A 49-YEAR-OLD MAN WHO HAD RECENTLY EMIGRATED FROM MYANMAR presented with a 6-month history of rusty brown sputum with hemoptysis. A tuberculin skin test was positive, but sputum smears were negative for acid-fast bacilli, ova, and parasites. A chest radiograph (see Fig. S1 and S2 in the Supplementary Appendix, available with the full text of this article at NEJM.org) and an axial computed tomographic image showed a cavitary lesion in the anterior segment of the left upper lobe, measuring 14 mm in its largest diameter (Panel A), ground-glass opacities in the right lung, a pretracheal lymph node measuring 11 mm in its largest diameter, and a partially loculated left pleural effusion. Laboratory investigations revealed a white-cell count of 8800 per mm³ (reference range, 4200 to 10,000), an absolute eosinophil count of 2300 per mm³ (reference range, 0 to 400), and IgE levels of 9000 IU per millimeter (reference range, 0 to 158). The results of an autoimmune workup were negative. The patient was treated empirically for tuberculosis, but there was clinical and radiologic progression of disease. Bronchoalveolar lavage was performed, and Papanicolaou staining of a specimen of the fluid revealed brown, oval eggs with an operculum (a cap) that were suggestive of *Paragonimus westermani* (Panel B). He received treatment with praziquantel, which was followed by clinical and radiographic resolution of disease within 2 months (see Fig. S3 in the Supplementary Appendix). *Paragonimus* species are endemic in East Asian countries and are parasites of crustacean-eating mammals. Humans may serve as reservoir hosts when they eat raw, partially cooked, or poorly processed crustaceans.

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