A Rare Case of Plastic Bronchitis Following Bronchial Thermoplasty

Barbarroja-Escudero J[1], Sánchez-González MJ[1], Ruíz-Peña A[2], Pérez-Labour RA[2], Rodríguez-Rodríguez M[1], Alvarez-Mon M[1]
[1]*Servicio de Enfermedades del Sistema Inmune-Alergia, Hospital Universitario Príncipe de Asturias, Departamento de Medicina y Especialidades Médicas, Universidad de Alcalá, Alcalá de Henares, Madrid, Spain*
[2]*Servicio de Neumología, Hospital Universitario Príncipe de Asturias, Departamento de Medicina y Especialidades Médicas, Universidad de Alcalá, Alcalá de Henares, Madrid, Spain*

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Bronchial thermoplasty (BT) is a safe nonpharmacological procedure for treatment of uncontrolled severe asthma that was approved by the United States Food and Drug Administration in 2010 [1]. However, adverse events and complications have been reported and include bronchiectasis, inflammatory polyps, pulmonary cysts with pneumothorax, artery pseudoaneurysms with hemorrhage, or recurrent atelectasis from fibrin plugs [2-6]. We report a new case of bronchial plugs following BT with an unexpected outcome.

In May 2013, a 27-year-old atopic woman (never smoker) diagnosed with uncontrolled severe asthma was referred to our outpatient clinic. She had experienced progressive asthma symptoms for the previous 15 years. Moreover, she was allergic to house dust mites, pollens, fruits, nuts, and *Anisakis simplex*. She experienced severe systemic reactions to omalizumab requiring a premedication protocol for each dose to complete 16 weeks of treatment. She fulfilled the criteria for New York Heart Association (NYHA) class III-IV despite following the treatment shown in the Supplementary Table.

Skin prick testing (SPT) was performed with a common battery of aeroallergens (mites, pollens, danders), food allergens (*Anisakis simplex*, fish, shellfish, milk, egg, cereals, fruits, nuts, vegetables, legumes, profilin, and lipid transfer protein), and latex (ALK-Abelló). Both a negative control (50% glycerinated saline) and a positive control (histamine, 10 mg/mL) were used. Moreover, a specific study on mold allergens was performed using SPT (ALK-Abelló) and serum specific IgE levels (Thermo Fisher) for *Aspergillus fumigatus*, recombinant *Aspergillus* allergens (rAsp f 1, rAsp f 4, rAsp f 6), *Alternaria alternata*, recombinant *Alternaria* allergen (rAlt a 1), *Penicillium notatum*, *Candida albicans*, and *Cladosporium herbarum*. Serum total IgE, baseline tryptase, and specific IgE levels against the same aeroallergens, food allergens, and latex were analyzed (Thermo Fisher). General and specific laboratory tests were performed. Additional tests included antinuclear antibody testing, protein profiling, α-1 antitrypsin test, sweat test, and determination of immunoglobulins, angiotensin-converting enzyme, rheumatoid factor, and antineutrophil cytoplasmic antibodies. Pulmonary function was also assessed (diffusion capacity, exercise testing, sleep studies, and echocardiography).

SPT was positive (wheal ≥3 mm greater than negative control), as was serum specific IgE, to mites, pollens, *Anisakis simplex*, fruits, and nuts. The results for the other aeroallergens and foods tested were negative. The remaining laboratory tests yielded normal results. Pulmonary function and laboratory values are shown in the Supplementary Table. Chest x-ray and computed tomography revealed laminar atelectasis located in the right middle lobe, thus ruling out bronchiectasis and pulmonary nodules or infiltrates (Supplementary Figure). There were no data on hypoventilation syndrome, sleep apnea syndrome, diastolic dysfunction, or pulmonary hypertension. We also ruled out cystic fibrosis, allergic bronchopulmonary mycosis, and sarcoidosis.

Given the lack of improvement after the abovementioned treatments, 3-session BT (Alair Bronchial Thermoplasty System) was performed under conscious sedation in April-May 2015, as previously described [1]. Two hours after the last session, more than 20 white rigid bronchial casts were expelled after several cough attacks (Figure). Unfortunately, histopathology was impossible because the casts were obtained and photographed at home after the last session of BT (this procedure is normally performed in an outpatient setting). Therefore, given the patient's atopic asthma background, she was diagnosed with plastic bronchitis.

We report an unusual case of plastic bronchitis associated with uncontrolled severe asthma in which BT was decisive. Several weeks after performing BT, prednisone was tapered and discontinued over 6 weeks, and the patient maintained NYHA class I-II for over 3 years. Between the last hospital admission and BT, the patient had gained more than 20 kg

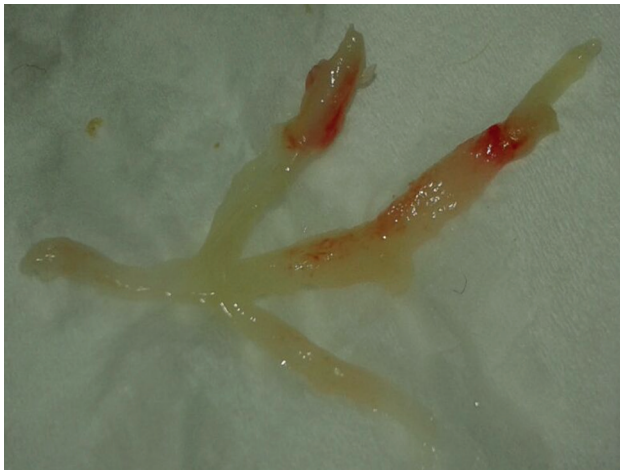

Figure. Cast measuring 10 cm in length showing the typical branching pattern of plastic bronchitis, expelled after the third bronchial thermoplasty session.

of weight because of long-term treatment with prednisone at doses of 30 mg/d and the inactivity resulting from asthma. For this reason, she needed nocturnal oxygen for 8 hours. This was discontinued within a few weeks of BT (Supplementary Table).

From December 2017, the patient required new cycles of prednisone (40-50 mg/d for 2-4 weeks every 3 months), which was combined with roflumilast (500 μg/d). Although her weight increased further, thus complicating her unstable clinical situation, she did not require nocturnal oxygen or new aerosol cycles. Furthermore, the low blood eosinophil levels during follow-up, both before and after the prednisone cycles, ruled out an eosinophilic pattern. However, given the aggressiveness of BT, we would have tried monoclonal antibody therapy (anti–IL-5 agents) if it had been available at the time (Supplementary Table).

Plastic bronchitis is an extremely rare complication of unclear etiology. The few cases reported in adults [6-9] involve bronchial mucofibrinous plugs or casts in the tracheobronchial tree that may have caused severe airway obstruction [10]. Two types of casts (inflammatory [type 1] and noninflammatory [acellular or type 2]) have been associated with various clinical conditions [7,8]. Type 1 casts are associated with diffuse bronchial hypersecretory disorders (asthma, cystic fibrosis, allergic bronchopulmonary aspergillosis, and infection) and are composed of an eosinophilic infiltrate [7,8]. Type 2 casts are associated with cyanotic congenital heart diseases, sickle cell acute chest syndrome, and lymphatic diseases and are composed of mucinous, fibrinous, or chylous infiltrates [7,8]. Although these plugs could be considered eosinophilic in the present case, we think that they were caused by the inflammation resulting from the bronchial thermoplastic process itself. Remarkably, the patient did not have fever, new expectoration, or discomfort during the weeks following BT. The follow-up analysis revealed no apparent infection, and the bronchial exudate culture was negative for bacteria and fungi. She only had to use rescue salbutamol during the following 24 hours.

Interestingly, we observed a very significant clinical improvement after a strong cough causing expulsion of hard, rigid, and large casts, thus making bronchoscopic extraction unlikely. While bronchoscopic extraction may not have been viable in the present case, it could prove effective in cases with more flexible plugs. We think that each patient should be assessed individually.

In conclusion, we report an exceptional case of an adult woman diagnosed with uncontrolled severe asthma where BT provoked plastic bronchitis. However, the spontaneous expulsion of casts was key to a considerable clinical improvement. The case we report may shed light on the utility of this therapeutic modality in some cases of severe asthma, although the possibility of producing rigid plugs in the bronchial tree must always be considered.

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Conflicts of Interest

The authors declare that they have no conflicts of interest.

Previous Presentations

This study was presented in part, in poster form, at the Congress of the Sociedad Española de Alergología e Inmunología Clínica, October 2016, San Sebastián, Spain.

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José Barbarroja-Escudero
Servicio de Enfermedades del Sistema Inmune-Alergia
Hospital Universitario Príncipe de Asturias
Departamento de Medicina y Especialidades Médicas
Universidad de Alcalá
Carretera Madrid-Barcelona Km 33.600
28805 Alcalá de Henares (Madrid), Spain
E-mail: jose.barbarroja@gmail.com; jose.barbarroja@uah.es

