Pulmonary aspergillosis caused by Aspergillus flavus

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Bronchopulmonary aspergillosis is usually caused by Aspergillus fumigatus. The six cases from the Sudan reported here were due to Aspergillus flavus. Three of the patients had primary invasive disease, one had Aspergillus mycetoma in a pre-existing lung cavity, and two had allergic aspergillosis. A special feature of the invasive disease was the clinical and radiographic simulation of malignancy, particularly in one patient who had multiple disseminated nodules of fungal granulomata in the skin of the lower abdomen.

Fungi of the genus Aspergillus are filamentous organisms that produce airborne spores and have a wide distribution as saprophytes in nature. Occasionally they become pathogenic to man and cause a variety of lesions, the most important of which is pulmonary disease. The latter appears in well-recognized clinical forms for which several classifications have been suggested (Gowing and Hamlin, 1960; Campbell and Clayton, 1964; Kennedy, Malone, and Blyth, 1970). Another type of aspergillosis is that affecting the paranasal sinuses, a rare condition elsewhere but not uncommon in the Sudan (Sandison, Gentles, Davidson, and Milošev, 1967; Milošev, Mahgoub, Abdel A'al, and El Hassan, 1969).

This paper describes the clinical types of pulmonary aspergillosis in the Sudan where, like the paranasal form, it is caused by Aspergillus flavus and not A. fumigatus, which is the commoner pathogen in many other parts of the world.

<table>
<thead>
<tr>
<th>Case</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td>50</td>
<td>50</td>
<td>45</td>
<td>45</td>
<td>50</td>
<td>27</td>
</tr>
<tr>
<td>Sex</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>Occupation</td>
<td>Farmer</td>
<td>Merchant</td>
<td>Farmer</td>
<td>Engineer</td>
<td>Farmer</td>
<td>Housewife</td>
</tr>
<tr>
<td>Presenting symptoms</td>
<td>Cough, sputum and haemoptysis. Loss of weight</td>
<td>Cough and breathlessness. Skin nodules over lower abdomen. Loss of weight X-ray not available</td>
<td>Cough</td>
<td>Cough, fever and breathlessness for 2 mth. History of asthma 1 yr</td>
<td>Cough</td>
<td>Cough and breathlessness; greenish and sometimes bloody sputum; fever</td>
</tr>
<tr>
<td>Radiography</td>
<td>Opacity in left lower lobe suggestive of neoplasm</td>
<td>Opacity in left lower lobe</td>
<td>Mottled appearance all over lung fields</td>
<td>Mottled appearance all over lung fields</td>
<td>Mottled appearance all over lung fields</td>
<td>Dense opacity at both bases; more near R. hilum. Smaller opacities in R. subclavicular region</td>
</tr>
<tr>
<td>Sputum culture</td>
<td>β-haemolytic streptococcus</td>
<td>Normal flora</td>
<td>Normal flora</td>
<td>C. albicans</td>
<td>Pneumococcus pneumoniae</td>
<td>Normal</td>
</tr>
<tr>
<td>Blood eosinophilia</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal—1030/mm³</td>
</tr>
<tr>
<td>Precipitations against A. flavus</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Histology</td>
<td>Pulmonary fungal granuloma</td>
<td>Amphotericin B</td>
<td>Aspergillus mycetoma</td>
<td>Excision of fungal mass</td>
<td>Amphotericin B</td>
<td>Ephedrine and phenobarbitone</td>
</tr>
<tr>
<td>Treatment</td>
<td>Lobectomy</td>
<td>Died</td>
<td>Alive and well</td>
<td>Not done</td>
<td>Not done</td>
<td>Died; anaphylactic shock after penicillin injection</td>
</tr>
<tr>
<td>Outcome</td>
<td>Alive and well</td>
<td>Died</td>
<td>Alive and well</td>
<td>Died</td>
<td>Died</td>
<td>Died since 1969.</td>
</tr>
</tbody>
</table>

TABLE
PULMONARY ASPERGILLOSIS: CLINICAL, RADIOGRAPHIC AND LABORATORY DATA
METHODS AND MATERIALS

This study includes six patients who were seen at the Sha'ab Chest Hospital in Khartoum between 1968 and 1971. The available clinical, radiographic, and laboratory data are shown in the Table. Sputum specimens were stained by the Ziehl-Neelsen method and cultured for bacteria and fungi daily for seven days. Blood agar, Lowenstein Jensen medium, and Sabouraud's dextrose agar with chloramphenicol were used. Total, differential white cell, and eosinophil counts were done. The serum from each patient was tested by means of Ouchterlony agar-gel diffusion for precipitins against four strains of A. flavus, A. fumigatus, A. terreus, A. nidulans, and A. niger. Antigens from these fungi were prepared by ultrasonic disruption of a float culture in phosphate-buffered saline and precipitation with acetone (Mahgoub, 1971). Pathological studies were performed on the left lower lobe from case 1, a subcutaneous nodule from case 2, and a resected pulmonary tumour from case 3. Paraffin sections of formalin-fixed tissue were stained with haematoxylin and eosin (H.E.), periodic acid Schiff (PAS), and methenamine silver. No culture was made from these tissues because all specimens were submitted in formalin.

RESULTS

The Table shows a summary of the clinical, radiographic, and laboratory data. All the patients but one were males whose ages were either 45 or 50 years. The single female was 27 years old. Three of the patients were farmers and patient 2 had been a farmer earlier in life. The major symptoms were cough and breathlessness. Haemoptysis occurred in only one patient. Radiographic examination showed either generalized mottling (Fig. 1) or opacities mainly at the lung bases (Fig. 2). Apart from their fungal infection these patients were healthy adults with the exception of patient 3, who had a pre-existing lung cavity. In particular, no patient had evidence of paranasal aspergillosis and none was on steroid or antibiotic therapy. The diagnosis of aspergillosis was established by demonstration of precipitins against A. flavus antigens in all cases, coupled with the presence of fungal hyphae that looked like Aspergillus species in histological sections from cases 1, 2, and 3; and a positive culture of A. flavus from the sputum in case 6.

SEROLOGY Precipitation arcs developed against A. flavus in all cases. No precipitation lines were seen with A. fumigatus, A. terreus, A. nidulans, or A. niger. These positive lines were sharp and more than one line developed with all sera, as Fig. 3 from case 2 shows.

CULTURE Sputum from case 1 yielded a β-haemolytic streptococcus and that from case 4 Candida albicans. From case 5 Pneumococcus pneumoniae was isolated and A. flavus was grown from case 6.
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FIG. 3. Case 2. Gel diffusion plate of serum against Aspergillus antigens:

2070
2800
4839
4841
A. flavus strains
A.F. A. fumigatus
A.N. A. nidulans
S Patient's serum.

PATHOLOGY

CASE 1 (Fig. 4) Arising in the left lower lobe bronchus was an irregular mass of yellowish white tissue measuring 2.7 cm in its greatest diameter. It was firm in consistency and the cut surface was of a homogenous close texture. The lumen of the main lower lobe bronchus was slightly narrowed and the overlying mucosa was apparently intact. The bronchial branches to the apical portion of the lobe were surrounded and stenosed by the mass at their origin, dilated distally, and they contained inspissated mucus. The rest of the lung showed patches of early bronchopneumonia. Histology of the mass showed several granulomata scattered in a dense hyaline fibrous tissue stroma. These granulomata were composed of epithelioid and multinucleated giant cells and in the centre of some there were small microabscesses (Fig. 5). The PAS and silver stains showed septate fungal hyphae which occasionally branched laterally, inside the giant cells, and in the microabscesses (Fig. 6). Focal areas of fibrinoid necrosis but without related fungal elements and with peripheral palisading of histiocytes were also seen. Some arteries showed an inflammatory reaction involving all coats composed

FIG. 4. The cut surface of the left lower lobe showing a tumour-like lesion arising in the wall of the lower lobe bronchus. Note bronchiectasis of branches to the apical segment.

FIG. 5. Section of the lower lobe bronchus showing multiple granulomata adjacent to the bronchial gland. H.E. ×73.
of lymphocytes, histiocytes, and neutrophils but fungal invasion of the vessel wall was not observed (Fig. 7). The inflammatory granulomatous reaction invaded the bronchial cartilage and there were small mucosal ulcers.

**CASE 2** The specimen received was an irregular mass of subcutaneous tissue measuring 1 cm in its greatest diameter. It was unencapsulated and firm in consistency and the cut surface was yellowish white and homogenous. Histopathology showed the same features as in case 1 with the reaction involving the dermis and subcutaneous tissues.

**CASE 3** The surgically removed specimen measured 4 cm in its greatest diameter. It was of a light brown colour and friable. Histopathology showed tangled fungal hyphae with septa and branching. Some of these carried vesicles typical of Aspergillus species.

**DISCUSSION**

The commonest cause of bronchopulmonary aspergillosis is *A. fumigatus* (Hinson, Moon, and Plummer, 1952; Campbell and Clayton, 1964; Landrigan, Wasty, and Nigam, 1968; Ikemoto, Watanabe, and Mori, 1971). Occasionally *A. flavus* is the causal organism (Finegold, Will, and Murray, 1959; Najj, 1959; Carbone, Sabesin, Sidransky, and Frei, 1964). Although *A. flavus* was isolated from one patient only in our series it is reasonable to assume that in all cases infection was due to this fungus as sera from all patients reacted with *A. flavus* antigens and not with any other Aspergillus species. The precipitin test is fairly reliable in the diagnosis of aspergillosis (Longbottom and Pepys, 1964; Walter and Jones, 1968). In cases of primary paranasal aspergilloma reported from the Sudan by Milošev et al. (1969) *A. flavus* was also the sole causative organism. It seems that the role of *A. fumigatus* as a pathogen in other parts of the world is performed by *A. flavus* in the Sudan.

Three types of pulmonary aspergillosis are demonstrated in this series. Cases 1, 2, and 4 are of a primary and invasive nature. There was no other associated disease. Isolation of *C. albicans* from the sputum of case 4 is of no significance because the
precipitation test against *C. albicans* was negative and the agglutination test was of very low titre. Case 3 was a typical aspergillosis mycetoma filling a cavity which was probably tuberculous in nature. Cases 5 and 6 were examples of the allergic type of aspergillosis. Patient 5 had a history of asthma and patient 6 had wheezing sounds over the lungs and a very high eosinophil count.

The clinical features of patients 1 and 2 suggested a carcinoma of the bronchus; the patients presented with cough, haemoptysis, and loss of weight, and in addition patient 2 had multiple skin nodules simulating metastases. Disseminated aspergillosis, with nodules in the skin, was reported previously by Vedder and Schorr (1969).

It is almost certain that the bronchiectasis in case 1 was the effect rather than the cause of the fungal granuloma; the patient had no history of antecedent respiratory disease and the healthy looking but dilated bronchi did not show evidence of bacterial or fungal infection. We believe that the histopathological changes in the first two cases are due to two factors: first, the invasive nature of the fungus and, second, the associated immunological reaction which is suggested by the presence of fibrinoid necrosis and arteritis. The role of fungal metabolites or toxin cannot be excluded.

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**REFERENCES**


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