

## Aspiration Pneumonia – Status Epilepticus in the Setting of Secondary Ca Lung Metastasis-CASE REPORT

Efstathios Konstantinou Koutsostathis

*Kerameikos Health Center, Greece*

**\*Correspondence author**

**Efstathios Konstantinou Koutsostathis**

Kerameikos Health Center,  
Greece.

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### Medical History

- Operated Ca testis (seminoma) 30 years ago.
- Multiple sclerosis (diagnosis 25 years old).
- Surgery of knee arthroscopy (car accident 2000).
- Metastatic adeno-Ca lung (bone and brain metastases).
- Non-smoker.

### Present Illness

This is a 47-year-old male patient who presented with headache and epilepsy episode (1<sup>st</sup> episode with gaze fixation, loss of consciousness and focal head spasms lasting a few minutes). The National Emergency Aid Center was called; the patient developed generalized tonic-clonic convulsions during his transport by ambulance and was intubated in the Emergency Department due to the reported epileptic episode for airway protection. The patient was probably aspirated during the episode of seizures. He underwent a brain and chest CT where the brain revealed a solitary lesion (a known lesion) with increased surrounding edema and pressure in the right lateral ventricle frontobrachially. From the chest CT, a known solid process was found on the inner surface of the left lung at the level of the left pulmonary portal to the left upper lobe, broncho-axial distribution around the left sternal bronchus, upper lobar bronchus and abnormal external borders. A mixed-type bony secondary localization is found in the right scapula and in the T10 vertebrae. The patient had discontinued the dexamethasone treatment he had been receiving for two days due to gradual reduction since months on medical advice. On medical evacuation he presented with generalised tonic-clonic convulsions and was intubated in the Emergency Department for airway protection and was febrile up to 38.6°C

He was subsequently transferred to the Intensive Care Unit for further management.

### Course of Illness

On admission to the ICU the patient was intubated under Mechanical Ventilation and was receiving propofol and midazolam sedation (RASS -3). Pupils in mid-position, in miosis with positive optokinetic reflex (APACHE II: 18, SOFA:9). He was on mechanical ventilatory support with gas

exchange ( $PO_2/FiO_2 > 220$ ). ABGs: pH = 7.39,  $pCO_2 = 41$  mmHg,  $PO_2 = 113$  mmHg,  $HCO_3 = 21$  mmol/l, Lac = 1.1 mmol/l with  $FiO_2 = 40\%$  and PEEP = 6. From the cardiovascular point of view, the patient was hemodynamically unstable with the need for administration of low dose vasoconstrictors (noradrenaline). He maintained satisfactory hourly diuresis by himself.

Due to the findings on chest CT and the presence of several purulent bronchial secretions, he received antimicrobial treatment with ampicillin/sulbactam (received for a total of 7 days) and empirically added piperacillin/tazobactam (received for a total of 9 days). No pathogenic microorganism was isolated in blood and urine counts and bronchial secretions.

The patient showed gradual improvement in his clinical picture and was successfully discharged on the 6th day of hospitalization. During his hospitalization he developed an episode of gastroplegia which was treated with drip omeprazole.

### Conclusions

There are four types of aspiration syndromes. Aspiration of gastric acid causes a chemical pneumonitis which has also been called Mendelson syndrome[1]. Aspiration of bacteria from oral and pharyngeal areas causes aspiration pneumonia. Aspiration of oil (eg, mineral oil or vegetable oil) causes exogenous lipoid pneumonia, an unusual form of pneumonia. Aspiration of a foreign body may cause an acute respiratory emergency and, in some cases, may predispose the patient to bacterial pneumonia. The pathophysiology, clinical presentation, treatment, and complications of each of these entities are different. (1,2)

Cancer is the cause of 26% of the deaths in the UK, and outnumbers heart disease as a cause of death. Seizures and epilepsy may therefore occur, coincidentally or otherwise, in some people with cancer, and the cancer may influence the incidence, treatment and prognosis of seizures and epilepsy(3). When all types of neurological problems among patients with cancer were analysed at a specialist cancer centre, seizures were found to occur in 13% of all patients with cancer and to account

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for approximately 5% of all neurological manifestations. Half of the seizures were attributed to intracranial metastasis, and most of the remainder to metabolic disturbances. As a considerable proportion of seizures among adults with systemic cancer arise due to intracranial metastasis, cancer sites that would be expected to be commonly associated with seizures include lung, breast, skin (malignant melanoma) and colon (4).

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