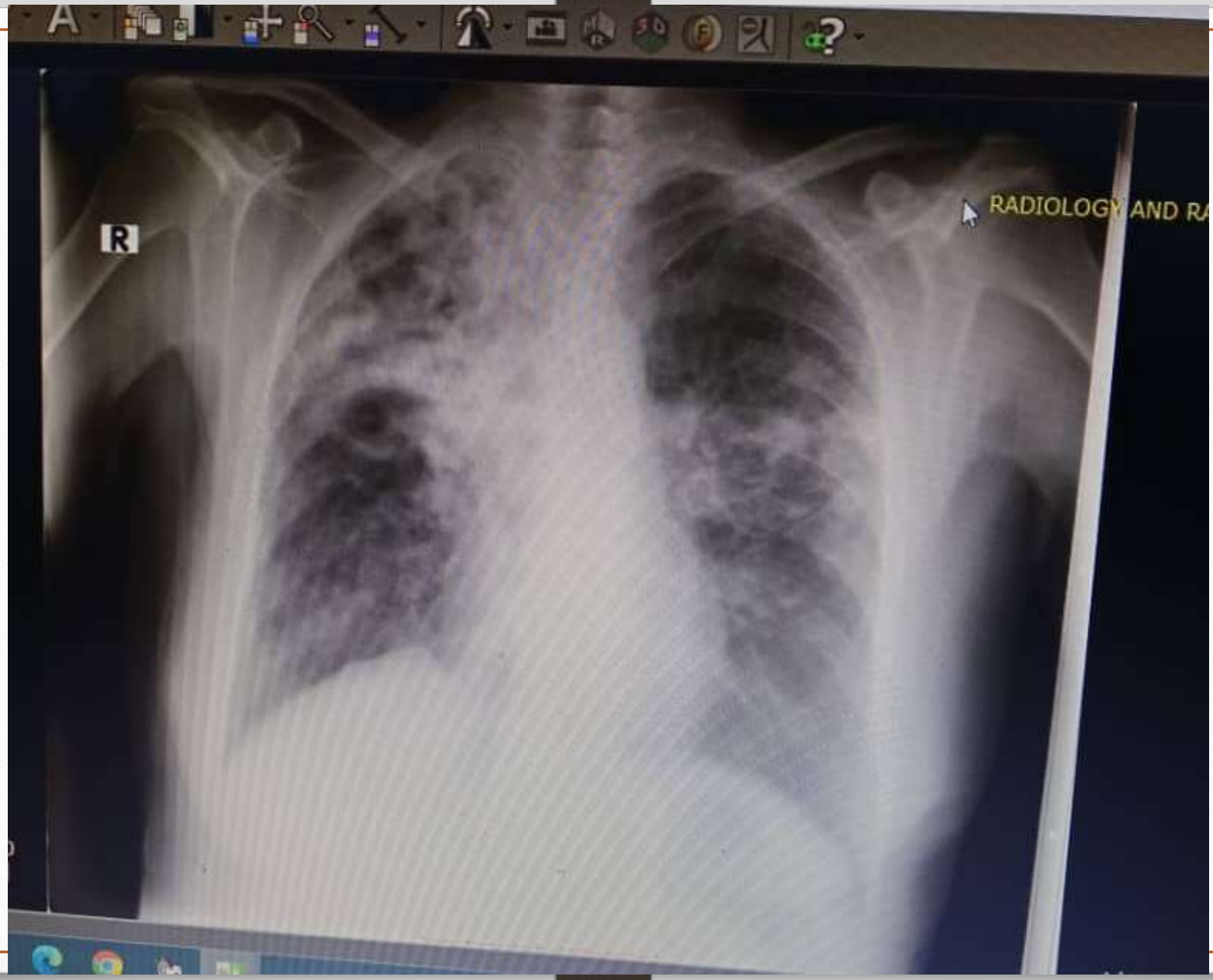
Clinical Case

Dr Abdulrahman Dakkak

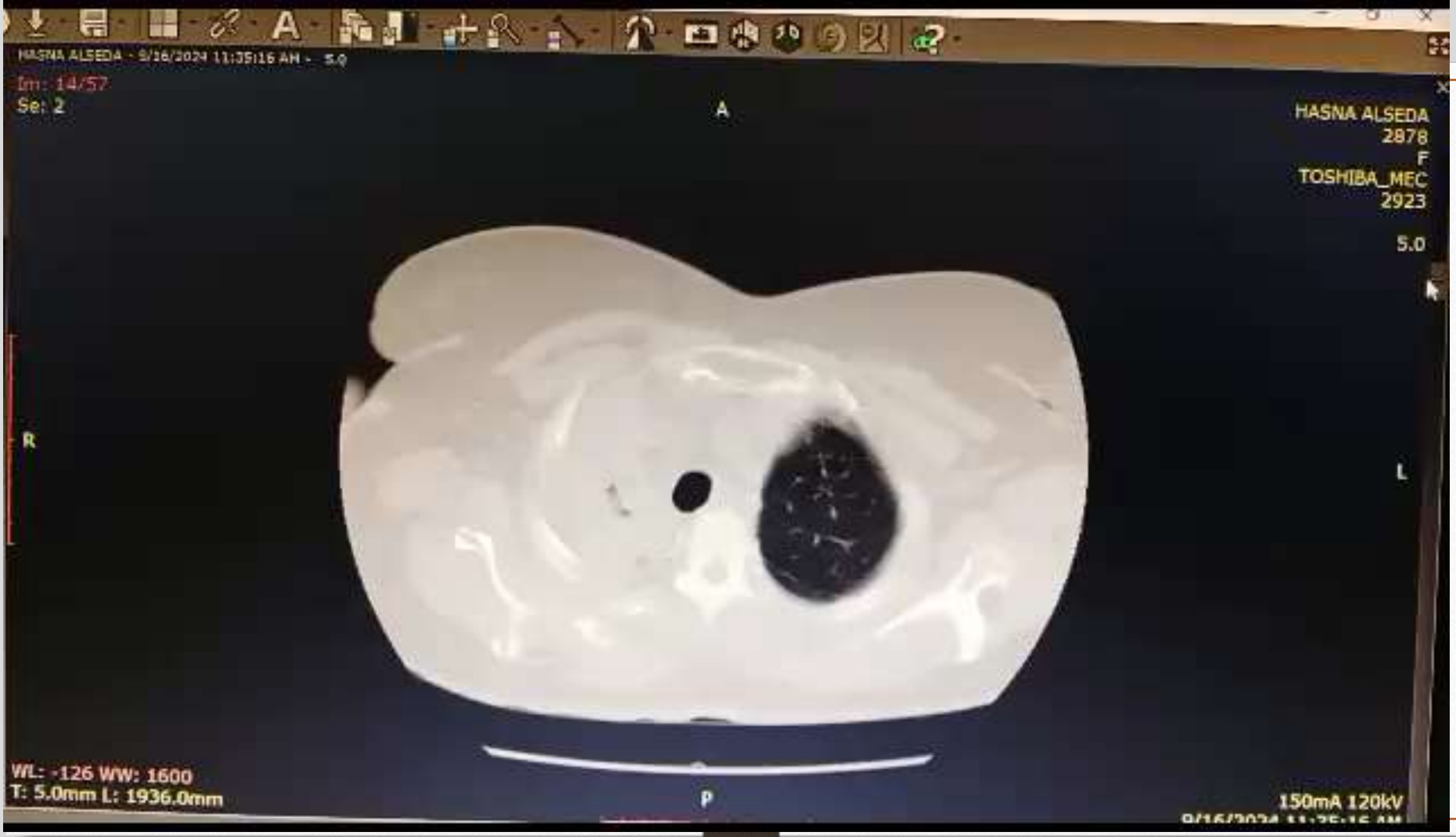
القصة المرضية

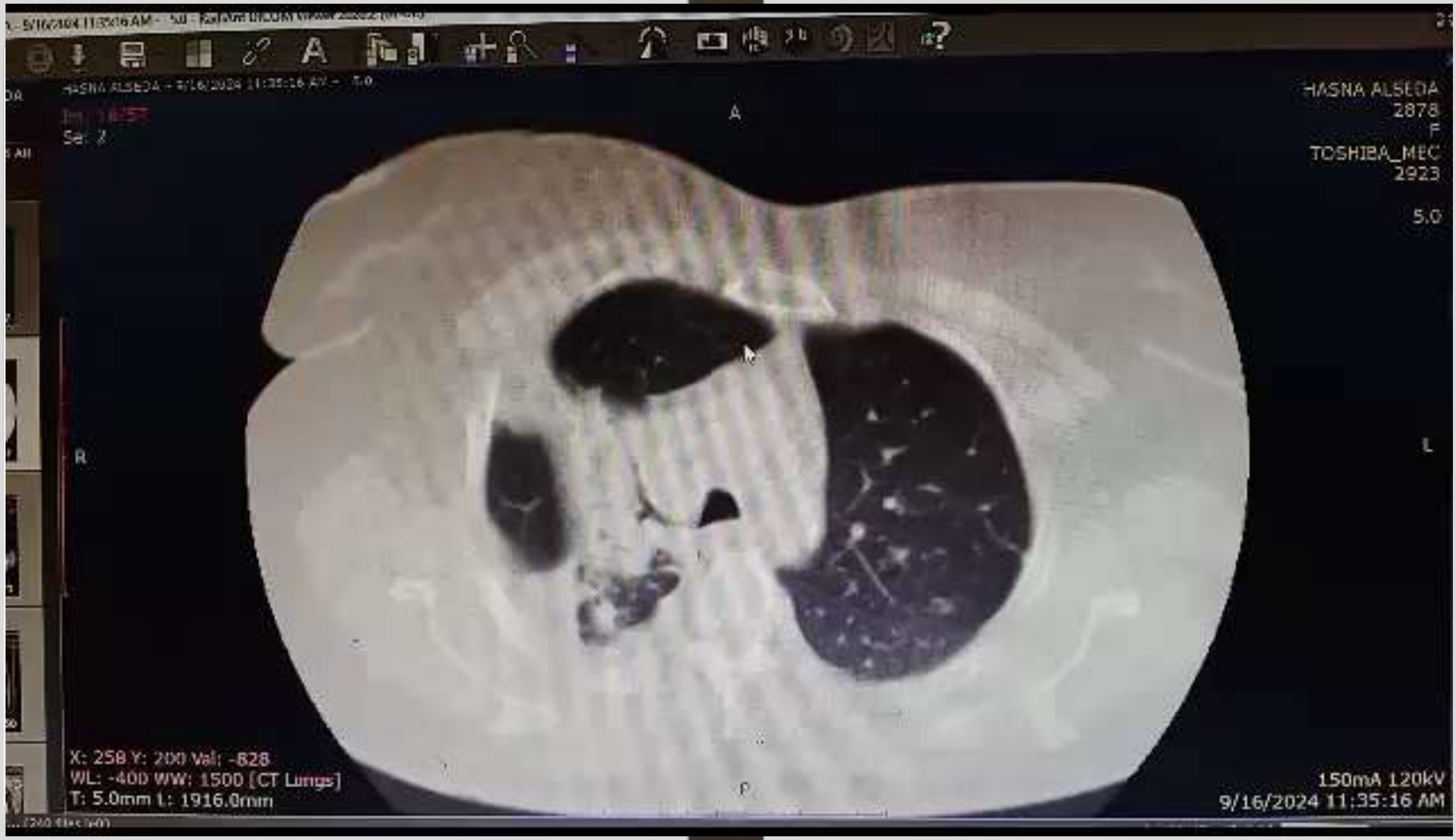
- المريضة ح س العمر: 65 سنة غير مدخنة متزوجة
- السوابق المرضية : داء سكري منذ 5 سنوات
- السوابق الدوائية : صادات
- بدأت قصة المريضة منذ 6 أشهر بسعال مستمر منتج لقشع غزير أخضر و أحياناً أصفر أو مدمى .
- مع زلة تنفسية و تعب ووهن عام و ترفع حروري


R
RADIOLOGY AND RA

مخبريا

WBCs	**18000**
neutro	80
lymph	17
HB	**9**
PLTs	150
CRP	**60**
ESR	**90**
GLUCOSE	**250**
Cr	1


HASNA ALSEDA - 9/16/2024 11:35:16 AM - 5.0
Im: 14/57
Se: 2
A
HASNA ALSEDA
2878
F
TOSHIBA_MEC
2923
5.0
R
L
WL: -126 WW: 1600
T: 5.0mm L: 1936.0mm
P
150mA 120kV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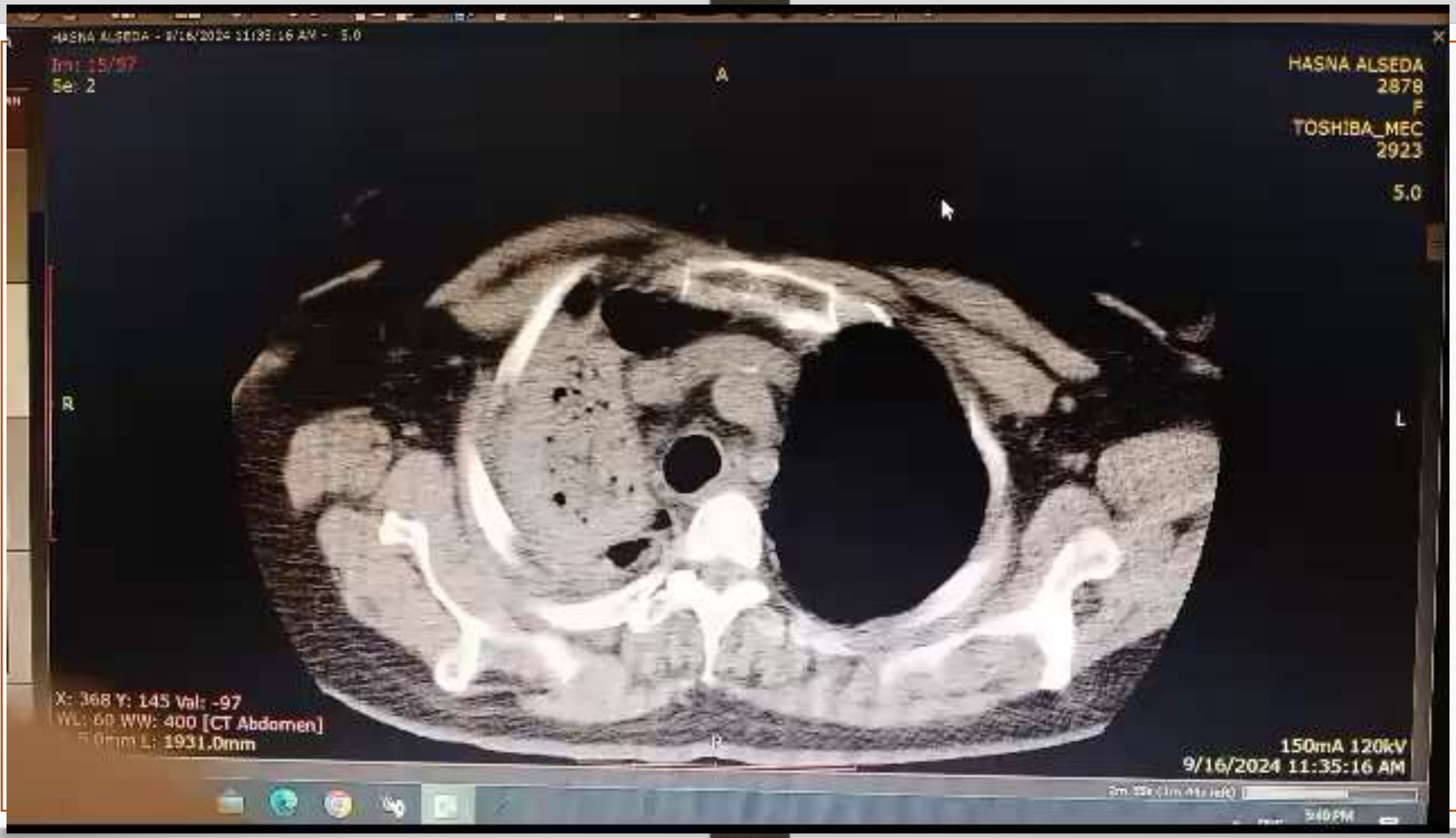
2878
F
TOSHIBA_MEC
2923
5.0
A
R
L
P
X: 258 Y: 200 Val: -828
WL: -400 WW: 1500 [CT Lungs]
T: 5.0mm L: 1916.0mm
150mA 120kV
9/16/2024 11:35:16 AM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Im: 15/97
Se: 2
A
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2878
F
TOSHIBA_MEC
2923
5.0
R
L
P
X: 368 Y: 145 Val: -97
WL: 60 WW: 400 [CT Abdomen]
L: 1931.0mm
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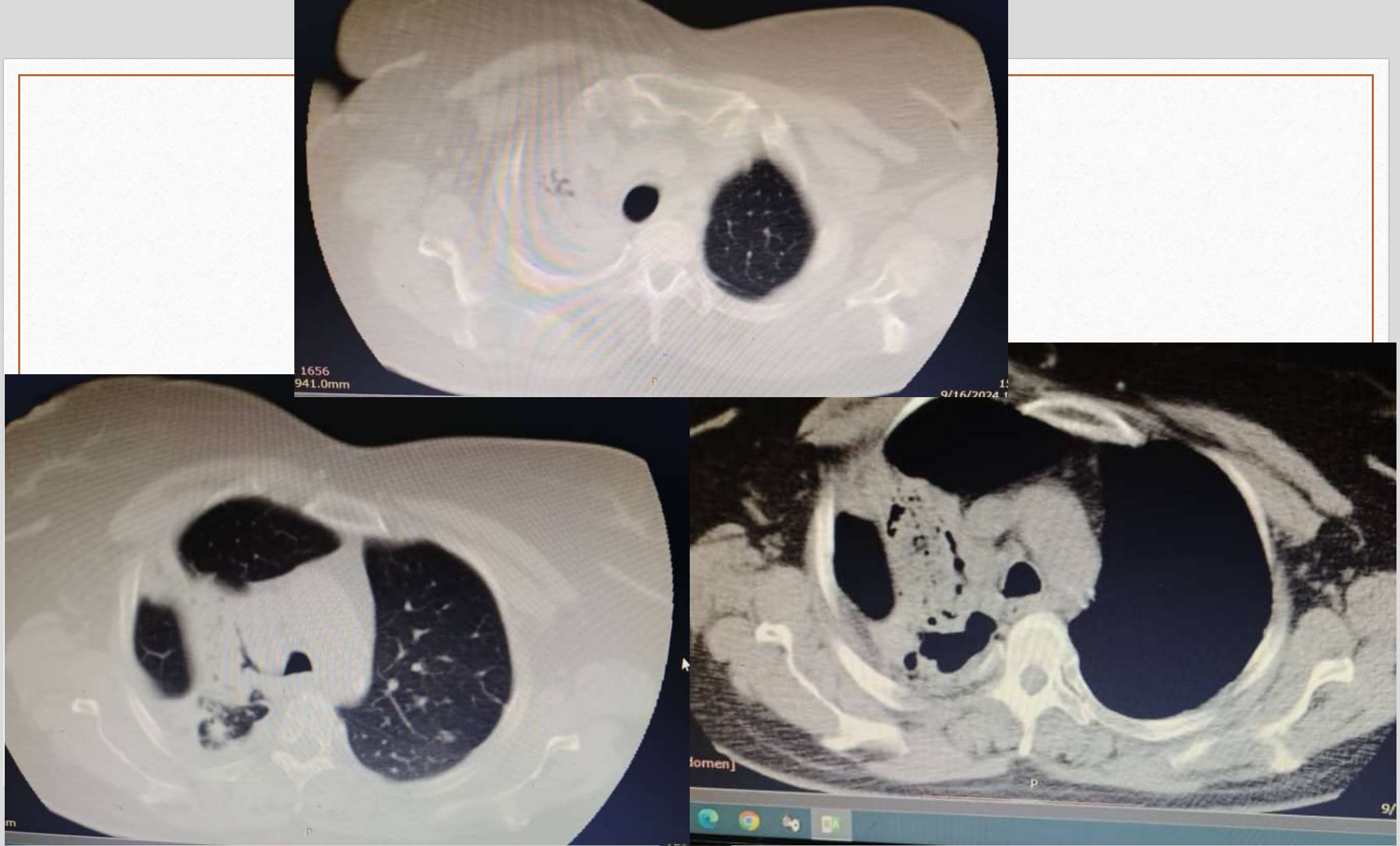
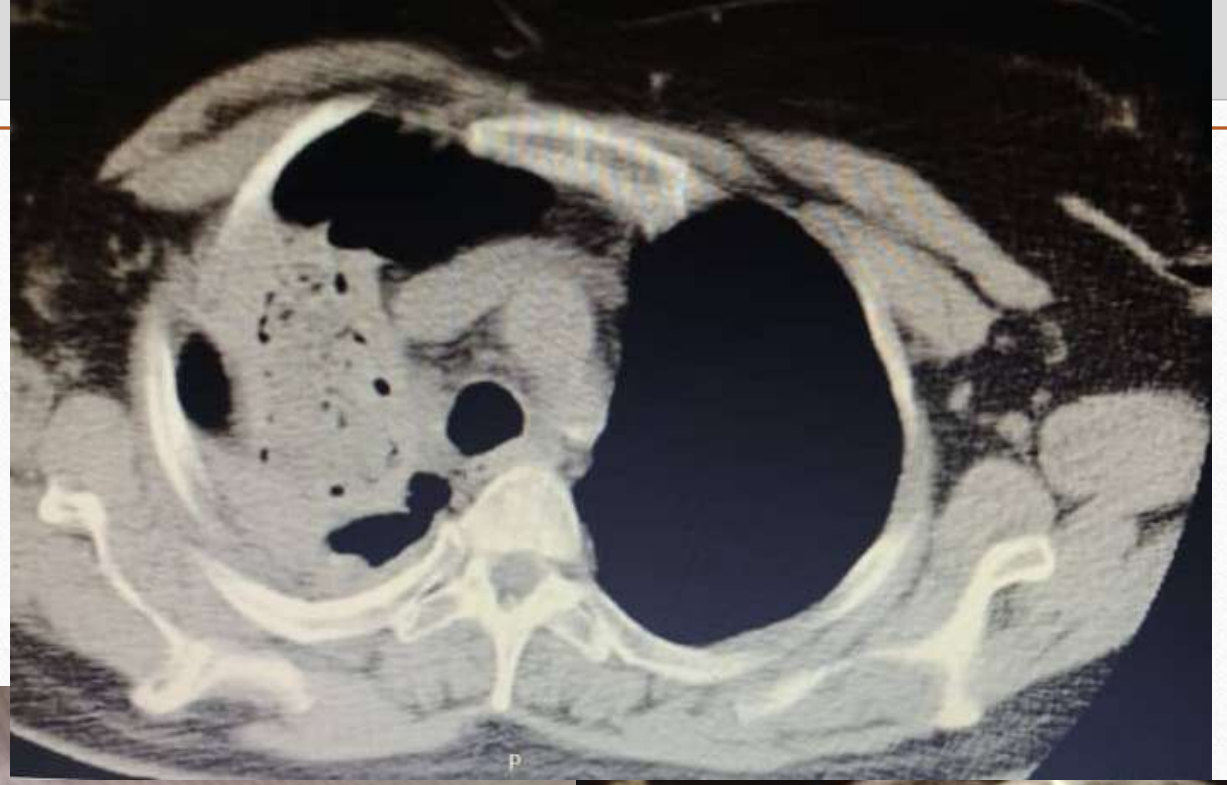
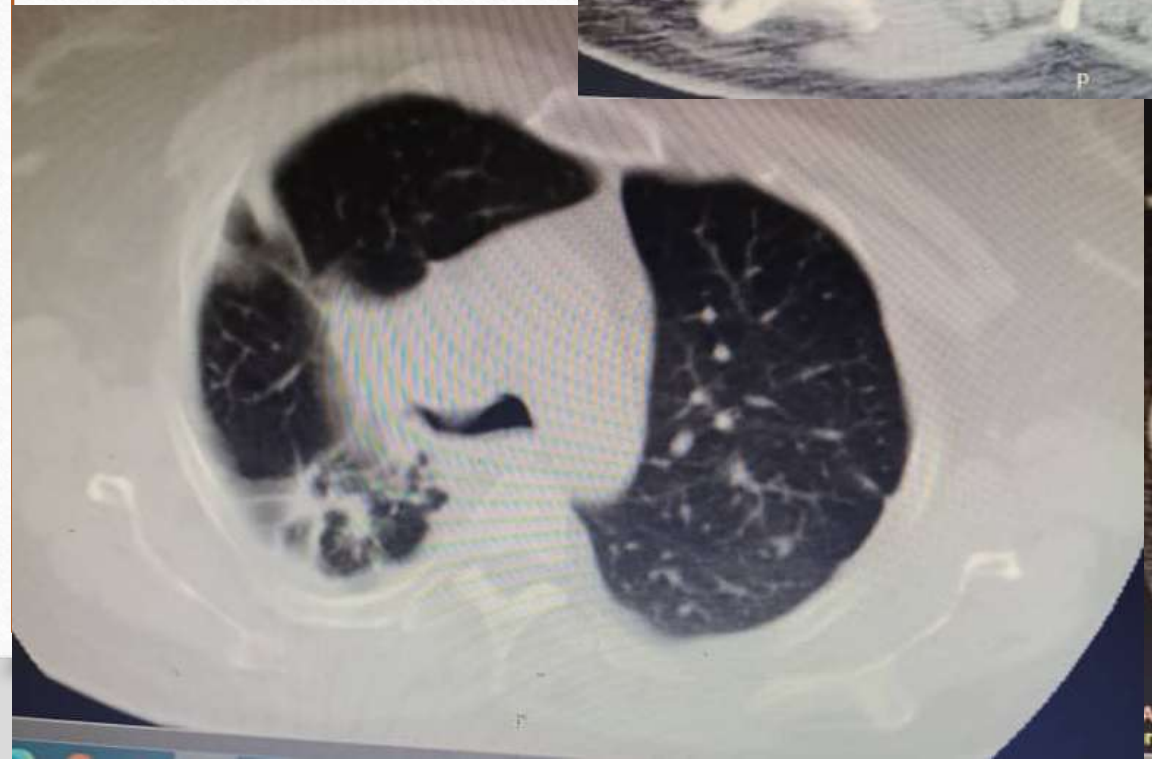
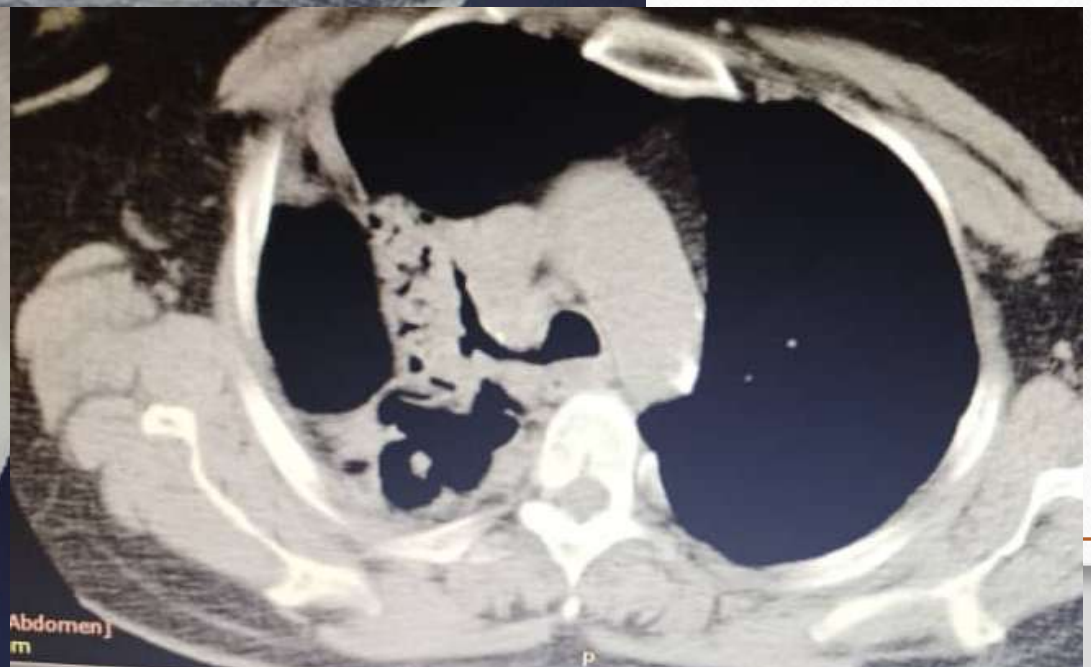
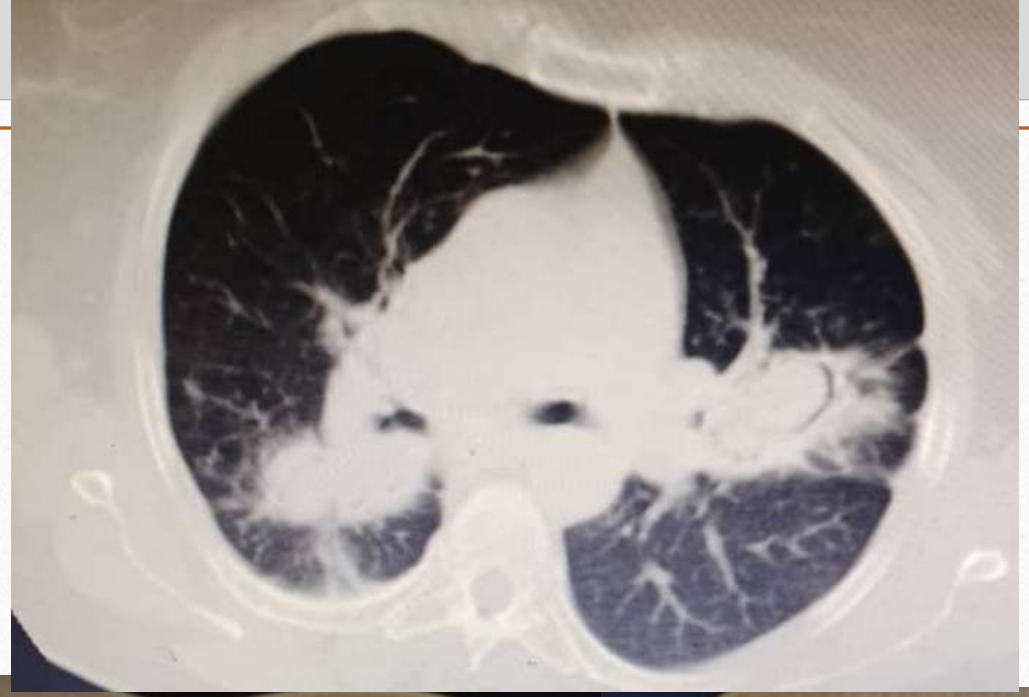
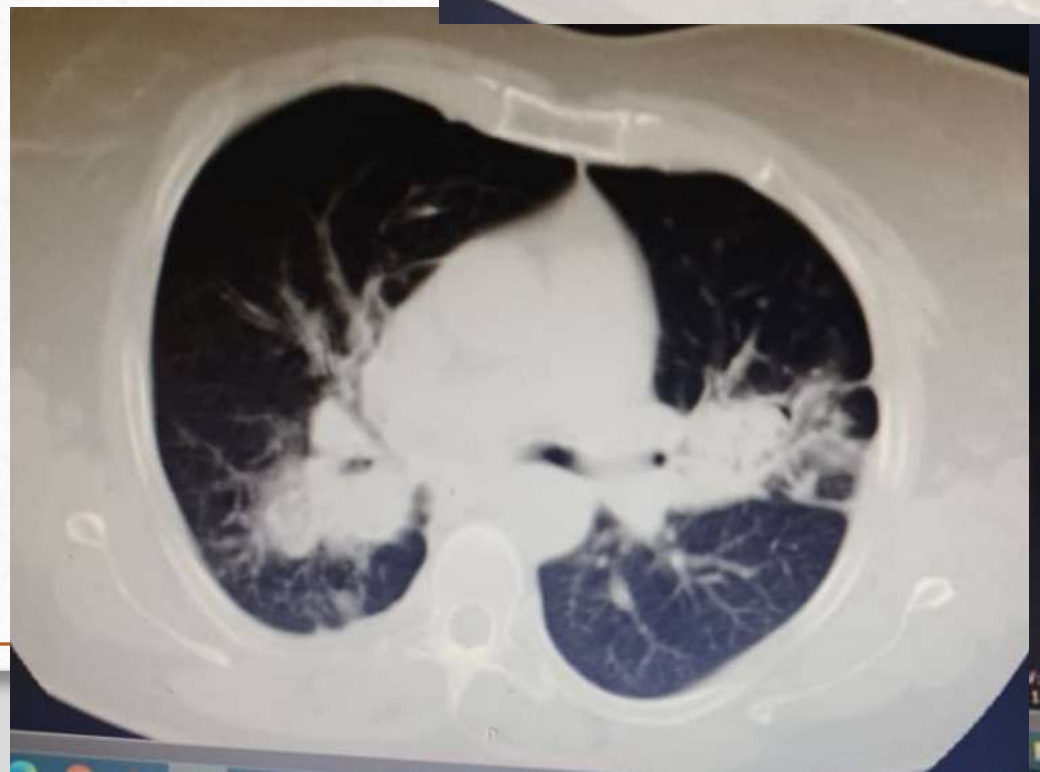

1656
941.0mm

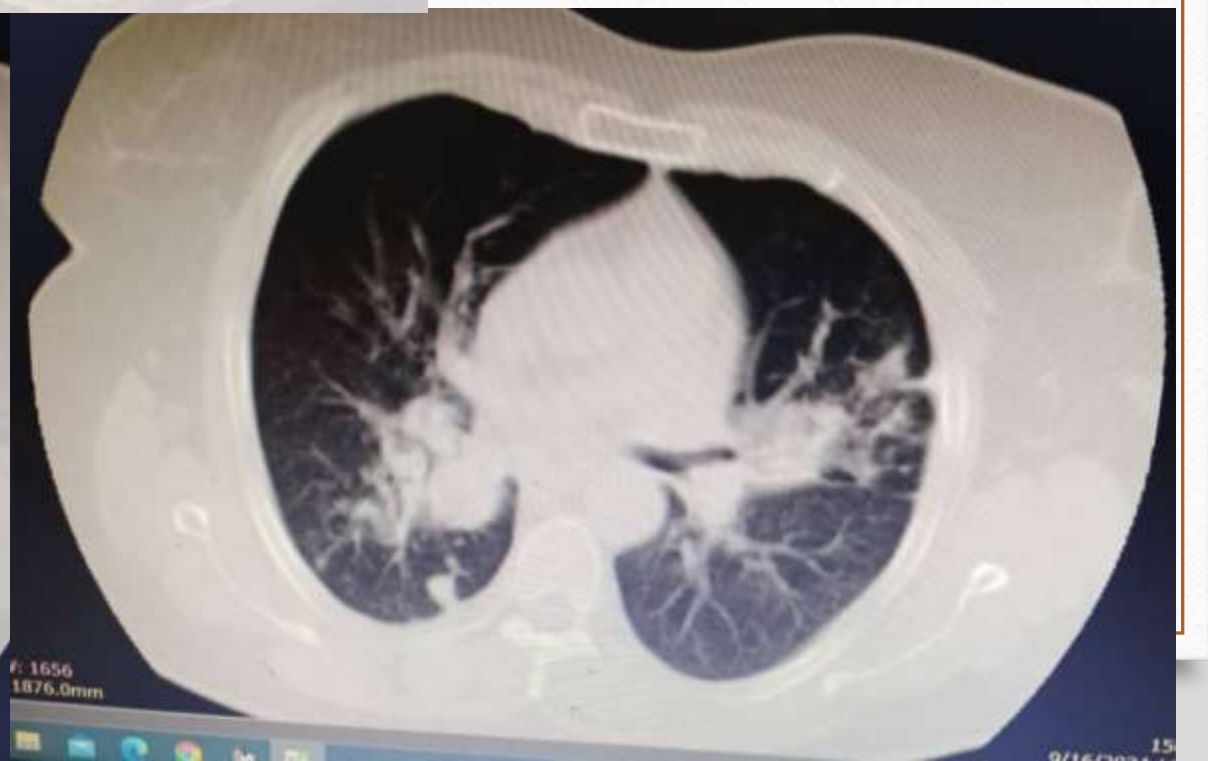






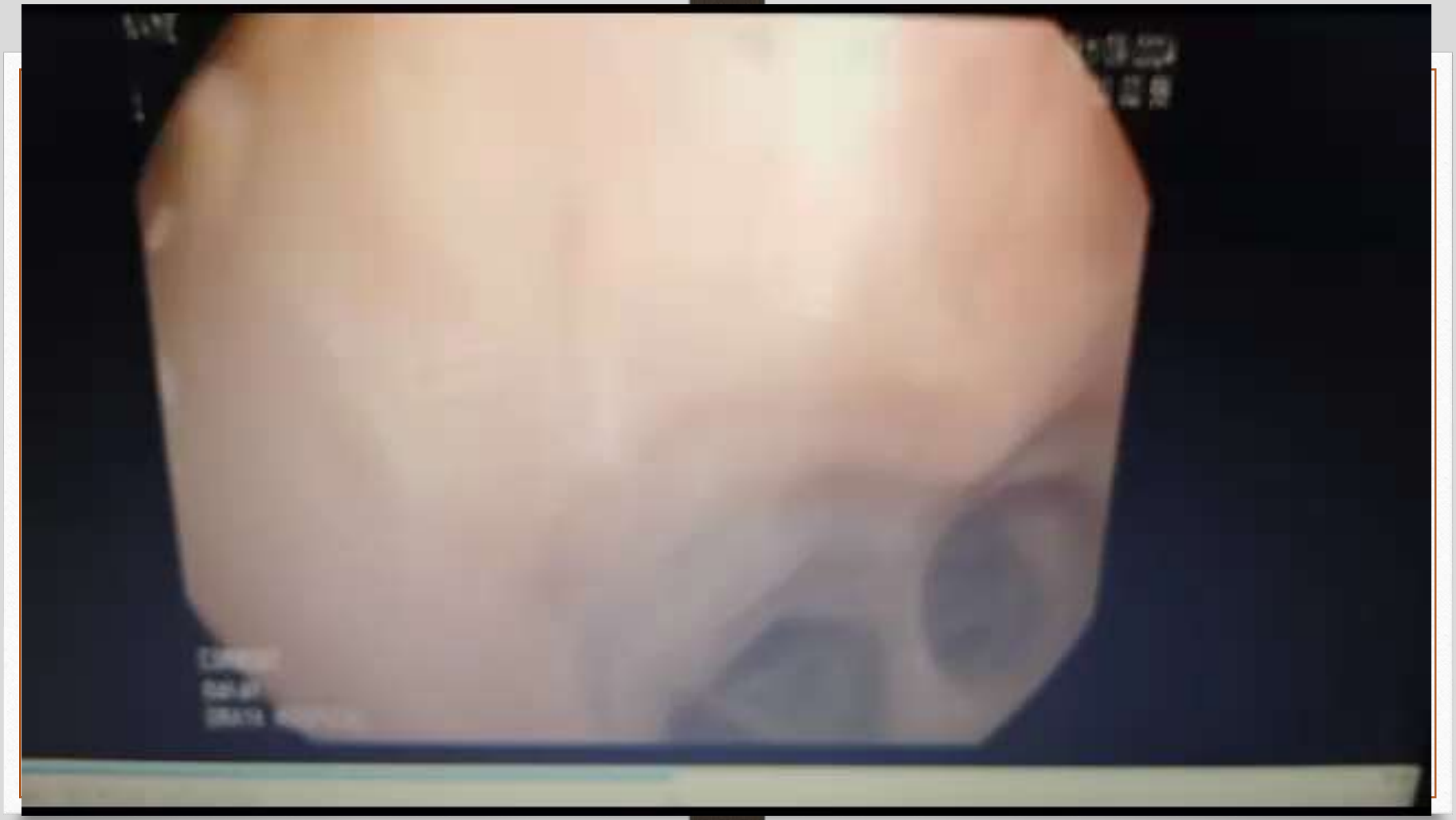


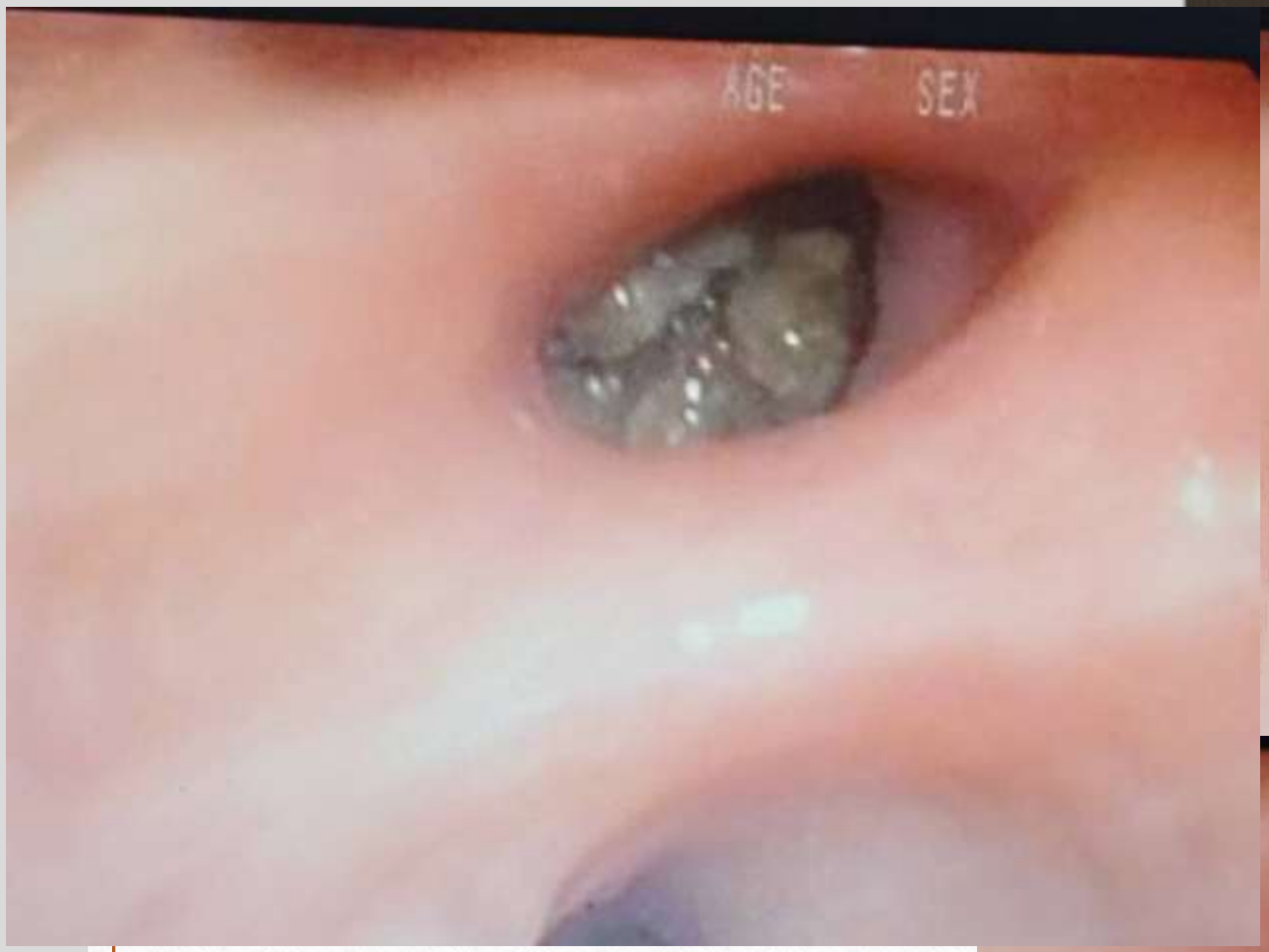


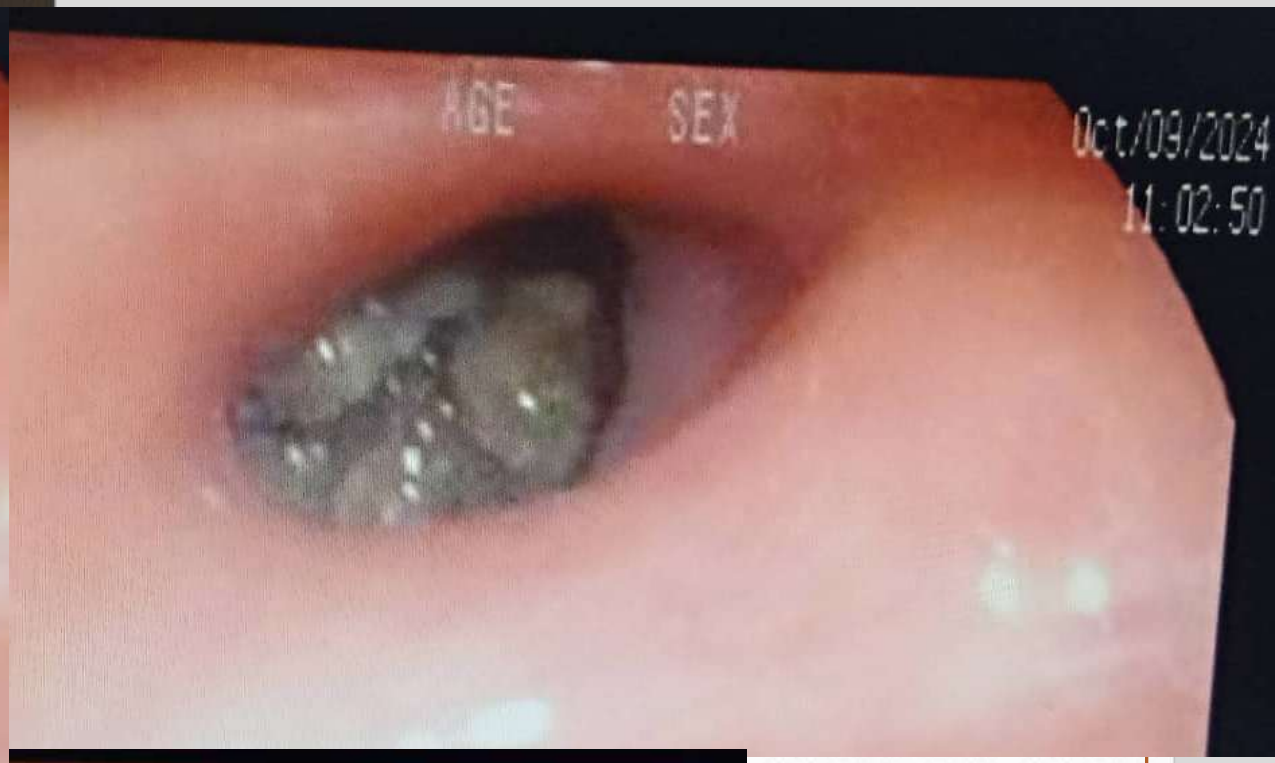

1656
1876.0mm


ما هو التوجه
السريري لهذه الحالة
؟؟؟

تم إجراء تنظير قصبات ليفى مرن




AGE
SEX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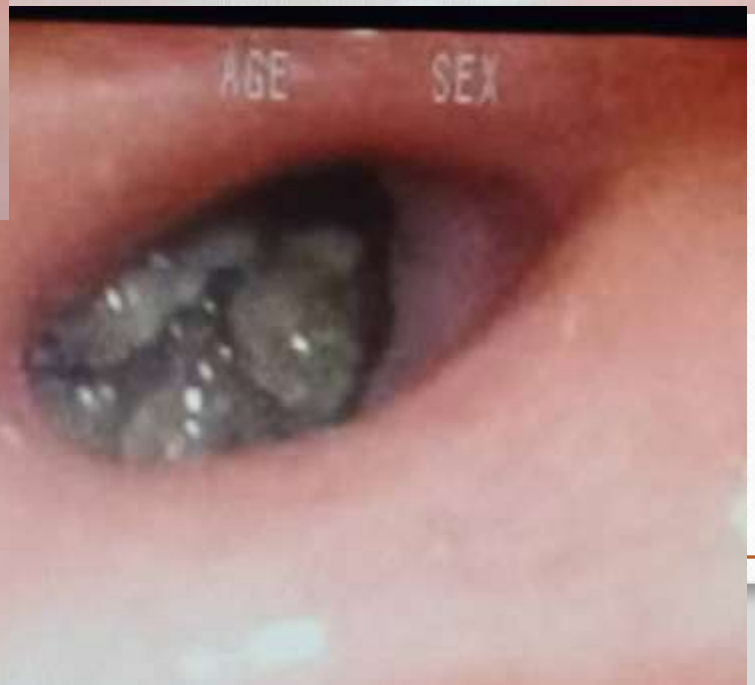
SEX
Oct/09/2024
11:02:50


AGE
SEX

دكتور : عبد الرحمن دكاك

Female 65 years

819 09/10/2024 : التاريخ

MICROBIOLOGY

Tests	Results	Reference ranges	Units	Last results
TB Detection (By staining technique)				
TB Direct Exam (Ziehl-Neelsen staining)				
Specimen Type : BRONCHIAL WASHING				
Acid Fast Bacilli	Negative	Negative		
Interpretation				
ZehilNeelsen stain to detect koch bacilli was used in the above test.				
FUNGAL DIRECT EXAMINATION				
Specimen type	BRONCHIAL WASHING			
Fungal spores	Negative	Negative		
Fungal myeilium	Negative	Negative		

Reviewed by lab director
Dr. Adnan Al-Khatib

المستشفى السوري التخصصي

دمشق ، شارع مرشد خاطر

الدكتور ماهر نصار
اختصاصي في التشريح المرضي
ماجستير في التشريح المرضي

الدكتور ملهم الريس
بورد أمريكي بالتشريح المرضي والسريري
بورد أمريكي بالتشريح المرضي للجهاز العصبي

الإسم	[redacted]	العمر	64	الجنس	أنثى	التاريخ	09/10/2024
الرقم	0[redacted]293	الطبيب	د._الدكتور_عبد_الرحمن_دكاك_المحترم				

Clinical Data

Diagnosis

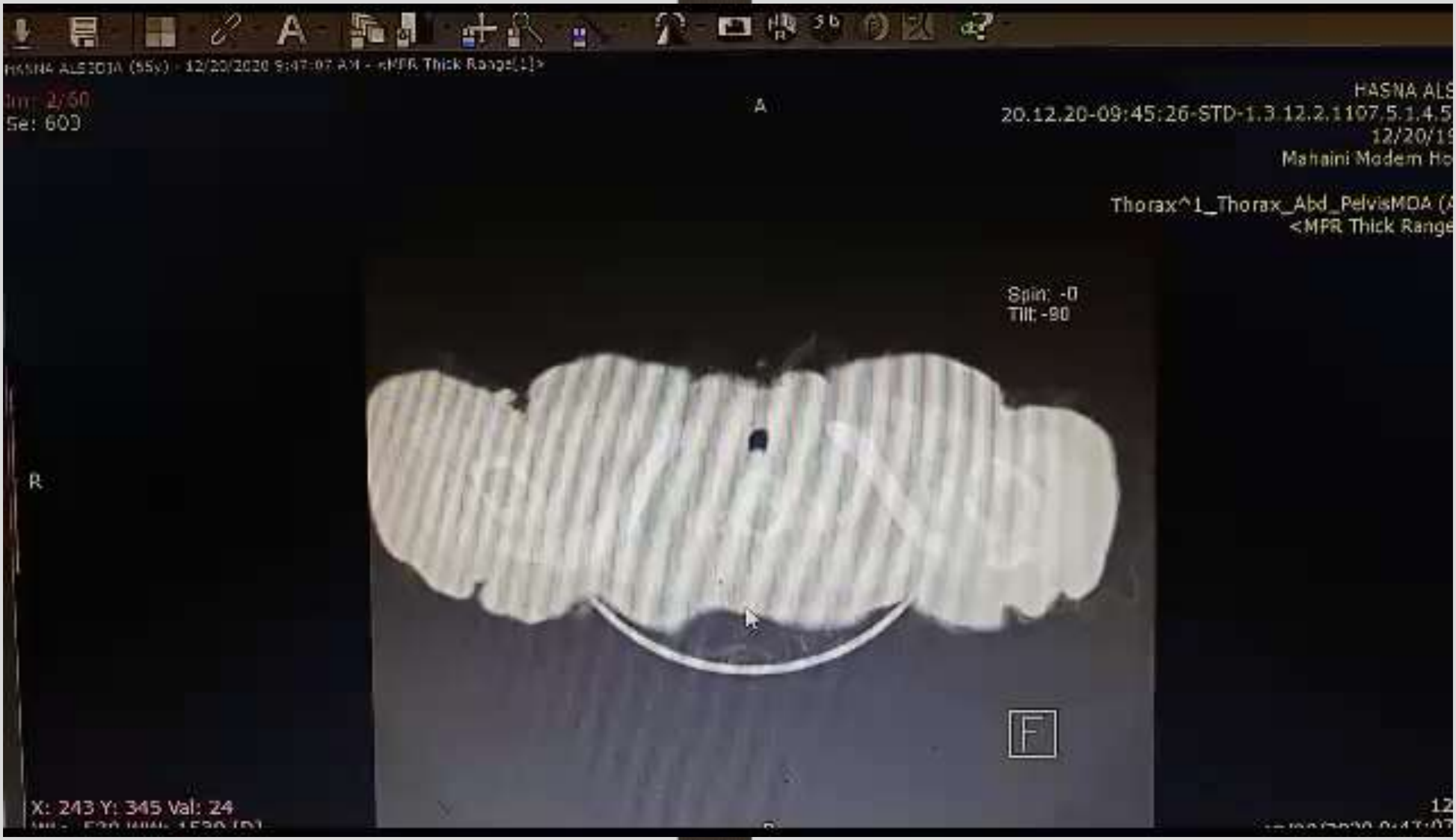
Bronchial biopsy: **Aspergillosis.**
- The material composed of large colonies of non-invasive fungal hyphae.
- No bronchial mucosal tissue included. No granulomas or atypical changes are seen

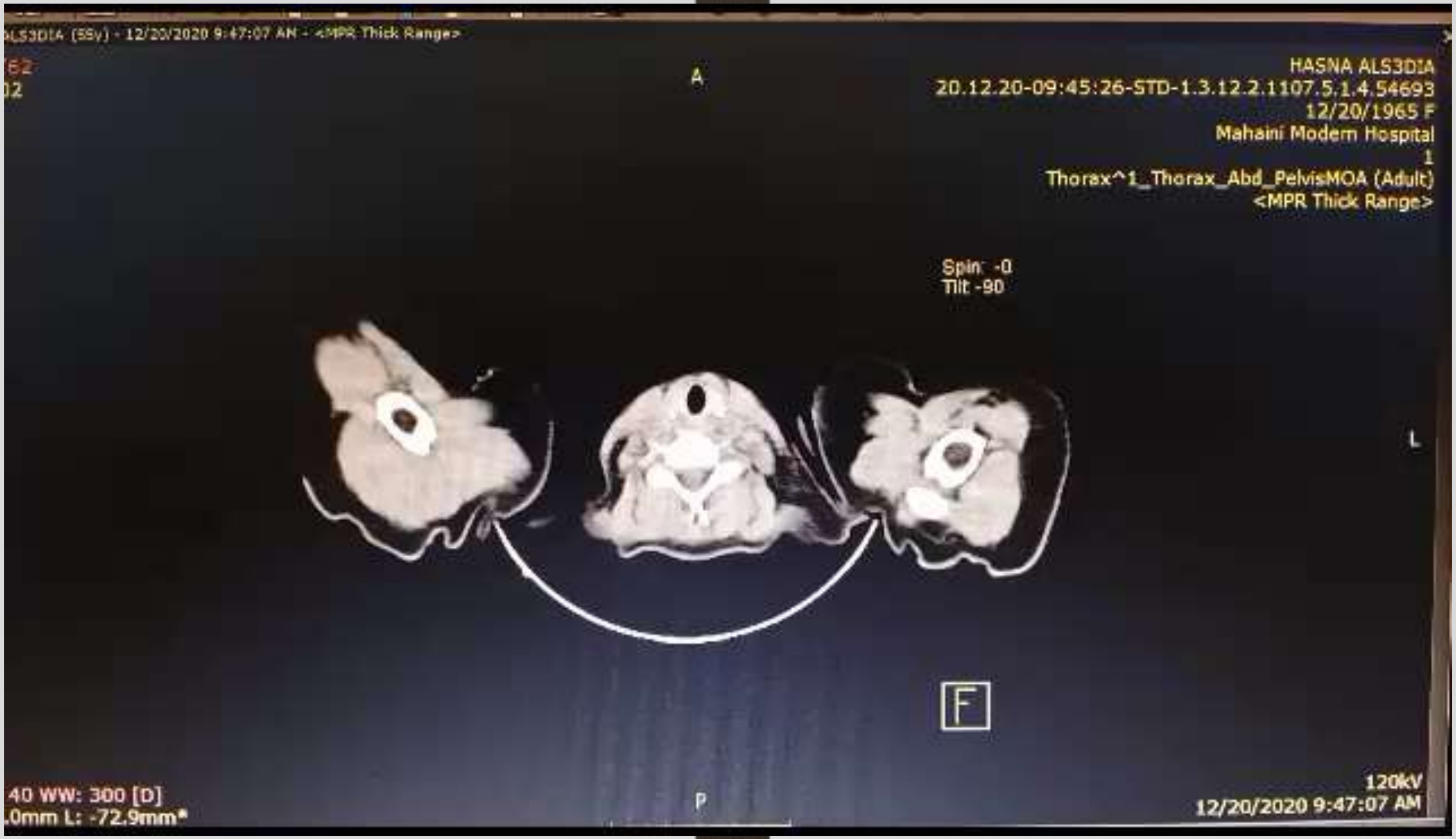
Gross Description

Soft tissue material measuring 0.5 x 0.4 x 0.4 cm

Maher Nassar,M.D.
Pathologist

طبقي صدر دون حقن قبل 4 سنوات (2020)


A
Se: 603
HASNA ALS
20.12.20-09:45:26-STD-1.3.12.2.1107.5.1.4.5
12/20/19
Mahaini Modern Ho
Thorax^1_Thorax_Abd_PelvisMOA (A
<MPR Thick Range
Spin: -0
Tilt: -90
R
F
X: 243 Y: 345 Val: 24


ALS3DIA (55y) - 12/20/2020 9:47:07 AM - <MPR Thick Range>
A
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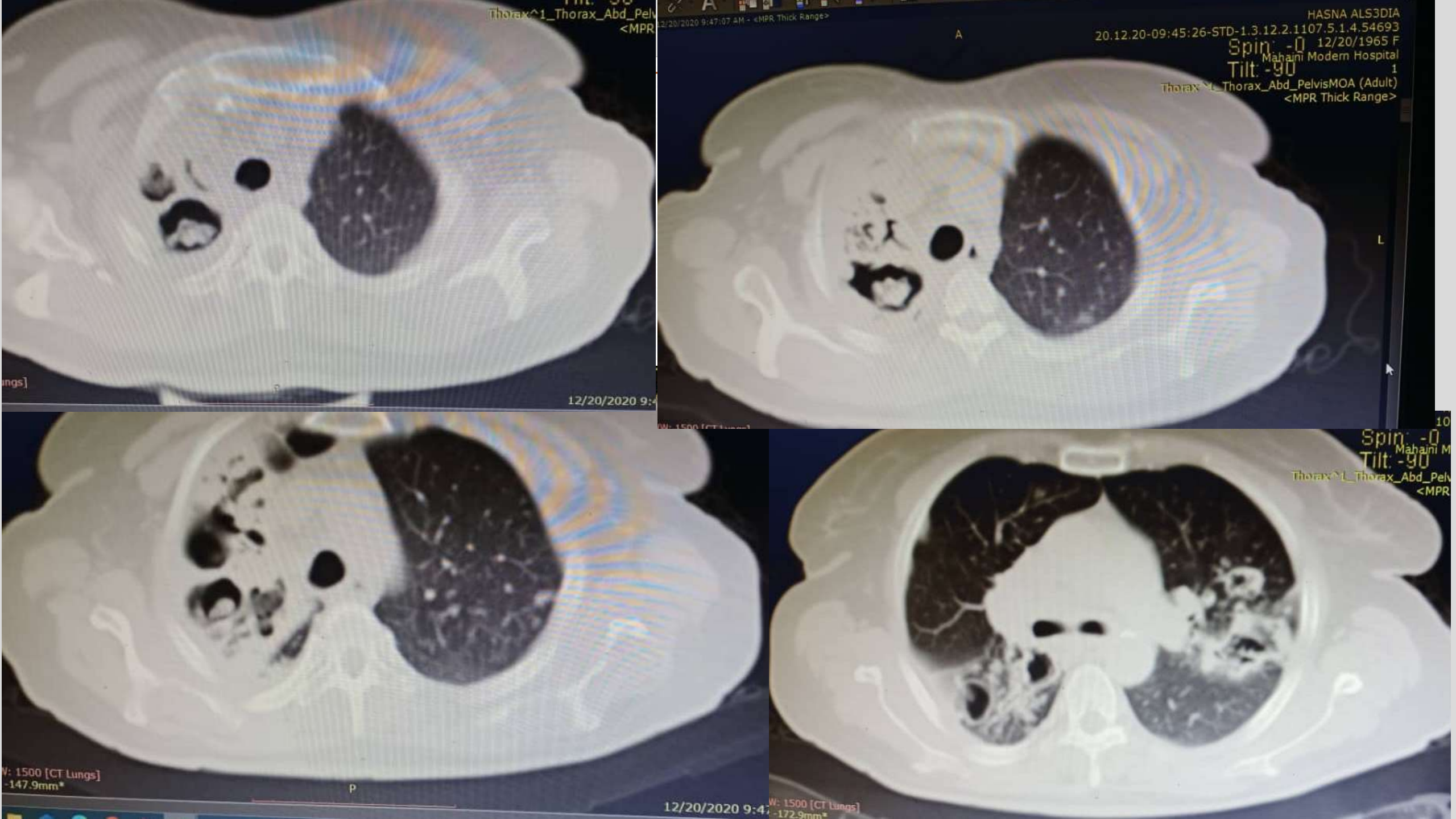
20.12.20-09:45:26-STD-1.3.12.2.1107.5.1.4.54693
12/20/1965 F
Mahaini Modern Hospital
1
Thorax^1_Thorax_Abd_PelvisMOA (Adult)
<MPR Thick Range>
Spin: -0
Tilt -90
L
F
P
120kV
12/20/2020 9:47:07 AM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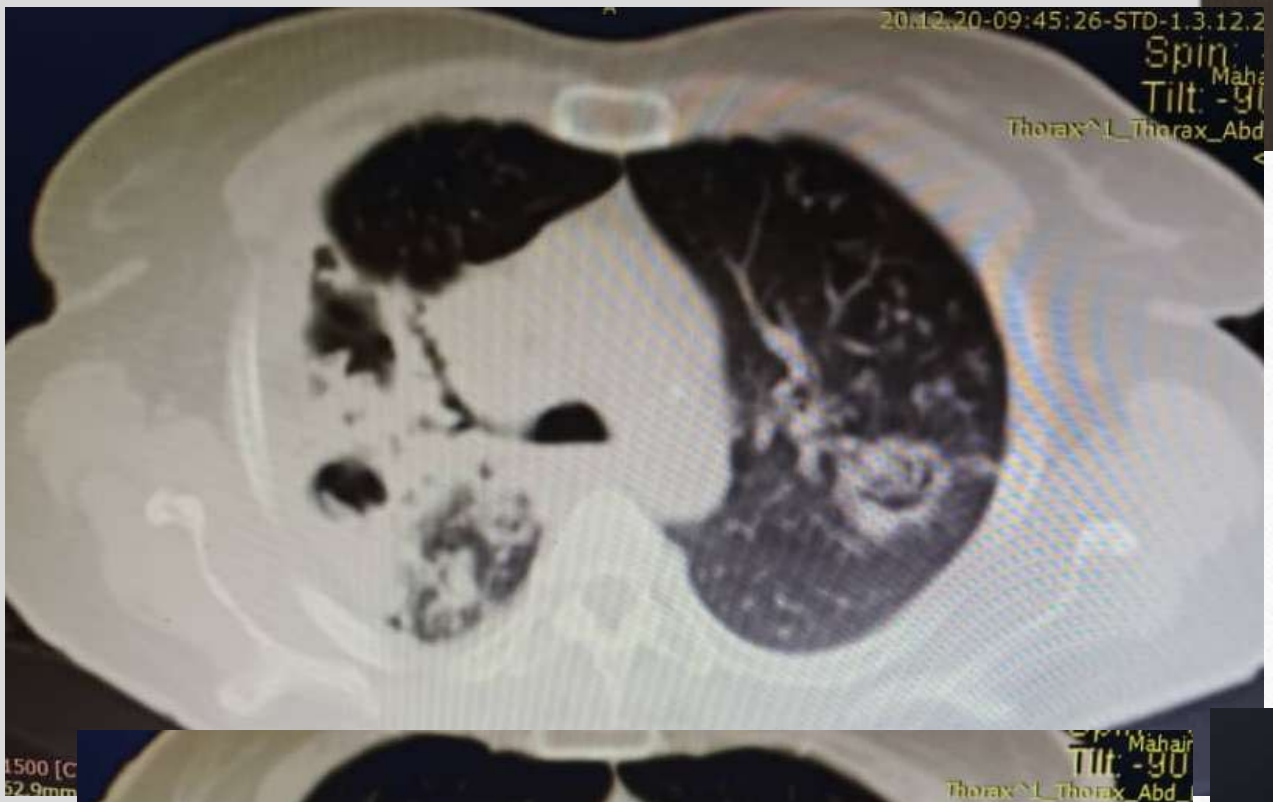
20.12.20-09:45:26-STD-1.3.12.2.1107.5.1.4.54693
Spin: -0
12/20/1965 F
Mahaini Modern Hospital
Tilt: -90
1
Thorax^1_Thorax_Abd_PelvisMOA (Adult)
<MPR Thick Range>
A
L
P
12/20/2020 9:47:07 AM - <MPR Thick Range>
W: 1500 [CT Lungs]
-147.9mm*
-172.9mm*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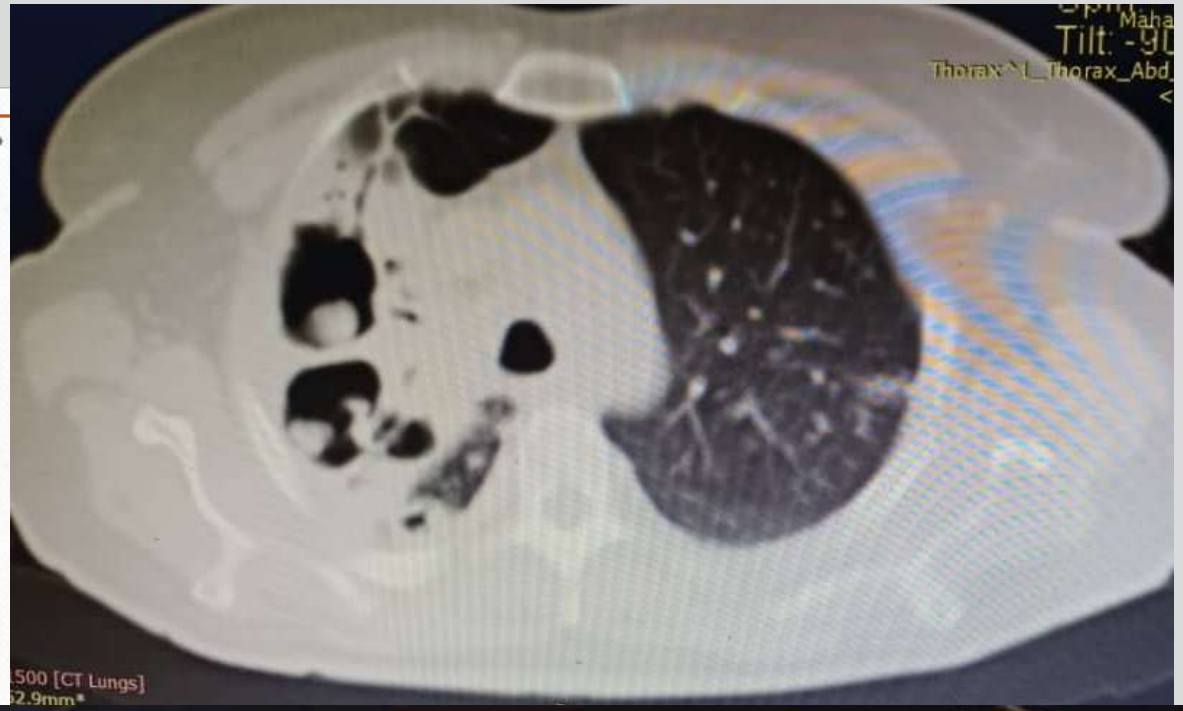
Tilt: -9
Thorax^1_Thorax_Abd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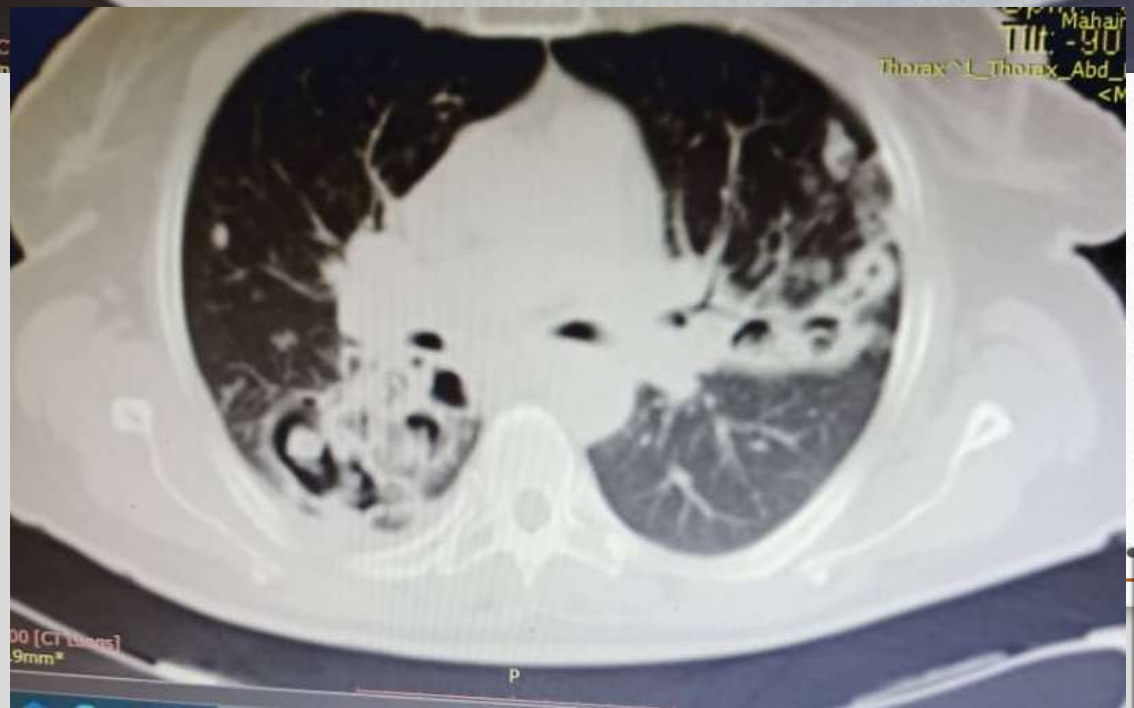
Thorax^1_Thorax_Abd
500 [CT Lungs]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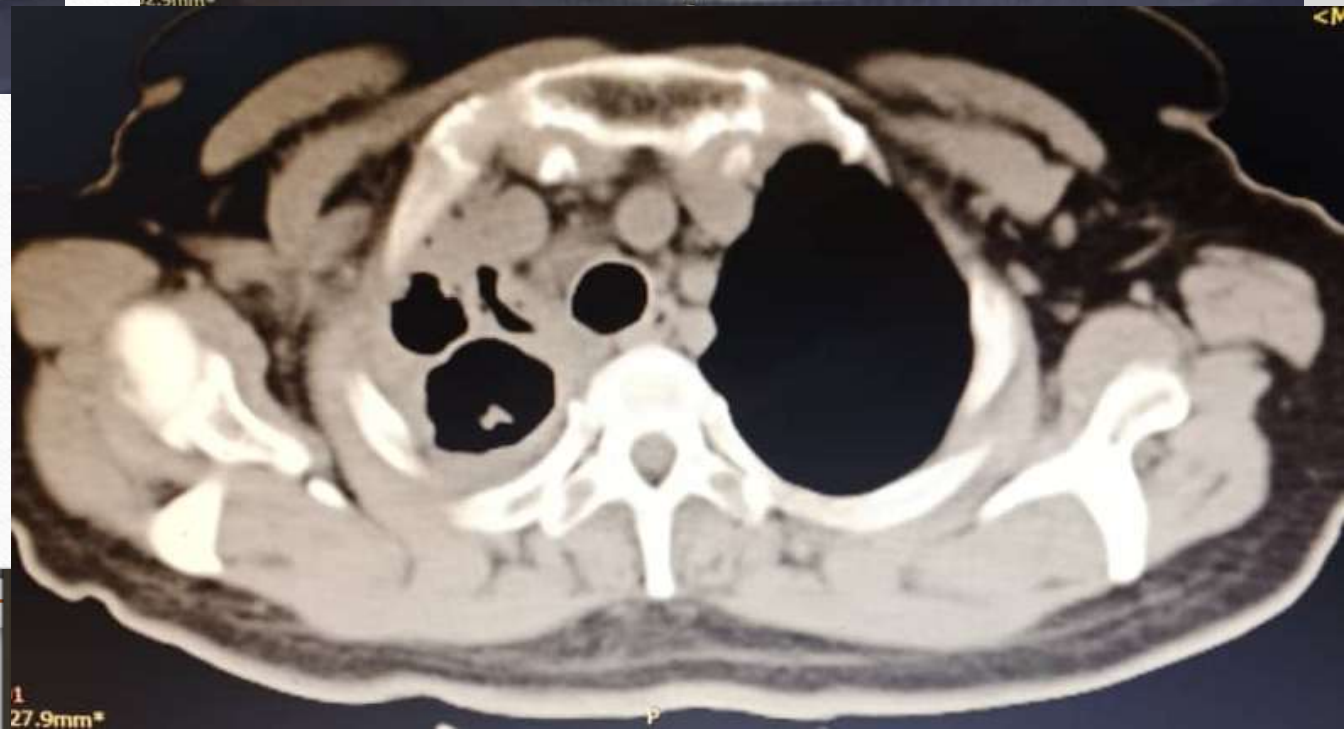
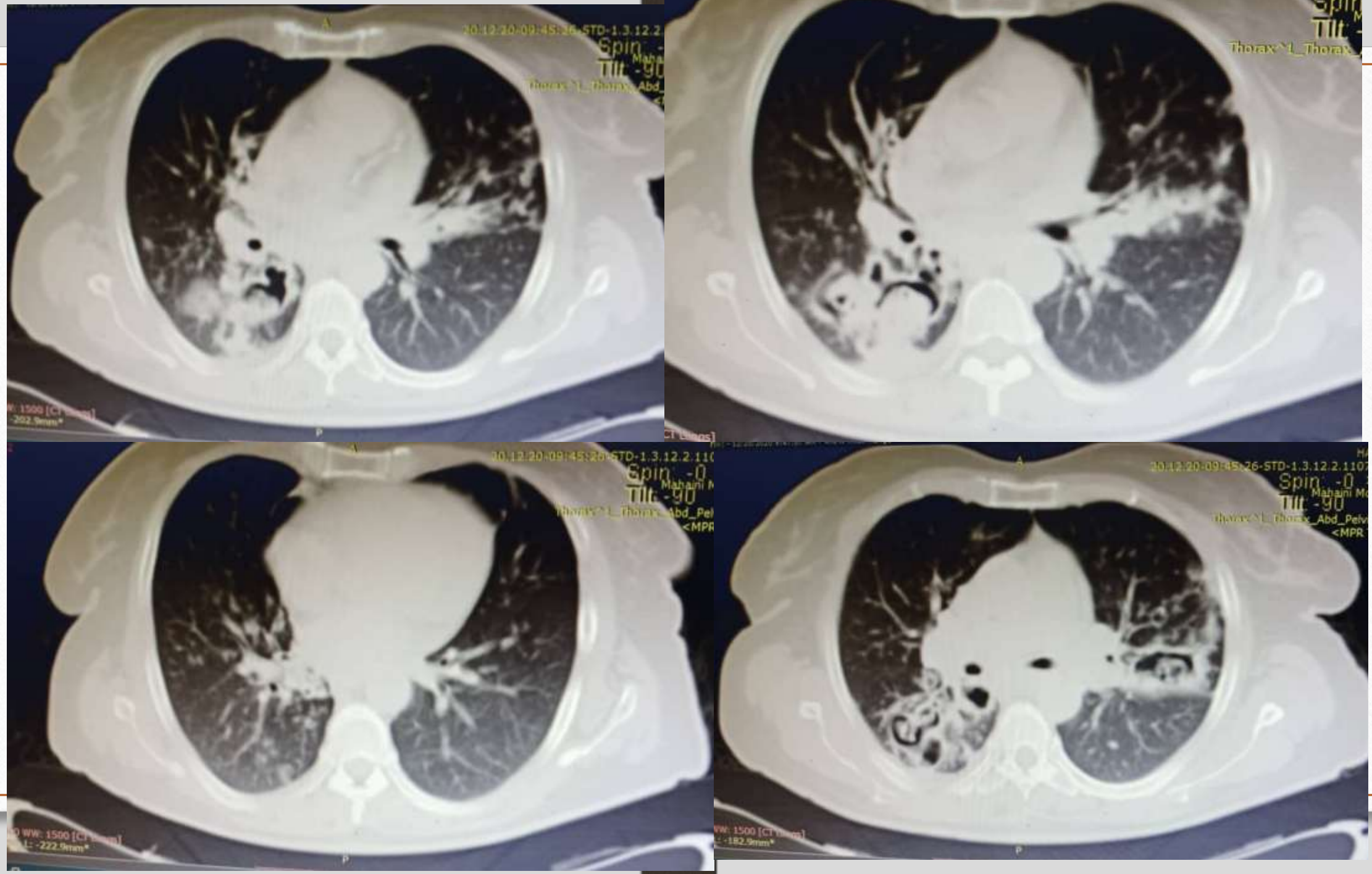
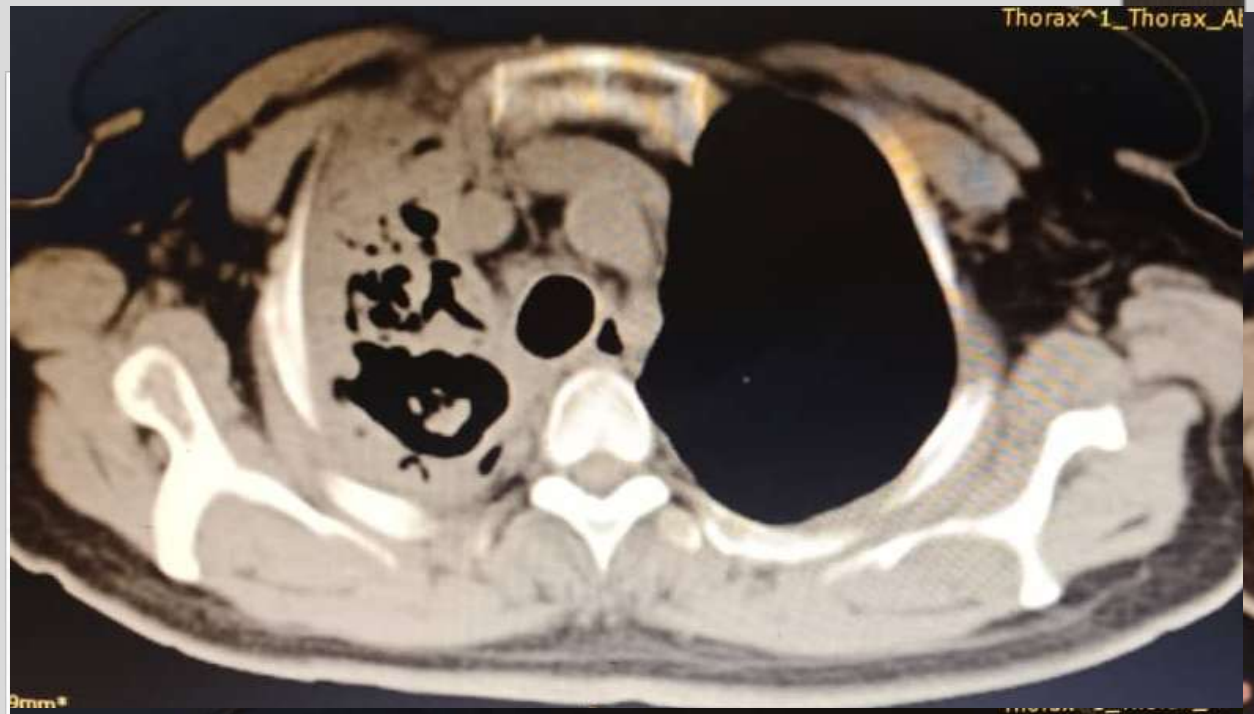
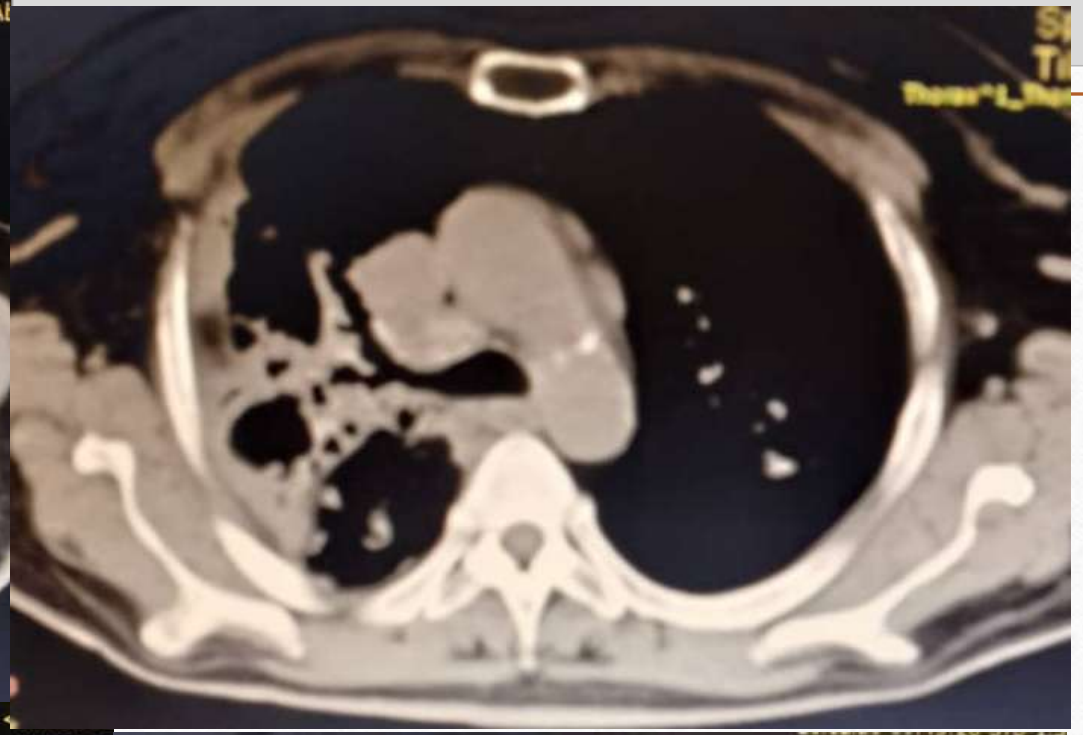
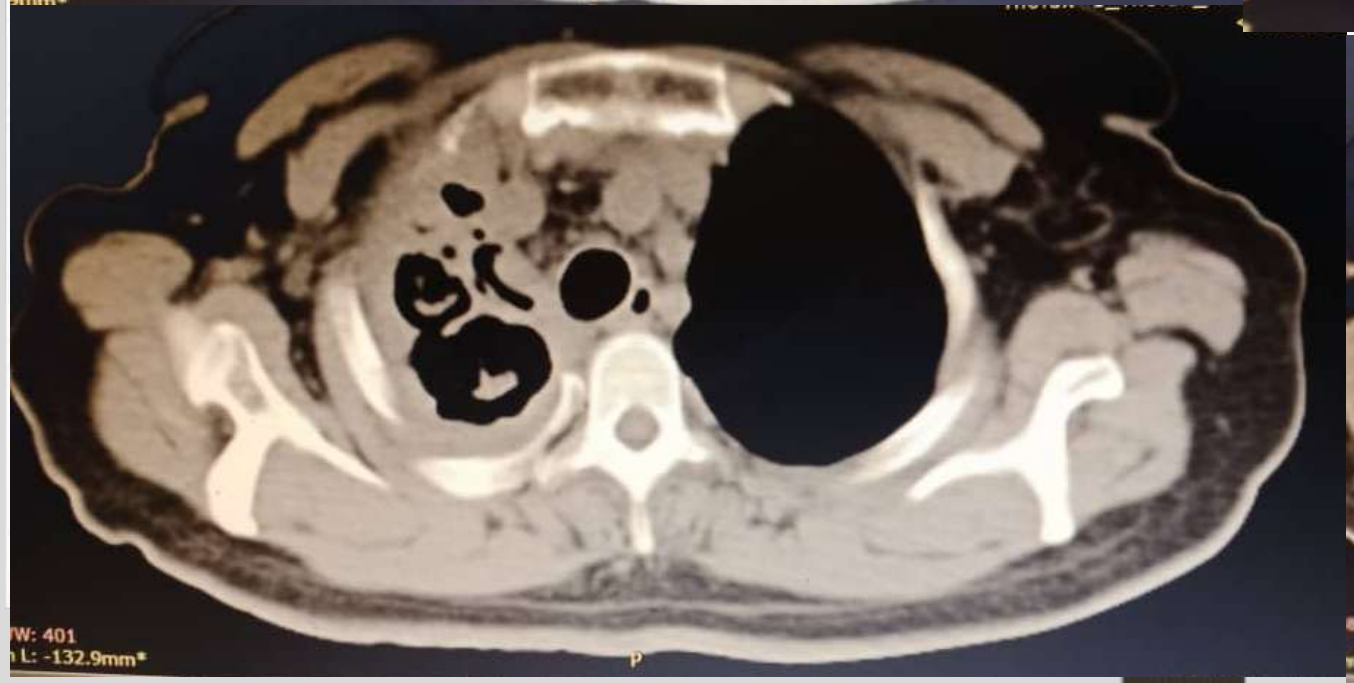
Thorax^1_Thorax_Abd
P

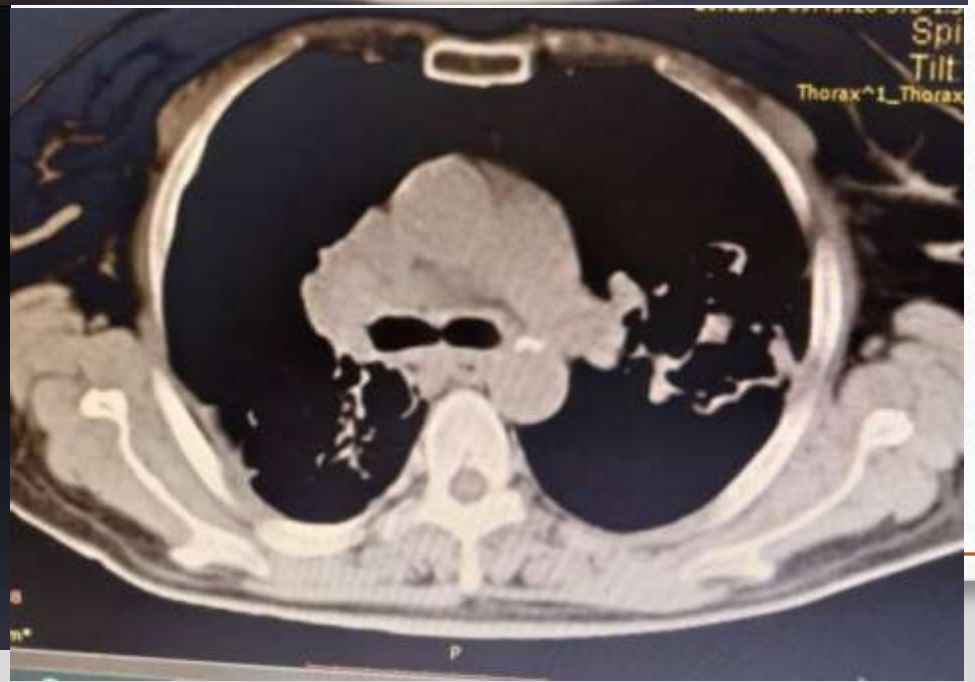

27.9mm*
P




Thorax^1_Thorax_Al




W: 401
L: -132.9mm*
P


Tilt
Thorax^1_Thorax
P

Aspergillosis Tretment

- **ANTIFUNGAL THERAPY**
- Choice of regimen — **Three classes of antifungal** agents are available for the treatment of aspergillosis: ***polyenes, azoles, and echinocandins***. Appropriate therapy for aspergillosis depends upon the host's immune status, organ function (kidney and liver), prior therapies, and risk of a resistant pathogen.

Patients with established diagnosis of invasive aspergillosis For initial therapy of invasive aspergillosis

- we recommend ***voriconazole*** if a resistant pathogen is not suspected. We use **monotherapy** for most patients, For patients with severe or progressive disease, we **suggest adding** two weeks of **echinocandin** therapy to voriconazole before transitioning to voriconazole monotherapy
- For patients who cannot tolerate voriconazole or when it is advisable to avoid its side effects, **posaconazole and isavuconazole are the preferred alternatives.**
- **Liposomal amphotericin B or amphotericin B lipid complex** are additional alternatives but these agents carry the risk of nephrotoxicity and are only available intravenously

- Combination therapy in patients who do not respond to initial therapy we typically give combination therapy with either voriconazole or another azole (isavuconazole or posaconazole) plus an echinocandin
- We do not use other combinations such as amphotericin B with a triazole as there are no clinical data to support their use.

Voriconazole Dose in Aspergillosis

Chronic cavitary pulmonary

- The recommended dosing regimen **is 6 mg/kg IV every 12 hours on day 1 followed by 4 mg/kg IV every 12 hours thereafter.**
- **Oral: 200 to 300 mg twice daily** or weight-based dosing (3 to 4 mg/kg twice daily)
- patients who are frail or low body weight (eg, BMI <18.5), **150 mg twice daily**
- **Duration: ≥6 to 12 months**; some patients require prolonged, potentially lifelong therapy

Voriconazole Dose

Invasive (including disseminated and extrapulmonary):

- **IV: 6 mg/kg twice daily for 2 doses, then 4 mg/kg twice daily**.
- Note: Once a patient is able to tolerate oral administration, consider transition to oral formulation
- **Oral: 200 to 300 mg twice daily or weight-based dosing (3 to 4 mg/kg twice daily)**
- **Duration:** ***Minimum of 6 to 12 weeks***, depending on degree/duration of immunosuppression, disease site, and response to therapy; immunosuppressed patients may require more prolonged treatment

Thanks