Desquamative Interstitial Pneumonia

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A 72 year-old, smoker (100 pack/years) patient presented to our outpatient clinic with dyspnea on exertion (MRC II/IV) and non-productive cough since 2 months. Auscultation revealed fine, bibasilar, end-inspiratory ("Velcro") crackles. Rest of physical examination was unremarkable. Laboratory tests were normal. Hemoglobin oxygen saturation (SaO2) was 88% breathing room air. His medical history included arterial hypertension and hypercholesterolemia. Pulmonary function tests revealed a restrictive pattern with impaired diffusion capacity for carbon monoxide (FVC: 61%pred, FEV1/FVC: 0.78, TLC: 55.6%pred και DLco: 43.4%pred). High resolution computed tomography (HRCT) showed bilateral, symmetric, diffuse ground glass opacities with minimal reticulation and absence of honeycombing (Figure 1). Bronchoalveolar lavage (BAL) reveled markedly elevated pigmented alveolar macrophages (99%). A diagnosis of Desquamative Interstitial Pneumonia (DIP) was assumed. Patient was strongly advised to quit smoking and low doses of corticosteroids were dispensed.

One year after smoking cessation, patient remains without symptoms. Follow-up HRCT shows no ground-glass opacities (Figure 2) and respiratory function has returned to normal, excluding a mild decrease in DLco (65%pred). Hemoglobin oxygen saturation is 96% and breathlessness over exertion is MRC I/IV.

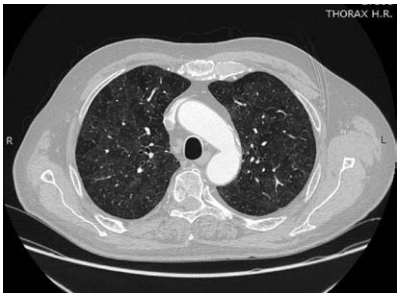

FIGURE 1. High-Resolution Computed Tomography showing diffuse, bilateral and symmetrical ground glass opacities with minimal reticulation and absence of honeycombing.

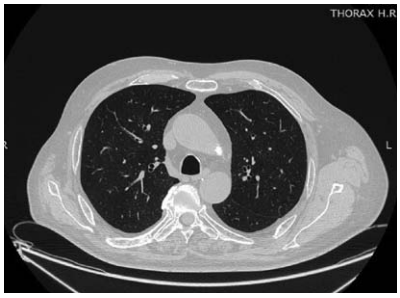

FIGURE 2. High-Resolution Computed Tomography one year after treatment initiation showing remission of ground-glass opacities.

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