A 36-year-old male was admitted with right-sided pleuritic chest pain that had lasted five days. There was no fever or chills, but he reported shortness of breath and long-standing coughing and wheezing. The cough was intermittently productive of brown sputum. The patient was diagnosed with bronchial asthma 10 years prior. He was managed by a pulmonologist until he lost his job and insurance three years before his presentation to the hospital. In those three years he continued to treat himself with 20 to 60mg prednisone daily to control his coughing and wheezing. His medical history was otherwise unremarkable. He was married with two healthy sons, and he had no history of smoking.

On examination, the patient was thin and in mild respiratory distress. Vital signs were as follows: temperature 37.6°C, heart rate 104beats/min (regular), blood pressure 127/76mmHg, respiratory rate 28breaths/min, and oxygen saturation 94% while on 2L/min of oxygen via a nasal cannula. Significant physical examination findings included
the following: right-sided pleural rub and shallow inspirations, regular heart sounds without murmurs or gallop, and no lymphadenopathy or rash.

Pertinent laboratory findings included the following: white blood cells count 12,200/μL (79% neutrophils and 15% lymphocytes), hemoglobin level 11.8g/dL, platelet count 276,000/μL, human immunodeficiency virus (HIV) test was negative. Liver enzymes, kidney function tests, and coagulation studies were within normal limits. Chest X-ray (CXR) on admission and computed tomography (CT) scan are shown in Figures 1 and 2. The patient underwent CT guided biopsy and histopathology [Figures 3 and 4].

**Questions**

1. What is your diagnosis?
2. How would you treat this disease?

**Answers to the quiz, and the full article, can be found online at www.omjournal.org.**