Pulmonary interstitial fibrosis associated with alveolar proteinosis

HW CLAGUE, AC WALLACE, WKC MORGAN

From the Departments of Medicine and Pathology, University Hospital, University of Western Ontario, London, Ontario, Canada

Alveolar proteinosis is characterised by the presence of an amorphous lipoproteinaceous material that fills the alveolar space and stains positively by the periodic acid Schiff (PAS) method.1 Alveolar walls are usually normal or only slightly thickened by cellular infiltrate, and interstitial fibrosis is unusual. We report a patient in whom severe interstitial fibrosis occurred early in the course of the disease and led to a delay in correct diagnosis and to inappropriate treatment with corticosteroids.

Case report

A 54 year old man who worked as a forklift truck driver presented with a two month history of effort dyspnoea, recurrent painful pleurisy, and fever with cough and sputum production. Physical examination revealed nothing abnormal but a chest radiograph showed basal interstitial nodular shadowing. A needle lung biopsy specimen2 (fig 1) from the left lower lobe was reported as showing interstitial fibrosis with considerable numbers of both interstitial and intra-alveolar macrophages. Despite treatment with oral prednisone (15 mg daily) the patient's dyspnoea worsened and the chest radiograph showed the development of extensive perihilar ground glass shadowing. Occasional paninspiratory crackles were audible at the lung bases. Pulmonary function testing showed a restrictive ventilatory defect (FVC 70% predicted; FEV\textsubscript{1} 83% predicted; FEV\textsubscript{1}/FVC ratio 88%), with a reduced gas transfer factor (29% predicted).

Six months later there was symptomatic improvement and significant radiological clearing. The clinical course, the lack of response to steroids, and the more recent radiographic changes led to a clinical suspicion of alveolar proteinosis. A further needle lung biopsy\textsuperscript{3} of the left lower lobe was therefore performed, but microscopic appearances confirmed interstitial fibrosis with intra-alveolar organisation and an accumulation of foamy macrophages. Two months later the patient presented with an acute febrile illness, haemoptysis, and an infective arthritis of the left ankle joint. The chest radiograph showed a dense right upper lobe infiltrate suggestive of tuberculosis. During a search of sputum and joint aspirate for Mycobacterium tuberculosis a truant rhodamine stain\textsuperscript{4} demonstrated the presence of large numbers of pus cells and Gram positive fluorescent filamentous rods, which on culture were identified as Nocardia asteroides. Administration of amoxicillin trihydrate 0.5 g four hourly for four weeks and sulphafurazole 2 g four hourly for eight weeks, with repeated joint aspiration, led to complete resolution of both the pneumonia and the infective arthritis.

Twelve months later the patient's dyspnoea had again worsened and fine end inspiratory crackles became audible at the left apex. At this stage an open lung biopsy of the left upper and left lower lobe was performed and on this occasion the main microscopic feature was the presence in both biopsy specimens of an amorphous intra-aveolar accumulation of PAS positive proteinaceous material (fig 2). In places the alveolar walls were disrupted with evidence of only slight thickening and fibrosis; but in other areas pronounced fibrosis of the interstitial tissue was evident, with replacement of alveolar walls by dense collagen.

Address for reprint requests: Dr HW Clague, Chest Unit, Fazakerley Hospital, Liverpool L9 7AL.
Accepted 11 March 1983

Fig 1 Appearances of first (needle) lung biopsy from left lobe (lower) showing alveolar hyperplasia with dense interstitial fibrosis but no alveolar exudate. (Haematoxylin and eosin, × 185.)
Pulmonary fibrosis is uncommon even in fatal cases and the respiratory bronchioles and alveolar walls are usually of normal thickness, but may be slightly thickened owing to a mainly lymphocytic infiltration. This contrasts with the findings in our patient, in whom there was evidence of severe interstitial fibrosis early in the course of the disease. The results of our first biopsy misled us into using corticosteroids, which are of no value in alveolar proteinosis and may even prove harmful by predisposing to opportunistic infection. The lung macrophage in alveolar proteinosis has reduced phagocytic potential and, perhaps because of this, patients are already predisposed to opportunistic infection. An association with nocardiosis has been well described.

Focal interstitial fibrosis of varying degree but of questionable significance has been reported previously. The presence of patchy mild interstitial fibrosis has in some cases been attributed to the presence of opportunistic infections, but this cannot be true of our patient as the development of fibrosis clearly predated infection with nocardia. In this case interstitial fibrosis appears to represent a late response to alveolar proteinosis. Hudson and associates have reported a case of a patient who died with severe pulmonary fibrosis some 13 years after an initial diagnosis of alveolar proteinosis.

Open lung biopsy may have given a more representative sample earlier on in our patient. Good results have however been claimed for diffuse lung diseases with the techniques that we used.

As the aetiological agent was not identified in the case that we report, it is possible that the offending agent was coincidentally fibrogenic. Nevertheless, our report demonstrates that the presence of severe interstitial fibrosis does not preclude a diagnosis of alveolar proteinosis.

References

H W Clague, A C Wallace and W K Morgan

Thorax 1983 38: 865-866
doi: 10.1136/thx.38.11.865

Updated information and services can be found at:
http://thorax.bmj.com/content/38/11/865.citation

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes