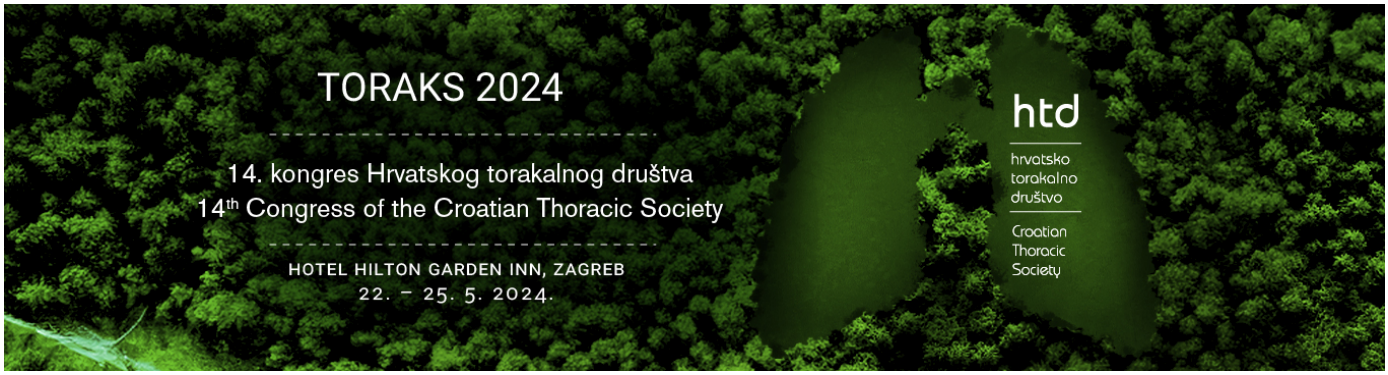

SEVERE PLEURAL EMPYEMA IN A YOUNGER PATIENT WITHOUT COMORBIDITIES- A CASE REPORT

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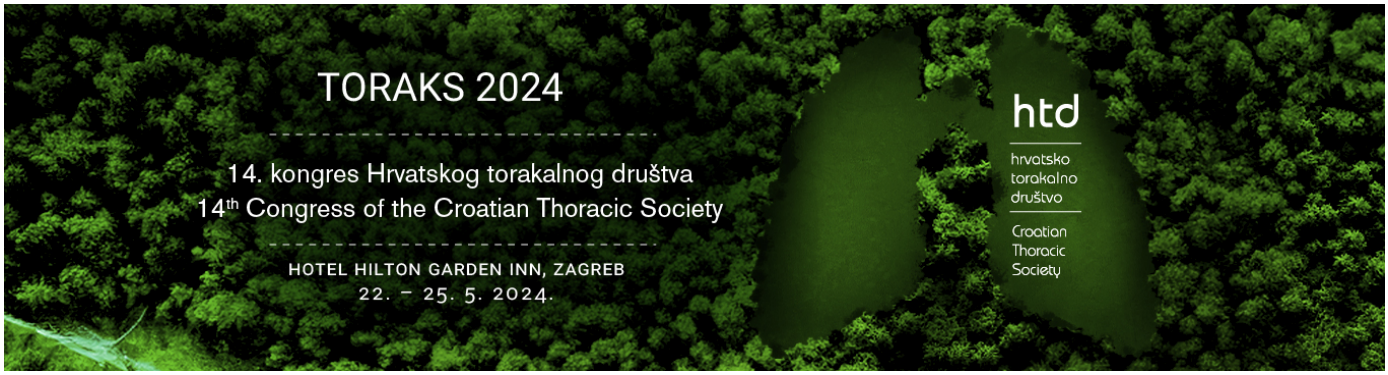
Background:

Pleural empyema is a complication of a bacterial pneumonia infection. Some independent risk factors for empyema development include age under 60 years old, poor oral hygiene, disorders with a predisposition to aspiration e.g. seizure or alcoholism, diabetes, liver cirrhosis and IV drug misuse. Empyema carries a poor prognosis if not treated early and aggressively from time of diagnosis. We present a case of severe pleural emypema in a younger male patient without comorbidities.

Conclusion:

Our case represents a young patient with severe clinical presentation of pleural empyema. As



latins would say „ Ubi pus, ibi evaqua“ we managed to cure our patient. Forehand diagnosis using combination of proper diagnostic tools helped us to diagnose and eventually treat our patient with positive outcome

Case:

A 47-year old male patient, smoker and alcohol consumer, presented in emergency department with residual dyspnea after the upper respiratory tract infection. On admission he was tachidispnoic, hemodinamically stable, afebrile at the moment. Also, his mouth was full of blood because he had a broken tooth. He was previously healthy, without any known comorbidites except daily alcohol consumation. On physical exam there was no breath sound on the left side with percutory dullness. Radiogram of the chest showed complete compression on the left lung due to pleural effusion (PE). Due to his condition an urgent MSCT of the thorax was performed which showed left-sided large pleural effusion with atelectasis from basis to apex. Ultrasound of the lung confirmed formation of consolidation with massive PE. His laboratory results showed elevated inflammatory markers. Urgent thoracocentesis was initiated. A two 12F chest tubes were inserted. Mucopurulent content was evacuated. Citology of the PE confirmed inflammation without provement of causative agent and no malignant cells were found.There was 8,3 L of pus drained in total. Patient was treated with antimicrobial therapy ceftriaxone and clindamycin which was continued and after discharge for 6 weeks in total. After evacuation of pus patient became respiratory sufficient on room air and was discharged home with reccomodation of control LDCT of the thorax.