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CHECKPOINT INHIBITOR-RELATED PNEUMONITIS

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A 78-year-old woman with urothelial bladder carcinoma and synchronous localized lung adenocarcinoma, on maintenance nivolumab and recent radiotherapy to a left upper lobe nodule, presented to the emergency department with acute respiratory failure.

The chest computed tomography on admission revealed bilateral pulmonary involvement characterized by extensive areas of ground-glass attenuation, with a patchy distribution and predominance in peripheral and posterior regions. These opacities were associated with interlobular septal thickening, resulting in a *crazy paving* pattern (Fig. 1, blue arrow). Additional subpleural consolidations (Fig. 1, green arrow) and traction bronchiectasis (Fig. 1, orange arrow) were identified in both lower lobes. No cavitations, tree-in-bud pattern, or solid nodules were observed. No pleural effusion or significant mediastinal lymphadenopathy was detected.

Diffuse rather than focal changes at the irradiated site made radiation recall unlikely. These findings, in its clinical context and after exclusion of infection, supported nivolumab-induced pneumonitis; a diagnosis of growing importance due to the widespread use of these agents in modern oncology practice.

Figure 1 |