CHEST

A 39-Year-Old Man With Diabetes, Pleuritic Chest Pain, and Multiple Cavitary Lung Nodules

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CASE PRESENTATION: A 39-year-old male presented to the ED with a 2-day history of fever (Temperature-Maximum 39°C), nonbloody productive cough, and worsening right-sided pleuritic chest pain. The patient denied shortness of breath, nausea, vomiting, sinus symptoms, and abdominal pain. His medical history included type 2 diabetes mellitus (glycated hemoglobin, 11.1), hyperlipidemia, and depression. He smoked marijuana but denied tobacco or illicit drug use. He reported no recent travels. He reported a 1-week history of left molar pain that began after he siphoned stagnant water with a straw from a refrigerator drip pan. He lived in Ohio all of his life. He denied any sick contacts. His medications include Lantus insulin at night, metformin, glimepiride, pravastatin, and Remeron. CHEST 2018; 154(3):e69-e72

Physical Examination Findings

His temperature was 37.1°C, blood pressure 144/96 mm Hg, respirations of 16 breaths/min, and saturated oxygen level of 95% on room air. He had dental caries and swollen erythematous oral mucosa with exposed root of a wisdom tooth in the left upper maxilla. His neck was normal. His lung examination showed dull note on the right lower lung fields on percussion. He had bilateral diffuse rhonchi with diminished lung sounds in the right lower lung fields, but no pleural rubs.

Diagnostic Studies

A complete blood count showed WBC of 12.2 K/μL with neutrophils 69.4%, lymphocytes 18.2%, monocytes 11.4%, hematocrit 44%, and platelets 286 K/μL. Cardiac enzymes, basic metabolic panel, and liver function tests were normal. His chest radiograph showed a mass-like opacity at the right lung base

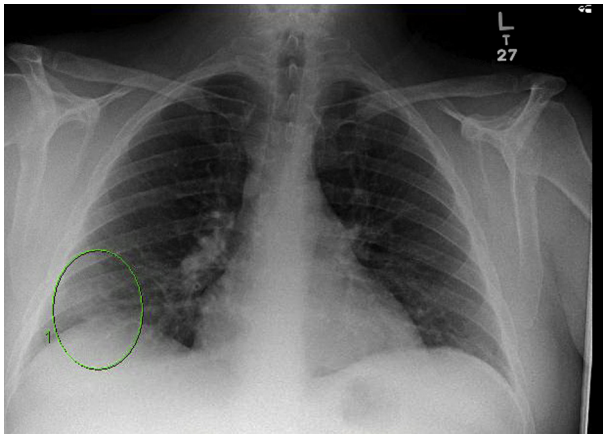

Figure 1 – *Chest radiograph showing a mass-like opacity at the right lung base over the right hemidiaphragm.*

(Fig 1). A CT angiography was negative for a pulmonary embolism but showed multiple peripheral

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bilateral thick-walled pulmonary cavitary nodules with prominent mediastinal lymphadenopathy.

Tuberculin testing and HIV screening were negative. Normal deep vein scan of bilateral internal jugular veins. A transthoracic ECG was negative for vegetation with an ejection fraction of 55%. CT scan of the neck showed a left upper lobe cavitary lung lesion and no filling defects in internal jugular veins or any cervical abnormalities.

Blood cultures showed gram-negative bacillus in the aerobic bottle and no growth in the anaerobic bottle. Sputum sample cultures were negative for bacterial or fungal organism.

Question: What pathogen could explain the patient's presentation?

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