

A 37-Year-Old Man With Nonresolving Pneumonia and Endobronchial Lesion

Merlin Thomas, MD; Tasleem Raza, MD, FCCP; and Mona Al Langawi, MD, FCCP

A previously healthy, immunocompetent 37-year-old man was hospitalized with a 3-month history of intermittent fevers and cough with mucopurulent sputum preceded by flu-like symptoms. Five episodes of similar symptoms had prompted two hospitalizations and three courses of outpatient antibiotics. The fever would subside with treatment but intermittent dry cough persisted. There was no history of weight loss, night sweats, wheezing, arthralgia, skin rash, hemoptysis, recent travel, sick contacts, or high-risk sexual behavior. He was a nonsmoker with no alcohol or recreational drug use. He was an accountant in the military with no history of significant organic or inorganic dust exposures. CHEST 2015; 148(2):e52-e55

Physical Examination Findings

Vital signs at admission were significant for a temperature of 39°C, pulse of 100 beats/min, and respiratory rate of 18 breaths/min. Chest examination revealed bronchial breath sounds with coarse crepitations at the right posterior basal region. Other systemic examination was within normal limits.

Diagnostic Studies

Hemogram results were significant for leucocytosis of $27 \times 10^3/\mu\text{L}$ with left shift. Renal and liver parameters were normal. C-reactive protein level was 130 mg/L, and erythrocyte sedimentation rate was 85 mm/h. Sputum Gram stain and culture and blood cultures revealed no growth. Chest radiograph at admission revealed right lower zone air space opacities (Fig 1). Similar chest radiograph findings were seen in two outpatient visits over the previous 3 months.

The patient was admitted with a presumed diagnosis of nonresolving community-acquired pneumonia and was started empirically on parenteral ceftriaxone 2 g once daily with azithromycin 500 mg once daily, resulting in improvement of fever after 2 days, although cough

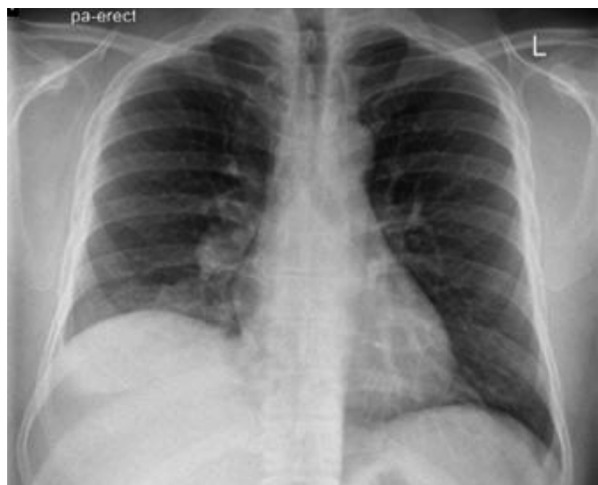


Figure 1 – Airspace opacity in right lower zone.

persisted. Sputum smear and culture were negative for acid-fast bacilli. A CT scan of the chest revealed an endobronchial lesion in the right lower lobe bronchus with consolidation of the right lower lobe and right hilar lymphadenopathy (Fig 2). Bronchoscopy revealed a globular endobronchial lesion obstructing the right lower lobe bronchus (Fig 3). Gram stain results of BAL

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AFFILIATIONS: From Hamad General Hospital - Pulmonary, Doha, Qatar.
CORRESPONDENCE TO: Merlin Thomas, MD, Hamad General Hospital - Pulmonary, Doha 3050, Qatar; e-mail: mmmts1983@gmail.com

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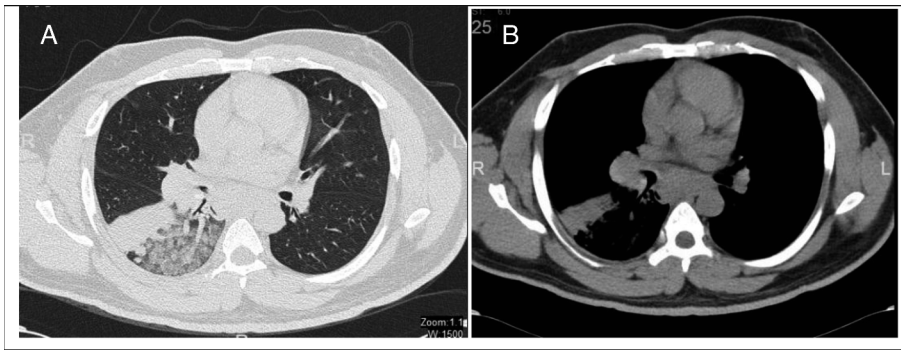
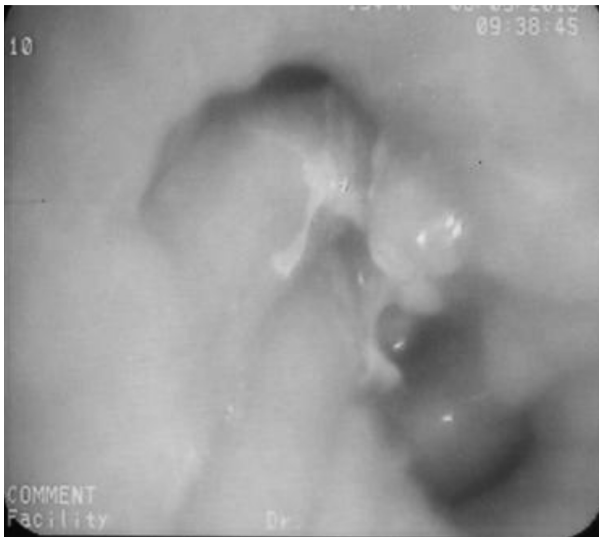


Figure 2 – A, B, Chest CT scan. A, Parenchymal window. Multisegmental consolidation of right lower lobe with obstructing lesion in right lower lobe bronchus. B, Mediastinal window. Globular-shaped dense structure obstructing right lower lobe bronchus with relative enhancement and right hilar lymphadenopathy.



showed profuse polymorphonuclear cells with normal flora, and cultures grew a sensitive strain of *Klebsiella pneumoniae*. Endobronchial biopsy pathology is shown (Fig 4).

What is the diagnosis?

Figure 3 – Bronchoscopy image. Multiple glistening, globular endobronchial lesions obstructing the right lower lobe bronchus.

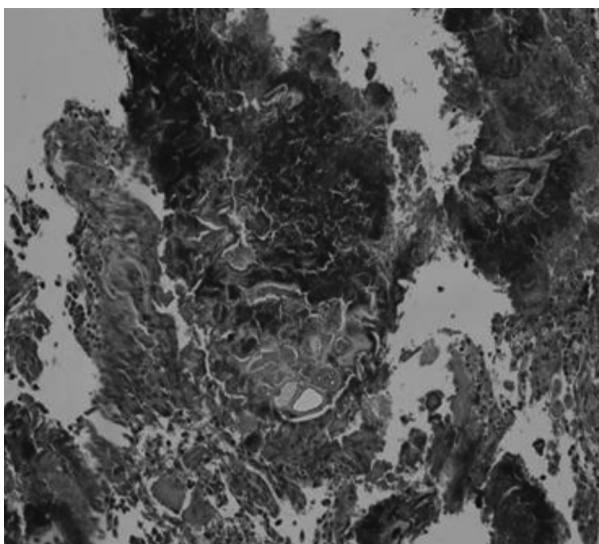


Figure 4 – Endobronchial biopsy specimen. Intense acute inflammation with granulation tissue reaction, inflammatory exudate, amorphous material, and dense collections of filamentous organisms (hematoxylin and eosin, original magnification $\times 400$).

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