edema (OR: 16.4; 95% CI: 1.8–142; P<.01) and platelet count <60 000 (OR: 5.6; 95% CI: 1.5–20; P=.009).

In conclusion, bronchoscopy is a useful tool for the diagnosis of occult alveolar hemorrhage in patients with HIV infection and respiratory symptoms.

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References


Ingrid Martínez Ramírez, a,∗ Adan Jose Luque, b Plutarco García Herreros c

a Fellow of Neumología, Universidad Nacional de Colombia, Bogotá, Colombia
b Medicina Interna, Universidad Nacional de Colombia, Bogotá, Colombia
c Unidad de Neumología, Instituto Nacional de Cancerología, Bogotá, Colombia

∗Corresponding author.
E-mail address: ijmartinezr@unal.edu.co (I. Martínez Ramírez).

Paraneoplastic Cutaneous Vasculitis Associated With Lung Cancer

Vasculitis cutánea paraneoplásica asociada a cáncer de pulmón

To the Editor,

Paraneoplastic vasculitis (PNV) represents 2%–5% of all types of vasculitis and occurs in approximately 1 in 1800 hematological malignancies and 1 in 80 800 solid tumors. 1 To be considered PNV, both vasculitis and malignancy must be identified within a period of 12 months. 2 The most common site for PNV is the skin, and almost half of all cases appear as leukocytoclastic vasculitis (LCV). We report the case of a woman who developed purpura in the lower limbs that led to a diagnosis of lung cancer.

A 57-year-old woman, former smoker of 15 pack-years, cessation 22 years previously, history of left intraductal breast cancer at the age of 36 years, treated with breast-conserving surgery, chemotherapy and radiation therapy, with no signs of relapse on her last check-up 2 years previously. She was admitted to the hospital with a 10-day history of wrist and knee pain, associated with purpuric lesions on the lower limbs. In the last 72 h, she had presented abdominal pain, vomiting and abundant liquid stools with no visible mucus, pus or blood. She reported a 6-month history of dry cough, anorexia-cachexia, and 4 kg weight loss. On physical examination, she was seen to be asthenic, with a poor-to-midding general condition, body mass index 17.42, blood pressure 139/93, temperature 36.7 °C. No significant lymphadenopathies were found on palpation, cardiopulmonary auscultation was normal. She had diffuse pain on palpation of the abdomen, which was soft, depressible and with no signs of peritoneal irritation. Musculoskeletal examination revealed palpable purpura on the lower legs, with some lesions on the thighs, nail clubbing in both the fingers and toes (Fig. 1), and no pain, joint limitation or synovitis. Clinical laboratory test results showed: Hb 12.7 g/dl, white blood cells 7.9 x 10^9/L, neutrophils 75%, lymphocytes 20%, monocytes 5%, hemoglobin 87 g/L, platelets 52.0 x 10^9/L, CRP 13 mg/L, ESR 30 mm/h. C-reactive protein was 13 mg/L.

Fig. 1. Palpable purpura lesions on the legs and nail clubbing in the toes.

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Loricera Carolina pub-

Perforación pleural maligno

To the Editor,

Malignant pleural mesothelioma is an aggressive form of cancer that originates in the pleural mesothelioma. The main pathogenic factor is exposure to asbestos. Histologically, it is classified as epithelioid (60%), biphasic (30%) or sarcomatoid (10%). It generally appears as local disease in the affected hemithorax, and metastases are rare. It is unusual for malignant pleural mesothelioma to manifest with gastrointestinal complications due to metastatic implants. We report a case of jejun perforation due to malignant epithelioid pleural mesothelioma metastasis.

A 67-year-old man with a history of malignant pleural mesothelioma (T3N2M0) underwent radical pleuropulmonaryectomy with lymphadenectomy in July 2010. Adjuvant chemotherapy was administered and the patient was followed up by the Oncology department. He presented in the emergency room in August 2011 with a 4-h history of sudden onset abdominal pain, initially in the lower abdomen, but which then became diffuse. On examination, abdominal guarding with signs of peritoneal irritation were observed. Clinical laboratory test results were within normal limits. No significant findings were detected on abdominal X-ray. An abdominal computed tomography with intravenous contrast medium was performed, revealing air in the peritoneal cavity, circumferential wall thickening of a short segment of the hypogastric small intestine (jejenum) with marked inflammatory changes and small adjacent air bubbles (Fig. 1). In view of these findings, emergency laparoscopic intervention with supra and infra-umbilical access was performed, revealing acute purulent peritonitis in the inframesocolic space due to a single perforation of the jejunum at the site of an ischemic lesion. Intestinal resection with manual end-to-end anastomosis was performed and the post-operative period was incident-free. Pathology reported epithelioid malignant mesothelioma metastasis in the intestinal wall and 2 isolated lymph nodes. The patient was referred to the oncology department for treatment with chemotherapy.

References

Lucía Pantoja Zarza,* Carolina Diez Morrono, Elena Castro Rodríguez

Unidad de Reumatología y Sección de Neumología, Hospital El Bierzo, Ponferrada, León, Spain

* Corresponding author.
E-mail address: lpantojazarza@gmail.com (L. Pantoja Zarza).

Jejunal Perforation by Metastasis of Malignant Pleural Mesothelioma

Perforación yeyunal por metástasis de mesotelioma pleural maligno

To the Editor,

Malignant pleural mesothelioma is an aggressive form of cancer that originates in the pleural mesothelioma. The main pathogenic factor is exposure to asbestos. Histologically, it is classified as epithelioid (60%), biphasic (30%) or sarcomatoid (10%). It generally appears as local disease in the affected hemithorax, and metastases are rare. It is unusual for malignant pleural mesothelioma to manifest with gastrointestinal complications due to metastatic implants. We report a case of jejunal perforation due to malignant epithelioid pleural mesothelioma metastasis.

A 67-year-old man with a history of malignant pleural mesothelioma (T3N2M0) underwent radical pleuropulmonaryectomy with lymphadenectomy in July 2010. Adjuvant chemotherapy was administered and the patient was followed up by the Oncology department. He presented in the emergency room in August 2011 with a 4-h history of sudden onset abdominal pain, initially in the lower abdomen, but which then became diffuse. On examination, abdominal guarding with signs of peritoneal irritation were observed. Clinical laboratory test results were within normal limits. No significant findings were detected on abdominal X-ray. An abdominal computed tomography with intravenous contrast medium was performed, revealing air in the peritoneal cavity, circumferential wall thickening of a short segment of the hypogastric small intestine (jejenum) with marked inflammatory changes and small adjacent air bubbles (Fig. 1). In view of these findings, emergency laparoscopic intervention with supra and infra-umbilical access was performed, revealing acute purulent peritonitis in the inframesocolic space due to a single perforation of the jejunum at the site of an ischemic lesion. Intestinal resection with manual end-to-end anastomosis was performed and the post-operative period was incident-free. Pathology reported epithelioid malignant mesothelioma metastasis in the intestinal wall and 2 isolated lymph nodes. The patient was referred to the oncology department for treatment with chemotherapy.

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Lucía Pantoja Zarza,* Carolina Diez Morrono, Elena Castro Rodríguez

Unidad de Reumatología y Sección de Neumología, Hospital El Bierzo, Ponferrada, León, Spain

* Corresponding author.
E-mail address: lpantojazarza@gmail.com (L. Pantoja Zarza).