Lady Windermere syndrome

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During an outpatient consultation, a 66-year-old woman, 46 kg, and diagnosed with bronchiectasis 8 years prior reported having had cough with little expectoration and fatigue for several years, as well as night sweats in the past 2 years. In the previous year, she was treated for pneumonia with clinical improvement. Nevertheless, months later, she had night sweats again and worsening of fatigue. A chest CT revealed worsened nodular bronchiectasis with surrounding parenchymal densification in the middle lobe and lingula (Figure 1). A scheduled bronchoscopy was performed. Mycobacterial PCR assay was positive on bronchoalveolar lavage fluid for nontuberculous mycobacteria, and the culture revealed macrolide-susceptible *Mycobacterium intracellulare*. The patient received a daily regimen of azithromycin, rifampin, and ethambutol for 14 months with substantial improvement.

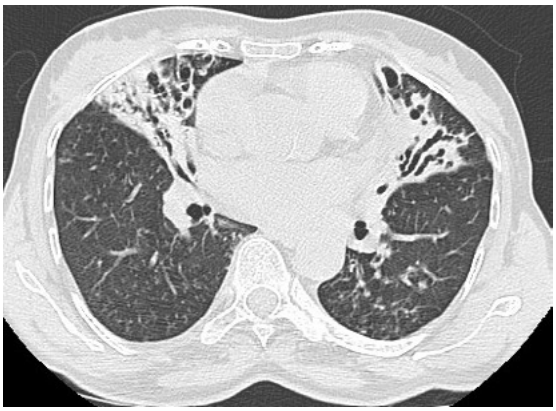

Figure 1. An axial chest CT scan showing nodular bronchiectasis with surrounding parenchymal densification in the middle lobe and lingula.

Lady Windermere syndrome is rare, corresponding to a pattern of pulmonary infection with *M. avium* complex, and is a cause of bronchiectasis.[1] Due to its insidious course, with nonspecific symptoms, it is probably underdiagnosed.[2] Although voluntary suppression of cough has been described as one possible pathogenesis of Lady Windermere syndrome,[1] this was not identified in our patient.

Bronchiectasis, especially in the middle lobe and lingula, in elderly White immunocompetent women should always prompt investigation for nontuberculous mycobacterial infection.

AUTHOR CONTRIBUTIONS

The authors equally contributed to this work.

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CONFLICTS OF INTEREST

None declared.

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