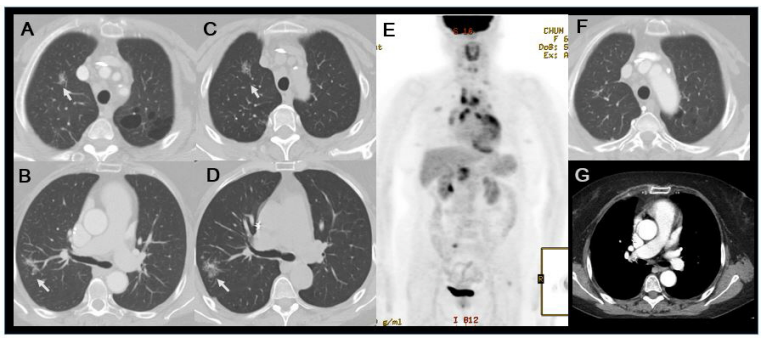
■ Sun-249 ■

A case with sarcoidosis mimicking advanced malignancy: A missed clue from past history of uveitis

경북대학교병원 내과

*권희원, 차승익, 김창호, 이재희

Sarcoidosis, an idiopathic systemic inflammatory granulomatous disorder, can involve any organ. Multiple organs can be affected serially or simultaneously and the lung is the most commonly affected site. However, when presenting unusual single site involvement in its early stages, diagnosis of sarcoidosis can be challenging. In addition, isolated pulmonary nodular lesion, a rare radiologic finding, makes diagnosis more difficult. Here, we report a case with sarcoidosis suspected to be advanced malignancy in a patient with previous history of bilateral uveitis and complete atrioventricular (AV) block of uncertain cause. A 64-year-old female was presented with incidentally found pulmonary nodular lesions in chest computed tomography (CT) scan. She lost her sight due to bilateral uveitis of unknown cause 20 years ago and underwent pacemaker insertion due to complete AV block 10 years ago. In August 2016, nodular opacity on right upper lung field was newly found in chest x-ray. Chest CT revealed two part solid nodules, measuring 1cm and 2.7cm, on right upper lobe (Fig. A and B). The nodules showed slow interval growth in follow-up chest CT taken after 15 months, suggesting malignancy (Fig. C and D). Positron emission tomography scan showed abnormal hypermetabolism in the lung nodules and in left supraclavicular, mediastinal, hilar, and periportal lymph-nodes (LNs) and sacrum (Fig. E). Fine needle aspiration for left supraclavicular LN was non-diagnostic. Thoracoscopic wedge resection for a larger lung nodule was performed and confirmed non-caseating granuloma without evidence of other granulomatous disease. She was diagnosed with sarcoidosis with multi-organ involvement. Also, her previous uveitis and AV block of unknown cause were presumed to be due to sarcoidosis. She was treated with corticosteroids and radiologic improvement was found in follow-up chest CT (Fig. F and G). This case shows that atypical imaging finding such as isolated pulmonary nodule may result in unlikely suspicion of sarcoidosis, eventually making diagnosis difficult. It should be reminded that previous history of uveitis or AV block may provide useful clue in this difficult situation.



■ Sun-250 ■

Fatal invasive aspergillosis by A. niger in liver cirrhosis patient

순천향대학교 서울병원

*김명, 어수택, 김기업, 구소미, 이보영

Background: Aspergillus species are ubiquitous in the environment. However, it can be an important cause of infection in immunocompromised patients leading to high morbidity and mortality. Aspergillus fumigatus is most common cause of invasive aspergillosis followed by A. fluvus. Here, we report a case of fatal invasive pulmonary aspergillosis by A. niger in a patient with liver cirrhosis. **Case report:** A 54 year-old man presented with 2 days of general weakness and confusion. He had liver cirrhosis with hepatitis C. Methicillin-susceptible Staphylococcus aureus was identified from blood culture. As no definite cause for bacteremia was found, he was given nafcillin. After a week, chest x-ray showed signs of pneumonia. Chest CT scan showed round peripheral ground glass opacity, and suspicious mucus plug at right central bronchus . Cefotaxime and levofloxacin were given. But chest x-ray was aggravated, showing right lower lung consolidation and hypoxia developed. To remove mucus plug shown on CT scan, bronchoscopy was performed. It revealed friable grey to black colored amorphous material covering right bronchus causing obstruction. A. niger was found on fungus culture and biopsy also showed numerous Aspergillus hyphae. As soon as the fungal culture result was reported, voriconazole was started. After 2 days, pneumonia progressed and voriconazole was changed to micafungin. Because of persistent right lung total collapse, bronchoscopic removal of necrotic material was performed. However, pneumonia progressed rapidly to the left side and the patient expired in spite of antifungal treatment. **Consideration:** Invasive aspergillosis is one of the major causes of morbidity and mortality in immunocompromised patients. According to IDSA guideline, those patients at risk of invasive aspergillosis are defined as those with prolonged neutropenia, allogeneic HSCT recipients, SOT recipients, patients receiving corticosteroids, those with advanced AIDS and those with chronic granulomatous disease. But as in this case, liver cirrhosis could also be regarded as immunodeficient and be cautious for fungal infection.