RHEUMATOID-LIKE PRESENTATION OF PULMONAR ASPERGILLOSIS

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BACKGROUND

Aspergillosis is a disease caused by the *Aspergillus fungus*, which can cause infection in primarily immunocompromised hosts and in individuals with underlying lung disease and may present with articular symptoms. The investigation must always be carried out in patients with great clinical suspicion and in normal hosts. The mere presence of *Aspergillus* spp. does not necessarily indicate an acute infection; however, in the immunocompromised host, the discovery of the fungus should prompt the physician to treat it as an acute infection.

CASE REPORT

AMV, 64 years old, woman, recently diagnosed with rheumatoid arthritis, using methotrexate, hydroxychloroquine, prednisone for a week, came to the rheumatology service due to wrist pain for about 2 months with edema of metacarpophalangeal and proximal interphalangeal joints, associated with morning stiffness for approximately 40 min in addition to fatigue. Past medical history of hypothyroidism, tuberculosis at age of 7, asthma since childhood in regular follow up with a pulmonologist and intermittent use of oral corticosteroids, with recent worsening of "attacks", with more frequent cough. She denied fever or weight loss. She was a former smoker (1–1.5 pack/day for 20 years; quit 10 years ago). Clinical evaluation showed reduction of the lung murmur on its bases as well as arthritis on the wrists, 2nd left metacarpophalangeal joint, 4th proximal interphalangeal joints bilaterally. Laboratory evaluation showed Hb 12, Hc 35, white blood cell 12,400, platelets 433,000, ESR 82, CRP 17, polyclonal hypergammaglobulinemia 18%, SSB-Ro, SSB-La, anti SM, anti RNP, anti-Jo-1, RF, ANTI-CCP nonreactive and ANA 1:80 with discrete nuclear dots. Chest CT showed bilateral apical pleural thickening; foci of consolidation with air bronchogram in the right middle lobe and bilateral basal ground-glass attenuation. Methotrexate was suspended and 10 mg of prednisone was maintained. Galactomannan in BAL was positive as well as positive culture for *Aspergillus* spp. Itraconazole was started and prednisone reduced to 5 mg/day. The patient had good response to treatment, showing significant improvement in weakness and joint complaints. The patient never had eosinophilia or increased IgE and the joint symptoms disappeared after the mycosis treatment. We assume that it was secondary to the pulmonary infection and that she was immunosuppressed by the courses of intermittent corticosteroids that were taken for her asthma.

CONCLUSION

It is always important to consider differential diagnoses in patients with symptoms suggestive of rheumatoid arthritis, especially in chronic corticosteroid users with high risk for infections.

KEYWORDS

Aspergillosis, Rheumatoid arthritis, Lung, Infection, Fungal.