

Reply***Réplica**

Dear Editor:

We have read with interest the recent comments about the SEPAR Guidelines for lung cancer staging that refer to the role of PET-CT.¹ The authors first suggest initially including for said test those patients who are provisionally classified in stage IIIB, supporting this suggestion with 2 important publications,^{2,3} one of which was included in the references of the Guidelines.² Those publications, as well as the SEPAR Guidelines, emphasize optimizing the selection of patients who are candidates for surgery. However, the authors of those studies based their opinions on the latest TNM classification by Mountain, and not on the recent, widely accepted edition of the IASLC.⁴ In the latter, the inclusion of subgroups T4N0 and T4N1 (some of which, depending on the T4 descriptor, could have a surgical option) in category IIIA (previously considered IIIB) means that the current limit between IIIA and IIIB is much closer to the limit that separates potentially resectable tumors from non-resectable tumors. Therefore, in our opinion, except for under very exceptional circumstances, when given a patient who has already been classified as IIIB by other means (according to the current TNM classification), PET-CT would not make much of a contribution to deciding on surgery. Nevertheless, we do agree with the comments about the potential of PET-CT to better program treatment with thoracic radiotherapy in patients who are candidates. Here, PET-CT may give a more exact definition of the volume to radiate.⁵

A second aspect commented on by the authors refers to the high diagnostic performance of PET-CT with possible bone metastasis. We completely agree with this as it is expressed in the Guidelines, which also mention the value of PET-CT for detecting possible hidden metastases in uncommon locations. However, we believe that bone scintigraphy, a more economic and universally available procedure (although less effective than PET-CT), is still useful. Often times, when scintigraphy results are interpreted together with a detailed anamnesis and physical examination, some patients are able to be classified in TNM stage IV with a reasonable certainty,

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which may avoid later tests. We believe that this procedure, which is common in many centers that do not have easy or fast access to PET-CT, is justified by a rational and efficient use of the means that are available. Naturally, this does not mean that it would not be more effective, if resources and delay times are permitting, to directly do a PET-CT.

In closing, we would like to thank the authors for their comments and suggestions, which, undoubtedly, contribute to clarifying the usefulness and the limits of lung cancer staging procedures.

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Pneumonia and Pleural Effusion Due to Brucella***Neumonía y derrame pleural por Brucella**

Dear Editor:

Brucellosis, or Maltese fever, is a zoonosis that is prevalent in the Mediterranean regions and is endemic in our country.¹ The disease is acquired fundamentally by consuming non-pasteurized milk and dairy products, such as cheese and cream.² Rarely, the pathogen can invade the respiratory system through inhalation. After an incubation period of 2–4 weeks, the brucellosis causes non-specific symptoms like fever of up to 40 °C, night sweats, anorexia, tiredness and weightloss.³ The serum tube agglutination or microplate agglu-

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tionation with Rose Bengal is especially used as a rapid screening test method for mass screening. Conventional serum tube agglutination (Wright agglutination test) is one of the most common laboratory tests used to confirm the diagnosis.⁴ The definitive diagnosis can be obtained with the isolation of the pathogen through hemoculture and a culture of a bone marrow sample.

A 20-year-old male patient who had just enlisted with the army came to our consultation complaining of cough, expectoration, sharp pain in the left hemithorax, night sweats, anorexia, fever in waves and dyspnea evolving over the previous 10 days. He also reported a weight loss of 3 kg in recent months. At the time, he had a fever of 38.4 °C with a respiratory rate of 22/min. Thoracic auscultation revealed bilateral basilar inspiratory rales. Leukocyte count was 27,930/mm³ and sedimentation rate was 68 mm/h. C-reactive protein was 141 mg/dl.

Chest radiography showed a pneumonic infiltrate in the right middle lobe and homogenous opacity in the left lower lobe. Computed tomography demonstrated bilateral pleural effusion