the responses of the diary could be compared. In any event, this study suggests that the use of the Spanish version of the ABSS symptoms diary is reliable in acute bronchitis.

References
Another important differential diagnosis that should also be taken into account in this case is respiratory bronchiolitis-associated interstitial lung disease (RB-ILD). RB-ILD is often observed in patients who are current or ex-smokers, although its appearance has also been described in non-smokers. Evidence has been obtained indicating an accumulation of macrophages with dark pigmentation in the respiratory bronchioles and in the surrounding airspace associated with a submucosal and peribronchiolar infiltration dotted with lymphocytes and histiocytes. Peribronchiolar fibrosis may also be observed. In this disorder, fibroblastic foci are not observed, which differentiates it from other idiopathic interstitial pneumonias.

This case poses the question of the utility of open lung biopsies being more frequently done and the need for a more sophisticated histologic analysis. The anathomopathological examination is less useful when obtained later on in the course of the disease or after treatment is initiated.

Our case is a contribution towards the limited amount of data published to date about this entity, which is reported very infrequently. It is the first reported case of spontaneous resolution of BIP. It is very important to be more aware of this entity, as many cases may not be diagnosed or may currently be misdiagnosed.

References

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Empyema due to Bordetella pertussis in an Adult Patient With Lung Cancer

Dear Editor:

Bordetella pertussis (BP) is a small Gram-negative coccobacillus with an exclusive affinity for the mucous layers of the human respiratory tract. BP is an important cause of respiratory disease and it is a persistent public health problem. In 2010, a BP epidemic was detected in the city of Aydin, Turkey. Although pleural effusions or empyemas with BP infection are extremely rare, we present a case of non-small-cell lung carcinoma and unilateral pleural effusion with infection due to BP. A 64-year-old woman was hospitalized due to progressive dyspnea and thoracic pain. The patient had a history of non-small-cell lung cancer and she was receiving treatment. Previously, she had smoked 4–5 cigarettes per day for a period of some 10 years. Upon exploration, she showed signs of illness and emaciation, while presenting clinical anemia and signs of massive left pleural effusion on chest CT (Fig. 1). Heart rate was 85 bpm, blood pressure 120/85, with no signs of heart failure. Chest radiography confirmed left unilateral effusion. Hemoglobin was 9.1 g/100 ml,

![Fig. 1. Massive left pleural effusion on chest CT.](image-url)