



Figure. Computed tomography of the chest in which a mass overlying a focal area of pleural thickening is observed in the lower left lobe with vessels that curve and converge towards the mass.

and left-sided pleural effusion caused by chest injury consulted us because of a 2-month history of chronic cough, left-sided pleuritic pain, and wasting syndrome. Rhonchus and crackles were heard at the base of the left lung. No abnormalities were seen in blood counts or biochemistry, a coagulation study or urine analysis. The chest x-ray showed a left basal opacity with a decrease in lung volume. A CT scan of the chest and abdomen revealed a peripheral mass at the posterior basal segment of the lower left lobe associated with a pleural thickening, with curvature and convergence of the hilar vessels towards the lesion (Figure). Simple spirometry found the following: forced vital capacity (FVC) of 3480 mL (100% of predicted value); forced expiratory volume in 1 second (FEV_1) of 2540 mL (96% of predicted); FEV_1/FVC , 72.9% of predicted; forced mid-expiratory flow (FEF_{25-75}) of 1100 mL (39% of predicted). Fiberoptic bronchoscopy revealed no endobronchial changes and cytologies of the bronchoalveolar lavage fluid and bronchial aspiration were negative for malignancy. After an x-ray to confirm growth of the mass, transthoracic needle aspiration was performed; cytologic findings were consistent with adenocarcinoma.

Lung Cancer Coexisting in Rounded Atelectasis

To the Editor: In rounded atelectasis (RA), the characteristic findings on a computed tomography (CT) scan include a rounded or oval lung mass 2 to 10 cm in diameter adjacent to an area of pleural thickening with an associated loss of volume and curvilinear bronchovascular bundles that converge towards the lesion (comet tail sign).¹ Since, in most cases, malignancy can be ruled out by the singular shape that a neoplasm such as RA presents, it has been proposed that cytological and histological study of the tumor is unnecessary.² However, we present a new case of a lung mass consistent with RA in which lung cancer was diagnosed.

A 62-year-old male farmer with a history of smoking (14 pack-years), pulmonary tuberculosis,

The pathogenesis of RA (Blesovsky's syndrome) is related to the presence of a pleural effusion or a pleural fibrosis that compresses and collapses a focal area of the peripheral lung parenchyma.³ Most cases are caused by asbestos exposure, although RA has also been associated with pleural effusion caused by lung infections, lung infarction, heart failure, pneumothorax, chest injury, and cardiac surgery.^{3,4} Hillerdal,⁵ after an extensive review of cases, asserted that no biopsy of the mass is necessary because malignancy can be ruled out when CT findings consistent with RA are combined with lack of evidence of a tumor during fiberoptic bronchoscopy. Nevertheless, we found a reported case of a lung mass with radiographic images consistent with RA in

which the biopsy confirmed the presence of carcinoma; the most likely hypothesis was that the neoplasm was resting on top of the RA.⁶ The shape of these tumors, therefore, does not guarantee they are benign. In conclusion, even if the association between RA and lung cancer in the aforementioned case and in the one we report is very rare, we believe that the neoplasm should be monitored periodically, initially by simple chest x-ray taken monthly or bimonthly, depending on each patient's level of risk, and later at longer intervals if no changes are noted. If an increase in size is observed, diagnostic procedures should be performed to confirm the nature of the mass.

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