bronchogenic cyst and branchial cleft, thyroglossal, thymic, thyroid and enteric duplication cysts, lymphangiomias, dermoid cysts, teratomas and neuromas with the same topography.2 Once diagnosis has been confirmed and any possible inflammation or sepsis have been treated, the treatment of choice is surgery. Choice of the surgical approach is wholly dependent on the topography and size of the cyst, and it is essential to remove the entire cyst in order to confirm the diagnosis, rule out neoplastic proliferation,4 and ultimately control the disease.

References


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Rasmussen’s Pseudoaneurysm in a Patient With a History of Pulmonary Tuberculosis

Seudoaneurisma de Rasmussen en un paciente con antecedente de tuberculosis pulmonar

To the Editor:

A 33-year old Romanian man was seen in the emergency room of our hospital for cough with hemoptysis. He reported fever lasting 48 h and night sweats lasting 2 weeks. He mentioned a history of pulmonary tuberculosis (TB) treated 5 years previously. The patient also showed signs of respiratory distress. Based on this information, we performed a chest X-ray, which showed bilateral interstitial and alveolar opacities. Subsequent contrast-enhanced multidetector computed tomography (MDCT) of the chest showed several consolidations (some cavitary), extensive bronchiectasis and a well-defined round lesion measuring 3 cm in the apical segment of the right lower lobe (RLL), with contrast uptake in the arterial phase and washout in the venous phase (Fig. 1). These

Fig. 1. Mediastinal window CT scan axial slices: lesion in the RLL with well-defined borders, showing contrast uptake in the arterial phase (A top) and washout in the venous phase (B top). Parenchymal window (A bottom) and mediastinal window (B bottom) CT scan coronal slices in the arterial phase: contrast-enhanced nodular lesion in the RLL and images of bronchiectasis and extensive cavitation in the left hemithorax.

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Severe Community Acquired Pneumonia Due to Legionella maceachernii Infection

Neumonia grave adquirida en la comunidad debida a la infección por Legionella maceachernii

A 39-year-old man (heavy smoker, hypertensive and moderately obese) presented at the Internal Care Unit in October 2012 suffering from a 3-day history of dyspnea, paroxysmal productive cough and retrosternal pain, with no fever. Scarce end-expiratory crackles in middle and lower lung fields bilaterally with associated mildly prolonged expiratory phase of respiration and mild leucocytosis were recorded. The patient refused hospitalization, and two days later he returned due to worsened, intense dyspnea at rest, heart rate of 130/min and fever (38.5°C). A new chest X-ray revealed more intense alveolar infiltrates, diffuse and expanded throughout the whole left lung and the right middle lung field (Fig. 1). Routine blood tests showed leukocytosis, elevated neutrophils and monocyes, relatively increased CRP (7.5 mg/dl), ESR (73 mm/h), ALT (83 U/L) and LDH (484 U/L).

The patient was administered levofloxacin, piperacillin/tazobactam, supplemental oxygen, inhaled bronchodilators and oseltamivir (for 5 days) because influenza pneumonia could not be excluded; however, his condition deteriorated and non-invasive bi-level positive pressure ventilation was applied with full-face mask for 24 h. Ten days later he was discharged completely recovered.

During hospitalization, 3 whole blood and serum samples (on second admission, at 21 days and one month later) were collected together with sputum, pleural fluid and urine samples. Sera were tested by IFA for IgM and IgG antibodies against L. pneumophila sg1, L. pneumophila sg2–4 and Legionella species (L. rubrilucens, L. anisa, L. bronensis, L. quinlivanii, L. maceachernii, L. oakridgensis, L. tauriniensis and L. londiniensis) using a homemade slide. Sera tested positive for L. maceachernii IgG antibodies in all samples (first: 1/960, second: 1/3840, third: 1/3840); titers for remaining species and/or serogroups ranged from 0–1/480. IgM antibodies tested positive (1/50) only for the first sample and only for L. maceachernii. All sera tested negative for Hepatitis Viruses, HIV, Coxielia burnetii, Mycoplasma pneumoniae and Chlamydia pneumoniae.

DNA was extracted (Qiamp DNA blood mini kit, Qiagen, Hilden, Germany) from whole blood and sputum samples and was tested by multiplex Real-time PCR for L. pneumophila and Legionella species, which was positive, at low copy numbers, for Legionella species on the pleural fluid only.

An isolate, following culture (buffered charcoal yeast extract medium supplemented with α-ketoglutarate (BCYE-α) and BCYE with polymyxin B, amoxicillin, and vancomycin petri dishes at 36°C/22% CO2 of whole blood pleural fluid and sputum samples was tested by MALDI-TOF MS (Bruker Daltonics) and matched Legionella species at a score of 1.99.

Legionella maceachernii infection is mostly expressed as pneumonia, although recently a case of soft-tissue infection by the pathogen was reported. All 6 patients described so