**CASE DESCRIPTION**

This patient (male, 59 years old) underwent cardiac re-transplantation for chronic rejection. Prior to re-transplantation, the patient was in NYHA class IV, with a clear chest x-ray. On 14th postoperative day, he presented hemoptysis. On chest x-ray, a left lower lobe opacity was seen. Therefore, a chest CT scan was done and it showed a round mass within a pulmonary cavity surrounded by airspace in proximity of the pulmonary artery. The radiologist strongly suspected a pulmonary lesion similar to an aspergillum’s disease. The radiological appearance together with the immunocompromised status of the patient made the diagnosis of aspergillosis possible. Considered the high risk of a devastating hemoptysis due to the aspergillum vascular invasiveness, a left lower lobectomy was performed. The following course was characterized by a difficult weaning from mechanical ventilation and the patient was discharged on 45th postoperative day post lobectomy. Surprisingly pathological examination showed an abscessual cavity in an area of pulmonary infarction.

We focused on aspergillosis in view of the above-mentioned aspects, nevertheless a differential diagnosis of pulmonary infarction could have been considered because of
the prolonged bed rest and recent surgery. Lung lobectomy appeared to be the correct treatment since, both in case of aspergilloma and in case of pulmonary infarction, the left inferior lobe would have never recovered a normal function.

Figures 1 and 2 are the Chest CT performed prior to left lower lobectomy.

KEY MESSAGE

Even if the lesion did not reveal to be a fungal lesion aspergilloma on definitive pathological examination, lung lobectomy was justified by the fact that the inferior lobe would have never recovered a normal function.

REFERENCES