



CASE REPORT

Spontaneous air in the retropharyngeal space presenting with hypoxemia and neck pain in a child with neuroblastoma: A case report

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Received 3 September 2007; accepted 30 October 2007
Available online 26 December 2007

KEYWORDS

Retropharyngeal air;
Cryptogenic organizing pneumonia;
Airway obstruction

Summary A 9-year-old white male with a stage IV neuroblastoma of thorax since 4 years of age presented to the routine clinic visit with several days history of nonproductive cough, neck pain and progressive dyspnea. The oxygen saturation was 87%. His head and neck exam was insignificant and there was no crepitus or tenderness to neck palpation. Chest X-ray was normal but neck X-ray showed a strip of air in the retropharyngeal space. Last transplant was allogeneic BMT 9 months back followed by grade-III chronic graft versus host disease of skin and gut. The CT scan of neck and chest confirmed pneumomediastinum with retropharyngeal air and bilateral faint pulmonary infiltrates. Systemic steroids were added to the treatment to stabilize his respiratory condition. After 10 days of ICU stay his condition improved and he was discharged home. Repeat neck X-ray after 14 days showed near complete resolution of retropharyngeal air.

From the clinical, radiological picture as well as therapeutic response to steroids the most likely diagnosis was cryptogenic organizing pneumonia formerly known as "bronchiolitis obliterans with organizing pneumonitis" (BOOP). Pneumomediastinum is reported in the literature as a rare cause of spontaneous air in the retropharyngeal space. Usually pneumomediastinum is a terminal event but in our patient it was a presenting symptom of BOOP. We also report a subtle presentation of BOOP and complete resolution with steroids.

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1. Introduction

Pneumoretropharynx or air in the retropharyngeal space has been reported secondary to blunt or

penetrating trauma to neck, soft tissue infections, cancer, dental procedures, esophageal perforations (Boerhaave's syndrome) and tracheobronchial ruptures [1]. Other occasional causes of spontaneous air in the retropharyngeal space include pneumomediastinum or pneumothorax. The likely events responsible for occurrence of spontaneous air in the retropharynx are barotrauma from violent

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Fig. 1 Strip of air on soft tissue X-ray neck on admission.

coughing, physical exertion, forceful swallowing or various situations producing valsalva maneuver [2]. In this report we present a case that was predisposed to this occurrence because of the patient's underlying illness and prior therapies.

2. Case report

A 9-year-old white male with a stage IV neuroblastoma, primarily of thoracic origin since 4 years of

age presented for routine clinic visit with several days history of nonproductive cough, neck pain and progressive dyspnea. His history was otherwise negative for trauma, fever, upper respiratory tract infection, dysphagia or severe vomiting. On examination, his oxygen saturation was 87%. Auscultation of lungs revealed bilateral rales. His head and neck exam was insignificant and there was no crepitus or tenderness to neck palpation. Chest X-ray was normal but neck X-ray showed a strip of air in the retropharyngeal space (Fig. 1). His white cell count was 6800. Past medical history was significant for bone marrow transplant (BMT) twice. Last transplant was allogeneic BMT 9 months back followed by grade-III chronic graft versus host disease (c-GVHD) of skin and gut. His immunosuppressive medications were stopped because of neutropenia but he was taking antiviral agents for several episodes of positive PCR for cytomegalovirus.

He was admitted to the hospital and supportive treatment was started with humidified oxygen with a facemask and intravenous antibiotics. His condition became worse with increasing respiratory distress so he was transferred to the ICU. The CT scan of neck and chest was done which showed pneumomediastinum and bilateral faint pulmonary infiltrates along with retropharyngeal air (Fig. 2). Systemic steroids were added to the treatment to stabilize his respiratory condition. After 10 days of ICU stay his condition improved and he was transferred to the floor and was slowly weaned of oxygen. Repeat CT scan after 10 days showed decreasing air in retropharynx with persistent pneumomediastinum and bilateral interstitial opacities (Fig. 3). Based on clinical improvement patient was discharged home. He did not develop fever or leucocytosis during entire hospital course. Repeat neck X-ray after 14



Fig. 2 CT soft tissue neck confirming pneumomediastinum as a source of retropharyngeal air.

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