

LETTERS TO THE EDITOR

Idiopathic Bronchocentric Granulomatosis

To the Editor: Bronchocentric granulomatosis is considered to be a histopathologic process that generally occurs as a nonspecific response to respiratory-tree lesions. Approximately half of all cases are associated with asthma and allergic bronchopulmonary aspergillosis.¹ Occasionally, however, there is no evidence of any disease which might give rise to this process.

We present the case of a 49-year-old woman with a history of uterine myoma, who had undergone bilateral mammoplasty 4 years before admission to our hospital. She was an ex-smoker of 15 cigarettes per day but had stopped smoking 6 months earlier. The patient was admitted because a chest x-ray during a preoperative examination prior to a uterine myomectomy revealed a solitary pulmonary nodule approximately 2 cm in diameter. The patient had no respiratory symptoms and the physical examination revealed no abnormal findings. Laboratory tests also showed no abnormalities and the chest x-ray confirmed the aforementioned lung nodule, possibly located in the lingula. A computed tomography (CT) scan showed the nodule to be approximately 2 cm in diameter, cavitated, and in close contact with the chest wall (Figure). Bronchoscopy results were normal and revealed no malignancy. CT-guided fine-needle aspiration was then performed and the cytology and microbiology results were also negative. Lung function test results and arterial blood gases were normal. It was decided to perform a left posterolateral thoracotomy with resection of the affected segment. The pathologic examination of the excised nodule revealed bronchocentric granulomatosis with intense lymphoid and eosinophilic infiltrates and no appreciable vasculitis; several types of stain (Ziehl, pararosanilic acid, and methenamine silver) and various immune histochemical techniques were performed but yielded no relevant findings.

Since Liebow described bronchocentric granulomatosis in 1973,² various etiological agents have been found to be related to this process. They include asthma, bronchopulmonary aspergillosis,³ bronchogenic carcinoma,⁴ granulomatous diseases, and infections due to bacteria, viruses, or parasites. The literature, however, includes cases where none of these supposed causes is identified,⁵ as was the case for our patient. Bronchocentric granulomatosis can therefore also be considered to be an idiopathic process. This leads us to consider the possibility of individual susceptibility that causes patients to react in this way in the event of stimuli (infectious, tumorous, or immunological), some of which are still unknown.

Though infrequent, bronchopulmonary aspergillosis is included in the differential diagnosis of the solitary nodule. The presence of cavitation,⁶ as shown in this case, does not preclude this diagnosis, although the first suspected diagnosis should be infectious or tumorous disease.

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Figure. Subpleural nodule in the left upper lobe with evident cavitation inside the nodule.