50. THE DILEMMA OF DIFFUSE PULMONARY DISEASE: THE OBVIOUS DIAGNOSIS IS NOT ALWAYS THE CORRECT ONE

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Introduction. Diffuse pulmonary disease represents one of the most challenging issues in clinical pulmonology in terms of diagnosis and treatment. Nonspecific clinical manifestations, absence of clear pathognomonic symptoms, and insufficient information from imaging studies are just a few of the problems clinicians face when performing a differential diagnosis in this group of diseases.

Case presentation. We analyzed two clinical cases admitted in IMSP, IP Chiril Draganiuc, Chisinau , initially with suspected pneumonia and differential diagnosis with pulmonary tuberculosis: Case 1: A 40-year-old man admitted to the intensive care, reported an insidious onset of dyspnea, progressively worsening over 5-6 months, accompanied by weight loss (5 kg), and periodic gum bleeding. Seven days prior to admission, he developed an inflammatory syndrome with fever (39˚C), fatigue, arthralgia, serous rhinorrhea and hemoptysis. A chest CT scan that revealed disseminated lesions with cavitations predominantly in the apical segments on the left side. Case 2: A 28-year-old woman presenting with a productive cough with hemoptysis and weight loss of 30 kg over 6 months. She had previously been treated for right-sided pneumonia without positive response, with radiological progression under antibiotic therapy. A "subtotal opacification" of the right lung and a positive c-ANCA (PR3) test unmasked the true diagnostic: Granulomatosis with Polyangiitis (GPA).

Discussions. The elements that guided the diagnosis in both cases were extrapulmonary manifestations such as gingival bleeding, arthralgias, and ENT(otolaryngology) involvement in the first case, otitis media with hearing loss in the second. Paraclinical findings revealed marked inflammatory syndrome, progressive anemia, and decisively, positive anti-neutrophil cytoplasmic antibodies (c-ANCA) (anti-PR3 >160). Imaging patterns in both patients showed polymorphic findings, ranging from cavitary nodules to diffuse alveolar infiltrates (alveolar hemorrhage confirmed by fiberoptic bronchoscopy in case 2). On a background of pulse therapy (Methylprednisolone 1000 mg) and Cyclophosphamide, both patients showed good clinical and radiological evolution.

Conclusions. These cases illustrate the diagnostic challenges and the need of a holistic approach when facing a diffuse pulmonary disease that is not responding to standard antimicrobial therapy and is suspected of tuberculosis. The absence of initial renal involvement, although is a good prognostic factor and it does not exclude the diagnosis of GPA. Considering assessment of autoimmune markers in atypical “pneumonia” is essential for improving long-term survival.

Keywords. Granulomatosis with Polyangiitis (GPA), Diffuse Pulmonary Disease, Anti-neutrophil Cytoplasmic Antibodies (c-ANCA).

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