

“Crack lung” ALI/ARDS as a cause of complex weaning from general anaesthesia for minor surgery

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A 54-year-old man was subjected to a general anesthesia for laparoscopic cholecystectomy. In the preoperative visit he was an ASA 2 due to smoke; no surgical and anesthesiologic complication were recorded. After surgery the patients had a violent recovery from anesthesia featured with unconsciousness, psychomotor agitation. The patient was extubated but after few minutes reintubated because agitation and desaturation. He was admitted in ICU. Complete blood count, comprehensive metabolic panel, and procalcitonin and c reactive protein were unremarkable. Urine toxicology was positive for cocaine. He underwent a brain and lung Ct scan. The brain CT was negative, instead the computed tomography of the chest revealed bilateral ground glass opacity. Echocardiography showed no evidence of a cardiac problem. Based on urine toxicology, CT finding and subsequent a bronco alveolar lavage with a typical featuring of ALI/ARDS the patient was diagnosed with an acute pulmonary syndrome triggered by cocaine inhalation (crack lung). The respiratory damage of gas exchange was mild so in the first days after surgery was tried a weaning from sedation and mechanical ventilation but the patient again was violent and unconsciousness. The patient was tracheostomized and treated with corticosteroid; after 1 week the CT shown a healing of the lung damage.

In the 8 days after surgery he was decannulated and completely recovered from neurological and respiratory symptoms.

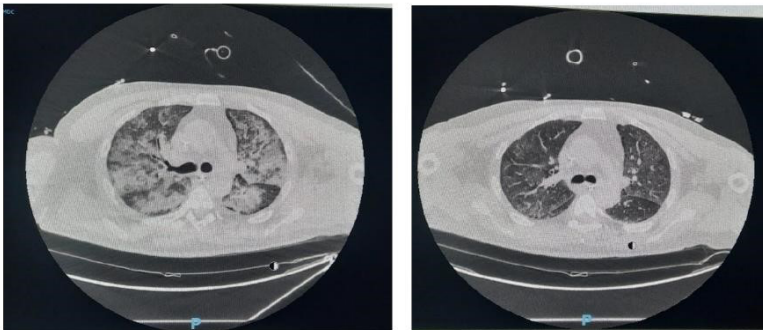


Figure1

Figure 2

Discussion: Crack lung it is uncommon in patients submitted in elective surgery. It normally is as an acute pulmonary syndrome consisting of diffuse alveolar damage and hemorrhagic alveolitis that occurs within 48 hours of smoking crack cocaine us our patient.^{1,2} Many patients require ventilatory support, either noninvasive positive pressure ventilation or endotracheal intubation with mechanical ventilation for respiratory failure. There were reports that patient has benefited from corticosteroid in severe cases. This case help to recognize this respiratory disease also in surgical setting in a patient with cocaine abuse, but also show how the cocaine abuser could have a complex weaning from general anesthesia and sedation; it could depend on the brain damage by the cocaine, non-visible in CT.

1. Dolapsakis C, Katsandri A. Crack lung: A case of acute pulmonary cocaine toxicity. *Lung India*. 2019 Jul-Aug;36(4):370-371.

2. Restrepo CS, Carrillo JA, Martínez S, Ojeda P, Rivera AL, Hatta A, et al. Pulmonary complications from cocaine and cocaine-based substances: Imaging manifestations. *Radiographics*. 2007;27:941–56.