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To the editor

A 50-year-old woman with a 2-month history of intermittent cough presented at the respiratory medicine outpatient clinic. She had a long history of obesity, hypertension, and diabetes mellitus. Her vital signs were normal. Physical examination and routine blood tests were unremarkable. However, a simple radiograph showed bilateral perihilar infiltrates and diffuse reticulonodular lesions (Figure 1A). Thoracic high-resolution computed tomography (HRCT) revealed bilateral, scattered ground-glass attenuation with interlobular septal thickening and intralobular lines (i.e., a crazy-paving appearance; Figure 1B). The patient underwent bronchoscopy with bronchoalveolar lavage (BAL) and transbronchial biopsies. Bronchoscopy showed mucosal swelling in both the lungs and BAL fluid revealed a characteristic milky appearance. Histopathological analysis of the biopsy specimen showed characteristic globules of periodic acid-Schiff-positive proteinaceous material. Based on the clinical and characteristic histopathological findings, the patient was diagnosed with having pulmonary alveolar proteinosis. **However, as her symptoms were mild and vital signs were stable, she was kept under close follow-up, with a treatment plan, including whole lung lavage in the progression of disease.** Pulmonary alveolar proteinosis is a rare lung disease characterized by abnormal intra-alveolar accumulation of large amounts of surfactants. Pulmonary alveolar proteinosis is classified into two types, primary (idiopathic) and secondary due to lung infections, myelodysplastic syndromes, leukemia, and inhalation of mineral particles or chemical material, including silica, titanium

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