A case of Invasive Pulmonary Aspergillosis occurring in a non-neutropenic patient at a Tertiary facility in North-West Nigeria

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Background
- Invasive Pulmonary Aspergillosis (IPA) is a severe disease
- It is mainly caused by Aspergillus fumigatus
- Commonly occurs among the immunocompromised, severely ill patients and those with chronic obstructive pulmonary disease
- Neutropenia is the most important risk factor for IPA
- We aimed to report IPA which occurred in a non-neutropenic patient with Chronic Myeloid Leukaemia (CML) to improve awareness and index of suspicion of IPA occurring in such patients

Methods
- We reviewed medical records of a patient with CML who developed IPA

Case report
- A 65 year old married male, farmer who was diagnosed to have CML 5 years ago presented with 3 week history of intermittent cough productive of scanty, mucoid sputum. No history of fever, difficulty in breathing, chest pain, haemoptysis, night sweats or weight loss
- He has had hypertension for 10 years, not diabetic, has never smoked cigarettes
- He was diagnosed to have TB adenitis 1 year ago and subsequently treated with Anti-TB regimen for 11 months
- His current symptoms developed 3 weeks after completing anti-TB therapy
- Clinical examination revealed elderly man, not ill looking, mildly dehydrated, not pale, anicteric acyanosed with axillary temperature 36.8°C

Management
- He was continued on Benylin cough syrup for another 2 weeks
- 10 days later he presented with worsening symptoms. Results of Sputum fungal culture were retrieved and showed Aspergillus species, GeneXpert negative for TB
- Clinical microbiologist reviewed and requested repeat Sputum MCS to rule out Aspergillus contamination and repeat CXR since patient couldn’t afford CT
- Repeat Sputum culture yielded Aspergillus fumigatus and Enterobacter gergoviae, CXR showed bilateral hilar fullness? Lymphadenopathy
- An impression of IPA in a patient with CML was made .He was commenced on tabs Itraconazole 200mg daily for 6 weeks and sample sent to another tertiary facility for Aspergillus galactomannan assay
- His symptoms markedly improved after 1 week on Itraconazole
- Results of galactomannan assay obtained 2 months later strongly positive so treatment continued for 8 months

Conclusion
- Diagnosis of IPA in this patient was delayed due to low index of suspicion
- We recommend IPA as differential diagnosis in patients with chronic cough

References