

POSTOPERATIVE DIAGNOSIS:, Mild tracheobronchitis with history of granulomatous disease and TB, rule out active TB/miliary TB.,PROCEDURE PERFORMED:, Flexible fiberoptic bronchoscopy diagnostic with:,a. Right middle lobe bronchoalveolar lavage.,b. Right upper lobe bronchoalveolar lavage.,c. Right lower lobe transbronchial biopsies.,COMPLICATIONS:, None.,Samples include bronchoalveolar lavage of the right upper lobe and right middle lobe and transbronchial biopsies of the right lower lobe.,INDICATION: ,The patient with a history of TB and caseating granulomata on open lung biopsy with evidence of interstitial lung disease and question tuberculosis.,PROCEDURE:, After obtaining an informed consent, the patient was brought to the Bronchoscopy Suite with appropriate isolation related to \_\_\_\_\_ precautions. The patient had appropriate oxygen, blood pressure, heart rate, and respiratory rate monitoring applied and monitored continuously throughout the procedure. 2 liters of oxygen via nasal cannula was applied to the nasopharynx with 100% saturations achieved. Topical anesthesia with 10 cc of 4% Xylocaine was applied to the right nares and oropharynx. Subsequent to this, the patient was premedicated with 50 mg of Demerol and then Versed 1 mg sequentially for a total of 2 mg. With this, adequate consciousness sedation was achieved. 3 cc of 4% viscous Xylocaine was applied to the right nares. The bronchoscope was then advanced through the right nares into the nasopharynx and oropharynx.,The oropharynx and larynx were well visualized and showed mild

erythema, mild edema, otherwise negative. There was normal vocal cord motion without masses or lesions. Additional topical anesthesia with 2% Xylocaine was applied to the larynx and subsequently throughout the tracheobronchial tree for a total of 18 cc. The bronchoscope was then advanced through the larynx into the trachea. The trachea showed mild evidence of erythema and moderate amounts of clear frothy secretions. These were suctioned clear. The bronchoscope was then advanced through the carina, which was sharp. Then advanced into the left main stem and each segment, subsegment in the left upper lingula and lower lobe was visualized. There was mild tracheobronchitis with mild friability throughout. There was modest amounts of white secretion. There were no other findings including evidence of mass, anatomic distortions, or hemorrhage. The bronchoscope was subsequently withdrawn and advanced into the right mainstem. Again, each segment and subsegment was well visualized. The right upper lobe anatomy showed some segmental distortion with dilation and irregularities both at the apical region as well as in the subsegments of the anteroapical and posterior segments. No specific masses or other lesions were identified throughout the tracheobronchial tree on the right. There was mild tracheal bronchitis with friability. Upon coughing, there was punctate hemorrhage. The bronchoscope was then advanced through the bronchus intermedius and the right middle lobe and right lower lobe. These again had no other anatomic lesions identified. The bronchoscope was then wedged in the right middle lobe and

bronchoalveolar samples were obtained. The bronchoscope was withdrawn and the area was suctioned clear. The bronchoscope was then advanced into the apical segment of the right upper lobe and the bronchioalveolar lavage again performed. Samples were taken and the bronchoscope was removed suctioned the area clear. The bronchoscope was then re-advanced into the right lower lobe and multiple transbronchial biopsies were taken under fluoroscopic guidance in the posterior and lateral segments of the right lower lobe. Minimal hemorrhage was identified and suctioned clear without difficulty. The bronchoscope was then withdrawn to the mainstem. The area was suctioned clear. Fluoroscopy revealed no evidence of pneumothorax. The bronchoscope was then withdrawn. The patient tolerated the procedure well without evidence of desaturation or complications.