LETTERS TO THE EDITOR

Mediastinal Panniculitis

To the Editor: The term panniculitis refers to a group of diseases characterized by an inflammation of adipose tissue. Although it usually involves the skin, some of its variants may exceptionally exhibit extracutaneous disease in the form of involvement of visceral fat. Such is the case of the controversial Weber–Christian disease or mesenteric panniculitis. Few publications mention pleuropulmonary involvement in panniculitis, and even fewer mention mediastinal involvement (only 3 are available in the literature). We present the case of a patient with a mass in the anterior mediastinum who was finally diagnosed with nonsuppurative mediastinal nodular panniculitis.

The patient was a 48-year-old man who smoked 3 to 4 cigarettes a day. He had a clinical history of pyelonephritis and 2 previous episodes of poisoning by organic phosphate insecticides. He was referred to our clinic for evaluation of a mediastinal mass that was discovered after a cold. He presented a 4-month history of pleuritic chest pain accompanied by moderate effort dyspnea. Physical examination on admission was unremarkable. Laboratory workup, baseline arterioral values, and the electrocardiogram were normal. The tumor markers analyzed (carcinoembryonic antigen, prostate-specific antigen, enolase, squamous cell antigen) were not raised. The results of both the Mantoux test and sputum cultures were negative. Computed tomography of the chest revealed a 5 × 4-cm mass of mixed formation containing fatty tissue and more solid densities of septate appearance. The mass was situated on the left anterior mediastinum and extended toward the chest wall (Figure). Selective pulmonary angiography was performed and enabled us to rule out vascular abnormalities of the pulmonary arterial and venous tree, as well as the thoracic aorta. Transthoracic needle biopsy was not performed in the patient’s referral hospital because of the presence of vessels in the mass. Finally, surgical exploration by left anterior thoracotomy revealed a tumor measuring 7 × 4 cm in the anterior mediastinum, from where it extended to the pericardium, lingula, and anterior chest wall. Block resection was performed from segments next to the fourth and fifth anterior ribs. The chest wall was reconstructed with expanded polytetrafluoroethylene mesh (Gore Tex, WL Gore y Asociados, SL, Sant Joan Despí, Barcelona, Spain). The patient progressed satisfactorily in the postoperative period and was finally diagnosed with nonsuppurative mediastinal nodular panniculitis.

Mediastinal involvement in panniculitis is exceptional. We found 3 cases in the literature. The first is considered a systemic variant of Weber–Christian disease. The second was a case of xanthogranulomatous panniculitis with an intracranial lesion and retroperitoneal, pericardial, and mediastinal involvement. The last was a case of secondary panniculitis and disseminated infection by Mycobacterium avium-intracellulare, and, in addition to the mediastinum, the spleen, liver, and gastrointestinal tract were infected. In the case we report, no possible etiologic agent was found; therefore, the panniculitis was considered idiopathic. As for the history of pesticide poisoning, no possible association with panniculitis has been reported in the literature. This exposure has been reported as a cause of severe pulmonary fibrosis and it has been related to a potential carcinogenic effect, thus increasing the risk—according to some studies—of lung cancer, leukemia, and non-Hodgkin lymphoma.

In conclusion, we present an exceptional case of mediastinal panniculitis with involvement of the parenchyma, lungs, pericardium, and chest wall.

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5. Sanderson TL, Moskowitz L, Hensley GT, Cleary TJ, Pennys N. Disseminated
and doors). Readings were taken with the CM from the floor, at a distance from windows 6 months under standard conditions (at least 65
using CR-39 detectors (Radosys Ltd, Budapest, household radon was measured and the same exclusion criteria as for the cases could not have been diagnosed with lung cancer injuries) in the same hospital as the case. They
cholecystectomy, or treatment of wounds and selected at random from all patients attended for emergency surgery (appendectomy,
living at their current address for less than 5 years aged less than 35 years and those who had been patients have been diagnosed in a hospital in Cantabria. Essentially, this result could be due to household radon. The authors found no
risk of lung cancer, we carried out a hospital-based case–control study. the effect of low doses of household radon on the
low radon activity and high rates of death due to lung cancer in Europe could be attributed (a region of Spain with elevated radon concentrations) showed similar results.
To the Editor: 2007;43:623-7), by Francisco Gandía Martínez et al, included a mistake in the listed authors. The fourth author should be Dr Íñigo Martínez Gil,
In November issue of this journal, the article titled "Postoperative Acute Respiratory Distress Syndrome After Lung Resection" (Arch Bronchoneumol.
were excluded from the study. For each case, 5 cases and 7 controls had exposures (1 case and its 2 controls) as 1 stratum. Exact
convergence problems. The statistical analysis was carried out using LogXact, version 6
maximum likelihood methods generated deviations were due to the high exposure in a
few individuals. Exposure to radon was greater
and 12 cases and 18 controls had exposures Bq/m
deviations were due to the high exposure in a
subsample (9 cases and 18 controls).

In summary, we did not find a link between
and Smoking

*Values adjusted for smoking.