scan, a soft tissue density infiltrative lesion was noted which surrounded the left hilum and extended to the basal pyramid, with a slight decrease in volume in the left lower lobe and bilateral pleural effusion (Fig. 1b). Bronchoscopy revealed a tumour in the left sixth segment; the biopsy was consistent with undifferentiated small cell carcinoma. Spirometry showed a severe obstructive disorder, with a negative bronchodilator test. With the diagnosis of pituitary metastasis with hypopituitarism secondary to undifferentiated small cell carcinoma (stage IV), the patient began chemotherapy. He remained stable and tumour size was reduced in the first six months. However, he died one year later due to disease progression.

Pituitary gland metastases are an uncommon presentation of carcinomas, because the pituitary gland does not receive a direct systemic blood supply. Its incidence is 3.6% in 500 autopsies.[2] A review from 1966 to 2004 found only 249 patients with metastatic involvement of the pituitary gland; breast and lung cancer were the most common primary tumours, occurring in two thirds of cases.[3] At diagnosis, most had generalised disease, usually associated with five or more metastatic sites, especially bone; rarely, as in our case, was it the first manifestation of an occult primary carcinoma as the only site of metastasis.[3] Cases secondary to bronchogenic carcinoma as a presenting form have been reported occasionally.[1] Since metastatic lesions in the pituitary gland are very rare, it is difficult to distinguish them from adenomas. In fact, CT is of limited use in distinguishing benign tumours; MRI has better diagnostic specificity.

The most common clinical symptoms of pituitary gland metastases are diabetes insipidus when they occur in the posterior lobe, and hypopituitarism when they occur in the anterior lobe, as in our patient. Pituitary gland metastases are symptomatic in only 7% of patients. Diabetes insipidus, anterior pituitary dysfunction, visual field defects, headaches and ophthalmoplegia are the most commonly reported symptoms.[4] Branch and Laws proposed that the triad of headache, ophthalmoplegia and diabetes insipidus was very indicative of metastases, even if the patient did not have confirmed cancer.[5] Our patient did not present headache or ocular impairment. His presenting symptoms were derived from hyponatraemia secondary to hypopituitarism. Hyperprolactinaemia has been found in only 6.3% of reported cases, but very high levels generally indicate prolactinoma rather than metastases. The mean survival of these patients is 6–22 months.[4]

## References

1. Ko JC, Yang PC, Huang TS, Yeh KH, Kuo SH, Luh KT. Panhypopituitarism caused by solitary parasellar metastasis from lung cancer. Chest. 1994;105:951–3.
2. Max MB, Deck MD, Rottenberg DA. Pituitary metastasis: incidence in cancer patients and clinical differentiation from pituitary adenoma. Neurology. 1981;31:998–1002.
3. Komninos J, Vlassopoulou V, Protopapa D, Korfias S, Kontogeorgos G, Sakas DE, et al. Tumors metastatic to the pituitary gland: case report and literature review. J Clin Endocrinol Metab. 2004;89:574–80.
4. Fassett DR, Couldwell WT. Metastases to the pituitary gland. Neurosurg Focus. 2004;16:E8.
5. Branch Jr CL, Laws Jr ER. Metastatic tumors of the sella turcica masquerading as primary pituitary tumors. J Clin Endocrinol Metab. 1987;65:469–74.

Patricia Pérez-Ferrer, Pedro Landete, Eusebi Chiner*

*Sección de Neumología, Hospital Universitario San Juan de Alicante, Alicante, Spain*

* Corresponding author.
*E-mail address:* Chiner_eus@gva.es (E. Chiner).

## Reply to Letter to the Editor "Infections by Gram-Negative Bacilliin Patients with Pulmonary Arterial Hypertension Treated with Intravenous Prostacyclin"☆

### *Réplica a la Carta al Director "Infecciones por gram negativos(BGN) en pacientes con hipertensión arterial pulmonartratados con prostaciclinas intravenosas"*

*To the Editor,*

We would like to thank Dr Gómez Sánchez[1] for his close reading and comments of our article on catheter-associated bloodstream infection in patients with pulmonary hypertension receiving intravenous treprostinil.[2] In this letter, we would like to mention the article by Kitterman et al.,[3] which was published after our manuscript was accepted for publication by *Archivos de Bronconeumología.* Some conclusions have been drawn from the analysis of this registry[3] that coincide with those of our study and with the results of previous studies carried out in the United States, which we cite in our article. In all of these papers, a significantly greater risk of bacteraemia is observed in patients receiving intravenous infusions of treprostinil, particularly bacteraemia due to gram-negative bacilli, than in patients treated with epoprostenol.

In our series, the distribution over time of the 5 episodes of bloodstream infection detected during the study period (1991–2011) in patients receiving intravenous treprostinil was as follows: 2 episodes in 2008 and 3 episodes in 2010. To this we can add that outside the follow-up period, between January and September 2012, four patients in our hospital received intravenous treprostinil of which one developed *Pseudomonas aeruginosa* subcutaneous tunnel infection, associated with the vascular catheter for drug delivery, and another developed vascular catheter-related bacteraemia, also caused by *Pseudomonas aeruginosa.* The small number of patients receiving treprostinil (10 in total), the limited number of episodes of bacteraemia and the short follow-up period make us cautious about drawing conclusions regarding a trend over time in the incidence of this complication.

The experience that we reported, together with other studies performed in North America, can be regarded as yet another element to be taken into consideration when making decisions on the use of prostanoids in the treatment of patients with pulmonary arterial hypertension.

We fully agree with Dr Gómez Sánchez in emphasising the use of strict aseptic methods in the insertion and handling of venous access catheters for the infusion of prostanoids. The complications associated with the intravenous infusion of prostanoids have led to the development of alternative forms of delivery, including a subcutaneous continuous infusion pump. Of the 85 patients followed in our hospital in whom this alternative method of infusion was used, no significant episodes of local or systemic infection have been recorded to date, so we currently consider this to be the method of choice for the administration of treprostinil.

☆ Please cite this article as: López-Medrano F, et al. Réplica. Arch Bronconeumol. 2013;49:217–8.

## References

1. Gómez Sanchez MA. Infecciones por gram negativos (BGN) en pacientes con hipertensión arterial pulmonar tratados con prostaciclinas intravenosas. Arch Bronconeumol. 2012. http://dx.doi.org/10.1016/j.arbres.2012.09.003, in press.
2. López-Medrano F, Fernandez Ruiz M, Ruiz Cano MJ, Barrios E, Vicente-Hernandez M, Aguado JM, et al. Alta incidencia de bacteriemia por bacilos gramnegativos en pacientes con hipertensión pulmonar tratados con treprostinil por vía intravenosa. Arch Bronconeumol. 2012, http://dx.doi.org/10.1016/j.arbres.2012.06.005.
3. Kitterman N, Poms A, Miller DP, Lombardi S, Farber HW, Barst RJ. Bloodstream infections in patients with pulmonary arterial hypertension treated with intravenous prostanoids: insights from the REVEAL REGISTRY®. Mayo Clin Proc. 2012;87:825–34.



Francisco López-Medrano, Mario Fernández-Ruiz,*
Maria José Ruiz-Cano, Pilar Escribano

*Unidad de Enfermedades Infecciosas y Unidad Multidisciplinar de Hipertensión Pulmonar, Servicio de Cardiología, Instituto de Investigación Biomédica Hospital 12 de Octubre (i+12), Hospital Universitario 12 de Octubre, Madrid, Spain*

* Corresponding author.
*E-mail address:* mario_fdezruiz@yahoo.es (M. Fernández-Ruiz).


8 October 2012 10 October 2012

## Deciduoid Pleural Mesothelioma in an Adolescent☆

### *Mesotelioma deciduoide pleural en un adolescente*

*To the Editor,*

Deciduoid mesothelioma is a rare variant of epithelioid mesothelioma, with a poor prognosis. It has unknown aetiology unrelated to asbestos exposure. Few cases have been reported in the literature to date. The best treatment remains a matter of debate.

We describe an unusual case (due to the age and lack of any history) of a 17-year-old patient that began with a persistent non-productive cough but no other symptoms, and which did not improve despite antibiotic and analgesic treatment. Laboratory tests revealed hypochromic microcytic anaemia, thrombocytosis and high C-reactive protein (CRP). On the X-ray, a multilobular mass was identified that the chest computed tomography (CT) scan described as a 9 cm heterogeneous solid mass in the left upper lobe. Atelectasia of the surrounding lung parenchyma was noted on magnetic resonance imaging (MRI), defining the mass as extrapulmonary and derived from the pleura; it also infiltrated the mediastinum, partially surrounding the left subclavian artery at its origin (Fig. 1). There were no endobronchial changes and bronchial aspirate (BAS) cultures were negative. The study was completed with a positron emission tomography (PET) scan, which showed hypermetabolism of the mass with maximum SUV of 8.55, and no uptake in the mediastinum.

A fine needle aspiration biopsy (FNAB) of the mass was performed, in which pathological malignant cells were obtained, followed by a diagnostic surgical biopsy. Samples of the mass were taken during the surgery, and infiltration of the mediastinum, aortic arch and aortopulmonary window was confirmed. The histopathology study found malignant large epithelial cells, with eosinophilic cytoplasm and round nuclei; the cytoplasm was positive for cytokeratin AE1/AE3, calretinin and WT-1; the nucleus was positive for epithelial membrane antigen (EMA) and negative for thyroid transcription factor 1 (TTF1). These findings were consistent with a diagnosis of deciduoid pleural mesothelioma. Clinical staging according to the International Mesothelioma Interest Group (IMIG)

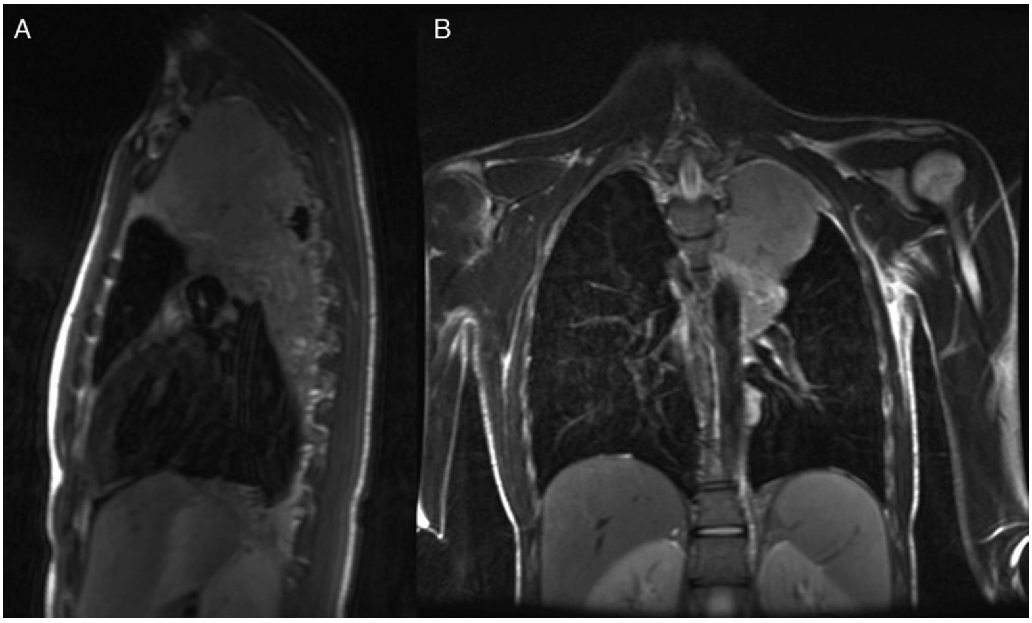


**Fig. 1.** Non-contrast chest MRI (T2 sequence): lobulated mass in the upper region of the left hemithorax, of extrapulmonary appearance, derived from the pleura. (A) Sagittal section. (B) Coronal section.

☆ Please cite this article as: Arango-Tomás E, et al. Mesotelioma deciduoide pleural en un adolescente. Arch Bronconeumol. 2013; 49:218-9.