addition of PPI therapy despite its potential effect on the activity of clopidogel. Hence the updated, consensus recommendations outlined above.

REFERENCES:

Abraham et al., ACCF/ACG/AHA 2010 Expert Consensus Document on the Concomitant Use of Proton Pump Inhibitors and Thienopyridines: A Focused Update of Expert Consensus on Reducing the Gastrointestinal Risks of Antiplatelet Therapy and NSAID Use, J Am College of Cardiology 2010; 56, No 24, 2051-2066

Bates et al., Clopidogrel-Drug Interactions, State of the Art Paper, J Am College of Cardiology 2011; Vol 57, No 11, March 15, 2011

CASE REPORT

VIKESH GUPTA MD, SHIKHA GUPTA MBBS
RAJIV DHAND MD, RAJA GOPALDAS MD

UNUSUAL CAUSE OF RECURRENT PNEUMONIA

A 24 year old male presented with a 2 week history of cough, high fever and right– sided pleuritic chest pain; the pain radiated to the right clavicle and right arm. He noted associated wheezing and streaky hemoptysis. Treatment of his symptoms had been initiated with oral Levaquin with limited improvement.

The patient reported a history of recurrent pneumonia in his right lung over a period of 3 years. Other PMH was unremarkable with no history of DM, hypertension or TB. His only medication was the prn use of albuterol. The patient smoked cigarettes for 3 years but quit 1 year ago; he denied alcohol or illicit drug use. There was no family history of lung disease or lung cancer.

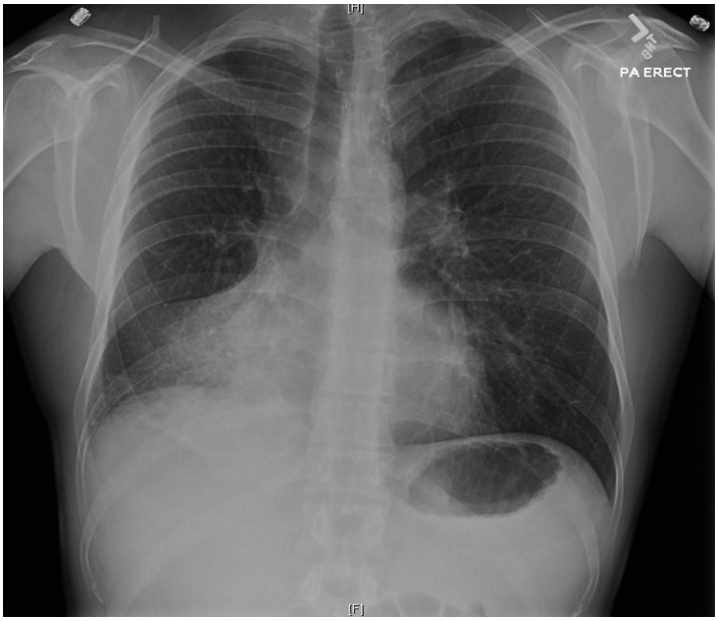
Exam on presentation was remarkable for T 36C, BP 114/77, P 67. He was alert and in no distress. HEENT was entirely normal with no cervical adenopathy. Chest exam was normal except for diminished breath sounds in the right lower lung. Cardiovascular, abdominal and neuromuscular examinations were entirely normal.

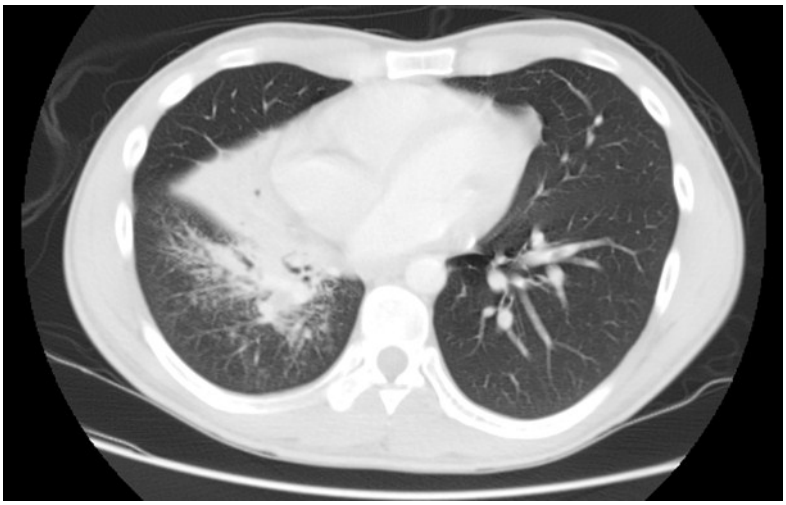
His CBC, CMP and EKG were normal; spirometry did not reveal any obstructive or restrictive defects.

A CXR demonstrated collapse of the right middle lobe and a CT of the chest confirmed the RML collapse and revealed the presence of an obstructing lesion in the right bronchus intermedius (**images on next page**).

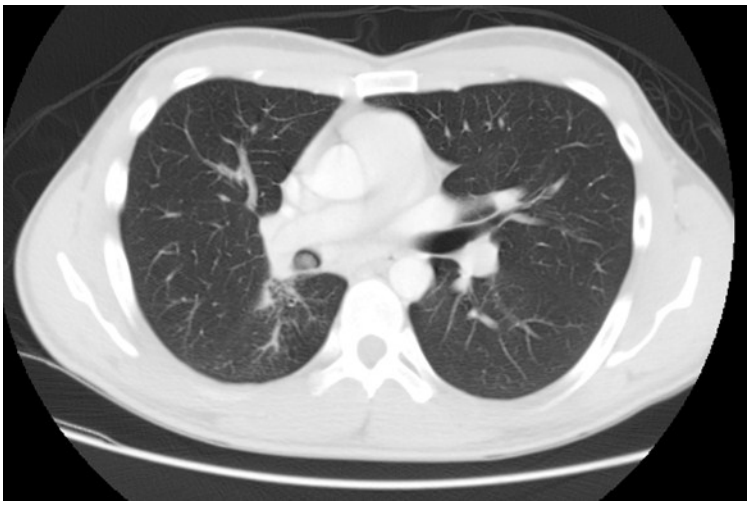
A bronchoscopy was performed and an endobronchial biopsy was obtained; this revealed features typical of carcinoid. Staging with a PET/CT and octreotide scan was negative for metastases. Cardiothoracic Surgery was thus consulted; they performed a right middle lobectomy with a sleeve resection and reconstruction of the right bronchus intermedius.

Pre-operative CXR shows RML collapse





Diagnostic CT Images show RML collapse and an obstructing lesion in right bronchus intermedius



DISCUSSION:

Recurrent pneumonia at the same location raises the suspicion of an endobronchial obstruction by a tumor (benign or malignant) or a foreign body. Bronchial carcinoid tumors are a rare group of pulmonary tumors characterized by neuroendocrine differentiation. Most are benign and slow growing but some are malignant and may metastasize.

The clinical presentation is variable and may include cough, hemoptysis, local wheezing, dyspnea and episodes of recurrent pneumonia at the same site. Diagnosis is via a Chest CT and bronchoscopic biopsy. Staging should include a PET/CT and an octreotide scan, as was performed in this case. Surgical resection is the treatment of choice for localized lesions and an effort is made to preserve as much functional lung tissue as possible. Due to the potential for malignant transformation, long term followup is advised.

POST SURGICAL CXR