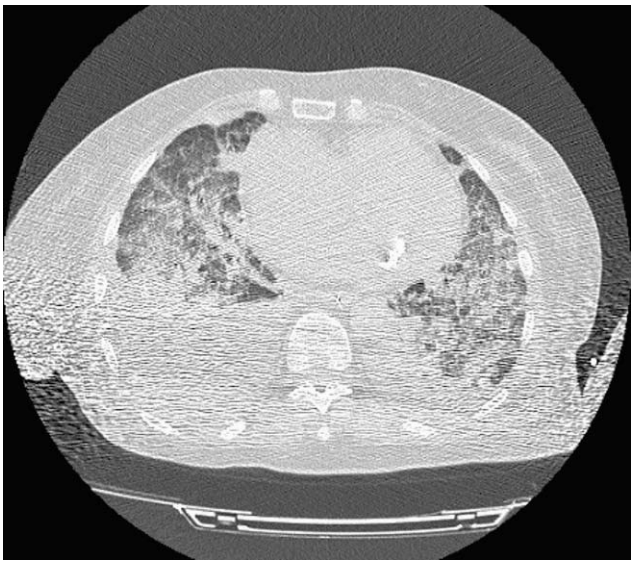

Figure 1. Chest computed tomography (CT) in which it was possible to see a bilateral reticulonodular interstitial pattern located in the centre of the lobes and affecting some subpleural nodes.

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Lung Resections in Patients with Only One Lung

Resecciones pulmonares en pacientes con pulmón único

To the Editor:

We have read the case report by Vázquez-Pellilo et al[1] "Surgical Treatment of Pulmonary Lesions in a Single Lung" in the May 2009 edition, with great interest. We would like to take this opportunity that this prestigious scientific publication gives us to communicate our experience in this field, given that it was the reason for a communication in the 41st SEPAR National Congress, held in Tenerife in June 2008, published in your journal.[2]

As pointed out by Vázquez-Pelillo et al, resections in patients who had previously undergone pneumonectomy are rare in medical literature, although there are, along with yours, 19 series that presented sample sizes from one to 24.

Vázquez-Pelillo et al described four cases of patients who had previously undergone pneumonectomy in a period of almost 15 years (1992-2007), of which 3 had undergone previous pneumonectomy for lung cancer and one for colon cancer. Our group presented a series of 9 cases treated in 9 years (1998-2007), during which the pneumonectomy had been performed solely for lung cancer (table 1).

Atypical resections were performed on 7 patients; 2 atypical resections were performed on one and 3 on another. Morbidity of the series was 44.4% due to the appearance of transitory auricular fibrillation in 2 cases, one case of respiratory failure that required temporary respiratory home oxygen therapy and one upper digestive haemorrhage, conservatively treated. There was no postoperative mortality in our series. The average postsurgical stay was 7.9 days (range: 3-14).

Of the 9 patients, 3 are alive and free of disease, with a survival of 11, 17 and 20 months, respectively. Of those deceased, the average survival was of 32 months (range: 23-44).

Table 1
Intervened Patient Data

Age (years)	FEV_1	Primary tumour		DFS	Histology 2nd surgery	Postoperative morbidity	Stay	SV	Current State
		Histology	TNM						
71	26	Scaly	T2N0M0	72	Scaly	–	14	10	Deceased
54	NA	Scaly	T3NOMO	12	Scaly	ACxFA	8	22	Deceased
65	59	Scaly	T2N2M0	24	Scaly	–	9	10	Deceased
78	54	Scaly	T3N0M0	24	Scaly	ACxFA	12	44	Deceased
78	68	Scaly	T3N0M0	79	Bladder cancer	–	6	20	Living
74	52	Scaly	T2N0M0	84	Scaly	Respiratory failure	8	29	Deceased
68	58	Adenocarcinoma	T2N0M0	26	Scaly	–	5	11	Living
77	61	Scaly	T2N0M0	20	MALT lymphoma	–	9	23	Deceased
81	NA	Scaly	T2N1M0	24	Nechrotic nodule	Digestive haemorrhaging	5	17	Living

ACxFA: cardiac arrhythmia from auricular fibrillation; FEV_1: forced expiratory volume in second 1; DFS: disease-free survival; MALT: muscosa-associated lymphoid tissue; NA: not available; SV: survival.

Therefore, and as a result of Vázquez-Pellilo et al's conclusions and our own experience, we consider that single lung surgery, in a selective manner, is a feasible procedure with which prolonged survival periods can be obtained despite the peculiarities of these patients.

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Pulmonary Epithelioid Hemangioendothelioma Presenting as Multiple Large Calcified Nodules

Hemangioendotelioma epitelioide pulmonar que se presenta como múltiples nódulos de gran tamaño y calcificados

To the Editor,

We have read the article published by Azcárate Perea et al[1] with great interest in which a patient with multiple calcified and bilateral pulmonary nodules is described and that was finally diagnosed as epithelioid hemangioendothelioma. This case emphasizes the importance of an accurate diagnosis in a patient with multiple lung nodules. We would like to inform of our experience with a similar case, even though the clinical and radiological characteristics were quite different.

Epithelioid hemangioendothelioma is a rare endothelium tumour, with a prognosis intermediate between benign vascular tumours (haemangioma) and high grade malignant tumours (angiosarcoma). Although it is more commonly found in the liver and lungs, it can spread to any other region of the body, including bones, breast, brain, meninges and lymph nodes.[2,3] In general, the pulmonary epithelioid hemangioendothelioma arises as multiple bilateral nodules and tends to follow a long clinical prognosis.[1] Only 2 cases of multiple calcified nodules detected by computerised tomography (CT)[4,5] have been reported in specialised literature. In both cases, the patients only developed calcifications 10 to 20 years after diagnosis. Following is our experience with a PEH case with multiple calcified nodules in the CT. According to our knowledge, this is the first documented case of PEH in which multiple calcified nodules on the lung are visible on the CT at the start of the presentation.

Female, 53 years of age with a history of progressive dyspnoea over the last 3 months, as well as persistent non-radiating pain in the lumbar region. She also reported a 15kg weight loss over the previous year. Painless purple lesions were observed on her right thigh. The remaining results of the physical examination and the laboratory tests presented no significant findings. The chest x-ray and CT showed multiple nodules on the pulmonary lobes, variable in size (5 to 25mm) with calcifications (fig. 1). The lower regions of the lungs were the most affected. No lymphadenopathy or pleural effusion were noted. Hypodense lesions on the liver and osteolytic lesions on the spinal column vertebrae were also observed, indicative of metastasis. A nodule resected via open lung biopsy established the diagnosis of epithelioid hemangioendothelioma. The biopsy of the thigh lesion confirmed the same histology.

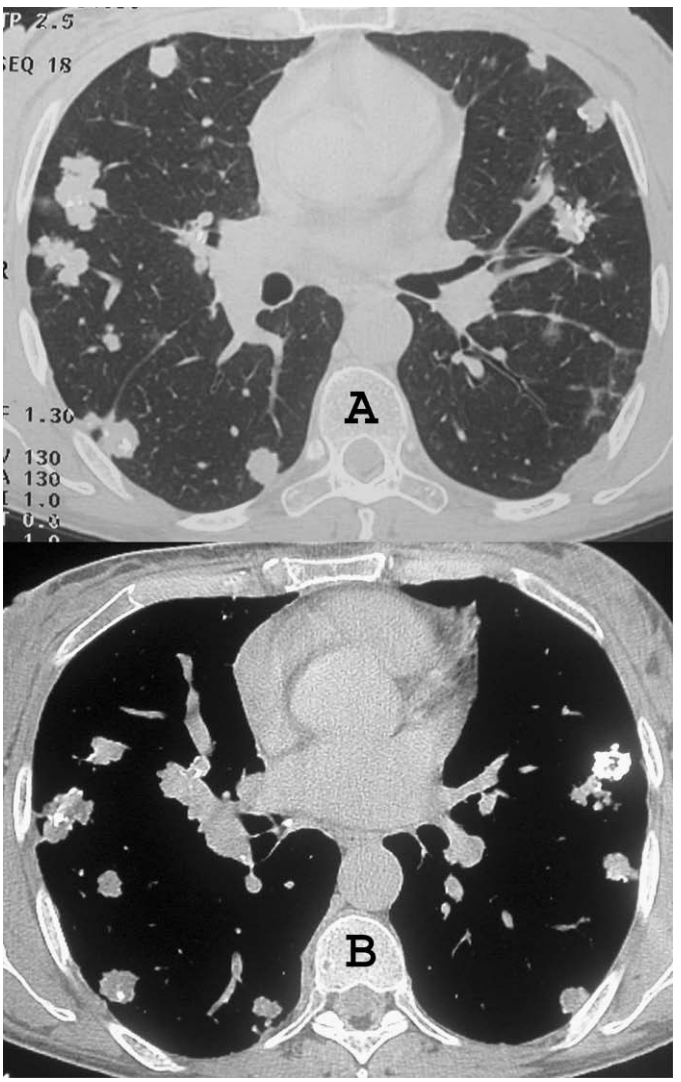

Figure 1. High resolution computerised tomography of the inferior lobes, with views of the lung *(A)* and mediastinum *(B)*, displaying multiple pulmonary nodes of variable size and irregular margins, some with calcification.

In the chest x-ray or CT, the PEH manifested as multiple perivascular nodules with well or badly defined margins and a bilateral distribution.[2,3,5] Despite the histopathology frequently revealing calcification and ossification, conventional x-ray rarely displays the calcic density.[3] The CT generally shows more nodules