Chemical pneumonitis due to inhalation of lycopodium: a case report

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ABSTRACT

Background: Lycopodium powder consists of dried spores of club moss plants, principally *Lycopodium clavatum* which is flammable when in contact with air due to its high oil content.

Case Presentation: A 15-year-old, previously healthy, female student presented to the Emergency Department with a 1-hour history of shortness of breath following accidental inhalation of lycopodium in school. The dyspnea was rapidly progressive and associated with multiple episodes of non-productive cough, chest tightness, and nausea. A portable chest X-ray showed opacified bronchi in the right lower lung with para hilar peribronchial prominence virtually indistinguishable from those seen in lower respiratory tract infection. She began desaturating on 15 L of oxygen and was unable to tolerate non-invasive positive pressure ventilation (NIPPV), hence, shifted to the intensive care unit (ICU). IV methylprednisolone was started at 40 mg q6h and was tapered to q8h the next day. The patient clinically improved and was stable by day 6.

Conclusion: An extremely rare case of lycopodium inhalation by a school student led us to realize not only the importance of a thorough history in cases where presentations can overlap but also safety recognition during school laboratory training sessions.

Keywords: Lycopodium, pneumonitis, NIPPV, case report.

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Background

Lycopodium (also known as club moss) grows along the ground and reproduces by producing spores. Lycopodium powder is generally used for educational purposes and can be moderately toxic when inhaled or ingested. Lycopodium is a class of alkaloid with a bioactive amine called Huperzine A [1]. It is widely used by homeopaths in the treatment of breathing disorders, as well as by the pharmacists in the olden days to help coat pills. The first professional use of lycopodium was by magicians in small quantities to perform the "dragon breath" trick as it is a highly flammable solid [2]. Lycopodium could be potentially lethal at high doses. Studies have shown its lethal dose is characterized by >4 mg/kg of body weight in male rats [3]. There are few reported cases of accidental exposure to lycopodium, and in this case report, we are presenting a case of student exposed to lycopodium that caused severe respiratory distress requiring ICU admission.

Case Presentation

A 15-year-old, previously healthy, female student of Arab origin presented to the Emergency Department with a 1-hour history of shortness of breath after she accidentally inhaled lycopodium powder in school during her chemistry laboratory session an hour ago. She explained that instead of blowing into the apparatus she accidentally **Correspondence to:** Mahroo Khalid *Gulf Medical University, Ajman, United Arab Emirates. **Email:** mahroo.khalid65@gmail.com *Full list of author information is available at the end of the article.*

inhaled the powder that immediately caused respiratory distress. The dyspnea was rapidly progressive and associated with multiple episodes of non-productive cough, chest tightness, and nausea. She denied loss of consciousness, headaches, dizziness, or visual disturbances. She reported no history of chronic medical conditions or previous hospitalizations.

The patient upon admission to the Emergency Department was alert and oriented. Examination showed a respiratory rate of 44 breaths/minute, pulse rate of 107 bpm, blood pressure of 114/67 mmHg, temperature of 36°C, and SaO2 of 78% on ambient air. She was in severe respiratory distress with tachypnea and suprasternal retractions. Lung auscultation revealed diminished breath sounds and crepitations on the right anterior and posterior lung bases. Examination of other systems was unremarkable.

Initial laboratory work showed normal differential cell count. Blood gas analysis showed a pH of 7.32, pCO₂ of 53.8 mmHg, pO₂ of 48.8 mmHg, and HCO₃ of 27.7 mmol/l. Urea and electrolytes were within normal limits. A portable chest X-ray showed opacified bronchi in the right lower lung with para hilar peribronchial prominence (Figure 1).

The patient was given 15 L of oxygen through a nonrebreather mask, which improved her oxygen saturation to 82%. She was also administered IV hydrocortisone, 250 mg once. However, she began desaturating on 15 L of oxygen and hence started on non-invasive positive pressure ventilation (NIPPV). The patient was unable to tolerate NIPPV for long as she reported feeling suffocated each time she was on it.

The patient was transferred to the Medical intensive care unit (ICU) on the same day with a diagnosis of chemical pneumonitis. A repeat chest X-ray showed a minor consolidation adjacent to the left heart border. Right lung appeared clear (Figure 2). IV methylprednisolone was started at 40 mg q6h and was tapered to q8h the next day. The patient refused a trial of NIPPV.

The next day, the patient's oxygen saturation was 97%–100% on 2 L oxygen. Her respiratory rate was 30–34 breaths per minute with suprasternal retractions.



Figure 1. Opacified bronchi in the right lower lung with radiographic pattern of para hilar peribronchial prominence.

On auscultation, bilateral rhonchi with decreased air entry were present on both sides. Laboratory findings revealed marked elevation of the white blood cell (WBC) count, from $10.67 \times 109/l$ at admission to $27.67 \times 109/l$; with a neutrophilic count of $26.28 \times 109/l$ following which, superimposed bacterial pneumonia was suspected and the patient was started on IV Piperacillin-Tazobactam 4g, q8h. Chest X-ray repeated showed no new finding (Figure 3). The patient remained afebrile.

On day 3, the patient got improved, with the respiratory rate in 20s and no suprasternal retractions. Auscultation revealed basal rhonchi and laboratory findings showed a decrease in WBC count to 21.80×109 /l. The oxygen nasal cannula was removed but she desaturated to 92% and hence kept on 2 L of oxygen via nasal cannula. Methylprednisolone was tapered to 40 mg BID and Piperacillin-Tazobactam was to be continued for 5 days.

On day 4, the patient improved clinically and required intermittent oxygen flow of 1 L/minute via nasal cannula as the oxygen saturation still dropped to 88% on activity. However, she was able to maintain the oxygen saturation at 93% on room air. The patient was shifted from the medical ICU to the general ward.

On day 6, her lungs were clear to auscultation and she was able to maintain an oxygen saturation of greater than 95% on room air for 24 hours. In light of the findings, the patient was discharged the same day with the following medications:

- Albuterol 2.5 mg, 1.25 ml, NEB, q6hr, PRN: Asthma symptoms.
- Budesonide: 0.5 mg, 1 ml, NEB, q12hr.
- Methylprednisolone: 20 mg, PO
- Pantoprazole: 40 mg, PO for 5 days

The patient was given an appointment to follow-up in the outpatient clinic after 1 week but the patient did not return. On the basis of a telephonic conversation, it was found that the patient is following up in private pulmonology clinic. She has been asymptomatic for 4 months



Figure 2. Minor consolidation adjacent to the left heart border. Right lung appears clear.



Figure 3. Normal cardio mediastinal contours with clear lungs.

since her acute illness and is planning to follow-up with the same doctor for a total of 6 months.

Discussion

Lycopodium powder consists of dried spores of club moss plants, principally *Lycopodium clavatum*. These spores are flammable when they come in contact with air due to their high oil content [4]. Lycopodium powder has been used in explosives and fireworks, in magic acts to create the fire breath, and in physics and chemistry laboratories of schools for experiments in accordance to its hydrophobic and flammable properties [2]. Our case happened during a high school chemistry experiment class.

However, there is evidence for the presence of medical advantages of Lycopodiaceae. Certain species of Lycopodiaceae were shown to have anti-inflammatory properties [5]. *Huperzia Serrata*, a species from the Lycopodium family produces a bioactive alkaloid called Huperzine A, is a potent inhibitor of acetylcholinesterase and is used for the treatment of Alzheimer's disease [6,7]. A homeopathic study on animals done in 2014 revealed that *L. clavatum* 30C had hepatoprotective effects in paracetamol-induced liver damage, characterized by reduced necrosis and inflammation of the liver tissue [8]. A 2010 study showed the plausible presence of anticancer properties of *L. clavatum* [9]. However, not many studies have been conducted to explain the toxicities of lycopodium.

Pulmonary aspiration syndromes encompass a group of diseases caused by inhalation or aspiration of foreign material into the lung. The type of syndrome is dependent on the amount and nature of the aspirated substance, duration of exposure, as well as the host responses [10,11]. These syndromes can be categorized into airway disorders, such as obstruction of large airways with a foreign body and bronchiectasis, or parenchymal disorders, such as aspiration pneumonitis and pneumonia [11]. A form of chemical pneumonitis caused by inhalation of liquid hydrocarbons such as lamp oils used for fire breathing, also called fire breather's pneumonia or hydrocarbon pneumonitis, has a similar presentation comparable to lycopodium inhalation and usually does not show specific clinical signs but 1%-2% might be fatal with cyanosis, apnea, or cardiac arrest [12].

A case similar to ours was presented in 2008, where a 23-year-old gentleman had accidentally inhaled lycopodium spores while fire breathing. The patient was initially being treated as a case of tuberculosis as his lung biopsy showed granulomatous changes. However, it was only after careful interrogation that it was revealed that the patient had aspirated lycopodium spores and this shows that a thorough history is vital in cases where presentations can overlap [13]. *L. clavatum* spores were used in dusting powders of many hospitals in the 20th century. Another case reported in 2015 was a 16-year-old female who accidentally inhaled hydrocarbon and developed hydrocarbon pneumonitis, commonly known as fire-eater's pneumonia. Although, the exact cause of her condition was not due to lycopodium. Both hydrocarbons, as well as lycopodium, are used by magicians in their fire-breathing trick and may have fatal consequences. Even though the patient recovered, there are no guidelines to treatment or management of these patients which means prognosis of every patient can differ [14].

There have been cases of lycopodium granulomas years after the spores enter the body. One such case was reported in 1988 where a patient was diagnosed with lycopodium granuloma nearly 50 years after an appendectomy. When lycopodium spores gain access into the body through a surgical wound, they can form a granulomatous lesion months or even years later. This implies the importance of adequate follow-up of patients having had a close encounter with lycopodium spores [15]. Two cases of asthma have also been reported following occupational lycopodium exposure, especially in firms making contraceptive sheaths for men [2].

In regards to the management of lycopodium aspiration pneumonitis, there is no standard therapy available, but most of the reported cases have tried IV steroid which may have caused an increase in the neutrophilic WBC count observed on day 2 in this patient.

Conclusion

There is minimal literature pertaining to the development of chemical pneumonitis due to aspiration of lycopodium despite the presence of medical advantages of Lycopodiaceae. The various risks of using lycopodium have yet to be clearly established. Hence, it was important to report this case and to focus on the implementation of safety precautions while using lycopodium powder not only in school setting but all other work environments that make use of such products. In this case, on a telephonic follow-up with the mother of the patient, it was found that this was the first time an accident of this nature took place in the school and therefore, the school decided to replace lycopodium powder with milk powder and enforce the use of mask as a mandatory requirement. We are happy that after 4 months, the patient is doing well and does not have any respiratory symptoms.

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List of Abbreviations

ICU Intensive care unit NIPPV Non-invasive positive pressure ventilation

Consent for publication

Informed consent was obtained from the patient.

Ethical approval

Ethical approval is not required at our institute to publish an anonymous case report.

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Patient (gender, age)	1	Female, 15 year old
Final diagnosis	2	Chemical pneumonitis
Symptoms	3	Rapidly progressing dyspnea associated with multiple episodes of non-productive cough, chest tightness, and nausea
Medications	4	15 L of oxygen, hydrocortisone, methylprednisolone, and Piperacillin-Tazobactam
Clinical procedure	5	15 L of oxygen through a non-rebreather mask and single dose of IV hydrocortisone 20 mg was administered on admission. On transfer to the ICU, IV methylprednisolone 40 mg q6h started and tapered to q8h on day 2 and BID on day 3. IV Piperacillin-Tazobactam 4 g q8h was started on day 2 as superimposed bacterial infection was suspected and continued for 5 days.
Specialty	6	Medical Intensive Care Unit (ICU)

Summary of the case