25 year old Hispanic man with a 3 year history of ulcerative colitis presented with 8 months of productive cough with over 200 ml of yellow sputum, fatigue, dyspnoea, diarrhoea, night sweats, and weight loss. At the time of presentation the patient was on a low dose of mesalamine (400 mg three times daily) and azathioprine (25 mg/day). Examination revealed coarse crackles at the lung bases and a prolonged expiratory phase. The white blood cell count was normal. The chest radiograph showed bilateral reticulonodular infiltrates with acinonodular opacities, and a high resolution CT scan showed diffuse bronchiectasis, centrilobular nodules, and a “tree-in-bud” pattern (fig 1). Obstruction with air trapping was found on pulmonary function tests. Bronchoscopic examination showed diffuse purulent secretions throughout the major airways (fig 2A). BAL fluid smears and cultures were negative for acid-fast bacilli, fungus, and bacterial pathogens. Transbronchial biopsies revealed dense lymphoplasmacytic inflammation and infiltration of the bronchial mucosa (fig 2B). Rapid resolution of pulmonary and gastrointestinal symptoms occurred after initiation of prednisone 40 mg/day and an increase in azathioprine to 100 mg/day.

Pulmonary manifestations of inflammatory bowel disease are uncommon and present as a clinical spectrum including airway disease, interstitial lung disease, parenchymal nodules, and serositis. Diagnosis is often delayed. Our patient presented with a chief complaint of bronchorrhoea due to diffuse bronchiectasis and bronchiolitis which ultimately proved to be due to inflammatory bowel disease.

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