中文題目：以為慢性咳嗽與活動性喘只是導因於冠心症與心衰竭: 一同時合併過敏性肺炎的年輕裝潢工

英文題目：Mis-regard chronic cough and exertional dyspnea only due to coronary artery disease and heart failure: a young male decorator coexist with hypersensitivity pneumonitis

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**Introduction:** Hypersensitivity pneumonitis (HP), a less common cause of chronic cough and exertional dyspnea, is difficult to diagnose especially in patients with coronary artery disease and heart failure. It is also interesting to search for the potential causes of HP.

**Case presentation:** A 38-year-old decorated man suffered from exertional dyspnea, chronic cough, and both feet pitting edema for several weeks before visiting to the cardiovascular out patient department. Initial survey, including chest X-ray, echocardiography, and NT-proBNP disclosed cardiomegaly, bilateral non-butterfly like pulmonary infiltrate, severe reduced ejection fraction (LVEF=20%), severe pulmonary hypertension (RVSP 90 mmHg) and elevated NT-proBNP(2542 pg/mL > 450 for age < 50). Coronary angiography revealed 3 vessels disease (LAD: middle total occlusion; LCX: OM-1 total occlusion; and RCA: proximal total occlusion).The inotropic agents, diuretics, beta-blocker and ARB were prescribed. However, cough was not resolved at all. High resolution CT of chest for bilateral pulmonary infiltrate was obtained, and it showed mosaic perfusion with marked difference between inspiration and expiration. The bronchoalveolar lavage was obtained, and the lymphocyte count was high (73 %). As he was a decorator, occupation related HP was impressed. Oral prednisolone was given, and coronary artery bypass surgery was also suggested. His cough and exertional dyspnea resolved a lot even before cardiac surgery.

**Discussion:** To regard chronic cough and exertional dyspnea due to heart failure and coronary artery disease is common. However, the non-butterfly like pulmonary infiltrate raised the suspicion of lung disease. The chest CT showed mosaic perfusion. Two category diseases, including airway diseases and vascular diseases, both presented mosaic perfusion. The high bronchoalveolar lavage lymphocyte count and absence of vasculitis serum markers proved to be HP. Patients with HP had better to completely avoid exposure the inciting antigen(s).

**Conclusion:** Any etiology associated with chronic cough and exertional dyspnea should be completely studied. HP, a not common disease, should be kept in mild in a high index of suspicion if antecedent treatment not satisfactory and non typical pulmonary edema chest radiographic findings.