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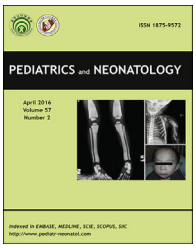

PEDIATRIC IMAGES

Endobronchial Tuberculosis Mimicking Foreign Body Aspiration

Mehmet Nuri Cevizci [a], Soner Sertan Kara [b,*], Ali İhsan Dokucu [c]

[a] *Erzurum Regional Training and Research Hospital, Department of Pediatric Surgery, Erzurum, Turkey*
[b] *Erzurum Regional Training and Research Hospital, Department of Pediatric Infectious Diseases, Erzurum, Turkey*
[c] *Sisli Etfal Training and Research Hospital, Department of Pediatric Surgery, Istanbul, Turkey*

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The first patient was a 4-month-old boy with fever, cough, and dyspnea for 1 month. History was suspicious for foreign-body aspiration (FBA). He had positive tuberculosis contact from his grandfather. He had received bacillus Calmette–Guérin vaccine 1 month before. Physical examination showed tachypnea, diminished breath sounds, and crackles on the left upper side. Chest x-ray revealed consolidation on the left side. Tuberculin skin test (TST) was 12 mm. Gastric-lavage fluid stained positive for acid-fast-bacilli (AFB). Chest computed tomography (CT) demonstrated left upper lobe atelectasis (Figure 1A); and rigid bronchoscopy revealed a vegetative mass obstructing the left main bronchus (Figure 1B).

The second patient was an 8-month-old boy with fever and dyspnea for 3 weeks. He had no previous bacillus Calmette–Guérin vaccination or tuberculosis contact; however, he had a history of FBA. Physical examination showed tachypnea, diminished breath sounds, and crackles on the right side. Chest x-ray revealed collapse of the right upper lobe (Figure 1C); and chest CT confirmed atelectasis (Figure 1D). AFB staining was negative in gastric lavage but TST was 22 mm. Rigid bronchoscopy showed a vegetative mass obstructing the right main bronchus.

Reverse transcription–polymerase chain reaction analysis from endobronchial samples of both patients showed *Mycobacterium tuberculosis* complex. Histopathology showed necrotizing granulomatous inflammation; AFB stain demonstrated mycobacterial organisms. *M. tuberculosis* did not grow.

Endobronchial tuberculosis is a form of pulmonary tuberculosis with signs and symptoms mimicking FBA.[1] Tuberculosis is a major health problem in Turkey with an incidence of 28/100,000 in the general population and 4.1/100,000 in children aged 0–4 years.[2] TST and AFB staining of the available samples, in addition to chest CT and direct visualization via bronchoscopy are useful in diagnosis.[3] Prompt recognition and diagnosis of this condition is of paramount importance for timely treatment with prolonged antituberculosis therapy regimen (9 months or more) to prevent tracheobronchial stenosis and eradicate *M. tuberculosis*.[4]

Conflicts of interest

The authors have no conflicts of interest relevant to this article.

* Corresponding author. Erzurum Regional Training and Research Hospital, Department of Pediatric Infectious Diseases, Erzurum, Turkey.
E-mail address: drsoner@yahoo.com (S.S. Kara).

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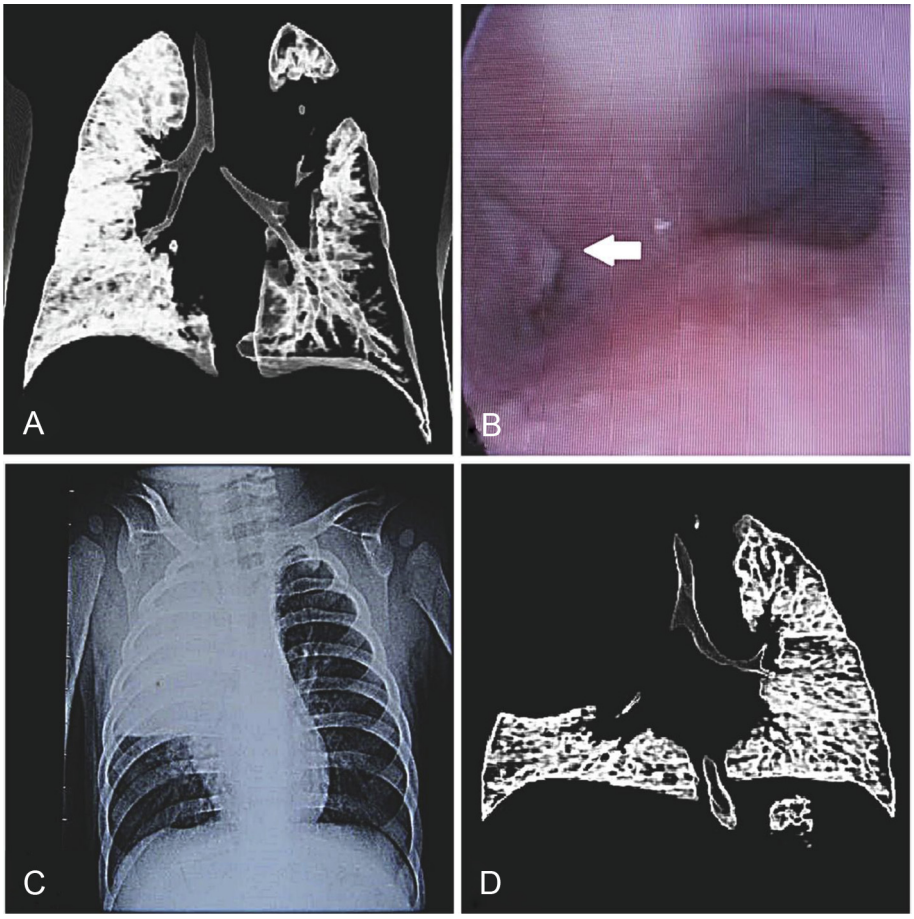

Figure 1 (A) An oblique frontal three-dimensional minimum intensity projection computed tomography image of the central airways and lungs shows a severe narrowing of the left main bronchus at the proximal portion. Note the left upper lobe atelectasis. (B) Bronchoscopy shows severely narrowed lumen of the left main bronchus at the level of carina. (C) Chest radiograph of the second patient shows the total opacification of the right upper lobe compatible with collapse. (D) Frontal three-dimensional minimum intensity projection computed tomography image of the central airways and lungs shows a severe narrowing of the right main bronchus, as well as right upper and lower lobe bronchus due to a vegetative mass. Note the right lobe atelectasis.

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