Clinical case

Pneumomediastinum and diffuse alveolar pain. Severe interstitial pneumopathy due to dermatomyositis

Juan Ramón de Dios, a, Ana Julia López de Goikoetxea, a Juan Carlos Vesga, a Laura Tomás, b Vanesa Zorrilla, b and José Luis Lobo b

aDepartment of Rheumatology, Hospital de Txagorritxu, Vitoria, Álava, Spain
bDepartment of Pneumology, Hospital de Txagorritxu, Vitoria, Álava, Spain

ABSTRACT

We have recently observed the case of a 36-year-old man with dermatomyositis of recent onset, who developed massive pneumomediastinum and subcutaneous emphysema at the onset of a progressive and severe pulmonary disease. Although there were no sign of parenchymal cysts, after the bronchoscopy it was possible to observe endobronchial necrotic injury, which was considered as the likely source of the air leak. He was treated with high dose of corticosteroids, cyclophosphamide and cyclosporin A that resulted in the disappearance of the pneumomediastinum and subcutaneous emphysema and the progressive improvement of both parenchymal lung disease and respiratory insufficiency, enabled us to progressively taper the dose of corticosteroids.

 INTRODUCTION

Spontaneous pneumomediastinum (SP) is a clinical entity of unknown origin and a benign progression which affects young individuals. It usually resolves in the course of a few days with conservative treatment. It occasionally produces an alveolar rupture as a result or parenchymal peripheral affection in interstitial disease that produces peripheral honeycombing, as occurs in dermatomyositis, associated frequently to the amyopathic presentation. Lung affection in these cases can be specifically severe, with an elevated mortality that is only reduced if potent immunosuppressive treatment is installed at an early stage.

CLINICAL CASE

A 36-year old male with no particular history of interest presented fever, erythematous, and descamative skin lesions on the face, hands and elbows as well as hair loss and weakness with considerable weight loss. Laboratory testing revealed a normal
deterioration, which merited oxygen treatment at an elevated FiO2 (38.5–39°C) increased and there was a progressive gasometrical worsening, obliging treatment with cyclosporine A (CyA) at a dose of 5 mg/kg/day. After 1 month of combined therapy, the patient experimented slow but progressive improvement, both clinical and radiological, with disappearance of the emphysema and pneumomediatinum, as well as of the skin lesions and the muscle weakness.

After 9 months of immunosuppressive treatment (trimestral pulse CFM, CyA at a dose of 5 mg/kg/day and steroids in a diminishing dose), there was no recidivating pneumomediatinum, the patient remained stable and was able to walk again. Arterial blood gases showed PO2 60 mm Hg and PCO2 37 mm Hg, 91% oxygen saturation. Respiratory function tests revealed a restrictive pattern with a reduction in the lung diffusion of oxygen. There was extensive bilateral honeycombing on the (Figure 2), with the disappearance of the ground glass lesions. Because of the severity of the residual lung alterations and the stability of the radiological images, the patient was sent to a hospital of reference in order to evaluate lung transplantation.

Discussion

Spontaneous pneumomediatinum is a clinical entity of unknown origin and benign progression that affects young individuals and is resolved in a few days with conservative treatment. The most probable cause is the rupture of the alveolar walls caused by thoracic hyperpressure maneuvers, with the consequential escape of air into the interstitium and a further centripetal dissection along the bronchovascular sheaths until it reaches the mediastinum through the hyllum.

Figure 1. Pneumomediatinum with extensive emphysema.

Figure 2. Interstitial lung disease with bilateral “honeycombing.”
Occasionally, alveolar rupture can occur during an attack of asthma or as the result of a peripheral parenchymal affection of interstitial processes that lead to honeycombing. Among these latter cases, an association with dermatomyositis and polymyositis has been described, which in some cases can also be accompanied by necrotizing tracheobronchial lesions of a vasculitic nature that lead to perforation and constitute the origin of air leakage into the mediastinum. 

Dermatomyositis is a connective tissue disease with a predominant affection of the skin and muscles, although the lung is affected in 5%–40% of cases, in the form of interstitial lung disease (ILD), with 4 clinical forms, each with a different underlying histology:

- Asymptomatic, diagnosed only through radiological or functional studies.
- Cryptogenic organizing pneumonia (COP).
- Interstitial lung disease with slow progression and occasional exacerbation. The underlying histology is usually non-specific interstitial pneumonia (NSIP).
- Acute-subacute interstitial pneumonia, with a rapidly progressive deterioration, usually exhibiting a biopsy with a diffuse alveolar damage pattern (DAD).

Spontaneous pneumomediastinum is a rare complication of dermatomyositis, with an incidence of 2/100 000, but frequently accompanying those cases with a greater clinical aggressiveness. Eighty-eight per cent of cases are present in patients under 40 years of age and occasionally can be complicated with spontaneous pneumothorax. The profile of the patient at risk for the appearance of SP has been described. They are usually young, with recent-onset disease, interstitial lung disease, skin vasculopathy (nail infarcts, erosive/ulcerative lesions on the tip of the fingers), mild or no elevation of CPK, and receiving treatment with steroids. Our patient, with the exception of the skin vasculopathy, had all of these risk factors.

The presence of anti-Jo-1 antibodies increases the risk of interstitial lung disease in patients with dermatomyositis. This antibody is present in 20% of cases and in 70% of patients with interstitial lung disease; it is usually negative in amyopathic dermatomyositis, even when interstitial lung disease is present. Other potential markers for dermatomyositis are KL-6, anti-ADAM 10, D protein of serum surfactant and PL12.

It has been proposed that the appearance of SP could be due to a hypothetical weakening of intestinal lung tissue due to treatment with steroids, although for most authors, the true cause would be the severity of the interstitial affection itself. In any way, the absence of this affection in some cases of SP leads to the postulation of other pathogenic hypothesis, among which would be the perforation of necrotic tracheobronchial lesions of a vasculitic nature, as was described above.

The therapeutic management of the cases of dermatomyositis and polymyositis with lung affection varies according to their severity. The treatment decision is based always on the extension and speed of progression of the disease.

In the case of localized, non progressive and asymptomatic disease, treatment should be postponed.

In the case of chronic interstitial lung disease with a histology suggestive of usual interstitial lung disease (UILD), according to the proposal of the ATS/ESR, treatment with prednisone 0.5 mg/kg/day and azathioprine 1–2 mg/kg/day or cyclophosphamide is suggested (although cyclosporine A or tacrolimus can be considered also).

In the case of acute-subacute interstitial lung disease with NSIP histology (cellular predominance), the treatment suggested is high dose steroids, cyclosporin A or tacrolimus and cyclophosphamide (if unresponsive to the first ones).

In the case of acute-subacute interstitial lung disease with organizing pneumonia histology, treatment suggested is high-dose steroids.

In the case of acute-subacute interstitial pneumonia with DAD histology, suggested treatment is pulse cyclophosphamide and cyclosporin A or tacrolimus.

Once cyclophosphamide and cyclosporine A have been combined, steroids should be reduced as rapidly as possible in order to reduce the risk of serious infectious complications. Current treatment recommendations are summarized in Table.

The experience with cases of dermatomyositis presenting SP is scarce, with only 42 cases described treated with high dose steroids by themselves (22 patients with a mortality >50%) or in combination with different immunosuppressive agents, which show a clearly superior response during progression.

### Conclusions

The appearance of SP in a patient with a collagen-related disease must always alert the clinician to the possibility of dermatomyositis with severe lung parenchyma disease. In spite of the limited number of cases described and that in other studies the progression has been favorable, given the poor prognosis faced by patients with dermatomyositis, interstitial lung disease and pneumomediastinum, control of disease activity is recommended with intense and early immunosuppressive treatment, in this case, intravenous CFM and oral CyA, after ruling out infectious causes and with a progressive reduction of steroids. Treatment in this case has been effective, with a resolution of the pneumomediastinum in 3 months and a clinical improvement at 5 months, corroborating the results of other studies.

---

**Table**

Current recommendations for the treatment of interstitial lung disease

<table>
<thead>
<tr>
<th>Clinical progression</th>
<th>Histology</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localized. Non progressive. Asymptomatic Chronic</td>
<td>UIP</td>
<td>Postpone According to ATS/ERS guidelines. Prednisone 0.5 mg/kg/day+AZA 1–2 mg/kg/day or CFM (can try CyA or tacrolimus)</td>
</tr>
<tr>
<td>Acute or subacute (including exacerbation of chronic ILD) DAD</td>
<td>COP (or suspicion after high resolution CT) High dose steroid * + pulse IV CFM + CyA or tacrolimus</td>
<td>High dose steroid</td>
</tr>
<tr>
<td>Acute or subacute</td>
<td>NSIP (predominantly cellular)</td>
<td>High dose steroid * + IV pulse CFM+CyA if unresponsive</td>
</tr>
<tr>
<td>NSIP (predominantly fibrosis)</td>
<td>High dose steroid * + IV pulse CFM+CyA if unresponsive</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: ATS, American Thoracic Society; AZA, azathioprine; CFM, cyclophosphamide; CyA, cyclosporin A; DAD, diffuse alveolar damage; NSIP, non specific interstitial pneumonia; UIP, usual interstitial pneumonia; COP, cryptogenic organizing pneumonia; CT, computerized tomography.

* Once CFM and CyA are combined, doses of steroid should be reduced as rapidly as posible to reduce the risk of severe infectious complications.
References


