



**HAL**  
open science

# CT Imaging Assessment of Response to Treatment in Allergic Bronchopulmonary Aspergillosis in Adults With Bronchial Asthma

Cendrine Godet, Anne-Laure Brun, Francis Couturaud, François Laurent, Jean-Pierre Frat, Sylvain Marchand-Adam, Frédéric Gagnadoux, Elodie Blanchard, Camille Taillé, Bruno Philippe, et al.

## ► To cite this version:

Cendrine Godet, Anne-Laure Brun, Francis Couturaud, François Laurent, Jean-Pierre Frat, et al.. CT Imaging Assessment of Response to Treatment in Allergic Bronchopulmonary Aspergillosis in Adults With Bronchial Asthma. *Chest*, 2024, 165 (6), pp.1307-1318. 10.1016/j.chest.2024.02.026 . hal-04473459

**HAL Id: hal-04473459**

**<https://u-picardie.hal.science/hal-04473459v1>**

Submitted on 15 Jul 2024

**HAL** is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

# **CT Imaging Assessment of Response to Treatment in Allergic Bronchopulmonary Aspergillosis in Adults With Bronchial Asthma**

Cendrine Godet <sup>1</sup>, Anne-Laure Brun <sup>2</sup>, Francis Couturaud <sup>3</sup>, François Laurent <sup>4</sup>, Jean-Pierre Frat <sup>5</sup>, Sylvain Marchand-Adam <sup>6</sup>, Frédéric Gagnadoux <sup>7</sup>, Elodie Blanchard <sup>8</sup>, Camille Taillé <sup>9</sup>, Bruno Philippe <sup>10</sup>, Sandrine Hirschi <sup>11</sup>, Claire Andréjak <sup>12</sup>, Arnaud Bourdin <sup>13</sup>, Cécile Chenivresse <sup>14</sup>, Stéphane Dominique <sup>15</sup>, Gilles Mangiapan <sup>16</sup>, Marlène Murriss-Espin <sup>17</sup>, Frédéric Rivière <sup>18</sup>, Gilles Garcia <sup>19</sup>, François-Xavier Blanc <sup>20</sup>, François Goupil <sup>21</sup>, Anne Bergeron <sup>22</sup>, Thomas Flament <sup>23</sup>, Pascaline Priou <sup>7</sup>, Hervé Mal <sup>24</sup>, Joe de Keizer <sup>25</sup>, Stéphanie Ragot <sup>25</sup>, Jacques Cadranel <sup>26</sup>; NebuLamB Study Group and GREPI Network

<sup>1</sup> Université Paris Cité, Assistance Publique - Hôpitaux de Paris, Hôpital Bichat, Service de Pneumologie B et Transplantation pulmonaire, Paris, France. Electronic address: [cendrine.godet@aphp.fr](mailto:cendrine.godet@aphp.fr).

<sup>2</sup> Service de Radiologie, Hôpital Foch, Suresnes, France.

<sup>3</sup> Université Brest, INSERM U1304-GETBO, CHU Brest, Département de Médecine Interne et Pneumologie, CIC INSERM 1412, CHU Brest, FCRIN INNOVTE, France.

<sup>4</sup> Université Bordeaux, INSERM, CRCTB, U 1045, F-33000 Bordeaux, France.

<sup>5</sup> Université Poitiers, INSERM, CIC 1402, IS-ALIVE, CHU Poitiers, Médecine Intensive Réanimation, Poitiers, France.

<sup>6</sup> Université François Rabelais, Tours, INSERM 1100, Tours, France; Service de pneumologie et explorations fonctionnelles respiratoires, CHRU de Tours, Tours, France.

<sup>7</sup> Service de Pneumologie et Allergologie, Centre Hospitalier Universitaire d'Angers, Angers, France.

<sup>8</sup> Service de Pneumologie, CHU Bordeaux site Haut Lévêque Pessac, France.

<sup>9</sup> AP-HP Nord-Université Paris Cité, Hôpital Bichat, Service de Pneumologie et Centre de Référence constitutif des Maladies Pulmonaires Rares, INSERM, UMR 1152, Paris, France.

<sup>10</sup> Service de Pneumologie, Hôpital NOVO, Pontoise, France.

<sup>11</sup> Service de Pneumologie, Centre de Compétence des Maladies Pulmonaires Rares, Hôpitaux Universitaires de Strasbourg, Strasbourg, France.

<sup>12</sup> Université Picardie Jules Verne, UR 4294, CHU Amiens Picardie, Service de Pneumologie, Amiens, France.

<sup>13</sup> Université Montpellier, INSERM, CNRS, CHU Montpellier, PhyMed Exp, Montpellier, France.

<sup>14</sup> Université Lille, CNRS, INSERM, CHU Lille, U1019 - UMR9017 - CIIL - Center for Infection and Immunity of Lille, F-5900 Lille, France; CRISALIS, F-CRIN Network, INSERM US015, Toulouse, France.

<sup>15</sup> Département de Pneumologie, Université Rouen Hospital, Rouen, France.

<sup>16</sup> Service de pneumologie CHI de Créteil, Créteil, France.

<sup>17</sup> CHU de Toulouse, Service de Pneumologie, CRCM adulte et Transplantation pulmonaire, Clinique des Voies Respiratoires, Hôpital Larrey, Toulouse, France.

<sup>18</sup> Service de Pneumologie, Centre Hospitalier Universitaire Côte de Nacre, Caen, France.

<sup>19</sup> School of Medicine, Université Paris-Saclay, Le Kremlin-Bicêtre, France; INSERM UMR-S 999 «Pulmonary Hypertension: Pathophysiology and Novel Therapies», Hôpital Marie Lannelongue, Le Plessis-Robinson, France; Department of Respiratory and Intensive Care Medicine, Assistance Publique - Hôpitaux de Paris, Pulmonary Hypertension National Referral Center, Hôpital Bicêtre, Le Kremlin-Bicêtre, France.

<sup>20</sup> Nantes Université, CHU Nantes, INSERM, Service de Pneumologie, CIC 1413, l'institut du thorax, Nantes, France.

<sup>21</sup> Service de pneumologie, CH Le Mans, Le Mans, France.

<sup>22</sup> Division of Pulmonology, Geneva University Hospitals, Geneva, Switzerland.

<sup>23</sup> Service de pneumologie et explorations fonctionnelles respiratoires, CHRU de Tours, Tours, France.

<sup>24</sup> Université Paris Cité, Assistance Publique - Hôpitaux de Paris, Hôpital Bichat, Service de Pneumologie B et Transplantation pulmonaire, Paris, France.

<sup>25</sup> Université Poitiers, INSERM, CIC-1402, Biostatistics, Poitiers, France, Faculté de Médecine et de Pharmacie de Poitiers, Poitiers, France.

<sup>26</sup> Université Paris Sorbonne, Assistance Publique - Hôpitaux de Paris, Hôpital Tenon, Service de Pneumologie et Oncologie Thoracique, Centre constitutif Maladies pulmonaires rares, Paris, France.

## **Collaborators**

- **NebuLamB Study Group and GREPI Network:**

Hervé Mal, Pierre Le Guen, Clairelyne Dupin, Jean Claude Meurice, Marion Verdaguer, Joe de Keizer, Céline Delétage-Métreau, Raphael Le Mao, Cécile Tromer, Gaëlle Fajole, Mélanie Rayez, Christel Saint Raymond, Hubert Gheerbrant, Anne Badatcheff, Christine Person, Julie Macey, Xavier Dermant, Jean-François Boitiaux, Marine Gosset-Woimant, Carine Metz-Favre, Tristan Degot, Claire Poulet, Elisabeth Popin, Anne Sophie Gamez, Clément Boissin, Anne Prevotat, Gilles Mangiapan, Danielle Brouquières, Hervé Le Floch, Hélène Morisse-Pradier, Caroline Sattler, Daniela Muti, Patrick Germaud, Stéphanie Dirou, Audrey Paris, Boris Melloni, Julia Ballouhey, Louise Bondeelle, Lucie Laurent, Chantal Belleguic, Mallorie Kerjouan, Gaëtan Deslée, Sandra Dury, Emmanuel Bergot, Romain Magnier, Hugues Morel, Bertrand Lemaire, Cécile Tumino, Agathe Sénéchal, Pascaline Choinier, Antoine Parrot

**Keywords:**

ABPA; CT scan; allergic bronchopulmonary aspergillosis; radiologic response; treatment outcomes.

**ABBREVIATIONS:**

ABPA = allergic bronchopulmonary aspergillosis;; ABPA-CPF = allergic bronchopulmonary aspergillosis-chronic pleuropulmonary fibrosis.

**CORRESPONDENCE TO:**

Cendrine Godet, MD;

**email:**

[cendrine.godet@aphp.fr](mailto:cendrine.godet@aphp.fr)

# Abstract

## Background:

One of the major challenges in managing allergic bronchopulmonary aspergillosis remains consistent and reproducible assessment of response to treatment.

## Research question:

What are the most relevant changes in CT scan parameters over time for assessing response to treatment?

## Study design and methods:

In this ancillary study of a randomized clinical trial (NEBULAMB), patients with asthma with available CT scan and without exacerbation during a 4-month allergic bronchopulmonary aspergillosis exacerbation treatment period (corticosteroids and itraconazole) were included. Changed CT scan parameters were assessed by systematic analyses of CT scan findings at initiation and end of treatment. CT scans were assessed by two radiologists blinded to the clinical data. Radiologic parameters were determined by selecting those showing significant changes over time. Improvement of at least one, without worsening of the others, defined the radiologic response. Agreement between radiologic changes and clinical and immunologic responses was likewise investigated.

## Results:

Among the 139 originally randomized patients, 132 were included. We identified five CT scan parameters showing significant changes at end of treatment: mucoid impaction extent, mucoid impaction density, centrilobular micronodules, consolidation/ground-glass opacities, and bronchial wall thickening ( $P < .05$ ). These changes were only weakly associated with one another, except for mucoid impaction extent and density. No agreement was observed between clinical, immunologic, and radiologic responses, assessed as an overall response, or considering each of the parameters (Cohen  $\kappa$ , -0.01 to 0.24).

## Interpretation:

Changes in extent and density of mucoid impaction, centrilobular micronodules, consolidation/ground-glass opacities, and thickening of the bronchial walls were found to be the most relevant CT scan parameters to assess radiologic response to treatment. A clinical, immunologic, and radiologic multidimensional approach should be adopted to assess outcomes, probably with a composite definition of response to treatment.

## Trial registration:

ClinicalTrials.gov; No.: [NCT02273661](https://clinicaltrials.gov/ct2/show/study/NCT02273661); URL: [www.clinicaltrials.gov](http://www.clinicaltrials.gov).

## Clinicaltrials:

(gov).

Allergic bronchopulmonary aspergillosis (ABPA) is a complex bronchopulmonary disease resulting from immunologic reactions mediated against *Aspergillus fumigatus*, occurring in about 2.5% to 32% of patients with asthma and 6% to 10% of those with cystic fibrosis.<sup>1, 2</sup> Untreated and repeated exacerbations of ABPA increase the risk of irreversible sequelae,<sup>3</sup> including development of bronchiectasis, permanent obstructive ventilation defect, and fibrotic lung lesions.<sup>1</sup> The diagnosis of ABPA is based on a combination of clinical, immunologic, and thoracic imaging findings. Thin-section CT scan of the thorax is the imaging modality of choice for the diagnosis and management of ABPA. Among the different radiologic findings associated with ABPA, central bronchiectasis with or without high-attenuation mucus is the most commonly observed.<sup>1, 2.</sup>

Because most patients require prolonged therapy, one of the challenges in ABPA management remains the assessment of response to treatment, in a consistent and reproducible manner that would consider the different phenotypes of the disease. The lack of standardization of clinical, immunologic, and thoracic imaging findings makes it difficult to compare response rates between clinical studies.<sup>4-7</sup> So far, response to treatment has been based on “either clinical or radiological improvement with at least 25% decline in immunoglobulin-E (IgE) levels of baseline.”<sup>1, 2.</sup> Thereby, its definition is conditioned by subjective clinical evaluation, immunologic criteria (ie, total serum IgE), of which the threshold can be equivocal and be influenced by corticosteroids, and imprecise radiologic criteria.<sup>1</sup> Modification of radiologic parameters is a key feature in the definition of response to treatment, relapse, and remission. Although CT scan findings have been profusely described at diagnosis, the precise changes occurring during ABPA exacerbations and under treatment have not been rigorously detailed. In addition, agreement between radiologic, clinical, and immunologic response is unknown.

The primary aim of this study was to assess CT scan changes occurring after standardized treatment of ABPA exacerbation to determine the most relevant CT scan parameters associated with a radiologic response to treatment. The secondary aim was to investigate agreement between these radiologic changes and clinical and immunologic response.

## Study Design and Methods

### Study Design

This study is an ancillary study of the NebuLamB trial, which was a randomized, single-blind, placebo-controlled clinical trial. In the NebuLamB trial, patients with ABPA were included from March 2015 to July 2017 in 30 French hospitals. The design was previously reported.<sup>7</sup> ABPA was defined as follows: (1) atopy or history of asthma and elevated serum total IgE level ( $> 417$  International Units/mL); (2) elevated *A. fumigatus*-specific IgE level ( $> 0.35$  kUA/L) or immediate cutaneous hypersensitivity to *Aspergillus* species antigen, associated with the following criteria: documented precipitating antibodies or positive *A. fumigatus*-specific IgG; (3) total blood eosinophil count  $> 500$  cells/mL; and (4) documented radiologic infiltrates consistent with ABPA.<sup>7</sup> Briefly, patients were first treated by a 4-month ABPA exacerbation treatment including corticosteroids and itraconazole and secondarily randomized to receive either 6 months of nebulized liposomal amphotericin B or nebulized placebo as maintenance therapy. The original trial was registered at [clinicaltrials.gov](https://clinicaltrials.gov) (No. NCT02273661). The study protocol was approved by the ethics committee at Centre Hospitalier Universitaire de Poitiers, France (No. 2014-000872-24). Written informed consent was obtained from all patients.

This study reports the analysis of radiologic data collected during the 4-month ABPA exacerbation treatment and does not overlap with the results presented elsewhere.<sup>7</sup>

## Patients

Patients were included in this ancillary analysis if they met the following criteria: absence of severe exacerbation during a 4-month ABPA exacerbation treatment period (glucocorticoids and itraconazole) and available CT scan at initiation (M0) and end of the 4-month ABPA exacerbation treatment (M4).<sup>7</sup>

The ABPA exacerbation treatment included corticosteroids and itraconazole as follows: oral prednisolone at 0.5 mg/kg/d for 2 weeks, followed by a gradual decrease over 6 weeks, based on clinical evolution and until discontinuation; and itraconazole (200 mg twice daily) for 4 months with dose adjustment based on plasma monitoring (range, 1.5-4 mg/mL).<sup>7</sup> In case of intolerance, itraconazole was replaced with voriconazole or posaconazole, according to the decision of the investigator.<sup>7</sup> No biological medications were administered during the study.

Patients with cystic fibrosis, invasive pulmonary aspergillosis, chronic pulmonary aspergillosis, exacerbation of asthma, or ABPA related to ongoing pulmonary infection were excluded ([supplementary material](#)).

## CT Scan Parameters and Measurement

CT scan images (without IV contrast agent) at M0 and M4 were independently reviewed by two chest radiologists (A.-L. B. and F. L.) blinded to the clinical data. In case of discrepancies, the two radiologists examined the issue together to reach a consensus. The initial M0 and M4 CT examinations were analyzed based on axial acquisitions, the readers being free to use multiplanar, maximum intensity projection, and minimum intensity projection algorithms. Definitions were those of the Fleischner Society glossary of terms.<sup>8</sup> Radiologic abnormalities were categorized for the presence and extent of bronchiectasis, severity of bronchial dilatation, severity of bronchial wall thickening, and mucus plugging, using the CT grading system described by Reiff et al,<sup>9</sup> a modified version of that described by Bhalla et al.<sup>10</sup>

The following features were examined in each lung (16 radiologic parameters included in the analysis): bronchiectasis, mucoid impaction, bronchial wall thickening, centrilobular micronodules with or without tree-in-bud features, non-calcified nodules, ground glass opacities and consolidations, mosaicism, allergic bronchopulmonary aspergillosis-chronic pleuropulmonary fibrosis (ABPA-CPF) features, focal parenchymal atelectasis, aspergilloma, pleural effusion, and pneumothorax (details of measurements are shown in [e-Table 1](#)).<sup>4-6,11</sup>

Bronchiectasis analysis included craniocaudal location (per lobe, considering three lobes on the right and two on the left), central/ peripheral location (central, distal, and central þ distal), number of segments involved per lung (one to three, four to seven, and eight to 10), and severity (mild, bronchial diameter < 2 times the neighboring arterial lumen; moderate, bronchial diameter 2-3 times as large as the neighboring arterial lumen; severe, bronchial diameter > 3 times as large as the neighboring arterial lumen).

Mucoid impaction analysis included craniocaudal location per lobe, number of segments involved per lung (one to three, four to seven, and eight to 10), and spontaneous attenuation.<sup>12,13</sup>

Bronchial wall thickening was categorized in three classes (normal, mild bronchial thickening within 20% to 50% of the external diameter of the bronchus, and marked bronchial thickening > 50% of the external diameter of the bronchus).

In each lobe, the following variables were categorized in four classes depending on their extension (absence, < 25% of the lobe volume, 25%-50%, 50%-75%, and > 75%): centrilobular micronodules with or without tree-in-bud features, non-calcified nodules, ground-glass opacities and consolidations, and mosaicism.

ABPA-CPF features including evidence of fibrosis and parenchymal scars, cavitating lesions were defined as present/absent and categorized depending on their extension (one to three segments, four to seven segments, and eight to 10 segments). Pleural fibrosis was defined as present or absent and categorized based on its extension and thickness (< 2 mm, 2-5 mm, 5-10 mm, and > 10 mm thickening).

Focal parenchymal atelectasis/collapse was noted (absence, subsegmental or segmental, lobar, and plurilobar). Aspergilloma, pleural effusion, and pneumothorax were noted when present. Labeled examples of CT scan parameters scoring are shown in [Figure 1](#).

## **Response to ABPA Exacerbation Treatment**

### ***Radiologic Response:***

For each CT scan parameter, the change between semiquantitative value at M0 and M4 (after 4-month ABPA exacerbation treatment) was calculated separately for the left and right lungs as the difference between M4 and M0. CT parameter change was then categorized in four groups combining both sides as follows: 1 (worsening if either side worsened), 2 (improvement if no side worsened and at least one side improved), 3 (stability if all remained the same), and 4 (maintained normality).

CT parameters demonstrating significant changes between M0 and M4 were then identified. Improvement of at least one of these parameters without worsening of the others defined the overall radiologic response.

### ***Clinical Response:***

Clinical response was defined by improvement between M0 and M4 of at least one of the four following criteria without worsening of the others: (1) decreased symptom score (score grading from 0 to 3 of the following symptoms: cough, sputum, wheezing, and chest pain) of at least 50%; (2) improvement of dyspnea as assessed by the Medical Research Council<sup>14</sup> of at least 1 point; (3) improvement of asthma control as assessed by the investigator, according to control levels defined by GINA guidelines<sup>15</sup>; and/or (4) improvement of asthma control as assessed by the patient according to the ACQ5 questionnaire.<sup>16</sup>



### ***Immunologic Response:***

Immunologic response was defined by a decrease at least 25% of serum total IgE levels between M0 and M4.<sup>1</sup>

### **Statistical Analysis**

CT scan parameters at M0 and M4 and qualitative changes between M0 to M4 (worsening, improvement, stability, and maintained normality) were described as number (%) for each category. To identify statistically significant change CT scan parameters during the ABPA exacerbation treatment, a one-sample Wilcoxon signed rank test was performed against 0 on parameter differences between M0 and M4;  $P < .05$  indicated a statistically significant variation in the parameter tested; and the parameter was then included in the definition of the overall radiologic response. To evaluate the homogeneity of the response for the different CT scan parameters, we calculated the nonparametric Spearman correlation coefficient between each of the parameter changes considered 2 \_ 2 and presented the results in a correlogram. In addition, we carried out an exploratory hierarchical clustering on principal component analysis to classify the patients according to their CT scan parameter changes between M0 and M4.

A Venn diagram was used to describe agreement between clinical response, immunologic response, and overall radiologic response. Agreement between each radiologic parameter change and the observed clinical response and the immunologic response was quantified by Cohen kappa coefficient. McNemar test was used to test the symmetry of discordant observations.  $P < .05$  was statistically significant. Data analysis was performed with R statistical package version 4.0.4 (The R Foundation for Statistical Computing).

## **Results**

### **Patient Characteristics**

From March 2015 to July 2017, 174 patients were included in the NebuLamB trial to receive an initial ABPA exacerbation treatment (M0). At 4 months (M4), 35 were excluded, 14 of them because of severe clinical exacerbation according to the investigators ([e-Fig 1](#)). Among the remaining 139 patients, 132 had CT scan data available at both M0 and M4 and were included in the current analysis. All of them were patients with asthma, whose clinical and demographic characteristics are detailed in [e-Table 2](#).

### **CT Scan Characteristics at M0**

At initiation of ABPA exacerbation treatment (M0) in 132 patients, CT scans showed bronchiectasis in 122 (92%), bronchial wall thickening in 117 (89%), centrilobular micronodules in 108 (82%), mucoid impaction in 81 (61%), including high-attenuation impactions in 47 (36%), consolidation and/or ground-glass opacities in 72 (55%), and mosaicism in 63 (48%). Subsegmental or segmental collapse was present in 30 patients (23%), and lobar collapse was present in four patients (3%). Pleural fibrosis was present in four patients (3%), evidence of ABPA-CPF was present in three patients (2%), and intrabronchial aspergilloma was present in one patient (1%) ([Table 1](#)). Two patients required a double reading because of inconsistencies in the initial radiologic report regarding bronchiectasis.

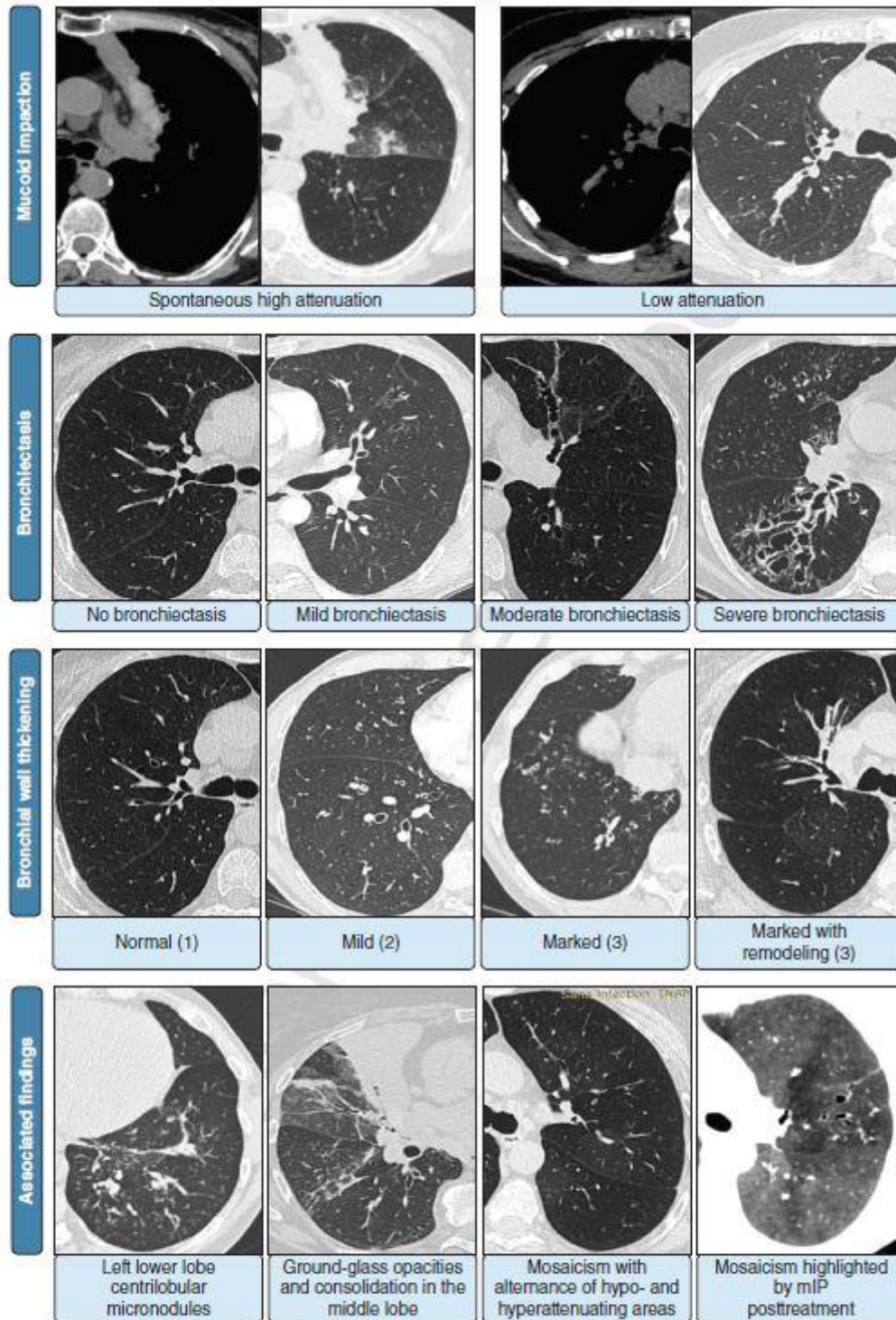


Figure 1 – Labeled examples of CT scan parameter scoring.

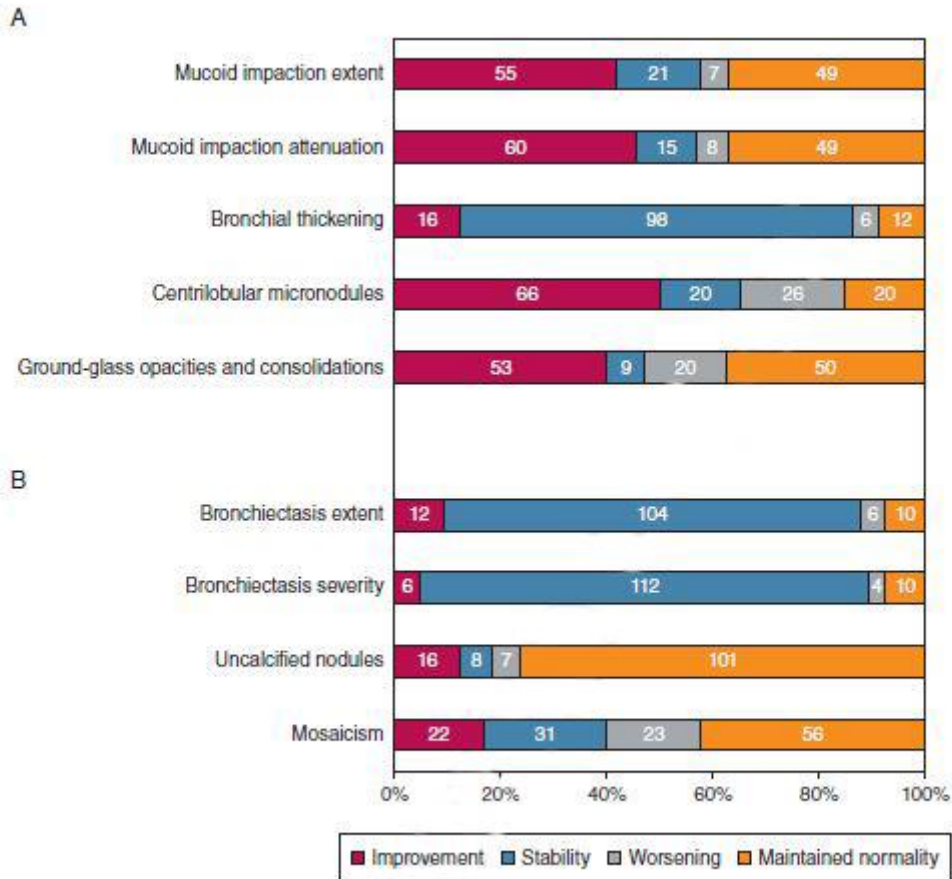


Figure 2 – A, Significant changes and nonsignificant changes (B) of CT scan parameters after 4-mo allergic bronchopulmonary aspergillosis exacerbation treatment. The x-axis represents percentage of patients. The number of patients in each level of change is indicated in the graph bars.

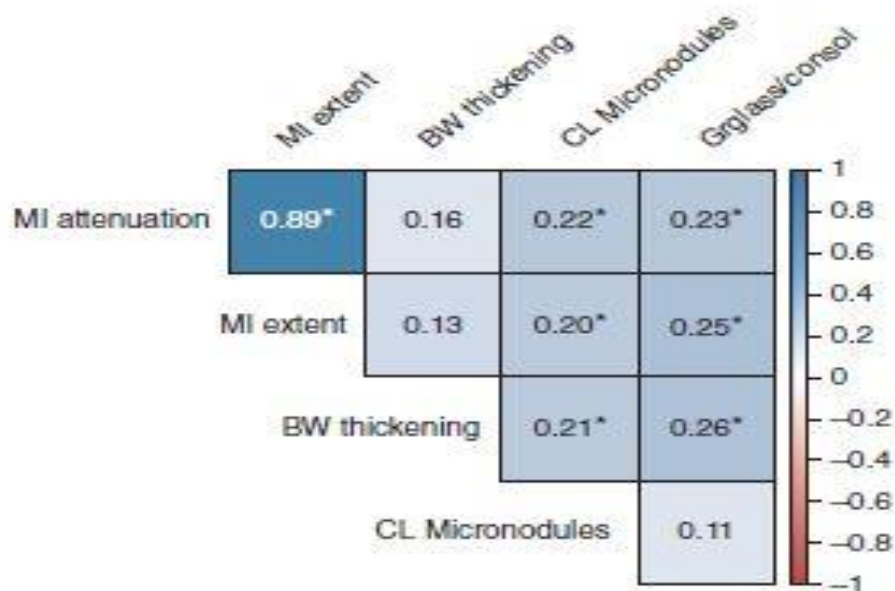


Figure 3 – Corrologram showing Spearman correlations between CT scan parameter changes \* $P < .05$ . BW = bronchial wall; CL = centrilobular; Grglass/consol = ground-glass opacities and consolidations; MI = mucoid impaction.

## Changes of CT Scan Parameters Between M0 and M4

Changes of CT scan parameters after 4-month ABPA exacerbation treatment (M4) are shown in [Table 1](#). Among the 16 CT scan parameters analyzed, five parameters were identified as showing significant radiologic improvement between M0 and M4 in 70 of 132 patients (53%): mucoid impaction extent, mucoid impaction density, centrilobular micronodules, consolidation/ground-glass opacities, and bronchial wall thickening. These five CT scan parameters were used to define the overall radiologic response.

Categorization of the CT scan changes in four classes (improvement, stability, worsening, and maintained normality) between M0 and M4 is shown in [Figure 2](#): 55 of 132 patients (42%) showed improvement in the extent of mucoid impaction, and 60 (45%) showed a decrease of their attenuation. The extent of centrilobular micronodules decreased in 66 patients (50%), and the extent of the consolidation/ground-glass opacities decreased in 53 patients (40%). Sixteen patients (12%) showed improvement in bronchial wall thickening. The other CT parameter changes are detailed in [Figure 2](#).

The correlations between changes in the five CT scan parameters, which define the overall radiologic response, are shown in [Figure 3](#). A strong correlation was found between mucoid impaction density and mucoid impaction extent changes ( $r = 0.89$ ,  $P < .001$ ), indicating that a change in density is closely associated with a change in extent. All the other correlations were nonsignificant or weak significant (Spearman coefficient correlation range, 0.20-0.26).

Hierarchical clustering analysis using the first eight axes of principal component analysis performed on CT scan parameter changes retained 88% of the information. This analysis confirms the heterogeneity of the radiologic response by the identified four clusters of patients ([e-Fig 2](#); [e-Tables 3, 4](#)).

## Agreement Between Radiologic, Clinical, and Immunologic Responses After 4-Month ABPA Exacerbation Treatment (M4)

A scoring evaluation of clinical response at M4 was available for 117 of 132 patients (89%), and clinical improvement was observed for 72 of them (62%) by using this scoring evaluation.

Immunologic data were available for 125 patients (95%) at M4, and immunologic response was observed for 98 of them (78%).

No concordance between changes in any of the five previously identified radiologic parameters and the clinical or immunologic response was found ( $k = -0.01$  to  $0.24$ ) ([Tables 2, 3](#)). Considering the overall radiologic response, no concordance was found with either clinical ( $k = -0.19$ ) or immunologic responses ( $k = 0.03$ ) ([Tables 2, 3](#)). Among patients with discrepancies between clinical and radiologic responses, improvement was more frequently observed with clinical response than with each radiologic parameter ( $P < .05$  by McNemar test) ([Table 2](#)). Similarly, the discrepancies between immunologic and radiologic responses showed that improvement was more frequently observed with immunologic response than with each radiologic parameter, and with overall radiologic parameters ( $P < .05$  by McNemar test) ([Table 3](#)).

**TABLE 2 ] Radiologic and Clinical Response Agreement**

	Clinical Response		κ Coefficient (95% CI)	McNemar P Value <sup>a</sup>
	Improvement (n = 72)	Stability or Deterioration (n = 45)		
Mucoid impaction extent			0.07 (-0.09 to 0.24)	<b>.0003</b>
Improvement	30 (26)	15 (13)		
Stability or deterioration	42 (36)	30 (26)		
Mucoid impaction attenuation			0.07 (-0.09 to 0.24)	<b>.0033</b>
Improvement	33 (28)	17 (15)		
Stability or deterioration	39 (33)	28 (24)		
Bronchial wall thickening			-0.02 (-0.12 to 0.08)	<b>&lt; .0001</b>
Improvement	8 (7)	6 (5)		
Stability or deterioration	64 (55)	39 (33)		
Centrilobular micronodules			0.24 (0.07 to 0.41)	<b>.0253</b>
Improvement	42 (36)	15 (13)		
Stability or deterioration	30 (26)	30 (26)		
Ground-glass opacities and consolidations			0.06 (-0.11 to 0.22)	<b>.0006</b>
Improvement	30 (26)	16 (14)		
Stability or deterioration	42 (36)	29 (25)		
Overall radiologic response			-0.19 (-0.37 to -0.02)	.0943
Improvement	42 (36)	17 (15)		
Stability or deterioration	30 (26)	28 (24)		

Values are No. (%) or as otherwise indicated.

<sup>a</sup>McNemar test used to test the symmetry of discordant observations. *P* < .05 indicates significant imbalance in the discordant pairs.

**TABLE 3 ] Radiologic and Immunologic Response Agreement**

	Immunologic Response		κ Coefficient (95% CI)	McNemar P Value <sup>a</sup>
	Improvement (n = 98)	Stability or Deterioration (n = 27)		
Mucoid impaction extent			-0.02 (-0.15 to 0.12)	<b>&lt; .0001</b>
Improvement	41 (33)	12 (10)		
Stability or deterioration	57 (46)	15 (12)		
Mucoid impaction attenuation			-0.08 (-0.22 to 0.06)	<b>&lt; .0001</b>
Improvement	42 (34)	15 (12)		
Stability or deterioration	56 (45)	12 (10)		
Bronchial wall thickening			0.01 (-0.06 to 0.07)	<b>&lt; .0001</b>
Improvement	12 (10)	3 (2)		
Stability or deterioration	86 (69)	24 (19)		
Centrilobular micronodules			-0.01 (-0.15 to 0.14)	<b>&lt; .0001</b>
Improvement	50 (40)	14 (11)		
Stability or deterioration	48 (38)	13 (10)		
Ground-glass opacities and consolidations			-0.06 (-0.19 to 0.07)	<b>&lt; .0001</b>
Improvement	38 (30)	13 (10)		
Stability or deterioration	60 (48)	14 (11)		
Overall radiologic response			0.03 (-0.12 to 0.18)	<b>.0001</b>
Improvement	55 (44)	14 (11)		
Stability or deterioration	43 (34)	13 (10)		

Values are No. (%) or as otherwise indicated.

<sup>a</sup>McNemar test used to test the symmetry of discordant observations. *P* < .05 indicates significant imbalance in the discordant pairs.

The agreement between clinical and immunologic responses was also quite poor ( $\kappa \frac{1}{4} 0.03$ ) (e-Table 5), and the improvement was significantly more frequent with immunologic than with clinical response (30% and 13%, respectively; *P* = .0056 by McNemar test). Among 110

patients with available data for the three categories of response, five patients did not show any response. As shown in Figure 4, of the remaining 105 patients, five patients (5%) showed isolated radiologic response, and 34 patients (32%) showed a combined radiologic, clinical, and immunologic response.

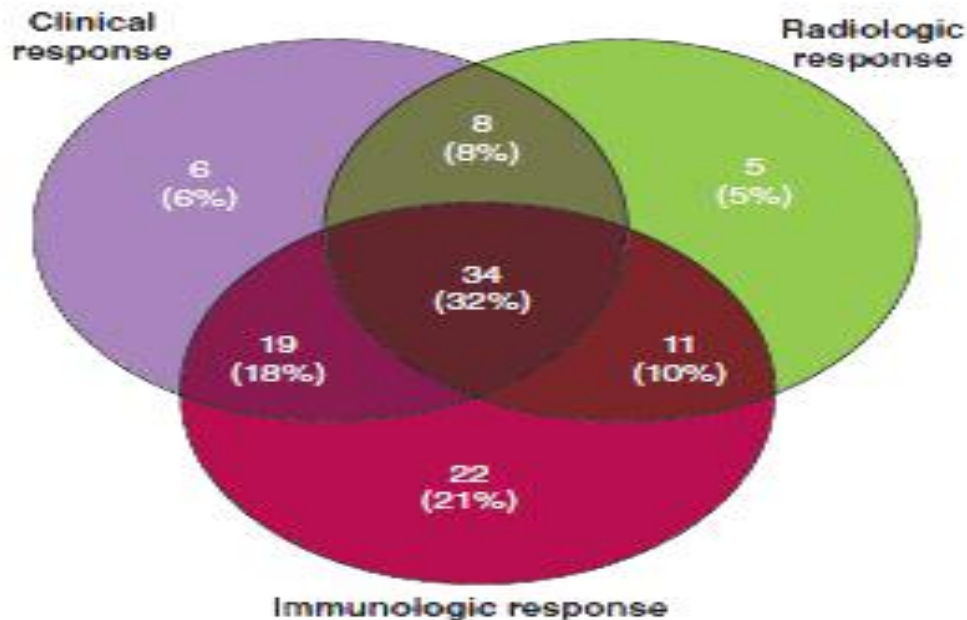


Figure 4 – Venn diagram showing agreement between overall radiologic response, clinical response, and immunologic response between CT scan at initiation and end of the 4-mo exacerbation treatment in the 105 patients with available data for the three types of response who were responders for at least one type of response (five patients did not show any type of response and are not represented in the diagram).

## Discussion

To our knowledge, this study is the first to assess CT scan changes in 132 patients with ABPA having received 4 months of standardized ABPA exacerbation treatment. Among the 16 CT scan parameters conventionally analyzed, this analysis identified five CT scan parameters showing significant improvement after a 4-month standardized ABPA exacerbation treatment: mucoid impaction extent, mucoid impaction density, centrilobular micronodules, consolidation/ground-glass opacities, and bronchial wall thickening.

This study simplifies the CT scan analysis by identifying only five relevant parameters changing over time under ABPA exacerbation treatment. Among these five CT parameters, only the extension and the attenuation of mucoid impaction were strongly correlated. Although the characteristics of mucoid impaction are important factors in ABPA detection and prognosis,<sup>17</sup> they had never previously been linked. Whereas central bronchiectasis and distal bronchiectasis have often been described in the literature as associated in about one-

third of the patients,<sup>1</sup> in our study, up to 25% of the patients presented with isolated distal bronchiectasis.

This study showed that the presence of high-attenuation mucus impaction is compatible with radiologic improvement, even if high-attenuation mucus has previously been found to be an independent predictor factor of frequent relapse.<sup>12,18</sup> In fact, we identified a large cluster of patients whose response was mainly linked to improvement in density/extent of mucoid impaction, thereby highlighting the distinctive features of this population as previously reported.<sup>3</sup> Moreover, these patients sometimes showed complete resolution of mucoid impaction, with bronchial diameter returning to normal, raising the question of the so-called irreversibility of bronchiectasis.

Regarding changes in the other CT scan parameters (apart from mucoid impaction), the absence of strong correlations among them suggests that changes in CT scan features over time and under treatment are not related to each other and that each parameter should be considered separately, whereas mucoid impaction, its density, centrilobular nodules, consolidation, and bronchial wall thickening represent different imaging manifestations of mucus plugging in large or small airways. The identification of four clusters also reinforces the concept of heterogeneous radiologic response.

The clinical and radiologic responses are sometimes discordant because some patients present with radiologic deterioration without experiencing clinical worsening.<sup>1</sup> This deserves a radiologic approach in addition to a clinical approach to assess response to treatment, as proposed in the International Society for Human and Animal Mycology recommendations.<sup>1</sup> In fact, the criteria proposed to evaluate clinical response (eg, improvement in daily life activities, health status) are subjective and suffer from lack of specificity for ABPA. Moreover, worsening of symptoms can be secondary to viral, bacterial, or mycobacterial infection, or exacerbation of underlying asthma.<sup>1</sup> Regarding immunologic investigations, the threshold of total serum IgE for diagnosing ABPA, and the percentage of total IgE decline for evaluating response to treatment, remains controversial.<sup>1</sup> Accordingly, these weaknesses justify consideration of not only both clinical and immunologic criteria, but also of objective radiologic parameters for assessing response to treatment. In this study, there was no concordance between the radiologic response and the clinical or immunologic response.

These findings highlight the importance of a multidimensional evaluation of response to treatment.<sup>1</sup>

Our study has several limitations. The response was evaluated after 4 months of itraconazole associated with corticosteroids during the first 2 months, and not after only 2 months of corticosteroids. However, a 4-month ABPA exacerbation treatment was better suited to a mixed population of patients with newly diagnosed ABPA and recurrent exacerbations. Moreover, radiologic changes were assessed after a 4-month exacerbation treatment to specify the current definition of stage 2 (ie, response) of the clinical staging of ABPA.<sup>1</sup> Radiologic changes after maintenance therapy could represent another approach to disease progression, as proposed in patients with severe persistent asthma.<sup>19</sup>

The variable scheme of corticosteroid dose reduction may have had an impact on total IgE levels at 4 months, but this scheme corresponds to real-life management adapted to a mixed population of patients suffering from newly diagnosed ABPA and recurrent exacerbations in

the context of severe corticoid-dependent asthma, in which the goal is to limit duration of corticosteroids.

Because the study population included only patients with asthma, our results may not be extrapolated to other underlying conditions (eg, COPD, cystic fibrosis).

Finally, to date, the radiologic scheme has no clear therapeutic implications. The added value of CT scan in assessing response to treatment still needs to be clarified by further studies, and in the absence of clinical worsening of the patient, a chest radiograph could be used during follow-up. These results should be regarded as exploratory.

The strengths of our study lie in a prospective and consensual blinded CT scan evaluation of a homogeneous population of patients with ABPA, who received a standardized ABPA exacerbation treatment, with therapeutic drug monitoring and absence of severe exacerbation during a 4-month ABPA exacerbation treatment period.

### **Interpretation**

This study showed that changes in extent and density of mucoid impaction, centrilobular micronodules, consolidation/ground-glass opacities, and thickening of the bronchial walls were the most relevant CT scan parameters to assess the radiologic response after a 4-month ABPA exacerbation treatment. A strong correlation between CT scan parameter changes was observed only for mucoid impaction density and mucoid impaction extent.

### **Funding/Support**

This study was supported by the Programme Hospitalier de Recherche Clinique Interrégional 2012 of the French Ministry of Health, and the firms PARI GmbH France (material and logistical support), ISIS Médical France, SOS Oxygène France, and AstraZeneca France. The University Hospital of Poitiers promoted the trial.

### **Financial/Nonfinancial Disclosures**

The authors have reported to CHEST the following: C. G. reports having received speaker fees and travel support from Pfizer and MSD; fees for board memberships from SOS Oxygène and Pulmatrix; and grant support from Ohre Pharma, Pfizer, Merck Sharp & Dohme, SOS Oxygène, ISIS Medical, LVL Médical, Oxyvie, Vivisol, Elivie, CF Santé, Boehringer, Sandoz, and AstraZeneca. A.-L. B. reports speaker fees from Boehringer. F. C. reports having received research grant support from Bristol-Myers Squibb/Pfizer and Bayer; fees for board memberships or symposia from Bayer, Bristol-Myers Squibb/Pfizer, Merck Sharp & Dohme, and AstraZeneca; and travel support from Bayer, Bristol-Myers Squibb/Pfizer, Leo Pharma, Merck Sharp & Dohme, and LeoPharma. J.-P. F. reports having received grants from the French Ministry of Health, outside the submitted work; grants, personal fees, and nonfinancial support from Fisher & Paykel HealthCare, outside the submitted work; and personal fees and nonfinancial support from SOS Oxygène, outside the submitted work. S. M.-A. reports having received consultancy for board membership, and consultancy or speaker fees and travel support from AstraZeneca, Boehringer Ingelheim, Novartis, GSK, BMS, Chiesi, Pfizer, and Roche. F. Gagnadoux reports having received grants and personal fees from Resmed; personal fees and nonfinancial support from Boehringer Ingelheim, Inspire,



Nyxoah, Sanofi, and Sefam; personal fees from Actelion, Cidelec, and Novartis; and nonfinancial support from Asten and Merck Sharp & Dohme, unrelated to the submitted work. E. B. reports having received consultancy or speaker fees and travel Gilead, Roche, Boehringer Ingelheim, SOS Oxygene, and ISIS Medical. C. T. reports having received consulting or advisory fees from Sanofi, GlaxoSmithKline, AstraZeneca, Novartis, Chiesi, and Stallergenes; and research grants from Sanofi and GSK, outside the submitted work. B. P. reports having received travel support from Oxyvie. S. H. reports having received research grant support from CSL Behring, and consulting or advisory fees from Boehringer Ingelheim, not related to this study. C. A. reports having received fees for board memberships or symposia and travel support from GSK, Astra-Zeneca, Zambon, and Inmed. A. Bourdin reports having received grants from AstraZeneca, Boehringer Ingelheim, Cephalon/TEVA, GlaxoSmithKline, Novartis, and Sanofi-Regeneron; has provided consultancy for Actelion, AstraZeneca, Boehringer Ingelheim, Chiesi, GlaxoSmithKline, MedinCell, Merck, Novartis, Roche, and Sanofi-Regeneron; and has acted as an investigator or coinvestigator for trials sponsored by Actelion, AstraZeneca, Boehringer Ingelheim, Chiesi, Galapagos, GlaxoSmithKline, Merck, Novartis, Roche, Sanofi-Regeneron, and Vertex. C. C. reports having received grants from AstraZeneca, GlaxoSmithKline, Novartis, and Santelys, outside the submitted work; personal fees from ALK-Abello, AstraZeneca, Boehringer Ingelheim, Chiesi, GlaxoSmithKline, and Sanofi-Regeneron, outside the submitted work; and congress support from AstraZeneca, Boehringer Ingelheim, Chiesi, Novartis, and Sanofi-Regeneron. S. D. reports having received consultancy for board membership, speaker fees, and travel support from Roche, Chiesi, Boehringer-Ingelheim, Astra-Zeneca, Novartis, and Actelion, outside the submitted work. G. M. reports having received consultancy for board membership and speaker fees from AstraZeneca and Sanofi. M. M.-E. reports having received consultancy for board membership or speaker fees, or travel support, from Inmed, Pfizer, Vertex, and Zambon. F. R. reports having received consultancy fees from Roche and Boehringer-Ingelheim. G. G. reports having received grants from AstraZeneca, GlaxoSmithKline, Novartis, Sanofi-Regeneron, and Chiesi; has provided consultancy for AstraZeneca, GlaxoSmithKline, Novartis, and Sanofi-Regeneron; and has acted as an investigator or coinvestigator for trials sponsored by AstraZeneca, GlaxoSmithKline, and Sanofi-Regeneron. F. Goupil reports having received travel support from Aliseo/Asten Santé, GlaxoSmithKline, Chiesi, Novartis, and Actelion. A. Bergeron reports being on the safety board for ENANTA, personal fees for the scientific committee, and speaker fees from Astra Zeneca, Novartis, and Congrès voyage Boehringer. P. P. reports having received travel support from Asten Santé and Viatrix. H. M. reports having received consultancy or speaker fees, or travel support, from LFB, Grifols, CSL Behring, Novartis, Boehringer, and PulmonX. J. C. reports having received speaker fees from Merck Sharp & Dohme and Pfizer. None declared (F. L., F.-X. B., T. F., J. K., S. R.).

## **Acknowledgments**

### **Author contributions:**

C. G. is the investigator of the study; contributed to study design; obtained funding; is a member of the steering committee; and contributed to data acquisition and collection, data analysis and interpretation, and drafting the manuscript. F. C., J. C., J.-P. F., A. B., A.-L. B., H. M., and F. L. contributed to study design, data acquisition and collection, data analysis and interpretation, drafting the manuscript, and critical revisions of the manuscript for important intellectual content. S. M.-A., F. G., E. B., C. T., B. P., S. H., C. A., A. B., C. C., S. D., G. M., M. M.-E., F. R., G. G., F.-X. B., F. G., T. F., and P. P. contributed to data acquisition and

collection and critical revisions of the manuscript for important intellectual content. S. R. and J. K. contributed to data analysis, data interpretation, and drafting of the manuscript.

**Role of sponsors:**

The funders of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. \*NebuLamB Study Group and GREPI Network Collaborators: Hervé Mal, Pierre Le Guen, and Clairelyne Dupin (Hôpital Bichat, Paris); Jean Claude Meurice, Marion Verdaguer, Joe de Keizer, and Céline Delétage-Métreau (CHU de Poitiers); Raphael Le Mao and Cécile Tromer (CHU de Brest); Gaëlle Fajole and Mélanie Rayez (CHU de Tours); Christel Saint Raymond and Hubert Gheerbrant (CHU de Grenoble); Anne Badatcheff and Christine Person (CHU d'Angers); Julie Macey and Xavier Dermant (CHU de Bordeaux); Jean-François Boitiaux and Marine Gosset-Woimant (CH de Pontoise); Carine Metz-Favre and Tristan Degot (CHU de Strasbourg); Claire Poulet and Elisabeth Popin (CHU d'Amiens); Anne Sophie Gamez and Clément Boissin (CHU de Montpellier); Anne Prevotat (CHU de Lille); Gilles Mangiapan (CHI de Créteil, Paris); Danielle Brouquières (CHU de Toulouse); Hervé Le Floch (Hôpital Clamart, Paris); Hélène Morisse-Pradier (CHU de Rouen); Caroline Sattler (Hôpital Bicêtre, Paris); Daniela Muti (CHU de Clermon-Ferrand); Patrick Germaud and Stéphanie Dirou (CHU de Nantes); Audrey Paris (CH Le Mans); Boris Melloni and Julia Ballouhey (CHU de Limoges); Louise Bondeelle (Hôpital Saint Louis, Paris); Lucie Laurent (CHU de Besançon); Chantal Belleguic and Mallorie Kerjouan (CHU de Rennes); Gaëtan Deslée and Sandra Dury (CHU de Reims); Emmanuel Bergot and Romain Magnier (CHU de Caen); Hugues Morel and Bertrand Lemaire (CHR d'Orléans); Cécile Tumino (CHU de Marseille); Agathe Sénéchal (CHU de Lyon); and Pascaline Choinier and Antoine Parrot (Hôpital Tenon, Paris). Other contributions: We thank Jeffrey Arsham (a translator employed by the CHU de Poitiers, Poitiers, France) for reviewing and editing the original English language protocol.

## Conflict of interest statement

Financial/Nonfinancial Disclosures The authors have reported to CHEST the following: C. G. reports having received speaker fees and travel support from Pfizer and MSD; fees for board memberships from SOS Oxygène and Pulmatrix; and grant support from Ohre Pharma, Pfizer, Merck Sharp & Dohme, SOS Oxygène, ISIS Medical, LVL Médical, Oxyvie, Vivisol, Elivie, CF Santé, Boehringer, Sandoz, and AstraZeneca. A.-L. B. reports speaker fees from Boehringer. F. C. reports having received research grant support from Bristol-Myers Squibb/Pfizer and Bayer; fees for board memberships or symposia from Bayer, Bristol-Myers Squibb/Pfizer, Merck Sharp & Dohme, and AstraZeneca; and travel support from Bayer, Bristol-Myers Squibb/Pfizer, Leo Pharma, Merck Sharp & Dohme, and LeoPharma. J.-P. F. reports having received grants from the French Ministry of Health, outside the submitted work; grants, personal fees, and nonfinancial support from Fisher & Paykel HealthCare, outside the submitted work; and personal fees and nonfinancial support from SOS Oxygène, outside the submitted work. S. M.-A. reports having received consultancy for board membership, and consultancy or speaker fees and travel support from AstraZeneca, Boehringer Ingelheim, Novartis, GSK, BMS, Chiesi, Pfizer, and Roche. F. Gagnadoux reports having received grants and personal fees from Resmed; personal fees and nonfinancial support from Boehringer Ingelheim, Inspire, Nyxoah, Sanofi, and Sefam; personal fees from Actelion, Cidelec, and Novartis; and nonfinancial support from Asten and Merck Sharp & Dohme, unrelated to the submitted work. E. B. reports having received consultancy or speaker fees and travel support from Pfizer, Merck Sharp & Dohme, Novartis, Gilead, Roche, Boehringer Ingelheim, SOS Oxygene, and ISIS Medical. C. T. reports having received consulting or advisory fees from Sanofi, GlaxoSmithKline, AstraZeneca, Novartis, Chiesi, and Stallergenes; and research grants from Sanofi and GSK, outside the submitted work. B. P. reports having received travel support from Oxyvie. S. H. reports having received research grant support from CSL Behring, and consulting or advisory fees from Boehringer Ingelheim, not related to this study. C. A. reports having received fees for board memberships or symposia and travel support from GSK, Astra-Zeneca, Zambon, and Insmmed. A. Bourdin reports having received grants from AstraZeneca, Boehringer Ingelheim, Cephalon/TEVA, GlaxoSmithKline, Novartis, and Sanofi-Regeneron; has provided consultancy for Actelion, AstraZeneca, Boehringer Ingelheim, Chiesi, GlaxoSmithKline, MedinCell, Merck, Novartis, Roche, and Sanofi-Regeneron; and has acted as an investigator or coinvestigator for trials sponsored by Actelion, AstraZeneca, Boehringer Ingelheim, Chiesi, Galapagos, GlaxoSmithKline, Merck, Novartis, Roche, Sanofi-Regeneron, and Vertex. C. C. reports having received grants from AstraZeneca, GlaxoSmithKline, Novartis, and Santelys, outside the submitted work; personal fees from ALK-Abello, AstraZeneca, Boehringer Ingelheim, Chiesi, GlaxoSmithKline, and Sanofi-Regeneron, outside the submitted work; and congress support from AstraZeneca, Boehringer Ingelheim, Chiesi, Novartis, and Sanofi-Regeneron. S. D. reports having received consultancy for board membership, speaker fees, and travel support from Roche, Chiesi, Boehringer-Ingelheim, Astra-Zeneca, Novartis, and Actelion, outside the submitted work. G. M. reports having received consultancy for board membership and speaker fees from AstraZeneca and Sanofi. M. M.-E. reports having received consultancy for board membership or speaker fees, or travel support, from Insmmed, Pfizer, Vertex, and Zambon. F. R. reports having received consultancy fees from Roche and Boehringer-Ingelheim. G. G. reports having received grants from AstraZeneca, GlaxoSmithKline, Novartis, Sanofi-Regeneron, and Chiesi; has provided consultancy for AstraZeneca, GlaxoSmithKline, Novartis, and Sanofi-Regeneron; and has acted as an investigator or coinvestigator for trials sponsored by AstraZeneca, GlaxoSmithKline, and Sanofi-Regeneron. F. Goupil reports having received travel support from Aliseo/Asten Santé, GlaxoSmithKline,

Chiesi, Novartis, and Actelion. A. Bergeron reports being on the safety board for ENANTA, personal fees for the scientific committee, and speaker fees from Astra Zeneca, Novartis, and Congrès voyage Boehringer. P. P. reports having received travel support from Asten Santé and Viatrix. H. M. reports having received consultancy or speaker fees, or travel support, from LFB, Grifols, CSL Behring, Novartis, Boehringer, and PulmonX. J. C. reports having received speaker fees from Merck Sharp & Dohme and Pfizer. None declared (F. L., F.-X. B., T. F., J. K., S. R.).

## References

1. Agarwal R, Muthu V, Sehgal IS, Dhooria S, Prasad KT, Aggarwal AN. Allergic bronchopulmonary aspergillosis. *Clin Chest Med.* 2022;43(1):99-125.
2. Agarwal R. Allergic bronchopulmonary aspergillosis. *Chest.* 2009;135(3):805-826.
3. Agarwal R, Chakrabarti A. Allergic bronchopulmonary aspergillosis in asthma: epidemiological, clinical and therapeutic issues. *Future Microbiol.* 2013;8(11):1463-1474.
4. Agarwal R, Aggarwal AN, Dhooria S, et al. A randomised trial of glucocorticoids in acute-stage allergic bronchopulmonary aspergillosis complicating asthma. *Eur Respir J.* 2016;47(2):490-498.
5. Agarwal R, Dhooria S, Singh Sehgal I, et al. A randomized trial of itraconazole vs prednisolone in acute-stage allergic bronchopulmonary aspergillosis complicating asthma. *Chest.* 2018;153(3): 656-664.
6. Agarwal R, Muthu V, Sehgal IS, et al. A randomised trial of prednisolone versus prednisolone and itraconazole in acutestage allergic bronchopulmonary aspergillosis complicating asthma. *Eur Respir J.* 2022;59(4).
7. Godet C, Couturaud F, Marchand- Adam S, et al. Nebulised liposomal amphotericin-B as maintenance therapy in allergic bronchopulmonary aspergillosis: a randomised, multicentre trial. *Eur Respir J.* 2022;59(6) 2102218..
8. Hansell DM, Bankier AA, MacMahon H, McLoud TC, Müller NL, Remy J. Fleischner Society: glossary of terms for thoracic imaging. *Radiology.* 2008;246(3): 697-722.
9. Reiff DB, Wells AU, Carr DH, Cole PJ, Hansell DM. CT findings in bronchiectasis: limited value in distinguishing between idiopathic and specific types. *AJR Am J Roentgenol.* 1995;165(2):261-267.
10. Bhalla M, Turcios N, Aponte V, et al. Cystic fibrosis: scoring system with thinsection CT. *Radiology.* 1991;179(3): 783-788.
11. Agarwal R, Chakrabarti A, Shah A, et al. Allergic bronchopulmonary aspergillosis: review of literature and proposal of new diagnostic and classification criteria. *Clin Exp Allergy.* 2013;43(8):850-873.

12. Agarwal R, Gupta D, Aggarwal AN, Saxena AK, Chakrabarti A, Jindal SK. Clinical significance of hyper-attenuating mucoid impaction in allergic bronchopulmonary aspergillosis: an analysis of 155 patients. *Chest*. 2007;132(4):1183-1190.
13. Phuyal S, Garg MK, Agarwal R, et al. High-attenuation mucus impaction in patients with allergic bronchopulmonary aspergillosis: objective criteria on high-resolution computed tomography and correlation with serologic parameters. *Curr Probl Diagn Radiol*. 2016;45(3):168-173.
14. CM F. Standardised questionnaire on respiratory symptoms: a statement prepared and approved by the MRC Committee on the Aetiology of Chronic Bronchitis (MRC breathlessness score). *BMJ*. 1960;(2):1665.
15. Xirouchaki N, Kondili E, Vaporidi K, et al. Proportional assist ventilation with load adjustable gain factors in critically ill patients: comparison with pressure support. *Intensive Care Med*. 2008;34(11):2026-2034.
16. Juniper EF, O'Byrne PM, Guyatt GH, Ferrie PJ, King DR. Development and validation of a questionnaire to measure asthma control. *Eur Respir J*. 1999;14(4):902-907.
17. Lu HW, Mao B, Wei P, et al. The clinical characteristics and prognosis of ABPA are closely related to the mucus plugs in central bronchiectasis. *Clin Respir J*. 2020;14(2):140-147.
18. Agarwal R, Khan A, Gupta D, Aggarwal AN, Saxena AK, Chakrabarti A. An alternate method of classifying allergic bronchopulmonary aspergillosis based on high-attenuation mucus. *PLoS One*. 2010;5(12):e15346.
19. Aligolighasemabadi F, Mirsadraee M, Sadeghdoust M, et al. Itraconazole improved bronchial wall thickness in severe persistent asthma: a double-blind placebo-controlled randomized clinical trial. *Iran J Allergy Asthma Immunol*. 2023;22(1):1-11.