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A Case of Rapidly Progressing and Fatal Endobronchial Aspergilloma Mimicking Lung Carcinoma

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Aspergillus species are found everywhere in nature, and the entrance of infectious pathogens into body through inhalation is a frequent event. Endobronchial aspergilloma is a very rare disease and occurred with aspergillus infection developed in the bronchial lumen. A case of endobronchial aspergilloma with difficulty in diagnosis may mimic lung carcinoma clinically and radiologically. In this case report, we aimed to discuss a case of endobronchial pulmonary aspergilloma mimicking lung carcinoma. A 77-year-old woman applied to our clinic with a two-month history of weight loss, malaise and cough. The non-smoker patient has been using azathioprine for the last 15 years due to the diagnosis of uveitis associated with sarcoidosis. In biochemical tests of case whose hemogram values were normal and C-reactive protein value was 1.48 mg/dL, no abnormality was detected. In the chest X-ray, homogeneous increased density was detected in paracardiac area of the right lower lung zone. In thoracic computed tomography imaging, central mass in the right lung, mediastinal lymphadenoma and bilateral pulmonary nodules were observed. In fiberoptic bronchoscopy, the mucosal swellings covered with necrotic material were observed in the right upper lobe posterior segment entrance and the right middle lobe orifice. Pathological examination of biopsy specimens was reported as benign. There was no reproduction in the tuberculosis and pure cultures of bronchoscopic lavage materials. Central mass in right lung (SUVmax:25.9), bilateral multiple nodules (SUVmax:7.5), multiple mediastinal lymphadenopathies (SUVmax:22.9), lesion in upper pole of right kidney (SUVmax:10.6), masses in bilateral adrenal glands (SUVmax:18) were detected with Positron emission tomography- computed tomography (PET-CT) imaging. Fiberoptic bronchoscopy was repeated in the patient who developed fever. Development of similar endoscopic findings were observed in medial wall of the left main bronchus. Pathological evaluation of biopsy specimens indicated necrotizing inflammation. In the case whose tuberculin skin test was found to be negative, the fiberoptic bronchoscopy were repeated due to negativity of acid-resistant bacteria, fever height and radiologic progression and empirical voriconazole therapy was initiated. On the pathology of bronchoscopic biopsy, the diagnosis of aspergillosis was confirmed upon observation of yeast hyphae of the aspergillus. The patient did not respond despite voriconazole treatment. Additionally, progression in chest X-ray, respiratory insufficiency and renal failure were developed. Respiratory arrest occurred and the patient was followed up in the intensive care unit. Cardiopulmonary arrest occurred in the intensive care unit on the fifth day of follow-up period. Consequently, in the cases where new endobronchial lesions developed rapidly and metastatic lung cancer was thought but not shown, the immunosuppression and fever should bring aspergillosis to mind.

Keywords: Aspergillosis, lung carcinoma, mortality