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Primary Pulmonary Aspergillosis

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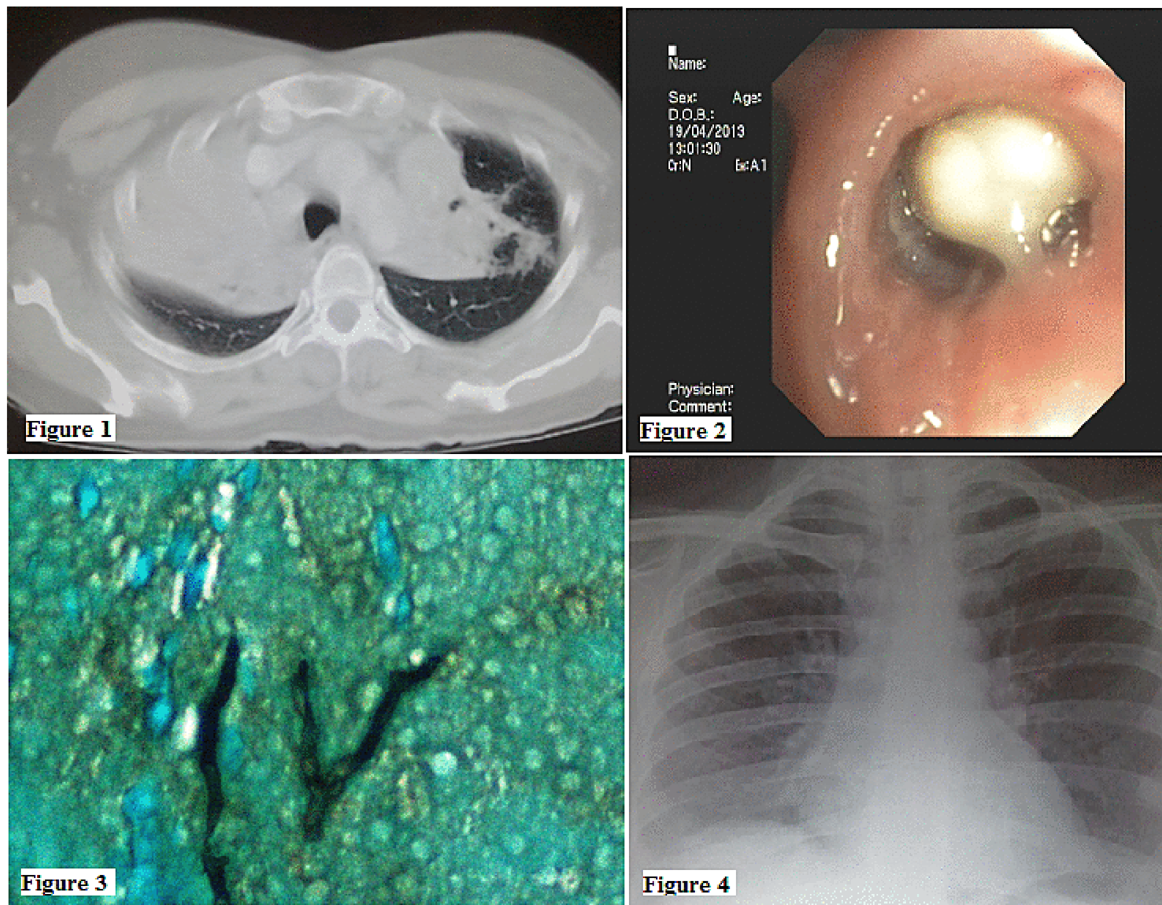
Clinical Image



Elderly immunocomptetent female presented with cough and breathlessness of 3 weeks duration. Physical examination revealed absence of breath sound in both upper lobe areas. Sputum examination was negative for acid fast bacilli (AFB). Chest radiograpgh showed bilateral upper lobe homogenous opaqcity. Contrast enhanced CT (CECT) chest showed complete cut off of right upper lobe bronchus with collapse of both right and left upper lobe. Bilateral upper lobe collapse is uncommon and can be secondary to mucous plugging in ventilated patients. In our case it was due to gelatinous mucous blobs occluding both the upper lobe segmental openings (Figure 1). Bronchoscopy image showing gelatinous mucous blob occluding right upper lobe. These blobs could be dislodged during bronchoscopic suction and there was an associated mucosal inflammation. Golden gelatinous blobs are quite typical of mycotic infections in the airways. This was confirmed by the bronchial lavage cytology sample which was suggestive of aspergillus by special staining and morphology. Bronchoscopy was also therapeutic as gelatinous blobs could be sucked out and collapsed lobe expanded (Figure 2). Periodic acid Schiff (PAS) stain for fungus from bronchial lavage showed occasional fungal hyphae and Gomori Methenamine Silver (GMS) staining showed septate fungal hyphae with acute branching suggestive of Aspergillus sps (Figure 3). Chest X-ray on follow up after one month showed drastic resolution of lung lesions after the patient underwent bronchoscopic suction and was also given a course of anti -fungal agent mycamine which is an ecchinocandin for 2 weeks followed by oral itracanazole for 4 weeks. Both the upper lobe collapse had resolved and upper lobes were re-aerated (Figure 4).