

Some Comments to the Article- Anthony Gikonyo., *et al.* “Uncovering Pneumonia: Comparing Chest Radiograph to Computed Tomography: An Analysis”

Igor Klepikov*

Professor, Pediatric Surgeon, St. NE Renton, WA, USA.

***Corresponding Author:** Igor Klepikov, Professor, Pediatric Surgeon, St. NE Renton, WA, USA.

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Dear colleagues, one of the articles published in the latest issue of your magazine caught my attention (Anthony Gikonyo., *et al.* “Uncovering Pneumonia: Comparing Chest Radiograph to Computed Tomography: An Analysis”. *EC Cardiology* 6.10 (2019): 1089-1093). This article describes three observations with a negative diagnosis of acute pneumonia on the primary chest x-ray. To identify the focus of inflammation in the lung, the authors were able only with the help of computed tomography. Based on this, the authors recommend resorting to computed tomography, if a patient with suspected inflammation in the lungs x-ray does not allow to clarify the diagnosis. All the material is presented logically and argumentatively, especially since the diagnostic advantage of computed tomography over standard radiography has long been proven and taken for granted.

However, a detailed acquaintance with the materials of this publication cannot, from my point of view, not cause some clarifications and comments.

First, in the last two (according to the sequence of presentation) observations on the submitted radiographs, shadow formations in the lungs are observed. In this regard, it is not quite correct to consider the results of radiography completely negative.

Secondly, in all the presented observations we are talking about the localization of the zone of inflammation in the basal parts of the lungs. Such localization of pathological formations in the lung tissue is one of the most difficult to diagnose. The lower parts of the lungs on straight (anterior-posterior) radiographs are layered on the shadow of the diaphragm and are not visible properly. Specialists dealing with pulmonary diseases are aware of this feature of diagnosis and therefore perform x-ray examination in two projections-straight and lateral (on the side of the alleged focus). Unfortunately, this publication presents only direct images of patients and there is no indication in the text of an additional side image. This fact does not allow us to consider the primary x-ray examination performed in accordance with the requirements.

Thirdly, from the descriptions provided it is not possible to determine in what period of time after the x-ray was performed computed tomography. Judging by the nature of the pathology on the tomograms, this study was conducted not immediately after the x-ray, but after a certain time. This is important to note because the changes found on the tomograms, from my point of view, would undoubtedly be visible on an x-ray. Particularly significant in this regard is the third observation, in which pleural complications had already developed by the time of tomography. The reason for this rapid transformation is that such patients are usually prescribed intravenous infusions to correct homeostasis disorders and eliminate the so-called intoxication. However, when acute inflammation begins in the pulmonary tissue, intravenous fluid infusion stimulates the processes of edema and infiltration in the affected area [1].

Finally, the authors' conclusion about the diagnostic role of ultrasound, which has not been the subject of consideration and discussion in this publication, is surprising. The classic conclusion should be the answer to the problem identified in the title and introduction, right?

The reviewer does not doubt the professionalism of the authors of the article, so the essence of the comments should not cause readers such a feeling. The reason for the analysis of this publication was dictated solely by the desire to make some additions and explanations based on their own experience. The process of our medical education cannot and should not be limited to the walls of the University, and the exchange of experience between colleagues is one of the forms of its continuation.

Bibliography

1. Igor Klepikov. "The Effect of Intravenous Infusion on the Dynamics of Acute Pneumonia". *EC Pulmonology and Respiratory Medicine* 4.1 (2017): 15-20.

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