

Cardiac herniation following pulmonary tuberculosis infection with sequential autopneumonectomy

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A 67-year-old woman had suffered from mild dyspnoea since she had been diagnosed with pulmonary tuberculosis in her 50s. She denied having had any previous surgery. Her chest X-ray showed near total opacity of the right lung with mediastinal shift (**Figure 1**). In addition, no heart shadow was seen on the left side of the chest. The computed tomography scan demonstrated near total destruction of the right lung with compensatory hypertrophy of the left lung lobe (**Figure 2**). Autopneumonectomy with cardiac herniation was diagnosed.



Figure 1. The chest X-ray showed total white out of the right lung with mediastinum shift to the right. The trachea and the left main bronchus deviated to the right. Multiple stable calcified granulomas are seen bilaterally in the upper lungs, suggestive of old pulmonary tuberculosis infection.

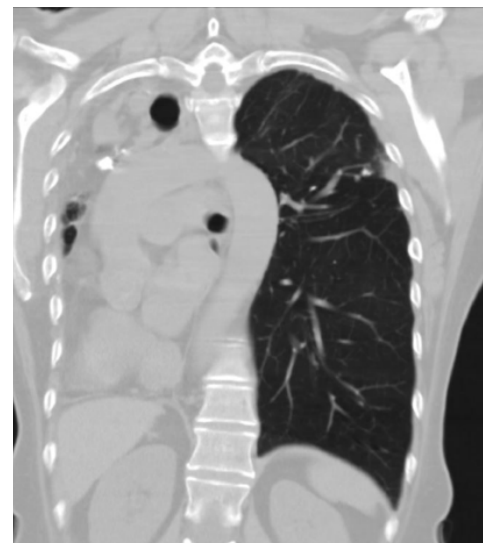


Figure 2. Coronal chest computed tomography demonstrated right lung destruction with herniation of the heart into the right chest cavity. These findings confirm the diagnosis of cardiac herniation following old pulmonary tuberculosis infection with sequential autopneumonectomy.

Lung destruction is not uncommon in people with tuberculosis. However, autopneumonectomy (near total destruction of the lung parenchyma without previous surgical intervention) is relatively rare (King et al, 2008). Patients with large volume lung destruction can have high-risk complications, including cardiac herniation and torsion, which is rare but has a high mortality rate (Onem et al, 2006). The previous relatively stable patient may suffer arrhythmia, myocardial ischaemia, and eventually develop cardiogenic shock (Montero et al, 2000). Computed tomography is important in these patients for evaluation of potential complications and to help inform the surgical plan.

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