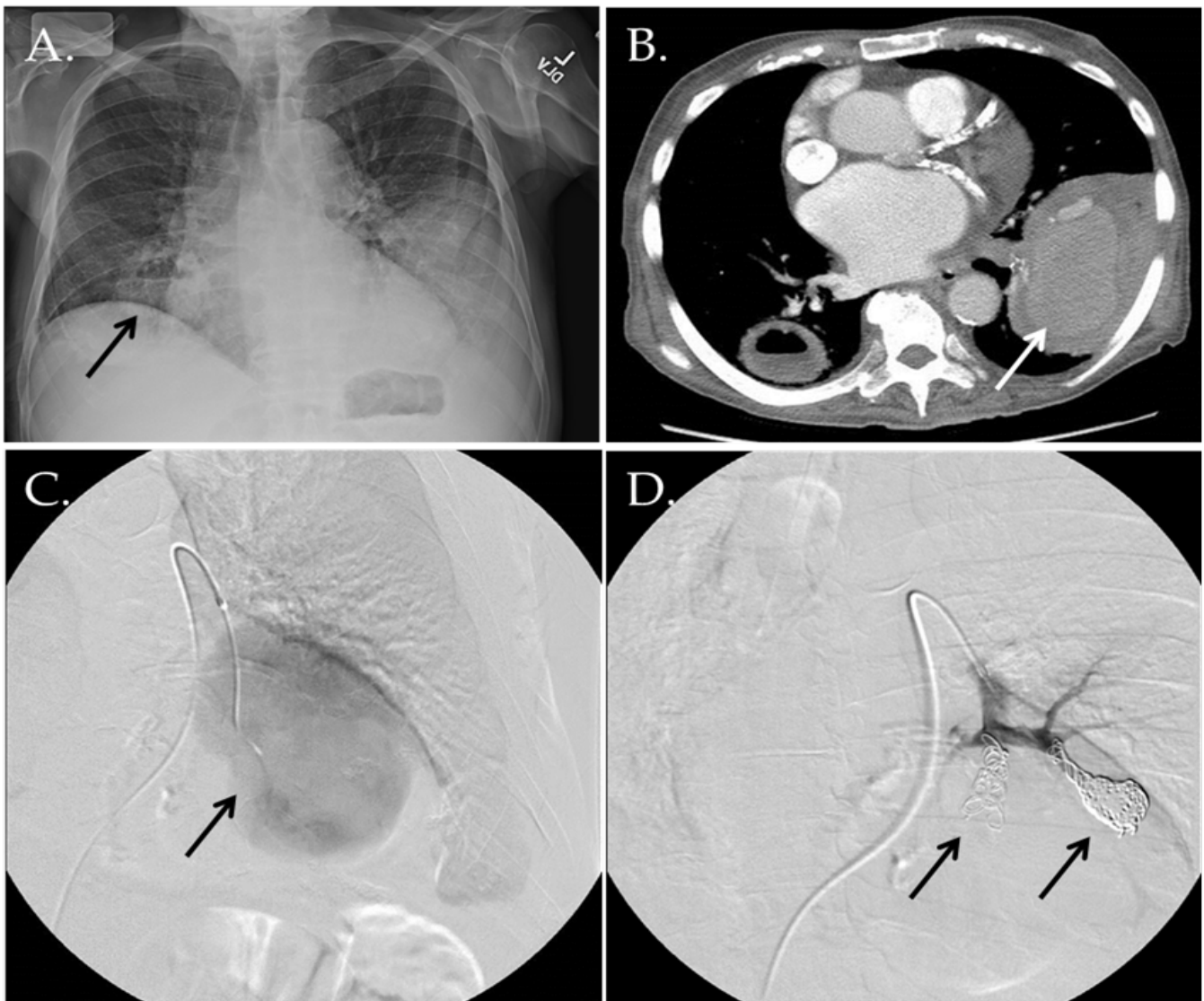


Giant Pulmonary Artery Pseudoaneurysm

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Clinical Image



An 82 year old male with transfusion-dependent myelodysplastic syndrome treated with Decitabine was admitted to hospital for an upper GI bleed. Chest radiogram (Panel A) revealed a cavitory infiltrate in the right lower lobe (RLL) and dense infiltrate without air bronchograms in the left lower lobe (LLL). Scant hemoptysis occurred and chest computed tomography (Panel B) demonstrated a 7 x 7 cm intraparenchymal hematoma in the LLL and a 4 x 6 cm thick walled cavitory lesion in the RLL.

Bronchoalveolar lavage was positive only for aspergillus antigen. Intravenous Amphotericin Bandbroad spectrum antibiotics were administered. Due to ongoing hemoptysis, a pulmonary artery angiography (Panel C) was performed and in the area of intraparenchymal hematoma in the LLL a giant 6 x 9 cm pulmonary artery pseudoaneurysm was noted. A second smaller pulmonary artery pseudoaneurysm was found adjacent to the first and both were successfully coiled and embolized (Panel D).

Key Points

Pulmonary artery pseudoaneurysms are parenchymal hematomas that form as a result of a leaking artery. They have non-specific radiologic features, including solitary pulmonary nodule(s) or focal consolidation [1].

CT may show central enhancement within a hematoma or consolidation, however definitive diagnosis requires pulmonary angiography which can be both diagnostic and therapeutic.

Pulmonary artery pseudoaneurysms are rare. The most common causes are infections; such as tuberculosis, endocarditis, pyogenic or mycotic infections, neoplasms, medium to large vessel vasculitis, trauma, or iatrogenic endovascular intervention [2]. High mortality may result from rupture leading to exsanguination and death [3].

References

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