To the Editor:

The presentation of community-acquired pneumonia with abdominal pain and a lower lobe pulmonary infiltrate \(^1\) is reminiscent of the clinical presentation with abdominal pain in a 53-year-old man in whom the eventual diagnosis was pulmonary embolism. \(^1\) Computed tomography angiography showed evidence of pulmonary embolism, and also showed an infiltrate in the right lung base, thought to represent a pulmonary infarct. \(^2\) As in the reported case of community-acquired pneumonia, \(^1\) ST-segment elevation in leads V1 to V4 can also occur in pulmonary embolism, \(^3\) in the latter instance with absence of autopsy evidence of acute myocardial infarction or coronary occlusion. \(^3\) Community-acquired pneumonia may also be characterized by stigmata of right ventricular strain, namely, S1Q3T3 pattern, right axis deviation, and right bundle branch block, and also by atrial fibrillation, \(^4,5\) changes similar to those documented in pulmonary embolism. \(^6,7\) Some of these electrocardiographic stigmata resolve within a few days in survivors of community-acquired pneumonia. \(^5\) Acute myocardial infarction can also occur as a complication of either community-acquired pneumonia \(^8\) or pulmonary embolism, \(^9\) in the latter example as a consequence of the mismatch between oxygen supply and the high oxygen demands of a dilated right ventricle with pressure overload and high wall tension. \(^9\) Radiographic stigmata are also comparable, lobar distribution of pulmonary infarction being sometimes indistinguishable from community-acquired pneumonia-related lobar consolidation. \(^10\) Additionally, pulmonary embolism-related loculated pleural effusions may be indistinguishable from the loculated parapneumonic effusions associated with community-acquired pneumonia. \(^11\)

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References