IMAGES IN CLINICAL MEDICINE

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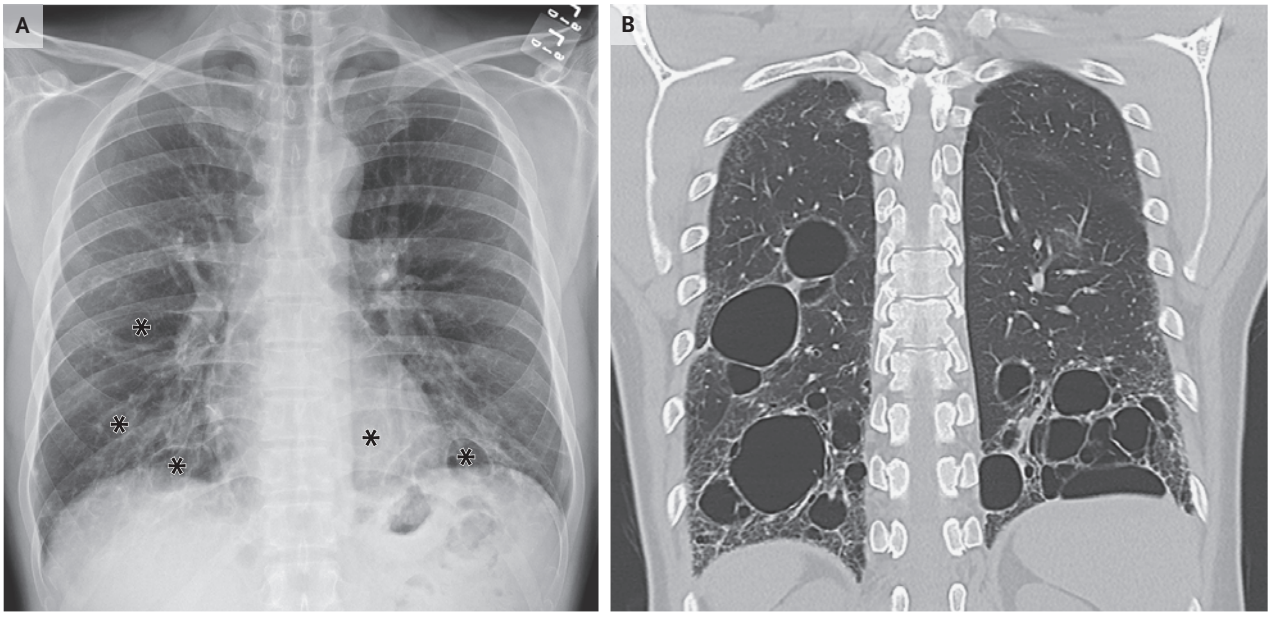
Lymphoid Interstitial Pneumonia



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This article was published on February 15, 2025, at NEJM.org.

A previously healthy 37-year-old man presented to the pulmonary clinic with a 10-month history of dry cough, fatigue, and dry mouth. He was a lifelong nonsmoker. On physical examination, crackles were heard at both lung bases. The oral mucosa and conjunctivae were dry, and dental caries were present. A chest radiograph showed reticular opacities at the lung bases and cystic lucencies in both lungs (Panel A, asterisks). Laboratory testing was negative for human immunodeficiency virus infection. Results were otherwise notable for normal immunoglobulin levels and an autoantibody profile consistent with Sjögren's syndrome, which was confirmed with a minor salivary gland biopsy. Computed tomography of the chest showed well-demarcated, thin-walled peribronchovascular cysts, predominantly in the lower lungs, as well as mild ground-glass opacities and subpleural reticulation (Panel B). A surgical lung biopsy showed dense interstitial lymphocytic infiltration with marked alveolar septal thickening. Immunohistochemical analysis was negative for CD1a-positive Langerhans' cells. A diagnosis of lymphoid interstitial pneumonia with Sjögren's syndrome was made. Treatment with prednisone was started. Three months later, mycophenolate mofetil was started, and the dose of prednisone was slowly tapered and then stopped after 6 months. At the 1-year follow-up, the patient's symptoms and radiographic findings were stable.

DOI: 10.1056/NEJMicm2411756