

A 68-Year-Old Man With Dyspnea on Exertion and Cough



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A 68-year-old man with a history of chronic lymphocytic leukemia well controlled on ibrutinib, hypertension, obesity, and a remote history of smoking (10 pack-years) presented with increasing dyspnea on exertion and cough. He had previously finished two courses of oral antibiotics for his symptoms without significant improvement. On presentation, he had no fevers or sputum production.

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Case Presentation

Physical examination revealed an afebrile, well-nourished male in no acute distress. His blood pressure was 130/80 mm Hg with a pulse of 87 beats/min and an oxygen saturation of 93% on room air at rest. Cardiovascular examination revealed normal cardiac rhythm without murmurs, rubs, or gallops. Bilateral rhonchi were heard on auscultation of the chest. CBC count revealed a WBC count of 8,800 cells/mm³ (lymphocyte count, 3,900 cells/mm³ [ie, 44%]) with hemoglobin of 12.6 g/dL and a normal platelet count. His serum chemistries were unremarkable. A CT scan of the chest showed scattered areas of mucoid impaction and nodularity in all lobes with predominant tree-in-bud opacities in the right upper, middle, and lower lobes (Fig 1). His pulmonary function tests revealed a moderately severe obstructive airway disease with an FEV₁ of 1.14 L,

FVC of 2.20 L, and an FEV₁/FVC ratio of 52% with a diffusing capacity for CO₂ of 63 mL/mm Hg/min (Fig 2).

Given his persistent symptoms, immunocompromised state, and CT scan findings, the patient underwent a diagnostic bronchoscopy with endobronchial and transbronchial biopsies. Diffuse secretions were seen through the entire tracheobronchial tree without any endobronchial lesions. The BAL was negative for malignant cells, and the stains for mycobacterium and pneumocystis were negative. Transbronchial biopsies showed diffuse infiltration by small, atypical lymphocytes in lung parenchyma, which were CD20-, CD79a-, CD5-, and CD23-positive and cyclin D1-negative consistent with a B-cell pattern (Fig 3 and 4). The endobronchial biopsy showed a mild increase in the small lymphocytes in the submucosa.

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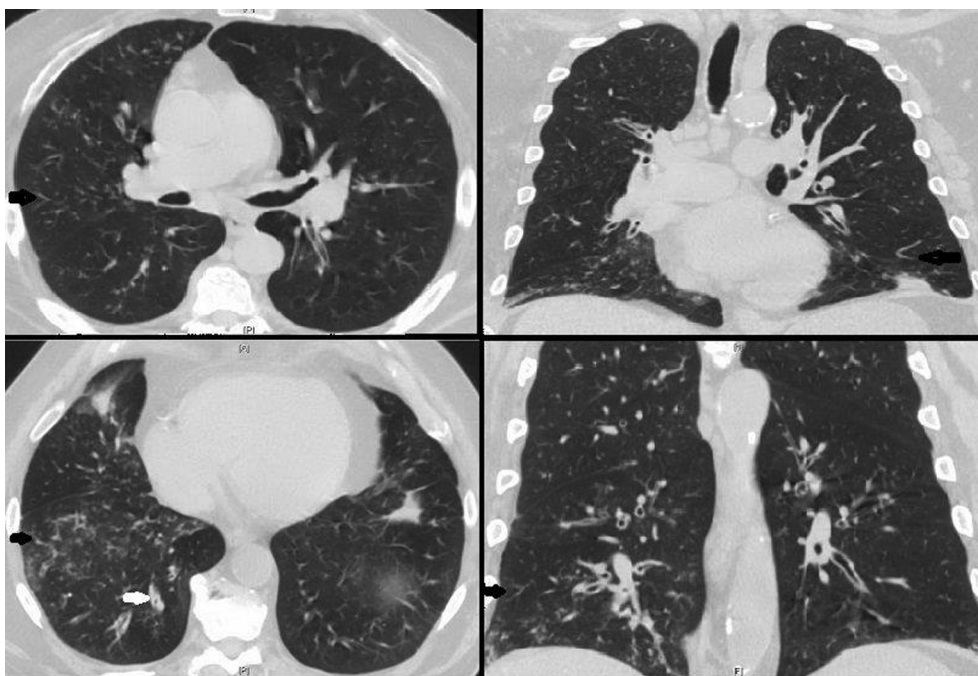


Figure 1 – CT scan of the chest showed scattered areas of mucoid inspissation and narrow airways (white arrow) and nodularity in all lobes with predominant tree-in-bud opacities (black arrows) in the right upper, middle, and lower lobes. The coronal images show some dilated airways.

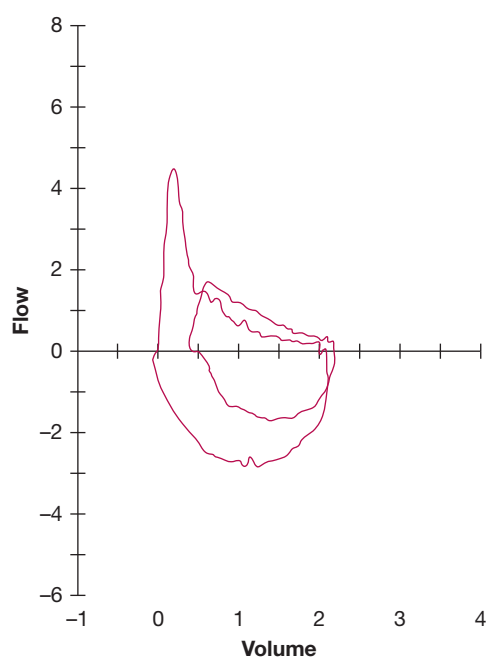


Figure 2 – Flow spirometry demonstrating an obstructive pattern.

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