

## Conflict of Interests

The authors declare having no conflict of interests.

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## Sleep Apnea-Hypopnea Syndrome and Multiple Symmetrical Lipomatosis<sup>☆</sup>

### Síndrome de apnea-hipopnea del sueño y lipomatosis simétrica múltiple

Dear Editor,

We believe that the readers of your journal will find it interesting the association of sleep apnea-hypopnea syndrome (SAHS) with a rare disease such as multiple symmetric lipomatosis (MSL), Madelung's or Launois-Bensaude syndrome. Said association has been reported in several publications in recent years, and we ourselves have witnessed this combination of diseases in one of our patients (Fig. 1). MSL is an uncommon disease of unknown etiology that is characterized by the symmetrical accumulation of fat in the form of non-encapsulated subcutaneous lipomas in different locations, although especially in the neck and shoulders.<sup>1,2</sup> It is most frequent in males between the third and fifth decades of life, and it is frequently associated with alcoholism, chronic hepatopathy and neuropathy. It sometimes causes symptoms caused by the compression of neighboring structures such as the larynx. It can be associated with metabolic diseases and with atherogenic risk factors. Given the therapeutic implications, it should be differentiated from other rare adipose disorders. Diagnosis is usually symptoms-based, and when in doubt either computed tomography (CT) or magnetic resonance imaging (MRI) can be of help. MSL is a progressive disease with an infiltrating behavior. Diet control, alcohol abstinence and lymphatic drainage are recommended. In some cases, surgical reduction of the fat masses is the only treatment that may be effective and is aimed at improving esthetic and psychological consequences as well as treating airway or digestive tract obstruction, if necessary.

Very few cases have been reported of MSL associated with SAHS.<sup>2-6</sup> The presence of large fatty deposits in the cervical area would contribute to the narrowing of the upper airway and could interfere with the normal function of the pharyngeal muscles during sleep, favoring the appearance of SAHS. The frequent association of alcoholism and obesity would likewise increase the risk for SAHS. The diagnosis and treatment of SAHS in patients with MSL is especially important due to the increased risk for cardiovascular and metabolic diseases when both diseases are associated. Although cases have been published in which SAHS has improved after surgical treatment of MSL, when we take into account the limited long-term effectiveness of this therapeutic

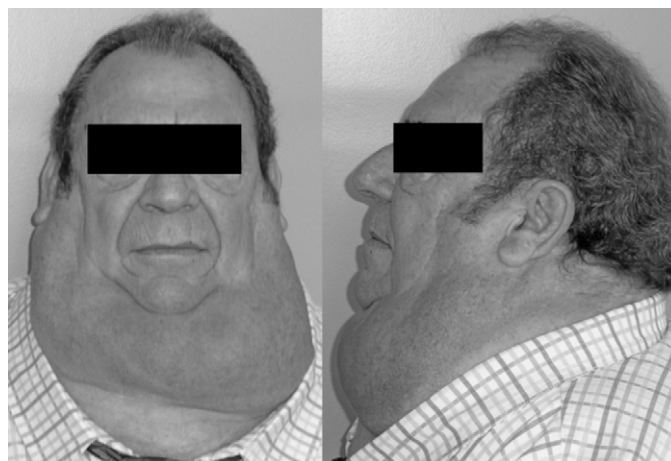


Fig. 1. Symmetric accumulation of fatty tissue in the neck of a patient diagnosed with multiple symmetric lipomatosis.

option and the success of continuous positive airway pressure (CPAP) treatment in patients with MSL who present SAHS, it seems reasonable to indicate CPAP as a treatment of choice (together with standard diet and hygiene measures) as long as surgery is not indicated for another reason.

In conclusion, in patients diagnosed with MSL, SAHS should be suspected if there are symptoms indicating it, and CPAP treatment should be offered due to the good results obtained to date in published cases.

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## Secondary Mediastinal Hydatidosis<sup>☆</sup>

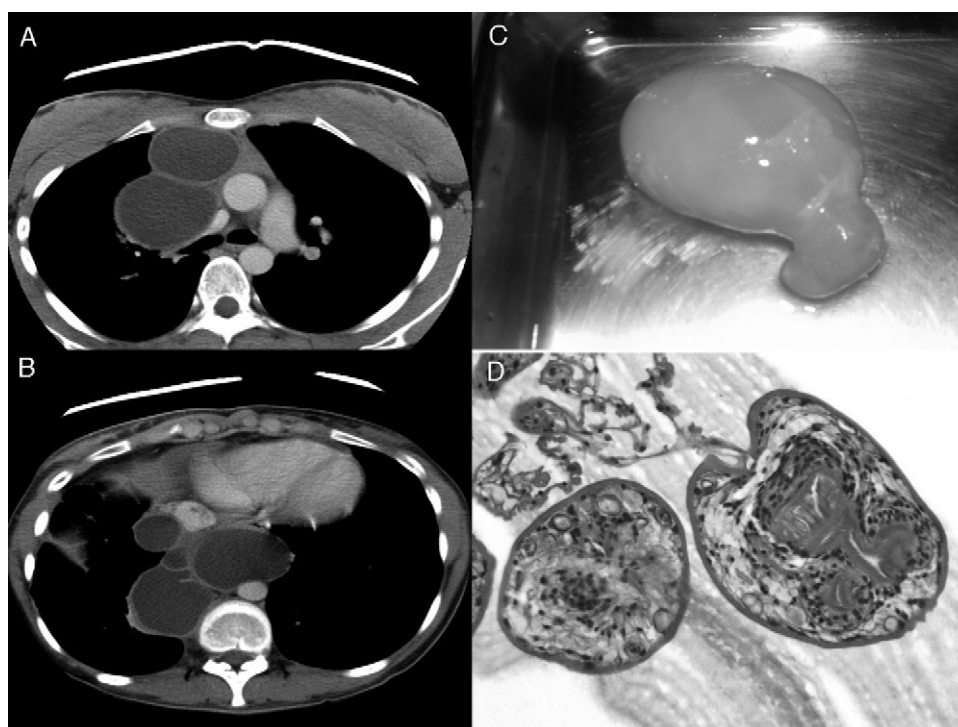
### *Hidatidosis mediastínica secundaria*

Dear Editor,

In humans, hydatid disease is most frequently caused by *Echinococcus granulosus*. It is endemic in many countries where livestock is bred, and it is usually located in the liver (50%–75%) and lungs (15%–25%). Mediastinal presentation is very rare and represents 0.1%–0.5% of all locations.<sup>1</sup> The case that we present is multiple mediastinal hydatidosis, quite probably secondary to hydatid dispersion from a previous intervention, which posed a surgical challenge given the multiplicity of the lesions.

The patient is a 20-year-old woman, originally from Moldavia, who came to the emergency department in March 2011 complaining of sharp chest pain in the right anterior region that had been evolving over the course of the previous 2 months, along with mild dysphagia for both solids and liquids. Her medical history included the resection in Moldavia of a “lung parasite” by means of right thoracotomy in 2006, followed by one year of anti-parasitic treatment. Physical examination confirmed a scar

from the right posterolateral thoracotomy and blood work showed mild anemia (Hb 11.7) with no leukocytosis or eosinophilia, with negative hydatid cyst serology. Imaging studies, including chest radiography, computed tomography (Fig. 1A and B) and magnetic resonance, revealed mediastinal widening due to the presence of multiple cystic mediastinal masses with affectation of the 3 compartments and craniocaudal extension, which produced a significant mass effect on the adjacent vascular structures and esophagus, with a minimal quantity of pericardial effusion. The liver presented no findings. Given the patient's history, we suspected mediastinal hydatidosis that was probably secondary, and right re-thoracotomy intervention was programmed. After the release of intense pleural adhesions, resection of the pericyst was initiated (Fig. 1C) with complete resection of all the cysts that had been observed by imaging techniques, using continuous lavage with hypertonic saline. The pericysts were resected, and those that could not be completely resected were left flat. The post-op period transpired without incident, and treatment was initiated with 400 mg albendazole every 12 h; the patient was released from the hospital after 7 days. Anatomic pathology and microbiology reports confirmed the presence of *E. granulosus*. With an optical microscope (Fig. 1D), the cystic capsule was able to be observed,



**Fig. 1.** (A and B) Computed tomography: axial slices obtained with mediastinal window showing a large multiseptated multicystic mass with linear enhancement extending in a craniocaudal direction. It affects the 3 mediastinal compartments and conditions the mass effect on adjacent vascular structures (superior cava in A and esophagus in B). (C) Entire hydatid obtained after opening the pericyst. (D) Image obtained by H–E 20× stain: hydatid cyst with laminated membrane and freed scolex; scolex with 4 suckers and rostellum with double crown of hooks.

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