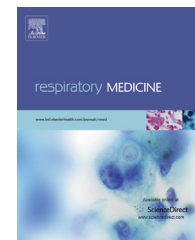


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LETTER TO THE EDITOR

Importance of the reversed halo sign for the diagnosis of angioinvasive pulmonary aspergillosis



To the Editor

We read with great interest the well-written article by Tunnicliffe et al. [1], who reviewed the clinical, radiographic, and histopathological aspects of pulmonary aspergillosis. They briefly mentioned that the reversed halo sign (RHS) has been described in invasive fungal infections (IFIs), although its sensitivity for identifying IPA remains to be tested in a larger number of cases.

As the early diagnosis of IFI relies heavily on computed tomographic findings [2,3], we would like to highlight the diagnostic importance of the RHS. The RHS has been reported in a wide spectrum of diseases, including infectious and noninfectious processes [5], but it is highly suggestive of IFI, particularly pulmonary zygomycosis or IPA, in the context of immunosuppression [2–7]. Wahba et al. [7] demonstrated that 4% of immunocompromised patients with pulmonary IFI exhibited the RHS early in the disease

course. The RHS may precede respiratory symptoms in most of these patients [7].

A recent study [8] demonstrated that certain morphological characteristics of the RHS (inner reticulation, outer consolidation rim thickness > 10 mm, presence of a pleural effusion) strongly suggest the diagnosis of IFI (Fig. 1). This diagnosis may be challenging, especially for general radiologists encountering patients outside the context of transplantation centers, and any delay in treatment can significantly increase mortality. The presence of the RHS with the above-described characteristics in a severely immunocompromised host is highly suggestive of IFI.

Conflict of interest statement

All authors inform that there are none conflicts of interest.

References

- [1] Tunnicliffe G, Schomberg L, Walsh S, Tinwell B, Harrison T, Chua F. Airway and parenchymal manifestations of pulmonary aspergillosis. *Respir Med* 2013;107(8):1113–23.
- [2] Georgiadou SP, Sipsas NV, Marom EM, Kontoyiannis DP. The diagnostic value of halo and reversed halo signs for invasive mold infections in compromised hosts. *Clin Infect Dis* 2011; 52(9):1144–55.
- [3] Godoy MC, Viswanathan C, Marchiori E, Truong MT, Benveniste MF, Rossi S, et al. The reversed halo sign: update and differential diagnosis. *Br J Radiol* 2012;85(1017):1226–35.
- [4] Marchiori E, Zanetti G, Escaissato DL, Souza Jr AS, Meirelles GD, Fagundes J, et al. Reversed halo sign: high-resolution CT scan findings in 79 patients. *Chest* 2012;141(5): 1260–6.
- [5] Marom EM, Kontoyiannis DP. Imaging studies for diagnosing invasive fungal pneumonia in immunocompromised patients. *Curr Opin Infect Dis* 2011;24(4):309–14.
- [6] Marchiori E, Irion KL. Commentary on: “Analysis of initial and follow-up CT findings in patients with invasive pulmonary aspergillosis after solid organ transplantation”. *Clin Radiol* 2012;67(12):1153–4.
- [7] Wahba H, Truong MT, Lei X, Kontoyiannis PD, Marom EM. Reversed halo sign in invasive pulmonary fungal infections. *Clin Infect Dis* 2008;46(11):1733–7.
- [8] Marchiori E, Marom EM, Zanetti G, Hochegger B, Irion KL, Godoy MC. Reversed halo sign in invasive fungal infections:



Figure 1 Pulmonary angioinvasive aspergillosis in a 55-year-old man with chronic lymphocytic leukemia. Computed tomographic image shows a reversed halo sign in the right lower lobe. The thickness of the outer consolidation rim is > 10 mm. Note also the reticulation inside the reversed halo sign.

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criteria for differentiation from organizing pneumonia. *Chest* 2012;142(6):1469–73.

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