A case report of MTX-induced pneumonitis

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INTRODUCTION

MTX is a disease-modifying drug for various chronic inflammatory diseases. It is an analog of folic acid and is used to block the synthesis of purines and thymidines, which are essential for cell proliferation. It is used in the treatment of various conditions, including psoriasis, rheumatoid arthritis, and Crohn's disease. MTX-induced pneumonitis is a rare but serious complication of MTX therapy. It is characterized by the development of pulmonary infiltrates, which can progress to respiratory failure.

CASE REPORT

A 79-year-old woman presented with a 3-month history of dyspnea on exertion and dry cough. She had a history of psoriasis and had been taking MTX for 3 months. On examination, she was found to have bilateral pulmonary infiltrates on chest X-ray. A lung biopsy was performed, which showed lymphocytic alveolitis and interstitial fibrosis. MTX was discontinued, and the patient was treated with corticosteroids. The patient's condition improved, and the pulmonary infiltrates resolved.

DISCUSSION

MTX-induced pneumonitis is a rare but serious complication of MTX therapy. It is more common in patients with rheumatoid arthritis and psoriasis. The diagnosis is usually made on clinical grounds, and the treatment is primarily supportive. In some cases, discontinuation of MTX and treatment with corticosteroids can be effective. Further research is needed to better understand the mechanisms underlying MTX-induced pneumonitis and to develop effective preventative strategies.

REFERENCES


necessary but pulmonary histology is characterized by alveolitis with epithelial cell hyperplasia and eventually, small granulomas and eosinophilic infiltration.

References


Calced Alveolar Septal Pulmonary Amyloidosis as an Initial Manifestation of Multiple Myeloma

To the Editor:

Systemic amyloidosis is caused by the extracellular deposition of protein in the form of fibrils, known as amyloid.1 This process causes functional impairment of the affected organs and is fatal if left untreated.

Lung involvement is relatively common, but rarely symptomatic. It can present in three ways: nodular, tracheobronchial and diffuse alveolar septal.

We describe below the case of a female patient, 65 years of age, history of COPD, former smoker, who reported a 6-month history of progressive dyspnea, with no other associated symptoms. On physical examination, she had dry crackles in both lung bases. Complete blood count and biochemistry were normal. An echocardiogram was performed, which was normal. Spirometry revealed a severe obstructive defect (FEV1 47%) with moderate restriction (FVC 61%). Diffusing capacity for CO was severely reduced (17%). The 6-min walk test showed a significant drop in oxygen saturation and had to be suspended due to significant dyspnea and O2 saturation of 73%. A chest computed tomography (CT) was performed that showed multiple nodular images, mostly densely calcified, with thickening of interlobular septa, mainly peripheral and in the basal segments (Fig. 1). A lung biopsy, performed by video-assisted