Wegener’s Granulomatosis with Parotid Gland Involvement and Pneumothorax

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Abstract

Objective: Wegener’s granulomatosis is a systemic vasculitis characterized by necrotizing granulomatous lesions mostly involving the upper and lower respiratory tract. The disease rarely causes parotid gland involvement and pneumothorax. We report a case of Wegener’s granulomatosis involving parotid gland, and complicated with a pneumothorax.

Clinical Presentation: A 45-year-old man admitted with a 3-week history of painful left parotid gland enlargement and hemoptysis. On physical examination a painful and hard mass was detected on the left pre-auricular area. Cervical CT revealed a 2 × 1.5 cm hypodense lesion mimicking an abscess on the left parotid gland. Chest radiograph and thorax CT demonstrated nodular and cavitating opacities on the right and left upper zones. There were numerous erythrocytes in urine sediment. The drained pus material from the parotid abscess demonstrated only gram-positive cocci (Staphylococcus aureus). Two weeks treatment with teicoplanin resulted in no improvement. Meanwhile, parotid gland biopsy revealed necrotizing granulomatous inflammation. There was a sixfold increase in serum cANCA levels. With the diagnosis of Wegener’s granulomatosis, cyclophosphamide and prednisolone were initiated. However, 1 month later, pneumothorax developed as a complication of rupture of a cavitary lesion. Conclusion: Parotid gland swelling may be the initial presenting symptom of Wegener’s granulomatosis. It can be confused with infectious or malignant diseases of the gland, and the lung involvement may be complicated with pneumothorax.

Introduction

Wegener’s granulomatosis is a systemic vasculitis, characterized by necrotizing granulomatous lesions mostly involving the upper and lower respiratory tract. It may afflict all organs, but the nose, paranasal sinuses and lungs are the main sites to be affected. Parotid gland involvement as an initial presentation is unusual and may be confused with other neoplastic and non-neoplastic diseases of the gland [1–6]. Pneumothorax is also a rare complication [7–12]. In this report, we present a case of Wegener’s granulomatosis with parotid gland involvement as a major initial manifestation and with pneumothorax as a complication of cavity rupture.
Case Report

A male patient, a 45-year-old beekeeper, was admitted with a 3-week history of painful left parotid gland enlargement and hemoptysis. He smoked 20 cigarettes per day. On physical examination, a painful and hard mass was detected on the left pre-auricular area. Hematological examination showed that the erythrocyte sedimentation rate was 80 mm/h, white cell count was 8,900 cells/mm³ and hematocrit was 31.5%. Serum protein and albumin levels were 6.1 and 2.3 g/dl, respectively, but other blood chemistry values were within normal limits. Viral serologic tests (mumps, Epstein-Barr virus, cytomegalovirus, hepatitis B and C, and HIV) were negative. There were numerous erythrocytes in the urine sediment. In the radiological evaluation, cervical CT revealed a 2 × 1.5 cm hypodense lesion mimicking an abscess in the left parotid gland. Chest radiograph and thorax CT showed nodular and cavitating opacities in the right and left upper zones (fig. 1–3).

With the diagnosis of parotid gland abscess, intravenous ampicillin-sulbactam was instituted and the patient was operated on. At operation, multiple abscesses with pus material were observed in the gland. After the pus material was drained, tissue and pus samples were obtained and examined for specific and non-specific infections (pyogenic, mycotic infections, tuberculosis, etc.). Microscopic examination revealed abundant polymorphonuclear leukocytes and gram-positive cocci (Staphylococcus aureus methicillin-resistant) but not other bacteria or fungi. Ampicillin-sulbactam was stopped and intravenous teicoplanin was given in accord with the sensitivity of the other bacteria or fungi. Ampicillin-sulbactam was stopped and intraoperative cephoperazone-sulbactam and amikacin were initiated, c-antineutrophil cytoplasmic antibody (cANCA) and rheumatoid factor (RF) were positive. RF was 19.1 IU/ml (normal <10 IU/ml) and cANCA was 27.0 U/ml (normal <4 U/ml). cANCA activity was confirmed with an IFA (immunofluorescence antibody) method.

Renal ultrasound and intravenous pyelography were normal. Nasal endoscopy showed masses obliterating both nasal cavities, with septal and conch perforation. Bronchoscopy revealed subglottic narrowing, mucosal changes and crusts. Pulmonary function tests gave results as follows; FEV₁: 2.03 litres (54% pred.), FVC: 3.27 litres (71% pred.), FEV₁/FVC: 62%, and FEF₂₅–₇₅: 1.66 litres (39% pred.).

Six weeks after admission to our hospital, cyclophosphamide and methylprednisolone were started with the diagnosis of Wegener's granulomatosis. However, kidney involvement was not proven by biopsy. Trimethoprim-sulphamethoxazole was also given. One month of treatment was accompanied by a significant improvement. The size of the parotid mass decreased and other complaints (fever, hematuria, hemoptysis, etc.) regressed. In contrast, pulmonary lesions progressed and cavitation occurred (fig. 4). One month after the onset of treatment, a pneumothorax developed on the right side and it could not be expanded despite the introduction of tube thoracostomy (fig. 5). Air leakage and empyema could not be controlled. Intravenous cephoperazone-sulbactam and amikacin were initiated, cyclophosphamide was stopped and prednisolone was tapered. The patient was then referred to another medical center for thoracic surgery. After referral for thoracic surgery the patient was not re-admitted to our hospital. On thoracotomy, pneumothorax, empyema and bronchopleural fistula had been detected, and cavity resection and decortication had been performed. It was learned from the patient’s epicerisis and from the responsible physician that, following surgery, immunosuppressive therapy was not restarted because of recurrent respiratory infections. The patient suffered progressive respiratory insufficiency due to these infections, severe cachexia and endobronchial involvement/narrowing as the illness progressed and died 8.5 months after diagnosis.

Discussion

Wegener’s granulomatosis is thought to be an autoimmune disease. There is a strong and specific association between the disease and ANCA. The sensitivity of granular cytoplasmic staining pattern (cANCA) was reported to be 91% [13] and antibody titers correlate with the clinical activity of the disease [14]. On the other hand, some exogenous factors, especially infectious agents, have also been postulated in the aetiology. Chronic nasal carriage of...
S. aureus has been reported to be an independent risk factor for relapse [15]. Stegemann et al. [15] reported that 63% of 57 patients with Wegener’s granulomatosis were chronic nasal carriers of S. aureus. The culture of pus from parotid abscess in our case revealed S. aureus colonization or infection, which led to initial misdiagnosis. Brons et al. [16] have also suggested that staphylococcal acid phosphatase acts as a planted antigen and initiates glomerulonephritis and vasculitis. Thus, effective therapy directed against this bacterium can be expected to reduce

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the number of relapses. A prospective, randomized and placebo-controlled study has shown that treatment with trimethoprim-sulphamethoxazole significantly reduced the incidence of relapses [17].

Immunosuppressive therapy, mainly using corticosteroids and cyclophosphamide, has been considered essential for the management of Wegener’s granulomatosis. This treatment induces remission in more than 90% of the patients [18]. While untreated Wegener’s granulomatosis is usually fatal, survival improved dramatically following the standard cyclophosphamide and corticosteroid therapy. One-, five- and 10-year survivals were reported to be 93, 79 and 75%, respectively, by Koldingsnes and Nossent [19] and another study by Reinhold-Keller et al. [20] reported a 10-year survival rate of 88% and a median survival of 21.7 years. Even with appropriate therapy, our patient died within the first year following diagnosis. Koldingsnes and Nossent [19] reported that, of 56 patients, 7.1% died within 1 month of starting treatment; all had multi-organ disease. Our patient had multiple organ involvement. Renal disease or impaired renal function, pulmonary involvement, advanced age, anemia and initial white blood cell count over than 10,000/µl are reported to be bad prognostic factors [19–23].

The disease mostly involves the upper respiratory tract, lung and the kidney. Parotid gland involvement is rare and unusual. It may be the initial symptom of the disease [4, 5]. Many conditions such as infectious diseases (viral, bacterial infections, tuberculosis, fungal infections, etc.) and non-infectious diseases (Sjögren syndrome, sarcoidosis, tumours, etc.) can result in parotid gland enlargement [1–4]. cANCA remains an important diagnostic test for Wegener’s granulomatosis, and histological examination confirms the diagnosis.

At the end of the 1-month treatment, rupture of the cavitary lesion in the right lung resulted in total pneumothorax in this patient. Pneumothorax is a rare complication of the disease [7–12] that may be seen as an initial presenting symptom or as a complication of situations such as immunosuppressive treatment or TTFNA [7, 8 12]. The rupture of the cavity, as in our case, may also cause pneumothorax [9, 11]. The pneumothorax in our case was not expanded despite the introduction of tube thoracostomy. This was probably related to continuation of air leakage due to delayed wound healing and lack of recovery of the ruptured cavity because of accompanying empyema and usage of immunosuppressive agents; cyclophosphamide and corticosteroid [24–26]. Treatment with these agents was tapered off to control infection and improve wound healing.

In conclusion, parotid swelling may be the initial presenting symptom of Wegener’s granulomatosis. It can be confused with infectious or malignant diseases of the gland, while lung involvement may be complicated with pneumothorax.
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