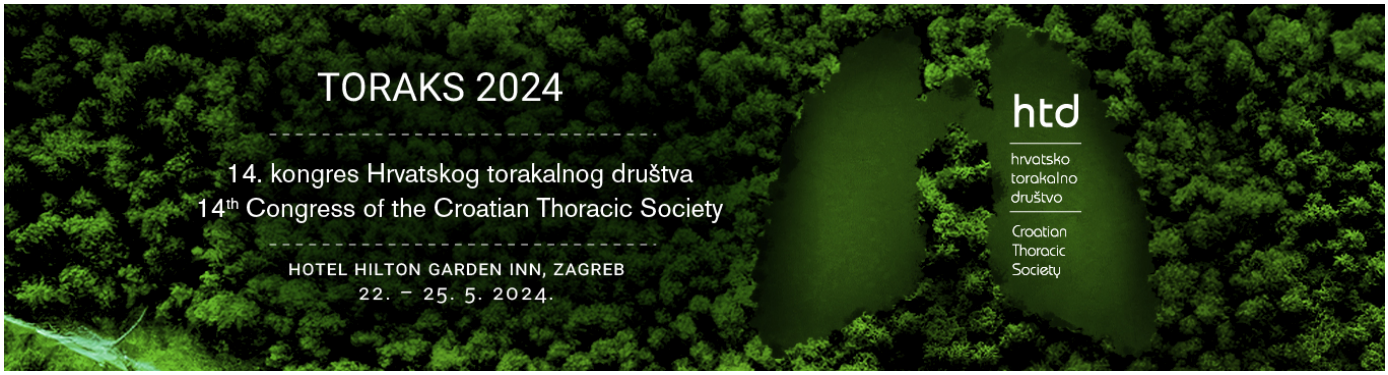

MISSED ELEMENTS FOR PROPER DIAGNOSIS IN PULMONOLOGY PRAXIS

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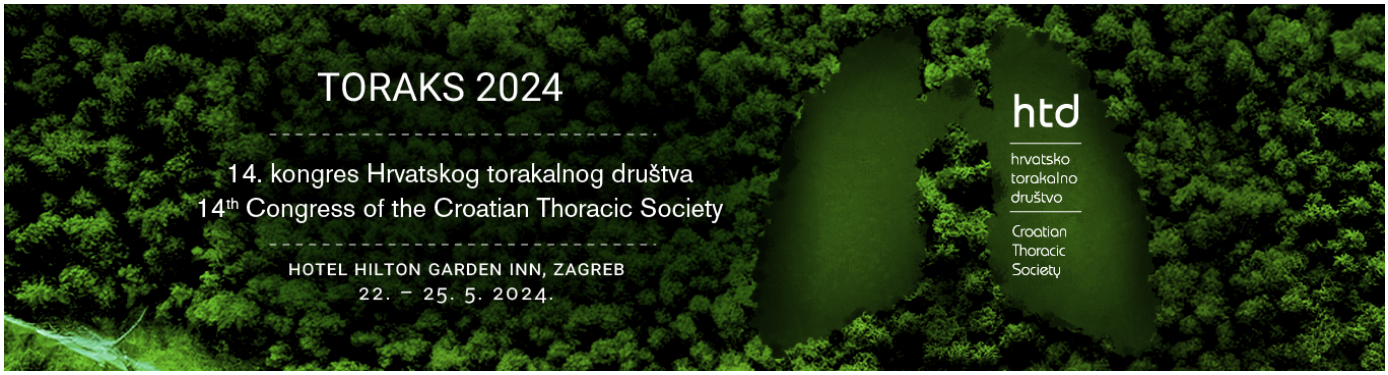
Background:

Asthma is a heterogenous disease, usually characterized by chronic airway inflammation. It is defined by the history of respiratory symptoms, such as wheeze, shortness of breath, chest tightness and cough, that vary over time and intensity, together with variable expiratory airflow limitation. Airflow limitation may later become persistent.

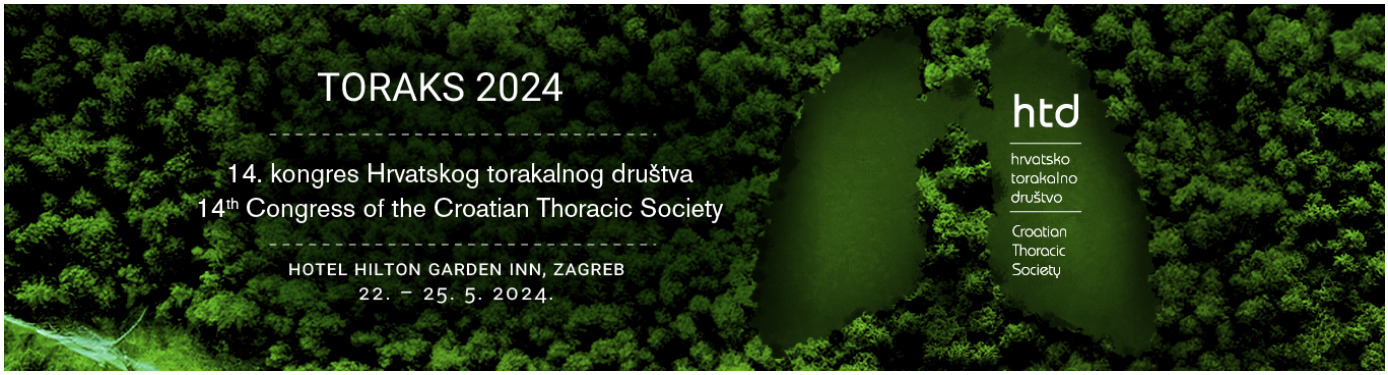


Conclusion:

The patient was misdiagnosed with COPD, but has severe eosinophilic asthma with nasal polyposis. Variability in lung function was not followed-up, as it is known that it is essential for the asthma diagnosis. Our patient had salbutamol test positive, +31% od 600 ml. FeNO measurement was never done, as one of the most important biomarkers for eosinophilic inflammation..The eosinophil blood count was not measured and needs to be recorded in each patient with obstructive pulmonary disease at least 3 times in one year. The patient had 4.8% of 365 eo/ µL.. Skin prick test on inhalation allergens, total IgE, specific IgE on Asp f and Der p were never conducted and they are basic diagnostic processing that establish if there are biomark ers increased for a T2 type inflammation.

Case:

The patient is a 60 year old adipose (BMI 34) male, former smoker 9PY, farmer, that was in regular pulmonary controls for 23 years, since 2001. and the exact diagnosis was determined in 2024. His father had TBC when the patient was 28. At early age he had bronchitis on multiple occasions and at the age of 15 years was diagnosed with bronchiectasis. He had nasal polypectomy 3 times from 2001.-2019. During 2001. was his first hospitalization because of left side pleuropneumonia and pansinusitis. On the first monitoring after the hospitalization, obstructive-restrictive ventilation disorder of medium degree was confirmed with positive Ventolin test and he was diagnosed with COPD at the age of 37 years. Following years he was treated with different inhalation therapy, from ICS/LABA in high dose, up to LABA/LAMA in the past 3 years and spirometry showed significant variations in FEV1 and FVC, with predominantly obstructive pattern. He was non-adherent with therapy since observing no significant improvement in overall health. He was hospitalized several times because of COPD exacerbation caused by recurrent pneumonia with last one being in 20019. Microbiological analysis was negative for Mycobacterium tuberculosis on several occasions. In the past year he had 2 exacerbations and was treated with OCS and antibiotic. ACQ 6/6, mMRC 1. The patient was instructed by otorhinolaryngologist to our Clinic.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