## Ground-glass Opacity Associated With Endobronchial Leech

### *Opacidad de vidrio esmerilado asociada a una sanguijuela endobronquial*

*Dear Editor:*

We report the case of a 49-year-old woman, who presented with a 6-week history of cough, rusty brown sputum with hemoptysis and hoarseness. She was a farmer and had a history of drinking field unboiled water. A computed tomographic scan of the chest showed a ground-glass opacity (GGO) in the medial basal segment of the right lower lobe, measuring 22 mm in its largest diameter (Fig. 1A). Laboratory investigations demonstrated a white-cell count of 5280 per $mm^3$ (reference range, 4000–10,000), an absolute eosinophil count of 600 per $mm^3$ (reference range, 50–500), hemoglobin level of 147.00 g/L (reference range, 110–160), and C-reactive protein levels of 11.30 ml/L (reference range, 0 068–8.2). The blood coagulation tests were normal. The differential diagnosis included lung cancer, eosinophilic lung disease and focal pneumonia. Bronchoscopy was performed, and revealed a brown worm-like moving foreign body almost completely obstructing the lumen of the medial basal segmental bronchus of the right lower lobe (Fig. 1B). The foreign body was removed from the bronchus by cryoadhesion with a cryotherapy probe passed through the channel of a flexible bronchoscope with resolution of the obstruction and was identified as a 4 cm long living leech (Fig. 1C). After removal of the leech, the patient was discharged from the hospital without any discomfort and complaint. Follow-up computed tomographic of the chest at 1 week showed the ground-glass opacity in the right lower lobe was almost completely resorbed (Fig. 1D).

Leeches are parasites that live in quiet pools and streams. Leeches are the very rare cause of airway foreign body around the world.[1–3] Leeches are hemophagic parasites, living on occasional meals of blood obtained by attaching to fish, amphibians, and mammals. They can enter the human body when people drink infested water from quiet streams, pools and springs. Although there are several case reports about leech in the airway, these leeches locate in the larynx or trachea.[1–3] Interestingly, the leech of our case was in the bronchus, and the chest CT showed a GGO. To the best of our knowledge, this is the first report of endobronchial leech showing a GGO on CT scan. The nature of this GGO induced by the parasite was unclear. We speculated that the cause might relate to blood tracking back into the parenchyma or an inflammatory response to the leech or its secretions. The differential diagnosis of GGO induced by endobronchial leech included lung cancer, eosinophilic lung disease and focal pneumonia.

Although extremely rarely seen, endobronchial leech infestation should be kept in mind especially in patients presenting with unexplained haemoptysis, hoarseness and elevated eosinophils and a history of drinking infested water from streams, pools and springs.

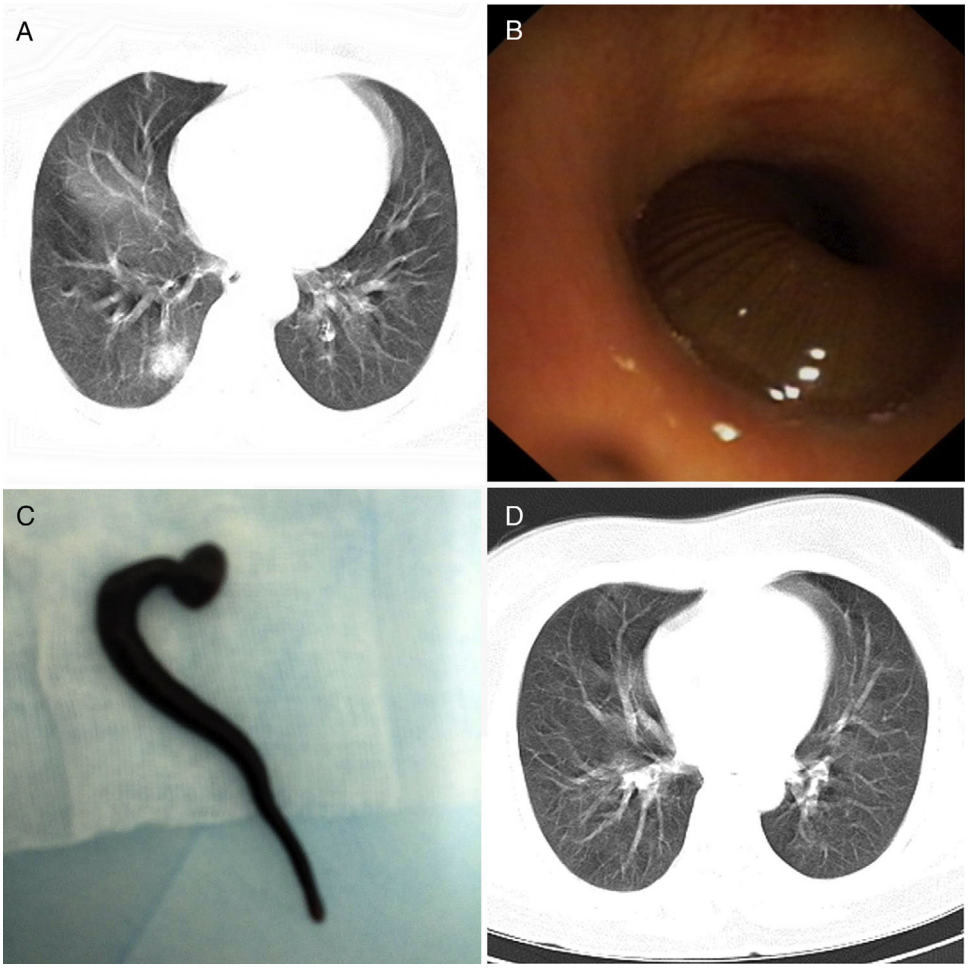


**Figure 1.** Chest computed tomography showed a ground-glass opacity in the medial basal segment of the right lower lobe (A). Bronchoscopy revealed a brown worm-like moving foreign body almost completely obstructing the lumen of the medial basal segmental bronchus of the right lower lobe (B). The foreign body was identified as a 4 cm long living leech (C). Chest computed tomography after 1 week showed the ground-glass opacity in the right lower lobe was almost completely absorbed (D).

## Funding

This work was supported by the "Special and Joint Program" of Yunnan Provincial Science and Technology Department and Kunming Medical University (No. 2014FA018), Science and Technology Program for Public Wellbeing of Yunnan Province (No. 2014RA020), and Young academic and technical leaders of Yunnan Province (No. 2017HB053).

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https://doi.org/10.1016/j.arbres.2017.10.022
0300-2896/


## Quilotórax recidivante por obstrucción de la vena cava secundaria superior

### *Recurrent Chylothorax Due To Secondary Superior Vena Cava Obstruction*

*Estimado Director:*

El quilotórax es el acúmulo de quilo en la cavidad pleural, causado por la lesión del conducto torácico o de alguna de sus ramas[1]. Contiene una alta concentración de triglicéridos en forma de quilomicrones, que producen el aspecto lechoso[1]. El diagnóstico definitivo se basa en el hallazgo de quilomicrones (patognomónico), o de una concentración de triglicéridos superior a 110 mg/dl[1]. Se clasifica en 2 grupos: traumáticos (iatrogénicos o no) y no traumáticos (neoplásicos, de causa miscelánea o idiopáticos)[1]. En el caso de los quilotórax no traumáticos, el tratamiento es el de la enfermedad subyacente, recomendándose, además, si su origen no es maligno, realizar dieta con exclusión de triglicéridos de cadena larga[2]. Por otra parte, en la mayoría de los quilotórax de origen traumático, se sugiere efectuar un tratamiento conservador inicial, aunque si su volumen es grande se recomienda recurrir a la cirugía precoz[1].

Presentamos el caso de una mujer adulta que presentó un quilotórax derecho recidivante secundario a una obstrucción de la vena cava, provocada por la oclusión del reservorio venoso subcutáneo colocado para quimioterapia (QT) previa, que fue tratada quirúrgicamente mediante la apertura de la vena cava superior, con resección de la fibrosis y reparación con parche de pericardio bovino heterólogo, con buena evolución.

Mujer de 57 años que en el año 2014 fue diagnosticada de carcinoma epidermoide de canal anal (T4N2), recibiendo tratamiento inicial con QT y radioterapia (RT) neoadyuvante y posteriormente con cirugía. Fue remitida a urgencias desde la consulta de oncología radioterápica por un cuadro de un mes de evolución de disnea de moderados esfuerzos, acompañado en los últimos días de dolor torácico pleurítico derecho. A la auscultación pulmonar presentaba una disminución del murmullo vesicular en el hemitórax derecho, siendo anodina el resto de la exploración. En la radiografía de tórax del ingreso se objetivó un derrame pleural derecho de cuantía

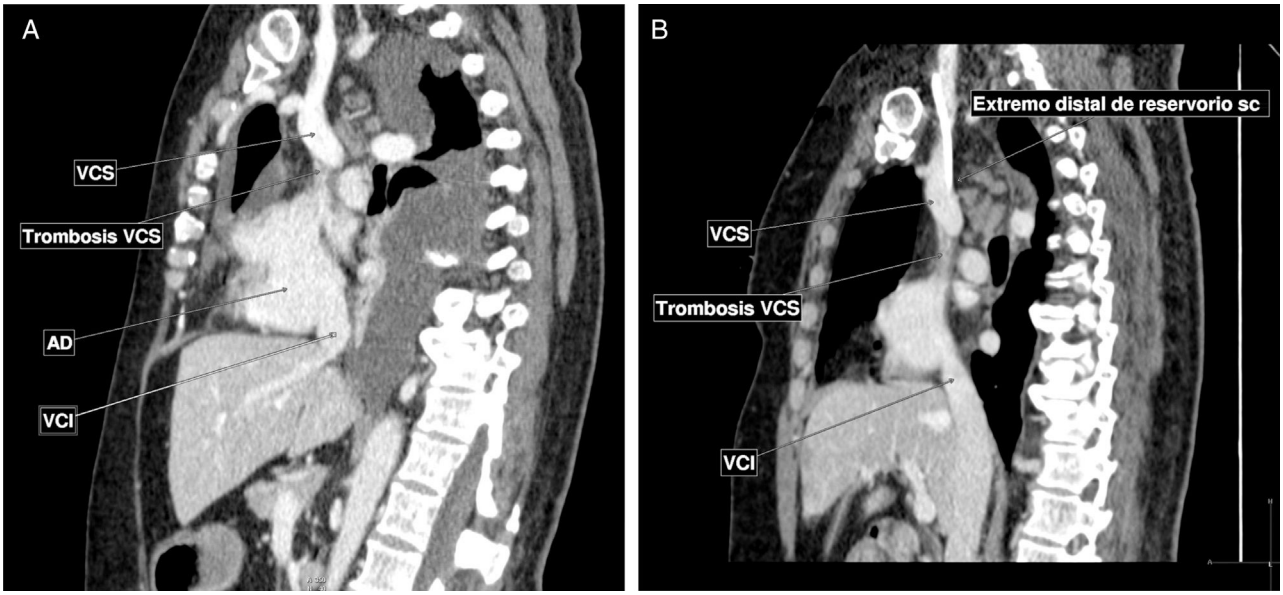


**Figura 1.** A) Tomografía computarizada con contraste intravenoso en fase venosa. Corte sagital. Se identifica un defecto de repleción de vena cava superior, proximal a la desembocadura del cayado de la ácigos, hasta la entrada en la aurícula derecha. Compatible con trombosis al menos parcial de dicha estructura. Asocia importante derrame pleural. B) Corte sagital. Extremo distal de reservorio subcutáneo, en relación con trombosis de vena cava superior.