in the Glasgow Coma Scale (Eyes = 2, Verbal = 2, Motor = 4), which prompted the placement of an external ventricular derivation to control the intracranial pressure. A drug-induced coma was maintained for 48 h. Upon awakening, the patient's vitals normalized, and the neurological deficits improved. The brain CT performed 3 days after the biopsy, showed complete resorption of the cerebral air bubbles and normal permeability of the main intracranial venous sinuses. She was discharged 10 days later, after complete recovery.

The pulmonary biopsy was positive for secondary localization of lymphoma and the patient died 8 months later due to graft-versus-host disease.

In this report, we showed how the use of the Hare et al. algorithm enabled a rapid diagnosis and quickened the decision-making treatment process. Our experience is limited to this single case; it is, however, important by virtue of cerebral SAE rarity and its life-threatening characteristics. In fact, most SAE reports describe cardiac and respiratory symptoms,[6] whereas only a few describe neurological manifestations. As reported by Kim et al., even simple needle insertion into the chest wall can cause air to flow through the pulmonary venous circulation thus, piercing the lung parenchyma may not be the only maneuver at risk for SAE.[7]

Our treatment course deviated from the recommendations previously described due to the absence of a hyperbaric chamber in our hospital and to the placement of a ventricular derivation, never reported before to treat SAE (Fig. 1D). This choice proved successful. It is in fact known that many forms of acute brain injury benefit from cerebrospinal fluid diversion and the continuous monitoring of intracranial pressure provided by the insertion of an external ventricular derivation which is one of the lifesaving procedures in the neurologic intensive care unit.[8]

In conclusion, physicians performing lung biopsies should be aware of the unpredictable manifestations of SAE and mindful of the usefulness of an emergency algorithm for its management.

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Primary Pulmonary Lymphoepithelioma-Like Carcinoma in a Non-Asian Patient☆

Linfoepitelioma-like primario pulmonar en paciente no asiático

Dear Editor:

Lymphoepithelioma is an undifferentiated carcinoma characterized by stromal infiltration due to the presence of atypical epithelial cells, associated with a dense benign reactive inflammatory infiltrate, rich in lymphocytes and plasma cells.[1] The vast majority of cases occur in the nasopharynx and characteristically in Asian patients, and an etiopathogenic association with Epstein–Barr virus (EBV) has been suggested. When lymphoepithelioma affects other anatomical sites (mostly the parotid salivary glands or the thymus), it is called lymphoepithelioma-like carcinoma.[2–7]

We report the case of a 66-year-old Caucasian male, ex-smoker of 22 pack-years, with a history of untreated chronic obstructive pulmonary disease GOLD grade 2. As a result of a persistent cough of several weeks' duration, computed tomography (CT) was performed that showed an irregular consolidation in the middle lobe (ML), multiple bilateral pulmonary nodules, and bilateral hilar and mediastinal lymphadenopathies of significant size, along with moderate pericardial effusion. Blood tests were significant only for raised CYFRA 21.1 (27.5 ng/ml) and neuron-specific enolase (50 ng/ml). A positron emission tomography (PET) showed increased uptake of ^{18}F-fluorodeoxyglucose both in the ML consolidation and in the mediastinal and hilar lymphadenopathies and lung nodules observed on CT.

Fiberoptic bronchoscopy performed before the PET showed thickened irregular mucosa suggestive of neoplastic infiltration at the entrance of the ML bronchus. The biopsy samples obtained (Fig. 1) confirmed the diagnosis of lymphoepithelioma-like carcinoma of the lung. An assessment was carried out by the ENT department that ruled out the presence of a primary lymphoepithelioma-like carcinoma of the nasopharynx. Three weeks after the first visit, the patient was referred to the medical oncology department with a diagnosis of stage IVA lymphoepithelioma-like carcinoma of the lung (T4N3M1a),[8] where he began treatment with carboplatin and pemetrexed. After 2 cycles of chemotherapy, the patient presented both pulmonary and pancreatic disease progression. Finally, a second

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