

Clinical image

Bilateral Organizing Pneumonia Secondary to Rhinovirus Infection in a Patient With a Solid Organ Transplant



Neumonía organizada bilateral secundaria a infección por rinovirus en paciente con trasplante de órgano sólido

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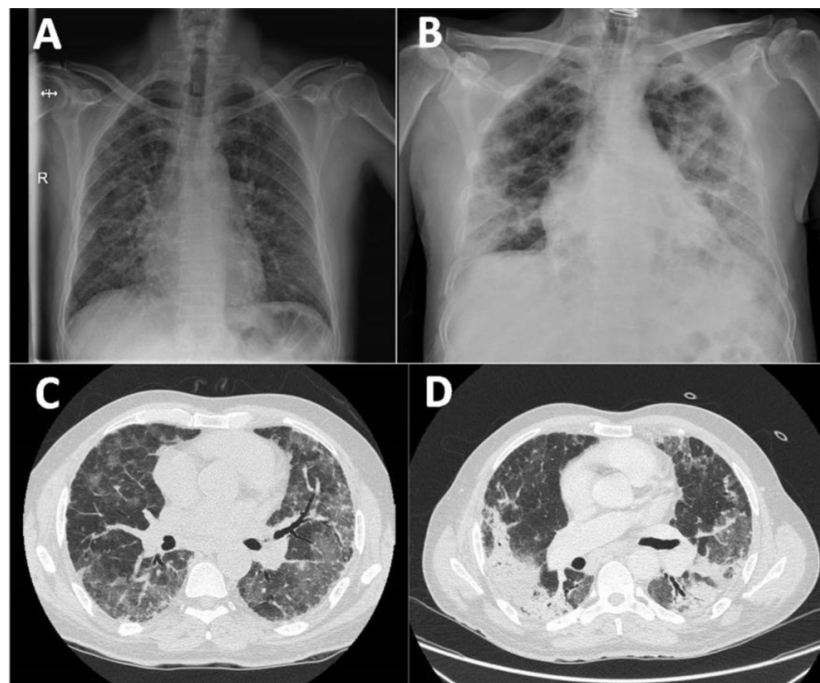


Fig. 1. (A) Initial chest X-ray with faint bilateral interstitial infiltrates with respect to costophrenic sinuses. (B) Chest X-ray on arrival at the intensive care unit showing increased persistent interstitial infiltrates bilaterally more accentuated at peripheral level with associated alveolar pattern. (C) Chest CT showed a crazy paving pattern initially with foci of incipient consolidation. (D) Chest CT performed after discharge from the intensive care unit showed radiological worsening with areas of consolidation in both upper and lower fields, in addition to presenting a cobblestone pattern and tarnished glass.

A 56-year-old male, not toxic habits, with hepatocellular insufficiency in cirrhotic liver after hepatitis B infection underwent a liver transplant in 2017 treated with tacrolimus, mycophenolate mofetil and entecavir.

The patient was admitted with dyspnea of one week's evolution and fever, laboratory tests showed an elevated of acute phase reactants, a chest X-ray revealed a bilateral alveolar interstitial infiltrate (Fig. 1A and B). Chest computed axial tomography (CT) showed a bilateral peribronchial (crazy paving) pattern with peripheral incipient consolidation foci (Fig. 1C).

Empirical treatment was started with levofloxacin, trimetopim-sulfamethoxazol and ganciclovir.^{1,2}

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Flexible fibrobronchoscopy was performed without relevant macroscopic findings with bronchoalveolar lavage positive for rhinovirus, other microbiological results were negative.

The patient was admitted to the intensive care unit with severe hypoxemic respiratory failure requiring high flow oxygen therapy.²

Chest CT performed later showing radiological worsening due to the appearance of predominantly peripheral consolidations affecting both upper and lower lung fields and a ground glass pattern¹ (Fig. 1D).

Second flexible fibrobronchoscopy was requested subpattern of organized pneumonia (NO) probably secondary to rhinovirus.

High doses of corticosteroids were necessary, which could be reduced after clinical improvement.²

Microorganisms of low virulence can cause serious infections and inflammatory processes such as NO.

Informed consent

The patient gives verbal and written consent for the educational use of his medical record.

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Authors' contributions

Marina Utrero Rico: editing; Cristina María Carrasco Carrasco: editing and correction; Jose Gregorio Soto Campos: revision.

Conflicts of interest

We declare that there are no conflicts of interest.

References

1. Razonable RR. Management of viral infections in solid organ transplant recipients. *Expert Rev Anti Infect Ther.* 2011;9:685–700.
2. Kotloff RM, Ahya VN, Crawford SW. Pulmonary complications of solid organ and hematopoietic stem cell transplantation. *Am J Respir Crit Care Med.* 2004;170:22–48.