Arch Bronconeumol. 2020;56(5):324

Sociedad Española de Neumología y Cirugía Torácica SEPAR

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Clinical Image

Crohn's disease with severe lung involvement☆

Enfermedad de Crohn con afectación pulmonar grave

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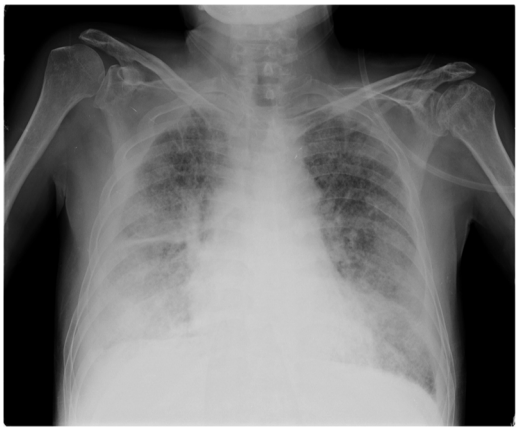

Figure 1. Anteroposterior chest X-ray. Bilateral pleural effusion, greater in the right hemithorax, extending into the fissure. Bilateral micronodular involvement. Ill-defined bibasal opacities in lower lung fields, predominantly in the right side.

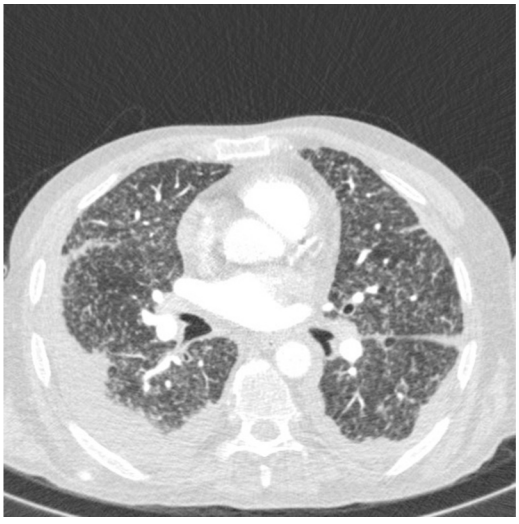

Figure 2. High resolution CT scan of the chest. After ruling out infectious etiologies, the findings were determined to be consistent with Crohn's disease.

We report the case of a 63-year-old man with severe Crohn's disease (CD) (A3L3B1-3) treated with mesalazine, deflazacort, calcium, and vitamin D, who presented with dyspnea and fever. Chest radiograph (Fig. 1) revealed pleural effusion with bilateral micronodular involvement. Chest computed tomography (CT) (Fig. 2) showed fibro-cicatricial septal thickening, patchy mosaic attenuation pattern, micronodular involvement, and hilar-mediastinal lymphadenopathies.

A study was conducted to determine infectious etiology: blood cultures, sputum cultures, bronchoalveolar lavage, and bronchial aspirate were sterile. ACE, Quantiferon®, and other immunological tests were normal. Using fiberoptic bronchoscopy, biopsies of lung parenchyma were obtained, showing microabscesses[1] free of tuberculoid and sarcoidal granulomas, consistent with pulmonary involvement of CD.[2] In view of the pathological findings and clinical progress, along with inflammatory bowel disease (IBD),[1] a diagnosis of CD with extraintestinal lung involvement was given.

Pulmonary involvement in IBD is a rare manifestation[3] that can compromise the pulmonary parenchyma, pleura, and/or the bronchial tree. Clinical presentation can be non-specific and mimic other lung diseases.

This case highlights the existence of pulmonary manifestations in IBD.[4] Knowledge of this entity helps towards early diagnosis and treatment, and these lesions respond well to therapy with corticosteroids.

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☆ Please cite this article as: Álvarez Troncoso J, Ramos Ruperto L, Robles Marhuenda Á. Enfermedad de Crohn con afectación pulmonar grave. Arch Bronconeumol. 2020;56:324.

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