

What potentially treatable opportunistic mould could be the cause of the patients' breathlessness?

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A 50-year-old male with advanced HIV infection and previously treated pulmonary tuberculosis (TB) presented to hospital with a nine-month history of constitutional symptoms, non-productive cough, and worsening dyspnea. Multiple sputa samples over the preceding nine months were culture-negative for TB.

A chest radiograph revealed an ill-defined opacity in the right upper lobe with associated pleural thickening (Fig. 1). Computer-tomography chest imaging demonstrated a cavity in the right upper lobe with associated intracavitary lesions (Fig. 2). The clinical history and radiological findings were consistent with a diagnosis of chronic cavitary pulmonary aspergillosis (CCPA).^[1] Blood serology and a fungal culture of sputa confirmed both exposure and active growth of *Aspergillus fumigatus*.

After an initial two-week regimen of intravenous *Amphotericin B* the patient was commenced on long-term oral voriconazole therapy.

At a six-week follow up, he reported significant resolution of his constitutional symptoms and radiological improvement was seen on a repeat chest radiograph. Close clinical follow up is planned.

1. Denning DW, Cadranel J, Beigelman-Aubry C. Chronic pulmonary aspergillosis: rationale and clinical guidelines for diagnosis and management. *European Respiratory J* 2015;47(1):45-68. <https://doi.org/10.1183/13993003.00583-2015>.

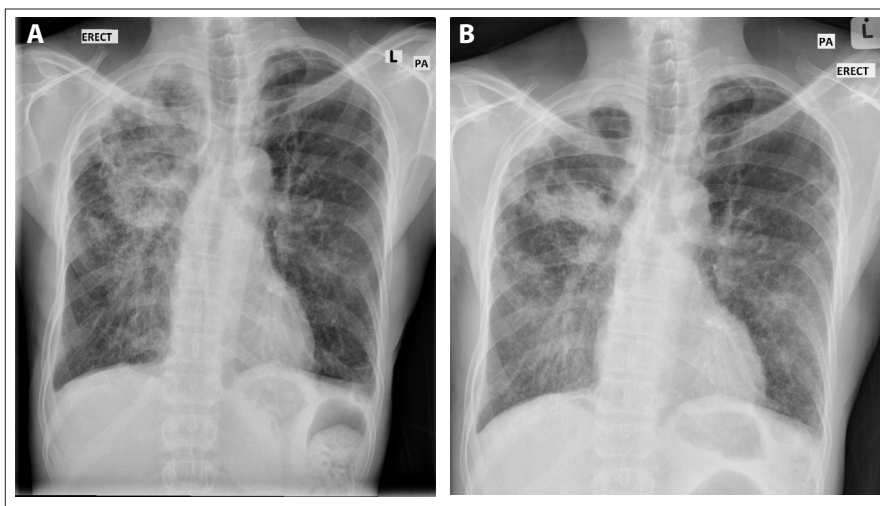


Fig. 1 (A). Chest radiograph on admission to hospital and (B) Follow-up imaging after six weeks of voriconazole therapy.



Fig. 2. Computer-tomography chest imaging demonstrating a cavity in the right upper lobe with associated intra-cavity lesion.