Two unusual organisms, *Aspergillus terreus* and *Metschnikowia pulcherrima*, associated with the lung disease of ankylosing spondylitis

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Two male patients with ankylosing spondylitis and upper lobe fibrosis and cavitation are described. A pneumonic disease in one was associated with mycological and serological evidence of infection with *Aspergillus terreus* but no other aspergillus species. A large pulmonary mycetoma developed in the second patient and among a number of other fungal isolates was found the yeast *Metschnikowia pulcherrima*. The association of ankylosing spondylitis with bronchopulmonary aspergillosis is considered; *A. terreus* is described for the first time as a human pulmonary pathogen, and the possible pathogenicity of *M. pulcherrima* in the debilitated human subject is discussed.

*Aspergillus fumigatus* is the fungal organism most commonly productive of pulmonary disease in this country, but a number of other Aspergillus species have, from time to time, been recognized as pathogenic to man. *Aspergillus terreus*, however, has infrequently been recorded in human disease and seems rarely, if at all, to have been suspected as a respiratory pathogen. Nor, to our knowledge, has the yeast *Metschnikowia pulcherrima* (previously *Candida pulcherrima*) been implicated in human pulmonary infection.

Two patients are described, each with long-standing ankylosing spondylitis. Pulmonary changes were present in both, characterized by fibrosis and cavitation in the upper lobes. The first patient showed evidence of infection with *A. terreus*. The second developed an *A. fumigatus* mycetoma, and *M. pulcherrima* was isolated from a number of sources.

**CASE REPORTS**

**PATIENT 1** A 54-year-old man was referred because of recent haemoptysis associated with an abnormality on the chest radiograph. He was moderately crippled by ankylosing spondylitis which had been diagnosed at the age of 20. At 26 he received a course of deep x-ray therapy to the spine. He smoked 15 to 20 cigarettes daily and had a morning cough but no breathlessness or wheeze. For four months the cough had been productive of white or yellowish sputum, and two weeks before presentation he noticed a few small spots of blood which recurred on one occasion several days later.

He had a moderate kyphosis and flexion deformity of both hips. Finger clubbing was not present. The chest radiograph showed an opacity in the upper zone of the left lung field and elevation of the left pulmonary hilar shadow. The forced expiratory volume in 1 second was 2.0 litres and the forced vital capacity 2.25 litres. A Heaf test was grade 1 positive, and three specimens of sputum were negative on direct examination and on culture for *Mycobacterium tuberculosis*.

He remained well, without treatment, for three months but then developed symptoms of a respiratory infection with a productive cough and right-sided pleural pain. His family doctor prescribed ampicillin but he continued to feel unwell and after three weeks attended the outpatient department. Coarse crepitations were audible over the right lower lung posteriorly. The chest radiograph showed an opacity in the right lower zone and a smaller one in the left lower zone (Fig. 1). He was admitted to hospital for treatment and for investigation of the possibility of pulmonary aspergillosis. His haemoglobin was 11.6 g/100 ml, white cell count 6,900/mm³, and ESR 116 mm in the first hour.

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During a 12-day period, 10 sputum specimens were specifically examined for fungi (see Methods) and in each specimen an aspergillus was isolated in moderate to large numbers, later identified as *A. terreus*. Bacteriological examination of the sputum yielded a commensal flora; examination and culture for tubercle bacilli were negative. Skin testing with *A. fumigatus* extract (Bencard) was negative. Serological studies are described below.

Clinical recovery was satisfactory, without antibiotic therapy, and the radiographic abnormalities in the lower zones cleared. *A. terreus* was still present in the sputum, however. Following discharge from hospital he was seen at monthly intervals and remained well. On each occasion the sputum was examined mycologically and yielded profuse growths of *A. terreus*. Six months after discharge skin tests were carried out by the prick method, using both proprietary solutions and an extract of broth culture fluid of the patient's own organism. Dermal sensitivity to *A. terreus* was demonstrated whereas there was no reaction to *A. fumigatus* (Table). He was most recently seen nine months after discharge when he was well and his sputum, for the first time, showed absence of fungal growth.

**PATIENT 2** A 43-year-old man was admitted to hospital with a two-month history of malaise, anorexia, weight loss, and cough productive of green sputum. He had a rigid spine due to ankylosing spondylitis dating from the age of 14 years. Between the ages of 20 and 26 he had received five separate courses of radiotherapy, varying in dose from 1,500 to 2,000 R. A chest radiograph showed a large thin-walled cavity, about 4 cm in diameter, occupying the right lung apex and containing in its lower part a dense rounded opacity (Fig. 2). Anteroposterior tomography indicated an intracavitary mycetoma. A radiograph of the cervical spine taken four years previously had shown no abnormalities in the lung apices. A Heaf test was grade I positive, and repeated examination and culture of the sputum for tubercle bacilli were negative. Mycelial fragments were demonstrated on microscopic examination of the sputum, and *A. fumigatus* was isolated on culture. Skin testing with *A. fumigatus* extract was

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**TABLE**

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<tr>
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<td><em>A. fumigatus</em> 5% (Bencard)</td>
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<td><em>A. terreus</em> 1% (Bencard)</td>
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<td><em>A. terreus</em> 1% (patient's)</td>
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<td><em>A. terreus</em> 10% (patient's)</td>
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*Fig. 1. Patient 1. Chest radiograph showing fibrosis and cavitation in the left upper zone and 'pneumonic' shadow in both lower zones.*
negative, but precipitating antibodies against *A. fumigatus* were present in the serum. It was decided to keep the patient under observation without specific treatment, but after two visits to the clinic he failed to attend and was not seen again until re-admission to hospital 22 months later. He was wasted, pale, and had marked finger clubbing. Radiographic examination of the chest showed a considerable increase in size of the right upper lobe cavity (Fig. 3). There also appeared to be cavitation in the left upper lobe. Serial sputum cultures were negative for *Mycobacterium tuberculosis*, but *A. fumigatus* and other aspergillus species were cultured. A pink yeast, subsequently identified as *Metschnikowia* (Candida) *pulcherrima*, was isolated from sputum and urine.

Despite supportive therapy his condition deteriorated. He developed diarrhoea which did not respond to treatment with salicylazosulphapyridine. During the sixth week treatment with the synthetic antymycotic clotrimazole was started (100 mg/kg body weight/24 hours). There appeared to be an initial improvement, but he then developed increasing difficulty in breathing and he died on the tenth day after clotrimazole therapy had begun.

**Necropsy findings** Much of the right pleural sac was obliterated by old fibrous adhesions. The upper lobe of the right lung contained a cavity 12.5 cm in diameter within which was a solid spherical mycetoma measuring 2.5 cm in diameter (Fig. 4). A cavity of 6 cm diameter was present in the left upper lobe. There were firm areas of consolidation in the right lower lobe, and elsewhere both lungs were congested and oedematous. The superior vena cava was occluded by antemortem thrombus. The large bowel was affected by a form of chronic ulcerative colitis.

**Mycological methods and results (Patient 1)**

**Sputum smear** Sputum samples were digested with pancreatic (Oxoid). The sediment obtained after centrifugation was used to make smears which were stained with polychrome methylene blue. This
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![Image](http://thorax.bmj.com/)

**FIG. 3.** Patient 2. Chest radiograph showing considerable increase in size of right upper lobe cavity and evidence of cavitation in left upper lobe.

**FIG. 4.** Patient 2. The mycetoma removed at necropsy from the right upper lobe cavity.

method was reported by Curry (1949) for the diagnosis of dermatophytes and has been found equally effective for staining hyphae in sputum.

**SPUTUM CULTURE** Two malt peptone agar plates were inoculated from each sputum. The entire sputum was spread over the surface of the medium of one plate with a cotton wool swab and incubated at 30°C. This swab was then used to inoculate the second plate which was incubated at 37°C.

**SPUTUM SMEAR RESULTS** The digested sputum was shown to contain branched septate hyphae which corresponded to the isolation of *A. terreus* on culture.

**SPUTUM CULTURE RESULTS** Daily specimens were received for 10 consecutive days and then at monthly intervals for six months following discharge from hospital. Culture consistently produced large numbers of *A. terreus*, a few colonies of which were also obtained on the swab plate (Fig. 5). No other filamentous fungi were isolated but occasionally small numbers of yeasts were recorded.

During the period of investigation it was observed...
that considerable variation occurred in the isolates of A. terreus which were obtained. The significance of this variation is obscure.

SEROLOGICAL METHODS AND RESULTS (PATIENT 1)

A 3-week-old culture filtrate of the A. terreus isolated from this patient was dialysed against running tap water for three days and freeze-dried after concentration with polyethylene glycol 6000. The extract was reconstituted at 30 mg/ml in saline and examined for precipitins using Ouchterlony plates treated to eliminate C-substance reactions (Longbottom and Pepys, 1964). A similar extract, reconstituted at 10 mg/ml, was sterilized by Millipore filtration and used for skin testing.

The A. terreus extract produced five clearly visible precipitin lines with the patient's serum (Fig. 6). There was no reaction between the patient's serum and A. fumigatus antigen (Bencard) nor between the A. terreus antigen and sera which had previously been shown to contain A. fumigatus antibodies. Parallel tests were conducted with the sera from 20 patients not known to have had contact with aspergilli using antigens from A. terreus and A. fumigatus (Bencard). No reactivity was recorded.

MYCOLOGICAL METHODS (PATIENT 2)

Specimens of sputum, urine, stool, and blood were examined directly as smears processed by the methenamine silver method of Grocott (1955) and in culture on malt agar plate incubated at 26° C and 37° C. Necropsy materials were subject to the same schedule.

RESULTS During the first month of a two-month sampling period the following results were recorded: Sputum A. fumigatus was cultured on six occasions the last four samples giving uncountably dense yields. Yeasts were isolated seven times, an assembly of pigmented species arising on two occasions. These were identified as Rhodotorula glutinis and M. pulcherrima.

A randomly distributed background flora of filamentous fungi included penicillia (P. lano-so-viride, P. herquei, P. tardum, and P. decumbens), aspergilli (A. ustus, A. versicolor, and A. niger), Ostracoderma sp., and Botrytis cinerea.

Urine M. pulcherrima was recovered from two samples, R. glutinis from two, and A. fumigatus from one.

Stool Candida tropicalis was the sole fungus isolated; blastospores were common in smears.

Blood All samples were negative for fungi.

During the second month of sampling A. fumigatus was not cultured from the sputum although on one occasion dichotomously branched hyphae were seen in smears. A. fumigatus occurred only twice in urine cultures. Stools gave a consistently high yield of C. tropicalis and smears showed numerous blastospores. At necropsy settle plates of malt agar exposed adjacent to the cadaver gave colonies of Cladosporium sp. A. fumigatus was cultured from the mycetoma and from the lower lobe of the left lung. Blood which remained in the thorax after dissection gave colonies of M. pulcherrima and Cladosporium sp. C. albicans and M. pulcherrima were isolated from the thrombus in the superior vena cava. A. fumigatus was also recovered from the cortex of the right kidney.
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DISCUSSION

The concurrence of ankylosing spondylitis and pulmonary aspergillosis may well have been fortuitous in the two patients described. Certain changes, however, may occur in the lungs in the presence of long-standing ankylosing spondylitis, and if cavitation develops there is an ideal site for colonization by fungi with airborne spores. There is a recognized association between ankylosing spondylitis and an increased incidence of pulmonary tuberculosis (Crofton and Douglas, 1969). Aspergillus species will colonize a significant proportion of residual tuberculous cavities, as has been shown by large-scale investigations (British Tuberculosis Association, 1968). Furthermore, attention has recently been drawn to a specific infiltrative and fibrosing lesion in the lungs of patients with ankylosing spondylitis, in which cyst formation occurs in the affected upper lobes (British Medical Journal, 1971). Davies (1971) has referred to a figure of over 50 reported cases. Pulmonary damage may also result from intensive midline irradiation for spinal disease.

Of the few patients in whom ankylosing spondylitis has been recorded as accompanying pulmonary mycetoma formation, that of Campbell and Clayton (1964) and that of Edwards and La Touche (1964) are noted also to have had bronchiectasis, perhaps secondary to irradiation damage. Five patients with pulmonary mycetoma and ankylosing spondylitis were reported by Krohn and Halvorsen (1968), but no details of radiotherapy were given. Leggat and de Kretser (1968) reported the development of an aspergiloma in a patient who had received radiotherapy for ankylosing spondylitis and who had fibrotic changes in both upper lobes. A mycetoma due to Allescheria boydii has been recorded in a patient with advanced ankylosing spondylitis; details of radiotherapy were not given (Adelson and Malcolm, 1968).

In a survey of patients with lung cavitation and fibrosis mimicking tuberculosis, Davies (1970) described four patients with ankylosing spondylitis having the specific upper lobe changes previously alluded to, all of whom developed unilateral or bilateral aspergilomata. One of these four was the patient reported by Leggat and de Kretser (1968). It seems probable that our own two patients are further examples of this specific pulmonary lesion in ankylosing spondylitis.

A. terreus is one of the most common and widely distributed of soil organisms. It is charac-
lates was the yeast *M. pulcherrima*, which occurred in sputum and urine during life, and also in post-mortem superior vena caval thrombus. *M. pulcherrima* could not justifiably be termed a pathogen on the present evidence and was probably no more than a secondary invader, but these observations do draw attention to it as a possible infecting organism in the debilitated human subject.

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