A 33-year-old man was admitted after an episode of hemoptysis (200 ml) following one-week history of non-productive cough. Chest roentgenography demonstrated infiltration and cavitation in the left upper lobe. Chest CT (Fig. 1) showed patchy airspace consolidation with cavitation in the left S1+2. Routine laboratory studies revealed anemia (Hb 12.5 g/dl) but...
no bleeding tendency. On the second hospital day, hemoptysis recurred and repeat chest roentgenography (Fig. 2) revealed atelectasis of the left lower lobe. Bronchial artery embolization (BAE) was performed the same day to avoid life-threatening aspiration. Figure 3A shows hypervascular change and extravasation in the left upper lobe visible on bronchial arteriography. Rasmussen’s aneurysm, which is often an important indicator of the source of bleeding, was not demonstrated in this patient. Gel foam embolization was performed, resulting in successful control of hemoptysis (Fig. 3B). On the third hospital day, bronchoscopy was performed to remove massive clots occluding the left lower lobe orifice. Although negative on the first day, after removal of clots, sputum was smear-positive for acid-fast bacilli (Gaffky score=8), and antitubercular chemotherapy was therefore initiated. Massive hemoptysis due to pulmonary tuberculosis as an initial symptom is extremely rare. Life-threatening massive hemoptysis requires immediate treatment and BAE is a well-accepted and widely used procedure for the management of massive or recurrent episodes. However, few reports have addressed its use in the control of massive hemoptysis due to pulmonary tuberculosis (1). In aspiration of massive hemoptysis, detection of pulmonary tuberculosis from sputum can be difficult and repeated examination of sputum for \textit{M. tuberculosis} after removal of clot is often necessary for diagnosis. BAE should be considered in the management of patients with massive hemoptysis even when the etiology is uncertain.

References


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