Clinical Image

Radiology, Bronchoscopy and Microbiology in Bronchopulmonary Aspergillosis

Radiología, broncoscopia y microbiología de la aspergilosis bronco-pulmonar

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We report the case of a 52-year-old woman with a history of 3 episodes of pneumonia and asthma. She consulted due to dyspnea, chronic cough, and low-grade fever. Clinical laboratory tests showed eosinophilia 7.7% (0.5 × 10⁹/l) and total immunoglobulin E (IgE): 6680 IU/l. Skin prick and radioallergosorbent (RAST) tests were positive for Aspergillus. Computed tomography images are shown in Fig. 1a and b. Bronchoscopy (Fig. 1c) revealed a large, thick, purulent mucus plug in the entrance to the right pulmonary tree. Bronchial aspirate fluid showed fungal mycelia and Aspergillus terreus was isolated on culture (Fig. 1d). Cytology revealed inflammatory cells and fungal structures consistent with hyphae.

Allergic bronchopulmonary aspergillosis (ABPA) occurs in susceptible patients who are exposed to Aspergillus spores. ABPA affects severe asthmatics and, particularly, patients with cystic fibrosis. Diagnostic criteria do not always present simultaneously. In cases such as ours, in which asthma and bronchiectasis coexist, aspergillosis should be considered in the differential diagnosis. ABPA is currently subdivided into 2 different subgroups, with and without bronchiectasis. Criteria for ABPA-bronchiectasis are asthma, proximal bronchiectasis, raised IgE, positive skin test for Aspergillus spp, and raised specific IgE and/or IgG in serum.

References


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