Since diffuse panbronchiolitis (DPB) was first described in 1969, it has been recognized as a distinct clinical syndrome [1, 2]. Symptoms of chronic cough, sputum production, dyspnea and wheezing, often accompanied by chronic sinusitis, are nonspecific and may suggest a diagnosis of asthma or chronic bronchitis. Radiographic findings usually include hyperinflation and fine nodular infiltrates in the bases or throughout the lungs. Found predominately in Japanese, and often associated with HLA Bw 54 antigen, it may be suspected clinically, although lung biopsy constitutes absolute confirmation. Several reports in the literature have emphasized the utility of erythromycin or other macrolide antibiotics in managing this condition over an extended period of time.

In this issue of Respiration, Kikawada et al. [3] describe a subset of patients with DPB that apparently are refractory to macrolide therapy. They employed an ultrathin bronchofiberscope through the working channel of a standard bronchofiberscope to inspect peripheral bronchioles to the 11th and 12th order branches. Responsive patients were free obstruction, but macrolide-unresponsive patients had secretions filling bronchial branches distal to 5th and 6th-order segments, and bronchoalveolar fluid contained increased percentage of neutrophils, compared with responders or controls. Although this entity has been seen largely in Japanese patients, it seems desirable to call attention for the broader international medical community because of greater travel and our increasingly mobile society. Fitzgerald et al. [4] described occurrence of DPB in non-Japanese patients in the United States and observed improvement in lung function in 3 patients treated with macrolides long enough to establish efficacy. Recognition that there may be two subsets of patients with DPB may serve to stimulate continued investigation into mechanisms of disease and host defenses and pursuit of alternative therapeutic regimens for macrolide-resistant patients.

References