

bronchiectasis, aspergillomas, and chronic pulmonary aspergillosis ([Chap. 217](#)) have been associated with TB. Chronic pulmonary aspergillosis may manifest as simple aspergilloma (fungal ball) or chronic cavitary aspergillosis. Early studies revealed that, especially in the presence of large residual cavities, *Aspergillus fumigatus* may colonize the lesion and produce symptoms such as respiratory impairment, hemoptysis, persistent fatigue, and weight loss, often resulting in the erroneous diagnosis of TB recurrence. The detection of *Aspergillus* precipitins (IgG) in the blood suggests chronic pulmonary aspergillosis, as do radiographic abnormalities such as thickening of the pleura and cavitary walls or the presence of a fungal ball inside the cavity. Treatment is difficult. Recent preliminary studies on the use of itraconazole for ≥ 6 months indicate improvement or stabilization of 60–75% of the radiologic and clinical manifestations. Surgical removal of lesions is risky except in simple aspergilloma.

HIV-Associated TB ([See also Chap. 202](#)) TB is one of the most common diseases among HIV-infected persons worldwide. Responsible for up to 30% of all HIV-related mortality (208,000 deaths per year), TB is likely the main cause of death in this population. In certain urban settings in some African countries, the prevalence of HIV infection among TB patients reaches 70–80% ([Fig. 178-11](#)).