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Aspergillus: From ABPA to Invasive Aspergillosis

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Aspergillus; It is a type of fungus that manifests itself in allergic, saprophytic and invasive forms. The response and the infectious process vary depending on the host's immune status. Allergic Bronchopulmonary Aspergillosis (ABPA) is a pulmonary disease that develops in patients with asthmatic and cystic fibrosis. Corticosteroid used in the treatment. The necessity of corticosteroids in the treatment of ABPA and the increased risk of invasive aspergillosis in immunosuppressed patients, this can cause changing of one form to another. of aspergillus can be seen together. The following case report demonstrates progression of allergic manifestations of Aspergillus to its invasive form in an individual with decreasing immunity. This can lead to uncertainties in diagnosis and management. Aspergillus overlap syndrome is defined as the occurrence of more than one form aspergillus disease in a single individual. 58 years old male patient had been followed for 10 years as asthma. She had weight loss, increased symptoms of asthma and a complaint of brown sputum for 14 months. Bronchiectasis in the thorax HRCT and peripheral eosinophilia observed. Total Ig E was 2100/mL. Aspergillus skin test was positive. As the IgE and IgG antibodies against aspergillus were found positive in serum, oral corticosteroid and itraconazole treatment was started with the diagnosis of ABPA. The patient presented with complaints of dyspnea, cough, sputum, and hemoptysis for 3 days. PAAC radiography showed bilateral diffuse reticulonodular infiltration and the patient was hospitalized with pneumonia and hemoptysis. Antibiotic therapy was started and 40 mg iv prednisolone was started because of the ABPA. New bilateral pneumonic consolidation with cavitary lesions were observed in thorax CT. Lactate level was measured as 3.4. Hypotension and tachycardia were present and the patient was transferred to intensive care unit. Bronchoscopy was performed in intensive care conditions. However, BAL and tissue biopsy could not be performed because of general condition. Blood Galactomannan antigen was positive (3.57). Due to the presence of CT findings and galactomannan positivity, invasive aspergillosis was considered and antifungal treatment was started. Intubation was observed on the 1st day of the intensive care follow-up. Deepening of pancytopenia was observed. Patient was dead at the 3rd day. There is a need for close clinical and radiologic follow up of patients with Aspergillus and our patient demonstrated overlap of complete spectrum of Aspergillus disease with march from one end to the other end.

Keywords: Asthma, aspergillus, invasive aspergillosis