

Case	(718) A not so uncommon cause of dysnea: iatrogenic hypersensitivity pneumonitis.
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CASE PRESENTATION

A 40 years old woman was referred to our hospital with severe dysnea. The patient has a history of breast neoplasia treated with Taxol, Trastuzumab and Pertezumab.

A chest radiograph and lung CT is requested to the Radiodiagnostic service with a urgent character to rule out TEP. In the study carried out, no defects of replection were seen in pulmonary, lobar or segmental arteries suggestive of TEP.

The pulmonary parenchyma present poorly defined centrilobular opacities "in ground glass" less than 5mm throughout both upper lobes. No pleural effusion.

DISCUSSION

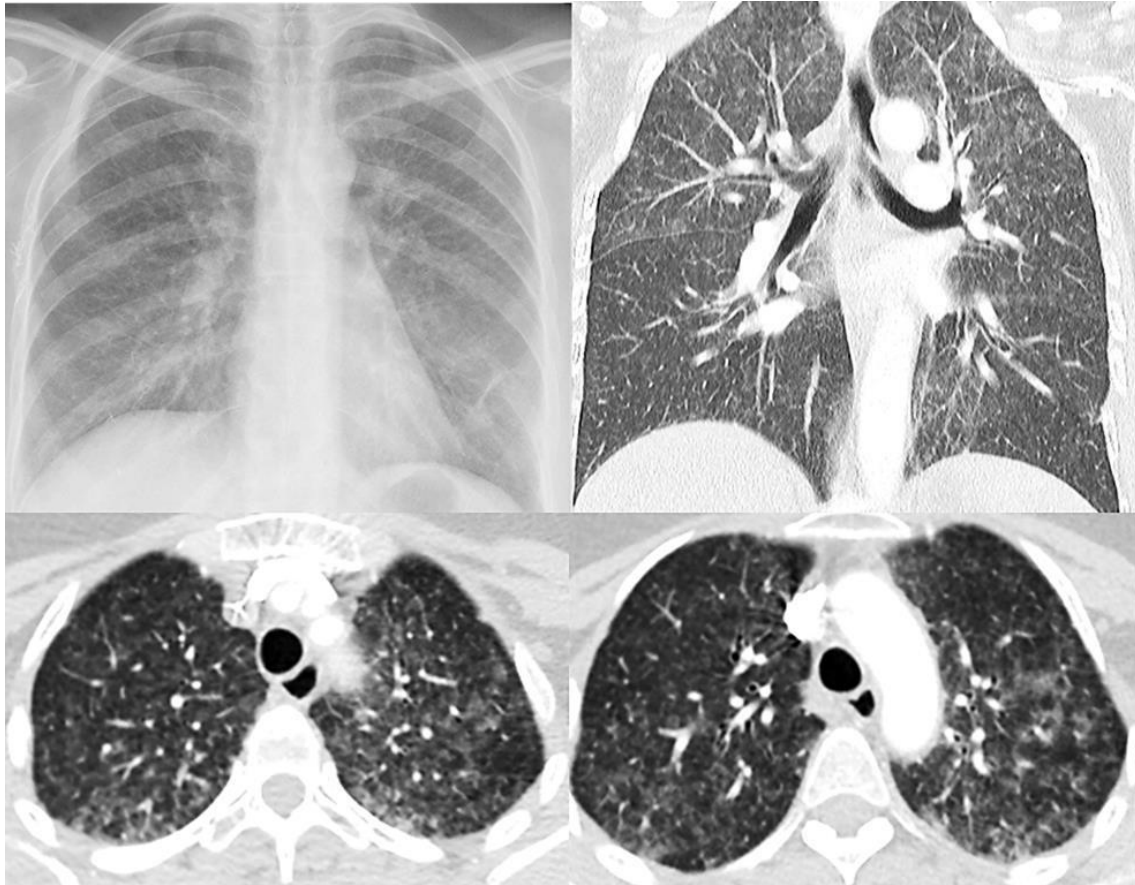
The radiological findings are compatible with hypersensitivity pneumonitis in subacute phase.

The typical high resolution CT abnormalities in hypersensitivity pneumonitis of acute onset without fibrosis include diffuse ground-glass opacification or more rarely, as consolidation, centrilobular ground-glass opacities and air trapping .The combination of patchy groun-glass opacities, normal regions, and air trapping is often referred to as the headcheese sign.

The diferential diagnosis includes: infectious bronchiolitis (airway spread of tuberculosis and non tuberculous mycobacterial infection, airway invasive aspergillosis), respiratory bronchiolitis- interstitial lung disease, NSIP, desquamative interstitial pneumonitis, acute eosinophilic pneumonia, viral infection and Pneumocystis jiroveci infection.

CONCLUSION

Drug-induced lung injury is a not uncommmon cause of acute and subacute dysnea. The prevalence of pulmonary toxicity is increasing with the introduction of new chemotherapy drugs. Hypersensitivity Pneumonitis requires prompt diagnosis because is crucial as it is a reversible condition when diagnosed early.



BIBLIOGRAPHY

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