


**Throw Caution to the Wind Instruments**

*To the Editor:*

We read with interest the two articles in *CHEST* (September 2010) from Metzger et al. and Metersky et al. that implicate wind instruments as a possible source of antigens triggering hypersensitivity pneumonitis (HP). We commend these authors for rigorously documenting antigen sensitization in one patient and documenting a classic clinical course of HP in another. Taken together, these articles provide evidence that suggests a causal relationship between microorganisms present in wind instruments and HP. However, we caution that overemphasizing the role of wind instruments not only stigmatizes wind instruments as a cause of lung disease but also creates a pitfall for clinicians that could cause other types of exposure and other types of interstitial lung disease to be overlooked.

As a case in point, we consulted on a 62-year-old male music teacher and professional saxophone player who sought care for a low-grade fever associated with fatigue and a dry cough. He had no other significant medical history. Physical examination was notable for bibasilar inspiratory rales. A panel of autoantibody tests was negative. Pulmonary function tests demonstrated normal spirometry, borderline lung volumes (total lung capacity, 81% predicted), and impaired diffusion capacity of the lung for carbon monoxide (62% predicted). High-resolution CT scan revealed subpleural reticulation, mild architectural distortion, and bronchiolitis within the middle and lower lung zones. A surgical lung biopsy specimen demonstrated patchy interstitial fibrosis around the small airways accompanied by small lymphoid aggregates, multinucleated giant cells, and numerous loosely formed granulomas in the form of desquamated cells (seen in the biofilm from the wind instruments) and saliva that are introduced into the peribroncholar distribution. This pattern was diagnostic for HP.

Upon further questioning, the patient revealed that rotting wood was removed from his home bathroom prior to the onset of symptoms, implying a likely diagnosis of “dry rot lung” that is associated with *Merulius.* Specific antibodies were not obtained at the time of the initial consultation, yet based on this history, there was little risk of reexposure. The patient was treated with a low dose of oral corticosteroids for several months, and pulmonary function improved. More importantly, he continued to play the saxophone without interruption and without extraordinary measures to clean the instrument.

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**References**

