A 59-year-old woman, never smoker, presented with complaints of dry cough, breathlessness and right-sided pleuritic chest pain for past 2 months. She had a history of oral corticosteroid intake for 5 years for undiagnosed rheumatological condition. She had no other co-morbidities and tested negative for HIV serology. Her physical examination was unremarkable. Complete blood counts, ECG, urine analyses and renal as well as hepatic functions were also within normal limits. The chest radiograph posterior-anterior view showed inhomogeneous opacities in right mid zone peripherally (Figure 1). Contrast enhanced computed tomography (CECT) of the thorax revealed areas of patchy consolidation in right upper lobe along with pleural involvement but without pleural effusion (Figures 2 A, B). Mantoux test with 1 TU failed to elicit any induration or erythema. CT-guided transthoracic biopsy was done from this peripherally located lesion, which on histopathology, showed features consistent with cryptococcosis (Figures 3 A, B, C). Subsequently, cryptococcal antigen was detected in serum. MRI brain and spine did not show any CNS involvement by cryptococcosis. Finally, a diagnosis of pleuro-pulmonary cryptococcosis was made on the basis of 1) histopathological findings and 2) detection of cryptococcal antigen in serum. The patient was started on oral fluconazole 200 mg twice a day and that led to significant clinical improvement in 2 weeks.

Pulmonary cryptococcosis is an uncommon form of cryptococcosis occurring predominantly in immunocompromised patients. Radiological manifestations mainly include pulmonary nodules, mass lesions, cavitation and consolidation. However, pleural involvement by cryptococcosis is further rarer and is usually accompanied by pleural effusion. In a recent retrospective study to evaluate thoracic CT findings in patients with pulmonary cryptococcosis, it was observed that pulmonary nodules / masses were the most common manifestation (65/72 patients, 90.3%). On the other hand, pleural involvement in the form of pleural effusion was seen in only 8/72 (11.1%) patients. However, pleural involvement without pleural effusion has been documented only once previously in a 50-year-old female from Japan who presented with multiple left pleural nodules. In our patient too, pulmonary and pleural cryptococcosis occurred but without pleural effusion, making it a rarely observed clinical entity. A high index of suspicion is therefore required to diagnose cryptococcosis in such places where prevalence of pulmonary tuberculosis far exceeds the occurrence of cryptococcosis.

References

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