



Thoracostomy showing pleural aspergillosis

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A 48-year-old man with no immunosuppression presented with community-acquired pneumonia caused by *Streptococcus pneumoniae* and influenza B virus, requiring orotracheal intubation. A pneumothorax occurred 5 days later, requiring placement of a drainage tube. A CT scan suggested necrotising pneumonia, and due to a persistent leak of the drainage tube, we did a lower left lobectomy with pleural decortication. The patient was discharged, but 14 weeks after surgery, he sought medical advice because of a persistent cough. A bronchoscopy was performed with evidence of bronchopleural fistula. We did a thoracostomy to correct the fistula. However, surgery revealed the presence of white growing structures and cloudy white sheets over the entire pleural cavity, suggesting fungal infection (figure). Microbiological cultures confirmed the growth of *Aspergillus fumigatus*. The patient was treated for 2 weeks with systemic isavuconazonium sulfate (200 mg once a day, after a loading dose of 200 mg every 8 h for six doses) and anidulafungin (100 mg once a day after a loading dose of 200 mg), and topical liposomal amphotericin B (100 mg once a day). His treatment was then switched to isavuconazonium sulfate (200 mg once a day) and topical amphotericin B (100 mg once a day) for 36 weeks. At last follow-up, the patient was asymptomatic. Pleural aspergillosis is extremely rare, especially in immunocompetent patients, and knowledge about its management is scarce. In this case, we believe that *A fumigatus* colonisation of the pleural cavity was secondary to surgery or, most likely, to the bronchopleural fistula.

Contributors

All authors treated the patient, and wrote and revised the paper.

Declaration of interests

We declare no competing interests.

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Figure: Surgical site showing white growing hyphae (green arrows) and white covering of the pleural cavity (red arrows) suggesting fungal infiltration

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