Caso Clínico
Clinical Case

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Pneumonia aguda fibrinosa e organizante

Acute fibrinous and organizing pneumonia

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Resumo

A designação *acute fibrinous and organizing pneumonia (AFOP)* foi proposta por Beasley *et al* para os casos em que as características histopatológicas das lesões não se enquadravam em outras situações clínicas (agudas ou subagudas) conhecidas. A presença de fibrina intra alveolar e de pneumonia organizativa, com distribuição difusa, é a principal alteração histológica associada a esta entidade.

Os autores descrevem o caso de um doente do sexo masculino, com o diagnóstico de AFOP, por biópsia pulmonar cirúrgica. O doente teve uma apresentação subaguda, apresentando por queixas principais tosse, dor torácica e febre. TAC torácica mostrou infiltrados bilaterais, difusos. Após início

Abstract

The term Acute Fibrinous and Organizing Pneumonia (AFOP) has been proposed by Beasley *et al* for cases that not fit into the histopathologic criteria of the recognized entities described as acute or subacute clinical presentations. The presence of intra-alveolar fibrin in the form of fibrin 'balls' and organizing pneumonia with patchy distribution are the main histological features of this entity. We describe the case of a male patient with the diagnostic of AFOP made by surgical lung biopsy. He had a subacute presentation of symptoms consisting of productive cough, chest pain and fever. Bilateral infiltrates with patchy and diffuse distribution were the predominant features in his chest HRCT scan. The patient had a good

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de corticoterapia sistémica e ciclofosfamida, o doente apresentou melhoria clínica significativa. Ao elaborar este caso, os autores esperam acrescentar mais alguns dados sobre esta nova entidade.

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Palavras-chave: AFOP, pneumonia organizativa.

clinical course after a treatment with prednisone and cyclophosphamide. Our hope in reporting this case study is to add some more data to the discussion of this new entity.

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Case report

In September of 2003 a 66 year old Caucasian man, with abnormal lung radiological findings and two month history of productive cough and diffuse thoracic pain was admitted to our hospital. He was a retired judge, smoker (20 packs a year) and had no relevant clinical history previous to the present episode. One month earlier he had visited his primary care physician who requested a chest radiograph which showed bilateral reticulonodular opacifications with basal predominance (Fig. 1). The CT scan confirmed bilateral lung consolidations with basal and peripheral prevalence (Fig. 2). Treatment with antibiotic was prescribed and his clinical condition improved. However radiological worsening with enlargement and spread of lung opacifications (Fig. 3) was seen in re-evaluation after antibiotic treatment. After this he was admitted to our ward where he did not present any other symptoms besides those initially described.

On admission he was alert, temperature was 36.4º, pulse 92 beats per minute, respiratory rate 19 breaths per minute and blood pressure 133/73 mmHg. No signs of respiratory discomfort were seen. Heart sounds and abdomen were normal and there were no peripheral edemas. Reduced respiratory sounds and diffuse crackles were heard in lung lower zones and heart sounds were normal.

The WBC count, sedimentation rate, serum electrolytes, liver tests, creatinine level and urinalyses were in the normal range. Sputum specimens contained few neutrophils, with no microorganisms. A serious restrictive ventilatory pattern and lung diffusion impairment were observed in lung function testing (Table I). Arterial blood gas measurements indicated a partial pressure of oxygen of 68 mmHg, a partial pressure of carbon dioxide of 39 mmHg and the ph 7.37. Cardiac doppler ultrasonography revealed no marked changes.

Table I

FVC	1.81 (42%)
FEV1	1.59 (48%)
FEV1/FVC	88%
VC	1.81 (40%)
TLC	3.85 (53%)
RV	2.04 (79%)
RV/TLC	40 (53%)
DLCO/VA (ml/mmHg/min/L)	2.25 (44%)