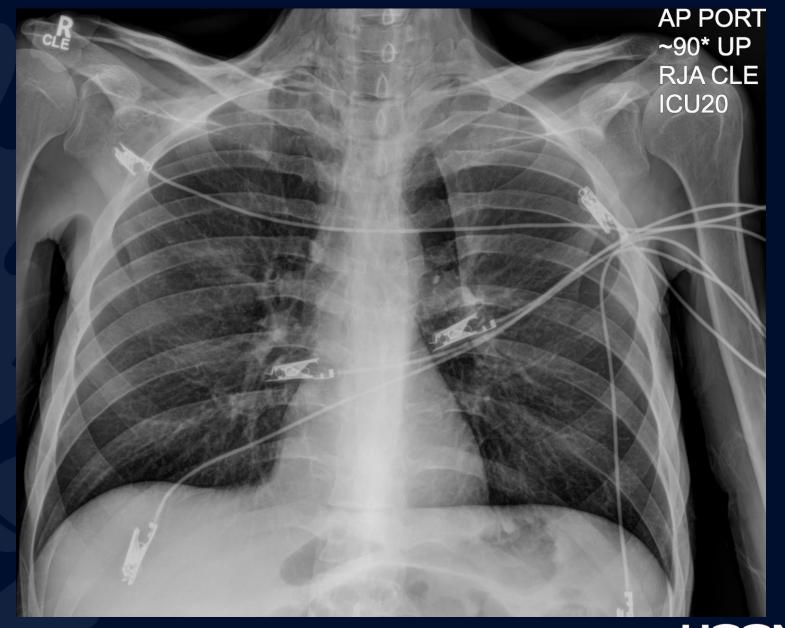
## 32M AMS, SOB

Krithika Srikanthan, MD





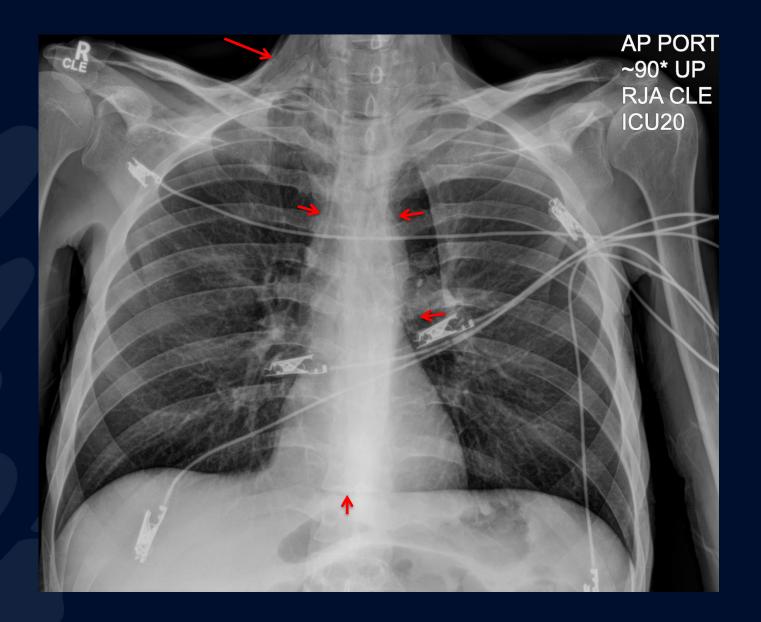






# Pneumomediastinum







## Radiographic findings on CXR

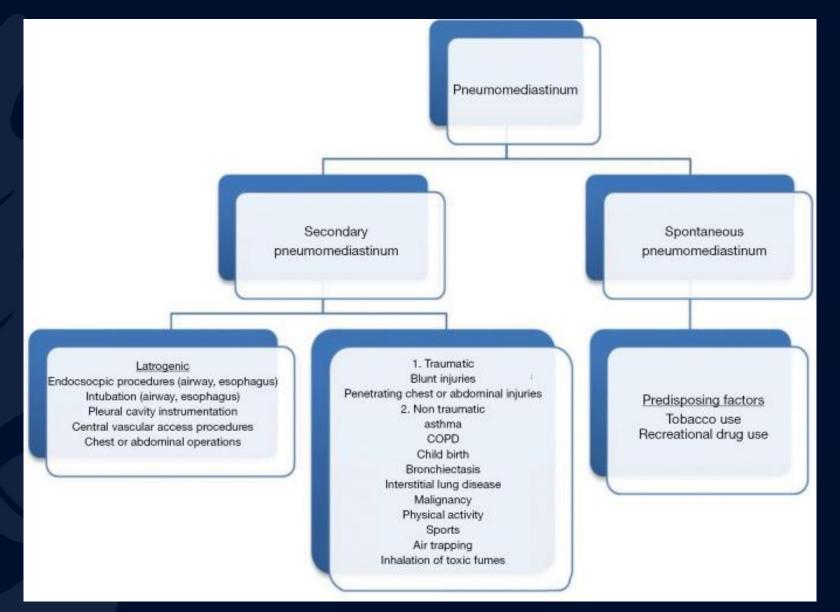
- Air ant/post to heart
- Air surrounds/outlines mediastinal structures
- Air dissects superiorly into neck SQ tissue and inferiorly into retroperitoneum
- Lateral view more sensitive than frontal radiograph (and CT more sensitive than radiography).
- Decubitus radiography air does NOT shift to nondependent positions



## Signs of Pneumomediastinum

- SubQ air in neck/chest well (70% will have this)
- Interstitial air double bronchial wall air on both sides of airway wall.
- Ring around artery sign air surrounding artery/vein seen en face
- Tubular artery sign air surrounding vessels along its length
- Continuous diaphragm sign air outlining inferior aspect of heart above diaphragm
- <u>Naclerio V sign</u> paravertebral air adjacent to left hemidiaphragm and descending aorta (suspicious for esophageal tear).
- "Spinnaker Sail sign" elevation of thymic lobes in peds







### Presentation

- Chest and/or neck pain(50-90%)
- Cough and/or dyspnea
- SubQ air palpable crepitus
- Dysphagia
- Rhinolalia
- Hoarseness/neck swelling
- Hamman Sign —"crunching" sound timed with the cardiac cycle, diminished heart sounds
- Decreased cardiac output possible in tension pneumomediastinum/pneumopericardium.



#### Demographics:

- Rare: ER 1/44,500; natural birth 1/100,000
- peak incidence 20-40yo
- Male>female

#### Course:

- Benign course usually resolves in 7 days (4-41days)
  - Typically the case. Clinical hx needed to exclude occult condition.
- Mortality >50% in Boerhaave syndrome
- Next step in management:
  - Spontaneous observe for tension ptx
  - If esophageal or airway injury suspected esophagram/bronchoscopy



#### References

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