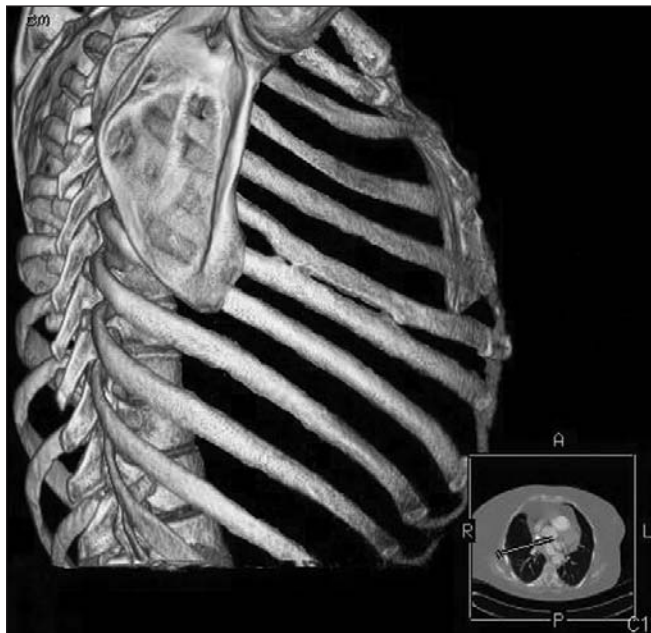


CLINICAL VISTAS BRIEFS

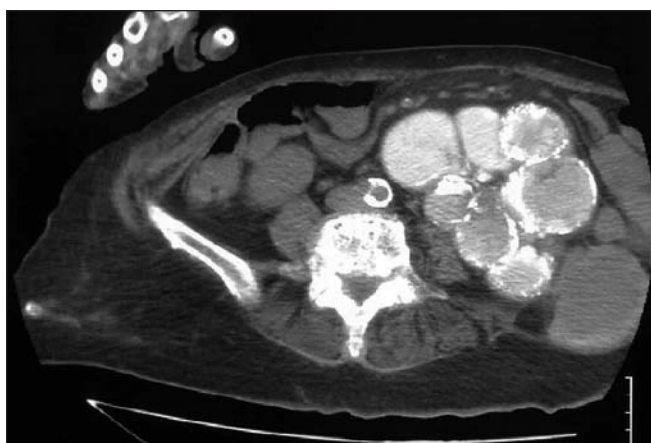
What's your call?



Three-dimensional reconstruction of a chest computed tomography scan of a 60-year-old woman with acute and chronic chest pain localized to the region of a 10-year-old thoracotomy scar.



Computed tomography scan of the abdomen of a 47-year-old woman with a history of fatigue and malaise associated with nausea, vomiting, lower back pain and acute renal failure.



Computed tomography scan of the abdomen of an 87-year-old woman with 4-day history of fever, dysuria and left-flank pain.

See page 1029 for diagnoses.

CLINICAL VISTAS BRIEFS

Chronic post-thoracotomy pain syndrome

The 3-dimensional reconstruction of the computed tomography scan was obtained at the time of admission to exclude pulmonary embolus and aortic dissection. It confirmed a narrowing of the fifth intercostal space (Figure 1) where the thoracotomy had taken place. Pain was believed to be related to an entrapment of the fifth intercostal nerve or chronic periostitis due to bone-on-bone contact between the fifth and sixth ribs, or both. Lasting pain relief followed selective neurolysis of the fifth intercostal nerve.

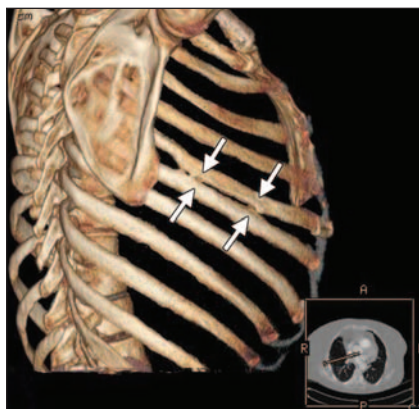


Figure 1: Three-dimensional reconstruction of helical chest computed tomography scan shows close contact between fifth and sixth ribs (arrows).

Chronic post-thoracotomy pain syndrome is defined as pain that recurs or persists along a thoracotomy incision for at least 2 months following surgery. It can occur in more than 50% of cases.¹ Multiple mechanisms leading to chronic post-thoracotomy pain syndrome have been proposed, including poorly repositioned rib fractures, costochondritis, costochondral disloca-

tion, intercostal neuroma, nerve entrapment and local infection.² Treatment is guided by the underlying cause, which in many cases is not clear.

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Xanthogranulomatous pyelonephritis

This patient had a history of renal colic and recurrent urinary tract infections. On physical examination she had tenderness at her left costophrenic angle. She had pyuria on a routine urinalysis, leukocytosis (leukocyte count 15.6×10^9 /L, 0.88 neutrophils) and acute renal failure (serum creatinine level $574.6 \mu\text{mol/L}$). Computed tomography of the abdomen showed a nonfunctioning left kidney and radiographic findings compatible with xanthogranulomatous pyelonephritis (Figure 1). (Additional computed tomography scans showing the extent of the pa-

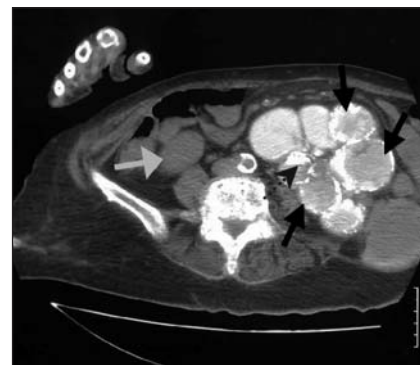


Figure 1: Computed tomography scan of the abdomen showing renal stone (dashed arrow) and cystic lesions (black arrows). Low pole of the normal right kidney is indicated with the grey arrow.

tient's kidney disease can be seen in Appendix 1, available at www.cmaj.ca/cgi/content/full/177/9/1027/DC1.)

Escherichia coli grew in a urine culture. The patient was prescribed broad-spectrum antibiotics (piperacillin and tazobactam), with significant clinical improvement. She was discharged 10 days later.

Xanthogranulomatous pyelonephritis is a severe, chronic bacterial infection of the kidneys characterized by the destruction of the renal parenchyma and the presence of granulomas, abscesses and foam cells.

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