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The Yule Log: Intrapulmonary Wooden Foreign Body Retained for Four Decades

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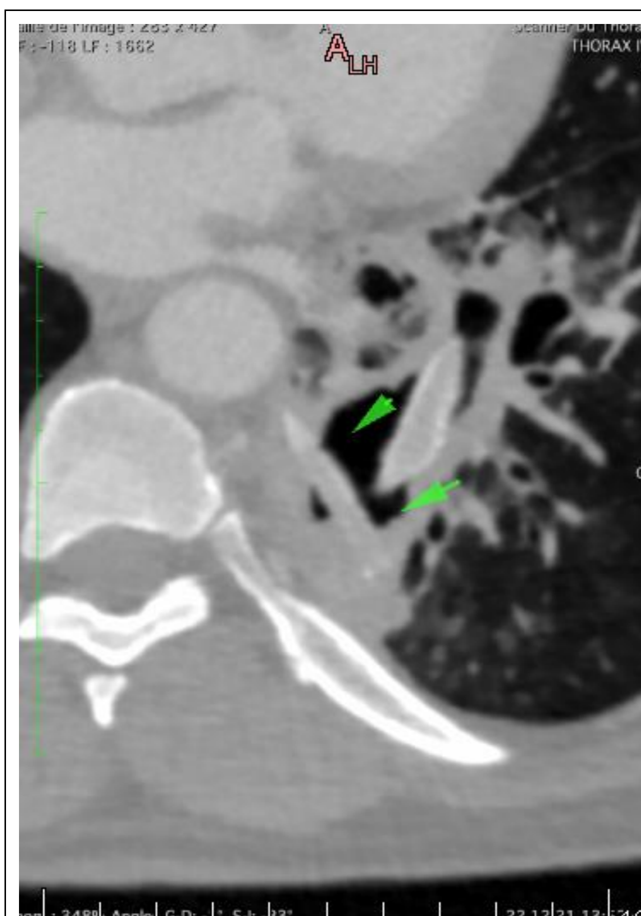

Figure 1: Axial CT image showing two hyperdense foreign bodies within a cavitary lesion of the left lower lobe.

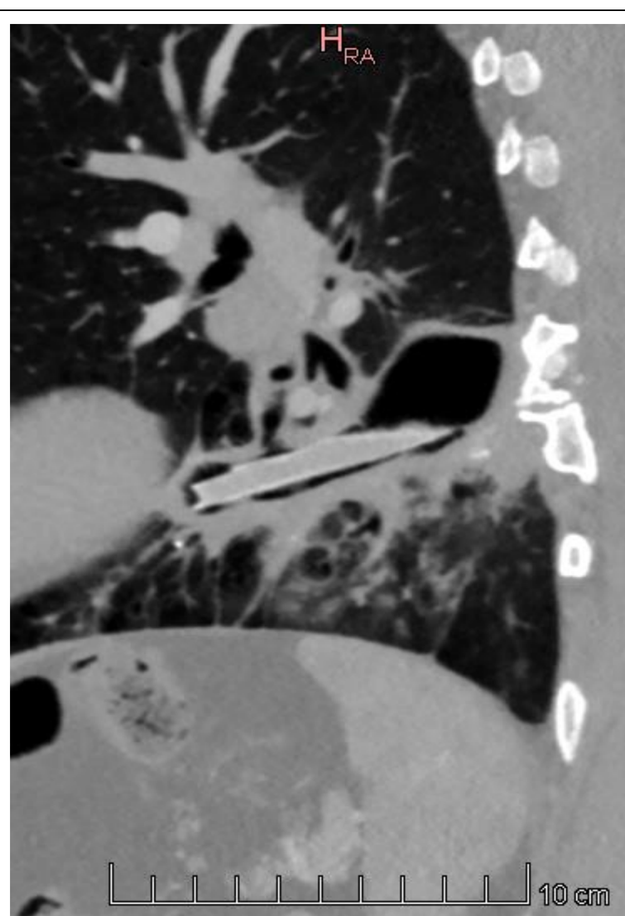

Figure 2: Sagittal CT reconstruction confirming intra-pulmonary foreign bodies within the left lower lobe.

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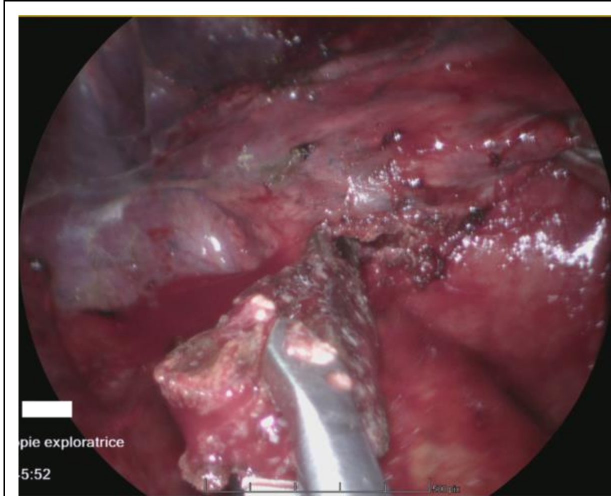

Figure 3: Intraoperative view during uniportal video-assisted thoracoscopic extraction.

Figure 4: Extracted wooden foreign bodies, the largest measuring more than 7 cm.

Clinical Image

A 49-year-old man presented with chronic cough, intermittent haemoptysis, and recent foul-smelling sputum. He was a non-smoker with no significant past medical history. Similar symptoms had been investigated in 2003–2004 with bronchoscopy and computed tomography, excluding malignancy, tuberculosis, and endobronchial obstruction. He reported a childhood thoracic trauma at age 10 in Ethiopia after falling onto a wooden fence, followed by surgery at the Black Lion Hospital in Addis Ababa.

Chest computed tomography demonstrated a cavitary lesion in the medio-basal segment of the left lower lobe containing two hyperdense intrapulmonary foreign bodies with surrounding consolidation and tree-in-bud opacities (Figures 1 and 2).
Surgical management was performed using uniportal video-assisted thoracoscopic surgery. Dense pleural adhesions and extensive parenchymal destruction required left lower lobectomy to avoid recurrent hemoptysis. Two pre-cut wooden fragments were extracted, the largest measuring approximately 7 cm (Figures 3 and 4). Histopathological analysis revealed acute and chronic multicystic pneumonia without granulomas. The postoperative course was uneventful.

Long-term intrapulmonary foreign body retention is rare and most frequently involves inorganic or iatrogenic materials. Retained wooden intrapulmonary fragments are exceptionally uncommon, particularly after latency periods extending over several decades. Progressive encapsulation and mineralisation likely explain the radiopaque appearance observed in this case. Persistent or unexplained respiratory symptoms associated with atypical imaging findings should prompt consideration of remote penetrating thoracic trauma.