Journal of Research in Medical and Dental Science
2023, Volume 11, Issue 6, Page No: 15-16
Copyright CC BY-NC 4.0
Available Online at: www.jrmds.in
eISSN No. 2347-2367: pISSN No. 2347-2545

A Case of Uncontrolled Asthma

Padmalatha K*, Sankar A, Umashankar R

Department of General Medicine, Sree Balaji medical college and hospital, Chennai, India

ABSTRACT

A 55 year old female came to our hospital with complaints of dyspnea, wheezing for 6 months since her last asthma attack which was severe, now she has come for Anti-IgE therapy. For the past six months patient was on budesonide and formoterol combination twice a day, montelukast 10mg/day and oral steroids in spite of adequate treatment patient symptoms were not relieved. Chest X-ray had done which revealed left-sided hilar opacity. Patient has been hospitalized and further evaluation has been done. Bronchoscopy done which revealed endobronchial lesion obstructing the left lower bronchus lumen. Computed tomography revealed a nodular lesion at left lower bronchus lumen. Patient underwent lobectomy and mediastinal lymph node dissection, following surgery patient improved symptomatically. Samples sent for pathological examination and revealed typical carcinoid tumour. Patient had no recurrence after the surgery. Uncontrolled asthma should be further evaluated for any other cause and also to be evaluated for other treatment options.

Keywords: Levofloxacin, hyper pigmented changes, CKD

HOW TO CITE THIS ARTICLE: Padmalatha K, Sankar A, Umashankar R, A Case of Uncontrolled Asthma, J Res Med Dent Sci, 2023, 11 (5): 15-16.

Corresponding author: Padmalatha K

e-mail✉: padmalatha1507@gmail.com

Received: 25-May-2023, Manuscript No. jrmds-22-75345;

Editor assigned: 29-May-2023, PreQC No. jrmds-22-75345(PQ);

Reviewed: 12-June-2023, QC No. jrmds-22-75345(Q);

Revised: 17-June-2023, Manuscript No. jrmds-22-75345(R);

Published: 24-June-2023

INTRODUCTION

Approximately 10% to 15% of asthma patients have refractory severe asthma to regular medications. A careful evaluation should be done in these patients to exclude other etiologies that could be contributing or presenting to or as uncontrolled asthma. There is various treatment options available to consider once underlying conditions are ruled out. This case represents a 55 year old female patient with uncontrolled asthma (persistent wheeze and dyspnea) that remains refractory to medications later diagnosed to be carcinoid tumour. Further evaluation for treatment and confirmation of diagnosis was required for the patients with uncontrolled asthma to look for any other conditions.

CASE REPORT

A 55-year old woman was admitted in our hospital with complaints of persistent dyspnea and wheezing for six months. She is a known case of asthma since 12years on regular medication and was well controlled using budesonide at 160 µg + formoterol at 4.5 µg B.I.D combination therapy until 6 months back. She had a severe asthma attack 6 months back associated with wheezing and had persisted. Patient was started on higher doses of budesonide 320ug + formoterol 9ug B.I.D, and also started on oral steroids 30-40mg/dl and montelukast 10mg/day. Patient did not show any improvement even on higher doses. She is also a known case of hypothyroid and on treatment. On examination patient vitals stable, systemic examination was normal except for respiratory examination (on auscultation reduced breath sounds on left side).

Investigations and Management

Patient routine investigations were done like complete blood count showed normal values. For further evaluation spirometry was done forced expiratory volume in 1 second: 82%; forced vital capacity: 110%; FEV1/FVC : 60%. There was no reversibility with bronchodilators unlike her previous admission there was 20% reversibility. Skin prick test was positive for dust mites. Total IgE levels were 115ku/l, suspecting bronchial asthma requiring Anti-IgE therapy. Chest X-ray was done which revealed hilar opacity in left lower side following which Computed tonigraphy was done which revealed 14mm diameter nodular lesion at the left lower lobe bronchus lumen. A fiberoptic bronchoscopy was done, which showed a highly vascularized endobronchial lesion obstructing the left lower bronchus lumen. Due to risk of bleeding biopsy was not done. Bronchial lavage was done and sent for cytological examination

which was normal. Invasion of the tumour into lung parenchyma was noted, Left lower lobectomy and mediastinal node dissection was done. Sample has been sent for immunohistochemical staining which revealed cytoplasmic positivity for pan cytokeratin, CD56, Chromogranin A and synaptophysin suggesting typical carcinoid tumor. Patient is asymptomatic after resection with the treatment for bronchial asthma

DISCUSSION

In spite of asthma patients treated with regular medications, many cases are showing recurrent attacks /flares. Proper work-up to be done to evaluate other comorbidities that aggravate the symptoms of asthma like carcinoid tumors, GERD, etc., and reconfirmation of asthma as diagnosis is required for appropriate treatment. Here we have a case of asthma with persistent wheeze and dyspnea after an acute flare of asthma, which on further evaluation diagnosed to be carcinoid tumour. Pulmonary carcinoid tumours are mostly misdiagnosed with asthma. The symptoms of pulmonary carcinoid tumours include hemoptysis, cough, wheeze, lower respiratory tract infections, only few cases are diagnosed as carcinoid tumours co-existing with asthma. In this case carcinoid tumour was diagnosed while working up the case. As it is a case of carcinoid tumour co-existing with asthma, and IgE are raised, the patient needs treatment with Anti-IgE therapy. The patient had recurrent attack of asthma after 8 months of surgery; hence the patient diagnosis of asthma can be confirmed. Further detailed evaluation of the any uncontrolled asthma in spite of proper treatment is required to evaluate the cause and to provide appropriate treatment. Currently the patient is symptomatically better and is on regular treatment for asthma.

REFERENCES

1. Dipaolo F, Stull MA. Bronchial carcinoid presenting as refractory asthma. Am Fam Physician 1993; 48:785-9.
2. Schrevens L, Vansteenkiste J, Deneffe G, et al. Clinical-radiological presentation and outcome of surgically treated pulmonary carcinoid tumours: A long-term single institution experience. Lung cancer 2004; 43:39-45.
3. Marty-Ané CH, Costes V, Pujol JL, et al. Carcinoid tumors of the lung: Do atypical features require aggressive management?. Ann Thorac Surg 1995; 59:78-83.
4. TURkTAS H, Mungan D, Uysal MA, et al. Determinants of asthma control in tertiary level in Turkey: A cross-sectional multicenter survey. J Asthma 2010; 47:557-62.
5. Hurt RA, Bates MI. Carcinoid tumours of the bronchus: A 33 year experience. Thorax 1984; 39:617-23.