

Fungal bronchitis or allergic bronchopulmonary aspergillosis . . . that is the question

Inderpaul Singh Sehgal¹, Valliappan Muthu¹ and Ritesh Agarwal¹ 

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We read with interest the study by Ozyigit et al. wherein the authors describe fungal bronchitis as a distinct clinical entity that responds to antifungal therapy.¹ The authors define “bronchitis” based on persistent productive cough and exacerbation of underlying airway disease. The same definition is also applicable to bronchiectasis, a widely recognized entity. Notably, 24 of the 31 study participants had bronchiectasis, which explains the symptoms attributed to “bronchitis”. Further, the mean serum *Aspergillus fumigatus*-specific IgE, *A. fumigatus*-specific IgG levels, and total IgE were 19.4 KUA/L, 54.3 mg/L, and 2.121 U/L, respectively, in the study population. The majority of the subjects in the study had asthma as their underlying airway disease. The constellation of asthma, elevated serum total IgE, *A. fumigatus*-specific IgE, and IgG, and bronchiectasis is consistent with allergic bronchopulmonary aspergillosis (ABPA). It would be interesting to know what proportion of patients in the current study satisfied the International Society for Human and Animal Mycology (ISHAM) ABPA-working group criteria for diagnosing ABPA.² Two different randomized controlled trials have demonstrated that oral triazoles are beneficial in treating ABPA.^{3,4} It is therefore not surprising that patients with “fungal bronchitis” responded to azoles in the current study.

Author contributions

ISS, VM, and RA involved in initial drafting, and correction of the manuscript.


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ORCID iD

Ritesh Agarwal  <https://orcid.org/0000-0003-2547-7668>

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¹ Department of Pulmonary Medicine, Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh, India

Corresponding author:

Ritesh Agarwal, Department of Pulmonary Medicine, Postgraduate Institute of Medical Education and Research (PGIMER), Sector-12, Chandigarh 160012, India.
Email: agarwal.ritesh@outlook.in



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