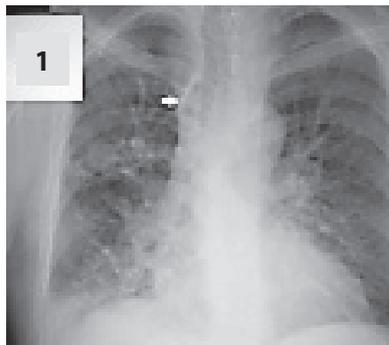


# Mounier-Kuhn syndrome

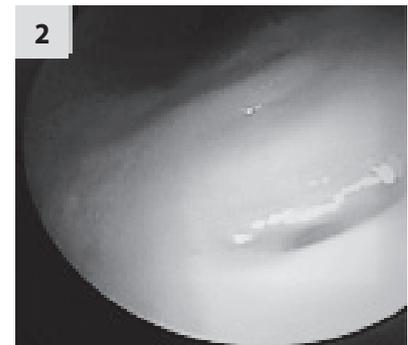
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A 65 year old male, nonsmoker was admitted into the Pneumology Department with the complaints of productive cough, dyspnea, chest pain and fatigue. He is a known patient, under treatment for chronic obstructive pulmonary disease. Over the years he had multiple lower respiratory tract infections. Physical examination showed bilateral inspiratory crackles and turgid jugular veins. Purulent sputum was analyzed and *Pseudomonas aeruginosa* was isolated. Blood analysis came normal. Spirometry test showed forced expiratory volume in the first second 35%, forced vital capacity 44% and tiffeneau index of 79. Arterial blood gases showed hypoxemia and hypercapnia with respiratory acidosis. The patient received nasal oxygen at 1.5 liters/minute, bronchodilators, antibiotics associated with mucolytic treatment and physical rehabilitation therapy<sup>1</sup>. Pneumococcal + flu vaccination, regular follow-up visits were suggested. After 14 days, the patient was discharged and has been doing well since.



**FIGURE 1.** Chest radiography postero-anterior view revealed right paratracheal lucency, reticular dense areas and cystic lesions mostly in the right middle and lower zones and ill defined opaque regions.



**FIGURE 2.** Bronchoscopy revealed diverticulum vents on the tracheal wall.



**FIGURE 3.** Chest computed tomography, axial view revealing bilateral cystic bronchiectasis presenting mainly in the right middle and lower lobe and also dilated trachea (>4 centimeters) and bilateral main stem bronchi diverticula emerging from the intrathoracic trachea.

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### REFERENCE:

1. Woodring JH, Howard RS 2<sup>nd</sup>, Rehm SR. Congenital tracheobronchomegaly (Mounier-Kuhn syndrome): A report of 10 cases and review of the literature. *J Thorac Imaging* 1991;6:1-10.