The presence of opacities, ground-glass scan chest findings, and cough, may be considered as an indicator of underlying disease. The diagnosis of these patients can be made by serological examination and by finding abnormality in other organs, such as liver, kidney, and bone marrow. However, other organ involvement may also occur in cases of CD. The patient presented with dyspnea, increased leukocyte count, and hypoalbuminemia. Since the symptoms of CD occurred in patients taking MTX, it is suggested that MTX is the major risk factor for such complications. The patient was discontinued from MTX and was maintained with 12.5 mg weekly of azathioprine. The patient was then diagnosed with pneumonia and was hospitalized for treatment. After a six-fold dose of azathioprine was discontinued, the patient was successfully treated with another drug. The patient was maintained on MTX and was discharged from the hospital. The patient was then discharged from the hospital. The patient was maintained on MTX and was discharged from the hospital.

Dear Editor:

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Neuromyelitis optica in a multiply exposed cervical cord: a case study of the prevention of permanent sequelae.

Hyposensitive thymol in a form of fever.


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necessary but pulmonary histology is characterized by alveolitis with epithelial cell hyperplasia and eventually, small granulomas and eosinophilic infiltration.

References


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Calcified Alveolar Septal Pulmonary Amyloidosis as an Initial Manifestation of Multiple Myeloma

Amiloidosis pulmonar alveolo septal calcificada como manifestación inicial de mieloma múltiple

To the Editor:

Systemic amyloidosis is caused by the extracellular deposition of protein in the form of fibrils, known as amyloid. This process causes functional impairment of the affected organs and is fatal if left untreated.

Lung involvement is relatively common, but rarely symptomatic. It can present in three ways: nodular, tracheobronchial and diffuse alveolar septal.

We describe below the case of a female patient, 65 years of age, history of COPD, former smoker, who reported 6-month history of progressive dyspnea, with no other associated symptoms. On physical examination, she had dry crackles in both lung bases. Complete blood count and biochemistry were normal. An echocardiogram was performed, which was normal. Spirometry revealed a severe obstructive defect (FEV1 47%) with moderate restriction (FVC 61%). Diffusing capacity for CO was severely reduced (17%). The 6-min walk test showed a significant drop in oxygen saturation and had to be suspended due to significant dyspnea and O2 saturation of 73%. A chest computed tomography (CT) was performed that showed multiple nodular images, mostly densely calcified, with thickening of interlobular septa, mainly peripheral and in the basal segments (Fig. 1). A lung biopsy, performed by video-assisted...