cal abnormality predisposes patients to pneumonia as a result of ineffectual clearance of secretions (Bourne et al, 1995).

## Conclusions

Despite the high prevalence of community-acquired pneumonia, recurrent pneumonia should always be further investigated in order to elucidate the aetiology. In this case, a previously unknown structural defect in the large airways predisposed the patient to recurrent, possibly aspiration pneumonias. Imaging modality of choice is computed tomography scan. A high index of suspicion is also necessary. This diagnosis helped the authors choose appropriate antibiotics and also arrange appropriate follow up for secondary prevention of pneumonia. BJHM


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### LEARNING POINTS

- Recurrent pneumonia or infections in an otherwise healthy patient should provoke further testing.
- Evaluation for both structural and immunological causes should be pursued in this clinical setting.
- Mounier–Kuhn syndrome is a rare, but important anatomical cause of recurrent pneumonia in young patients.
- The imaging modality of choice is computed tomography and a high index of suspicion is necessary.



# Idiopathic calcinosis cutis

An 83-year-old woman presented with hard lumps over both shins. The past medical history was significant for congestive cardiac failure, type 2 diabetes, hypertension and diverticulosis. She was bedbound as a result of spinal cord compression.

Medication included baclofen, folic acid, aspirin, omeprazole, furosemide, bisoprolol, gliclazide, pregabalin, alendronate, Adcal and clonazepam. Examination revealed multiple firm nodules over both shins (*Figure 1*) and calves. There was no tenderness, ulceration or erythema to suggest infection.

Radiographic examination demonstrated an extensive latticework of calcification in a subdermal plane, with additional vascular calcification (*Figure 2*).

The serum calcium, phosphate, parathyroid hormone and creatinine kinase levels, and auto-antibody screen were normal.


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Histology from a punch biopsy showed irregular epidermal acanthosis with parakeratosis and full thickness atypia, in keeping with Bowens' disease. The underlying dermis showed chronic inflammation, vascular proliferation and perivascular aggregates of eosinophilic material. No evidence of invasive carcinoma was seen. Congo red staining was weakly positive, but immunohistochemistry for amyloid A was negative.

Idiopathic calcinosis cutis was diagnosed, a relatively rare condition whereby insoluble calcium phosphate crystals form in the skin. Most cases are not idiopathic, occurring in response to tissue injury, systemic metabolic defect, inheritable disease or an autoimmune condition (usually systemic sclerosis or dermatomyositis) (Gutierrez and Wetter, 2012).

There is no accepted first-line therapy, with many proposed, including surgical excision, laser therapy, extracorporeal lithotripsy, diltiazem, minocyclin, colchicine, probenecid, warfarin, biphosphonates, aluminium hydroxide and intralesional steroids (Reiter et al, 2011). Management hinges on the extent of the condition, tissues involved and symptomatology, which in this case did not require treatment. BJHM

***Figure 1. Photograph of shin of right leg.***

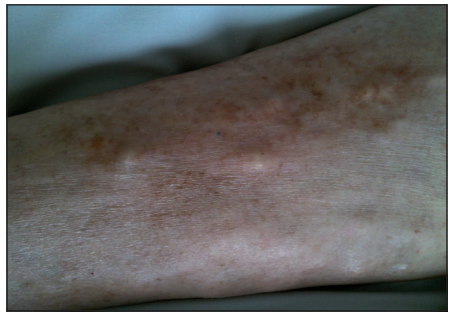


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***Figure 2. Radiographic image of the right lower leg.***