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Clinical Images

Mass like lesions disappearing with treatment in a young patient

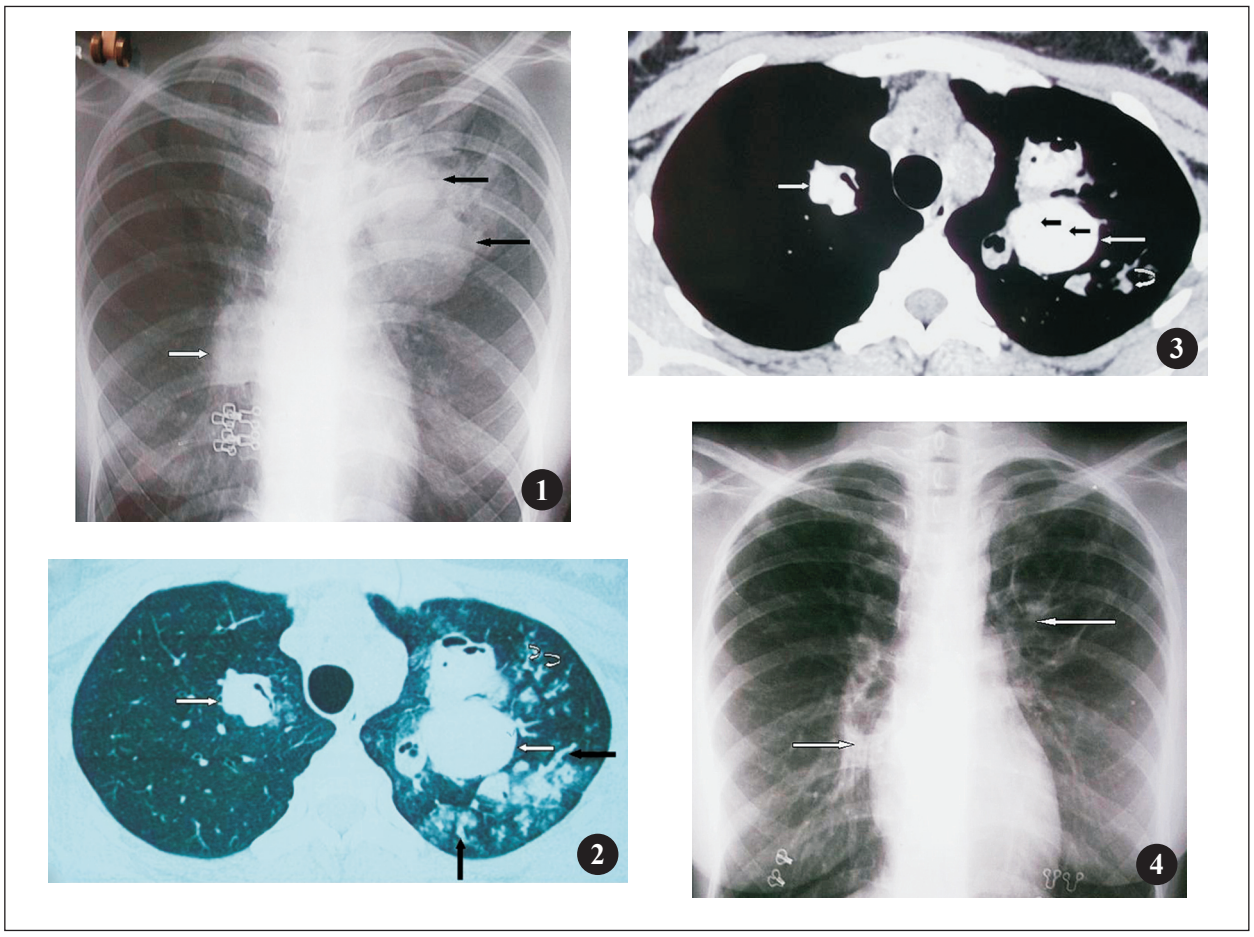

Fig. 1. Chest radiograph (postero-anterior view) showing superimposed mass like lesions in the left upper and mid zones (black arrows) and smaller mass lesion in the right hilar area (white arrow). **Fig. 2.** High resolution cuts at contrast enhanced chest tomography showing saccular (white arrows) to varicose (black arrows) central bronchiectasis, with the surrounding lung showing air spaces with nodules with tree in bud appearance (curved arrows) suggestive of transbronchial spread of infection. **Fig. 3.** Non contrast chest tomography showing saccular (white arrows) to varicose (curved arrows) central bronchiectasis with hyperattenuating mucus (black arrow). **Fig. 4.** Chest radiograph (postero-anterior view) after three months of treatment revealing near complete resolution of mass like lesions (white arrows).

A 20 year old female patient presented to the Pulmonary Medicine department, Government Medical College, Chandigarh, India, in December, 2013 with breathlessness, cough with expectoration, and scanty haemoptysis since six preceding weeks. There was no history of tuberculosis or asthma. Chest radiograph showed mass lesions in left upper and mid zones with right hilar prominence (Fig. 1). Mantoux test, sputum for acid fast bacilli and malignant cytology were negative.

Contrast enhanced computed tomography (CECT) chest with high resolution cuts revealed multiple nodular and mass like opacities with cavitary changes and hyperattenuation, mediastinal lymphadenopathy and central bronchiectasis (Figs 2 and 3). Bronchoscopy was normal. CT guided fine needle aspiration cytology (FNAC) revealed no evidence of malignancy. Reviewing patient's CECT findings and blood eosinophilia, she was investigated for allergic broncho-pulmonary aspergillosis (ABPA). There was immediate cutaneous hyper-reactivity on *Aspergillus* skin test. Total and specific IgE levels for *Aspergillus fumigatus* were raised (11853 IU/ml and 6.79 kUA/l, respectively). Spirometery showed mild obstruction with little reversibility.

Diagnosis of ABPA as per Rosenberg Patterson criteria[1,2] was made. The patient's condition improved on treatment with oral corticosteroids and itraconazole. Chest radiograph after three months revealed marked resolution (Fig. 4). Total IgE levels were reduced. Rapid resolution of mass lesions following treatment of ABPA emphasizes on consideration of non malignant aetiologies as differentials of mass lesions in young patients. It also highlights a rare radiographic presentation of ABPA *i.e.* mass lesions even in patients with no asthmatic history.

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