Correspondence

Allergic bronchopulmonary aspergillosis mimicking pulmonary tuberculosis

Sir,

Dr. Al-Amoudi is to be commended for his case reports[1] on misdiagnosis of allergic bronchopulmonary aspergillosis (ABPA) as pulmonary tuberculosis (TB). I believe that more awareness is needed to this condition, since some cases may be overlooked.[2] We previously reported a series of 10 patients with ABPA,[3] and one of those patients was misdiagnosed as having TB. However, equal importance is to remember also that these 2 conditions are not mutually exclusive; another patient in our series had both ABPA and TB proven fully by all the diagnostic criteria. It is important to screen patients with ABPA for TB and considers prophylactic therapy when intending to start patients on systemic steroids.[4] The latter may be required for prolonged periods for many patients with ABPA, and may lead to reactivation of TB. Two other points might also deserve some comments for completeness. Firstly, Dr. Al-Amoudi quoted the prevalence of ABPA between 5% to 15% from western studies. In a recent study from Riyadh, Kingdom of Saudi Arabia (KSA),[2] the prevalence among patients with asthma was 2.7%. Secondly, although *Aspergillus fumigatus* was implicated in both patients in Dr. Al-Amoudi case reports, *Aspegillus niger* was commoner in both of our studies.[2,3] Physicians should not be surprised to find the syndrome associated with other Aspergillus species, or indeed other fungi that are common in our environment (allergic bronchopulmonary mycosis).

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Reply from Author

I read with great interest the valuable comments of Dr. Al-Mobeireek regarding the case reports on misdiagnosis of allergic bronchopulmonary aspergillosis (ABPA) as pulmonary tuberculosis (TB).[1] I agree with Dr. Al-Mobeireek that more awareness is needed for diagnosing this condition, as there were several cases that have been misdiagnosed and treated as TB. Since this report, I have treated one more female patient with ABPA who was also misdiagnozed as TB and treated with anti-TB therapy, although her investigations for TB were negative. I agree to screen all patients diagnozed with ABPA, for TB, as both conditions may coexist in the same patient, but I disagree, to start anti-TB therapy empirically if the investigations for TB were negative. However, as long as oral steroid is the main line of therapy for ABPA, prophylactic chemotherapy for TB should always be considered for the high risk group.[4] The prevalence of ABPA in the Kingdom of Saudi Arabia (KSA) was unknown. I was not aware of your study in which, you evaluated the prevalence of ABPA in the KSA.[2] It was published almost at the same time of my report and it seems, this was the first study in the KSA in which, the prevalence of ABPA in asthmatics was found to be 2.7%. It was lower than the incidence of ABPA in western studies that was found to be 5% to 15%.[5] However, I do believe that more studies from different centers are needed to reach into the final incidence of ABPA among asthmatics in the KSA. In western studies, *Aspergillus fumigatus (A.Fumigatus)* was considered to be the most common and the most virulent species causing damage to the airways in asthmatics.[6] This was also the case in my report. In the studies,[2,3] *Aspergillus niger* was found to be more common than *A. fumigatus* in ABPA patients. This was a very interesting finding and may indicate geographical variations in the prevalence of *Aspergillus* species. So, further studies are also needed to evaluate the pattern of ABPA in the KSA.

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