In our case, a primary lesion was suspected due to the slow progress observed in radiological monitoring and the possibility of tumor relapse was ruled out in view of the stability of the LUL lesion.

The intrapericardial site of the lesion posed problems, including a high risk of bleeding during histological sampling. For this reason, a surgical approach was taken, and an intrapericardial pneumonectomy was performed, in view of the tumor location. Decision-making in this case was a tangible diagnostic and therapeutic challenge.

References

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Empyema due to Aggregatibacter aphrophilus and Parvimonas micra Coinfection

Empiema secundario a coinfección por Aggregatibacter aphrophilus y Parvimonas micra

Aggregatibacter aphrophilus, formerly known as Haemophilus aphrophilus, is a facultative anaerobic Gram-negative coccobacillus that forms part of the oropharyngeal flora. Although it is not highly pathogenic, it has been associated with infections, such as endocarditis, cerebral abscesses, bone and joint infections, and endophthalmitis.1,2 Pleuropulmonary involvement, however, remains exceptional.3 Another common commensal of the oropharyngeal cavity is Parvimonas micra, formerly Peptostreptococcus micra, a strictly anaerobic Gram-positive coccus that has been associated with polymicrobial infections (intracranial abscesses, paranasal sinus infections, periodontitis and septic embolism).4-5 Reports of P. micra as a pathogen in lung infections are exceedingly rare. We report the first case of pleural empyema due to A. aphrophilus and P. micra coinfection.

A 49-year-old man was admitted with a 4-day history of dyspnea, cough with purulent expectoration and fever. In the previous 3 months, he had suffered asthma and anorexia and had lost 12 kg in weight. He was a habitual smoker (1 pack-year) and his alcohol intake was 80 g ethanol/day. He had no other comorbidities. On physical examination, temperature was 37.4 °C, hypotension in the lower half of the right hemithorax on lung auscultation, and poor oral hygiene, with extensive caries and evidence of periodontitis. Clinical laboratory results revealed a white blood cell

![Fig. 1. (a) Upper and lower right lobe infiltrates and pleural effusion; (b) right lower lobe atelectasis with pleural effusion.](image-url)
Intrathoracic Schwannoma of the Vagus Nerve

Schwannoma intratorácico del nervio vago

We report the case of a patient diagnosed with intrathoracic vagus nerve schwannoma. Vagus nerve schwannomas are highly unusual. In the last 40 years, 30 cases at most have been reported, of which only 2 have been published in Spanish.¹ ²

A 74-year-old woman, with no significant clinical history, presented with clinical symptoms of dry cough, asthenia and dyspnea on minimal exertion. Standard chest X-ray showed mediastinal widening, so a computed tomography (CT) was performed, revealing a posterior, retrovascular, paratracheal mass in the mediastinum measuring 9.3 cm × 4.3 cm (Fig. 1A) extending to the carina, causing substantial dilation and right shift of the esophagus, but with no evidence of stenosis. The mediastinal mass showed pathological uptake on positron emission tomography (SUV 7.57). Endoscopic ultrasound revealed a well-defined hypoechochogenic lesion, containing heterogeneous areas, 30 cm from the dental arch, protruding into the submucosa. Fine needle aspirati

References


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