urine (noradrenaline 1208.4 μg/24 h, adrenaline 532 μg/24 h, normetanephrine 5748.6 μg/24 h, metanephrine 12,281.6 μg/24 h) confirmed the diagnosis of pheochromocytoma. The patient was treated with alpha blockers (phenoxymazamine 10 mg/8 h), later combined with a beta blocker (propranolol 10 mg/8 h). After 7 days of progressive improvement, fiberoptic laryngoscopy revealed pharynx and larynx free of bleeding and bronchoscopy was normal. Bronchoalveolar lavage contained no malignant cells and abundant hemosiderophages (> 20%). Anti-DNA, c-ANCA, anti-MPO and anti-GBM antibodies and cultures were negative. After the patient stabilized, left adrenalectomy was performed by laparoscopy; the pathology examination revealed pheochromocytoma with malignant histological features. During follow-up the patient remained asymptomatic and all tests requested were normal (2 months after the episode, the patient had a PaO₂ of 85 mmHg).

On rare occasions pheochromocytoma can present with atypical manifestations such as hemoptysis, acute coronary syndrome with normal coronary catheterization or dilated cardiomyopathy. Pathophysiological mechanisms most often involved in hemoptysis are lung metastases and coagulation disorders. When all of these have been ruled out, hemoptysis may be related to the hypertensive crisis triggered by cromaffin tumor secretion. In these cases, the paroxystic HT crises will produce pulmonary vein hypertension causing capillary rupture and the passage of erythrocytes to the alveolar space, resulting in hemoptysis. The interest in this case is that the presence of pheochromocytoma should be considered in the differential diagnosis of DAH of unknown origin, and that failure to diagnose may be potentially fatal.

References

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Fig. 1. Proportion of spirometries performed in each participating center by quality. HUAV: Hospital Universitari Arnau de Vilanova.

Conflict of Interests

The authors declare that they have no conflict of interests.

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