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Chronic cavitating pulmonary aspergillosis with lung abscess

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DESCRIPTION

This is a case of chronic cavitating pulmonary aspergillosis complicated by bacterial infection in a 71-year-old gentleman. He had a history of chronic obstructive pulmonary disease (COPD; severe, Forced expiratory volume in 1 s=0.94) and was treated with Seretide and Tiotropium. Prior to this illness he had a good functional status. He presented with a 1-month history of progressive shortness of breath. Chest radiograph showed a large well-demarcated cavity in the left upper zone (figure 1). Further investigation by CT showed a large 10×10 cm cavitating lesion in the left upper lobe (figure 2). Bronchoscopy and bronchoalveolar lavage were performed and *Aspergillus fumigans* cultured. He had a positive *Aspergillus* precipitans with a titre of 1 in 16. Cultures for acid fast bacilli were negative (figure 3).

He was successfully treated with a combination of antifungals and antibiotics. The treatment included 13 days of Fungizone 50 mg daily with Piperacillin/Tazobactam

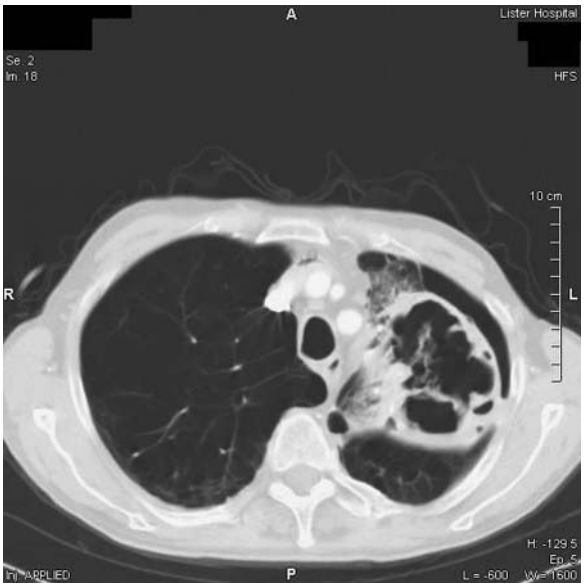

Figure 2 Presenting thorax CT. Demonstrates a cavitating lesion on the left side of the chest measuring 10×10 cm with a thick, irregular wall and internal septations. There was a further smaller lesion in the left lower lobe of 1.2 cm. Supero-laterally to the larger lesion there is a small associated pneumothorax. Note also the general emphysematous change.

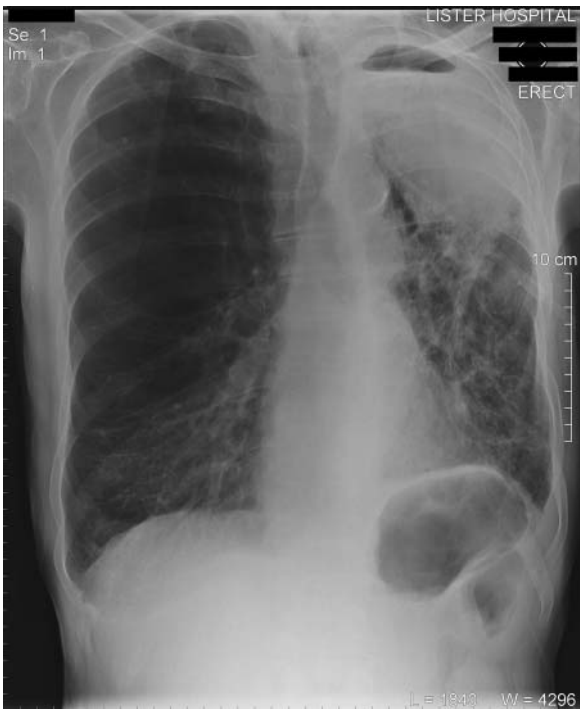

Figure 1 Presenting chest radiograph showing a large fluid-filled cavity in left upper lobe. The lungs are overinflated with emphysematous change in both lung fields.

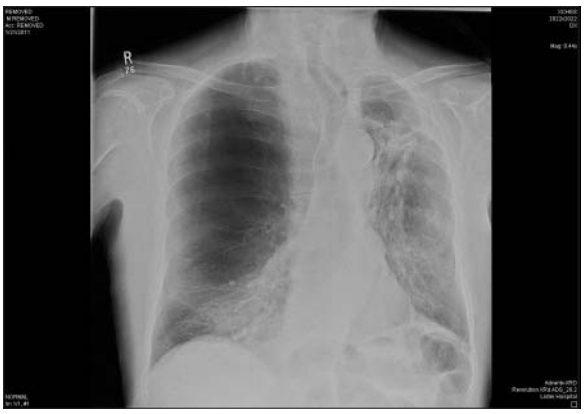

Figure 3 Post-treatment chest radiograph showing persistent cavity. Emphysematous changes in the right upper lobe and fibrotic scarring in the left upper zone.

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initially. There was no clinical improvement and this was changed following microbiological advice to Ambisome 150 mg daily and Meropenem of which he received 22 days in total. Colomycin nebulisers and oral Itraconazole were then started and continued on discharge for 3 months. Treatment duration was guided by clinical recovery and C-reactive protein levels. Two years later, he remains clinically well under outpatient review. A recent chest radiograph demonstrates marked improvement.

COPD is now a recognised risk factor for chronic aspergillosis, and the diagnosis should be considered in all patients who present with an indolent history, previous pulmonary disease and a pulmonary cavity on chest radiograph.[1–3]

Competing interests None.

Patient consent Obtained.

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