

A Case of Chronic Cavitary Pulmonary Aspergillosis

Um Caso de Aspergilose Pulmonar Cavitária Crónica

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A 53-year-old man, with a history of poorly-controlled HIV-1 infection diagnosed 15 years ago, who abandoned antiretroviral (ARV) therapy 5 years ago, pulmonary and ganglionic tuberculosis treated 7 years ago and a past history of intravenous drugs abuse, presented to the emergency department with a three months history of dyspnea, cough, hemoptysis, weight loss (63% total body weight) and asthenia.

At admission he was febrile 38°C, normotensive but tachycardic and with peripheric oxygen saturation of 98%. He was cachectic (IMC 15.6 kg/m²) and presented bilateral rhonchi. Blood tests revealed anemia (hemoglobin 11.1 g/dL), thrombocytopenia (platelets 131 x10⁹/L), elevation of C-reactive protein (4.46 mg/dL) and erythrocyte sedimentation rate (80 mm/h). CD4+ cell count was 134/uL and HIV viral load was 9769 copies/mL. Chest radiograph showed a nodule in the right upper lobe (Fig. 1) and computed tomography (CT) thorax scan revealed a mass inside a large cavitation with 40x42 mm and multiple areas of consolidation in the medium lobe and lower lobes (Figs. 2, 3 and 4).

Due to suspicion of *Aspergillus* spp. disease, specific IgG for *Aspergillus fumigatus* and serum galactomannan *Aspergillus* antigen were tested, and the patient was started on voriconazole.

A. fumigatus IgG was positive after 3 days; mycology culture of sputum identified *A. fumigatus* after 15 days. Serum galactomannan *Aspergillus* was also positive. Additionally, *Haemophilus influenzae* was identified on sputum culture, suggesting a superinfection, and ampicillin was initiated. Bacilloscopy, blood and sputum culture in Löwenstein–Jensen medium and aerobic and anaerobic blood cultures were negative. Symptoms improved substantially after initiation of both medications. Aminocaproic acid was needed to control hemoptysis. Patient restarted ARV with tenofovir alafenamide/ emtricitabine + dolutegravir 8 days after admission. He was considered for surgery and was discharged 26 days after admission awaiting procedure. Patient returned to the HIV clinic maintaining adherence to treatment and achieving recovery of CD4+ and undetectable viral load. He was submitted to right superior lobectomy 6 months after discharge and continued voriconazole for 11 months. There was no relapse.

Chronic cavitary pulmonary aspergillosis (CCPA) is the classic form of chronic pulmonary aspergillosis.¹ Radiologically, it typically presents with a cavitary lung lesion with surrounding inflammation, with continued destruction of adjacent lung tissue. Symptoms include cough, chest pain, hemoptysis, dyspnea, weight loss, night sweats and tiredness, and constitutes

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differential diagnosis with tuberculosis.^{1,2} Diagnosis requires 3 conditions: persistent symptoms for 3 months at least, radiological findings compatible with aspergillosis for 3 months at least and direct evidence of *Aspergillus* infection, that can be on culture from biopsy or in the presence of IgG for *Aspergillus*, after exclusion of alternative diagnosis.² A culture from sputum or bronchoalveolar lavage does not contribute to the diagnosis as it may be related to colonization.^{1,2} First line treatment is voriconazole or isitraconazole³ for a minimum of 6 months in patients with local and systemic symptoms or with progressive loss of lung function. Lung resection should be considerate, especially in patients with hemoptysis.^{2,4} Without treatment, mortality rate is higher than 50% within the first year, however with prompt treatment, prognosis improves significantly.⁵



Figure 1. Nodule in upper right lobe on thorax radiography

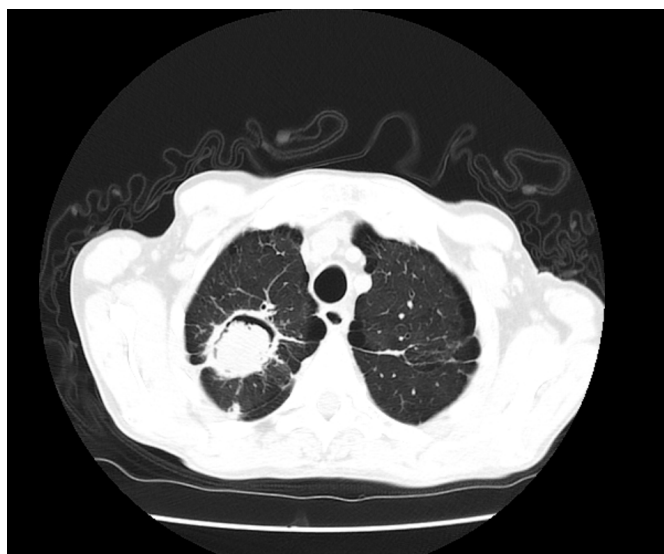


Figure 2. A mass (mycetoma) inside a cavity in coronal plane on CT thorax scan



Figure 3. A mass (mycetoma) inside a cavity in sagittal plane on CT thorax scan



Figure 4. A mass (mycetoma) inside a cavity in axial plane on CT thorax scan

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