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Sonali Bishnoi

Lehigh Valley Health Network, sonali.bishnoi@lvhn.org

Ashley Wojtek DO

Lehigh Valley Health Network, ashley.wojtek@lvhn.org

Clarissa Hayes

Lehigh Valley Health Network, clarissa.hayes@lvhn.org

Gregory Karamian

Lehigh Valley Health Network, gregory.karamian@lvhn.org

C. Gerard Petersen

Lehigh Valley Health Network, C_gerard.petersen@lvhn.org

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A Case of Massive Hemoptysis Due to Pulmonary Aspergilloma

Sonali Bishnoi, DO, Ashley Vojtek, DO, Clarissa Hayes, DO, Gregory Karamian, MD, C. Gerard Petersen, MD

Lehigh Valley Health Network, Allentown, Pa.

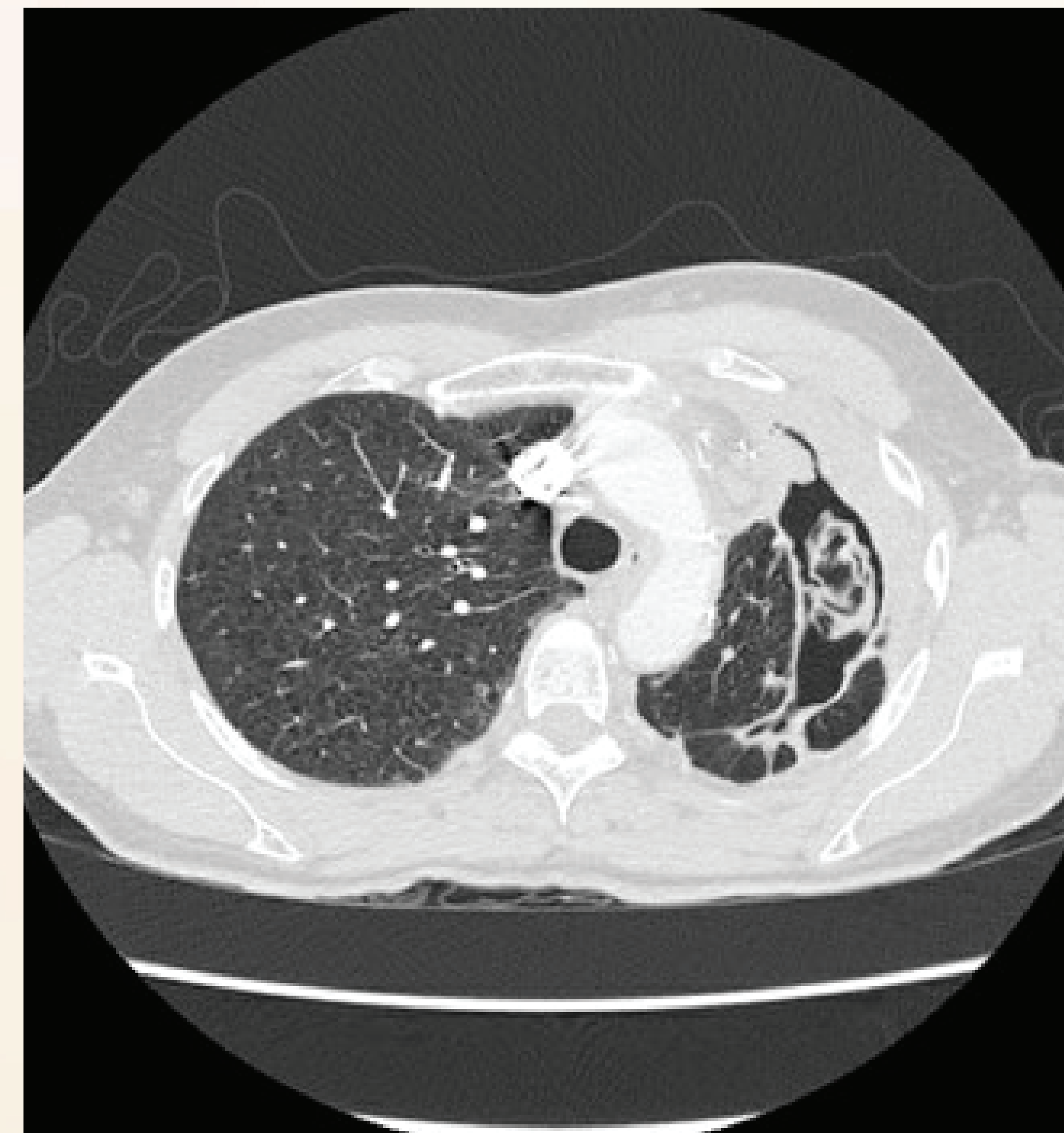
Introduction

Pulmonary aspergilloma is caused by the colonization of a preexisting pulmonary cavity by *Aspergillus fumigatus*. Such cavities are typically a consequence of previous tuberculosis infection. Aspergillomas cause bronchial hypervascularization, which could cause life-threatening hemoptysis. This can be resolved with bronchial artery embolization in as many as 90% of patients. Here we present the case of a 62-year-old female with previous left upper lobectomy due to cancer who then developed massive hemoptysis from an Aspergilloma that remained refractory to embolization.

Case Summary

A 62-year-old female active smoker with past medical history of COPD and lung cancer status-post left upper lobectomy presented to the pulmonary office for intermittent hemoptysis. A routine surveillance chest CT noted a new left upper lobe lesion concerning for aspergilloma. Bronchoscopic fungal cultures yielded 1 colony of non-specified *Aspergillus* for which a 6-month course of isavuconazole was started. The patient was deemed a high surgical risk, so evacuation of the lesion was not pursued.

Approximately 1 year later she was hospitalized for massive hemoptysis. Repeat bronchoscopy found active bleeding, so the patient underwent bronchial and intercostal artery embolization. The hemoptysis persisted, requiring 5 days of nebulized tranexamic acid and a repeat course of isavuconazole. Completion pneumonectomy was attempted as a heroic measure, however it could not be completed due to significant adhesions and bleeding. The patient underwent a series of surgeries to remove the infected lung tissue as well as repeat embolization of the intercostal arteries. She was eventually discharged to LTACH with a tracheostomy and a percutaneous endoscopic gastrostomy tube.



Discussion

The presence of an aspergilloma has been identified as a major risk factor for recurrence of hemoptysis following bronchial artery embolization. This complication carries a mortality rate as high as 31%. As a result, surgery is highly recommended for definitive management. For patients who are deemed poor surgical candidates, like ours, the percutaneous instillation of antifungal agents has shown promising results. Unfortunately, our patient's lesion had a thick rind that made percutaneous biopsy or instillation of antifungals highly risky.