

Fig. 1. (A) Chest high-resolution computed tomography showing ground glass and peripheral reticular opacities, particularly evident in the lung bases. (B) Histopathological examination revealed the following: widened alveolar septa with type II pneumocyte proliferation and inflammatory mononuclear infiltrate with interstitial fibrosis in a patchwork pattern, suggesting usual interstitial pneumonia (hematoxylin-eosin staining, original magnification 100 \times).

fibrosis with a UIP pattern on HRCT and histopathological signs were detected one year after an influenza-like infection, but otherwise, the patient was a healthy adult who did not present any of the comorbidities usually associated with influenza.

Several cases of ARDS subsequent to H1N1 have been described in the literature,^{4–6} but this is the first report of a correlation between H1N1 and UIP, and we believe this to be the unique feature of our case.

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Occult Alveolar Hemorrhage in a Patient With Bronchopulmonary Kaposi Sarcoma[☆]



Hemorragia alveolar oculta en paciente con sarcoma de Kaposi broncopulmonar

We report the case of 23-year-old man with human immunodeficiency virus (HIV) infection and a history of Kaposi sarcoma of the palate, treated with radiation therapy and antiretrovirals 2 years previously. He presented due to the appearance of violaceous skin lesions on the face, dyspnea and pleuritic pain with a CD4 T-lymphocyte count of 149 cells/mm³ and viral load of 52 092 copies/ml. High resolution computed tomography of the chest (Fig. 1) revealed bilateral nodules with irregular margins and ground glass opacities, peribronchial cuffing and left pleural effusion. Bronchoscopy showed a raised lesion in the mucous membrane of the apical segment of the right upper lobe. Abundant hemosiderophages were found in the bronchoalveolar lavage (BAL) fluid, confirming alveolar hemorrhage. Immunohistochemistry was positive for human herpesvirus 8 (HHV-8). Treatment began with liposomal doxorubicin and antiretroviral treatment was switched. The patient remains alive at 8 months.

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Kaposi sarcoma involving the lung occurs in 6%–32% of patients with acquired immunodeficiency syndrome (AIDS). It presents with skin lesions,^{1,2} and in 47%–75% of patients it is diagnosed *post-mortem*.³ Lesions can appear in the pulmonary parenchyma, bronchial tree, pleura, chest wall, and mediastinal lymph nodes,^{1,3} and CD4 T-lymphocyte count is generally <100 cells/mm³. In 80% of cases, death is a result of co-infection, due to cytomegalovirus, *Mycobacterium avium* complex, *Pneumocystis jirovecii*, bacterial pneumonia and herpes simplex infection.¹

Chest computed tomography reveals poorly defined bilateral nodules, distributed symmetrically around the bronchial vessels (flame-like lesions). Other findings include septal peribronchial and interlobar cuffing, progressive air space consolidation and ground glass opacities.³

Lesions on the palate are a strong predictor for bronchopulmonary involvement.¹ Typical lesions observed on bronchoscopy are red or violaceous cherry-like plaques in the bronchial tree.¹ HHV-8 is detected in BAL, which is highly specific (95%–98.9%) with variable sensitivity (58%–100%).

Occult alveolar hemorrhage has been described in HIV-positive patients with respiratory symptoms and abnormal radiological findings in the absence of hemoptysis. In 35.6% of cases, bronchopulmonary Kaposi sarcoma was detected, and of these 60.5% had occult alveolar hemorrhage.⁴

Vincent et al.⁵ subsequently characterized the following risk factors for AIDS-related alveolar hemorrhage: Kaposi sarcoma (OR: 5.3; 95% CI: 1.8–16.7; *P*=.003); cytomegalovirus pneumonia (OR: 9.8; 95% CI: 1–100; *P*=.05); hydrostatic pulmonary

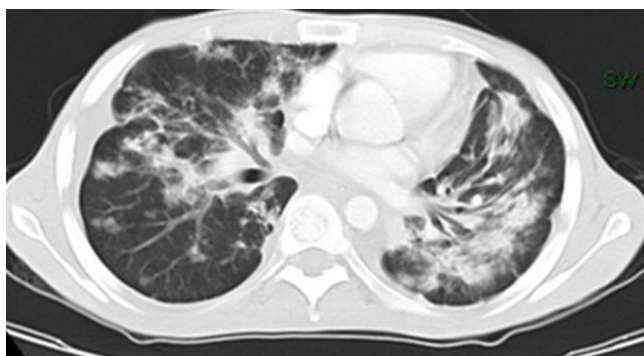


Fig. 1. High resolution computed tomography of the chest showing bilateral nodules with irregular margins, ground glass opacities and peribronchovascular thickening.

edema (OR: 16.4; 95% CI: 1.8–142; $P=0.01$) and platelet count $<60\,000$ (OR: 5.6; 95% CI: 1.5–20; $P=0.009$).

In conclusion, bronchoscopy is a useful tool for the diagnosis of occult alveolar hemorrhage in patients with HIV infection and respiratory symptoms.

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Paraneoplastic Cutaneous Vasculitis Associated With Lung Cancer[☆]



Vasculitis cutánea paraneoplásica asociada a cáncer de pulmón

To the Editor,

Paraneoplastic vasculitis (PNV) represents 2%–5% of all types of vasculitis and occurs in approximately 1 in 1800 hematological malignancies and 1 in 80800 solid tumors.¹ To be considered PNV, both vasculitis and malignancy must be identified within a period of 12 months.² The most common site for PNV is the skin, and almost half of all cases appear as leukocytoclastic vasculitis (LCV). We report the case of a woman who developed palpable purpura in the lower limbs that led to a diagnosis of lung cancer.

A 57-year-old woman, former smoker of 15 pack-years, cessation 22 years previously, history of left intraductal breast cancer at the age of 36 years, treated with breast-conserving surgery, chemotherapy and radiation therapy, with no signs of relapse on her last check-up 2 years previously. She was admitted to the hospital with a 10-day history of wrist and knee pain, associated with purpuric lesions on the lower limbs. In the last 72 h, she had presented abdominal pain, vomiting and abundant liquid stools with no visible mucus, pus or blood. She reported a 6-month history of dry cough, anorexia-cachexia, and 4 kg weight loss. On

physical examination, she was seen to be asthenic, with a poor-to-middling general condition, body mass index 17.42, blood pressure 139/93, temperature 36.7 °C. No significant lymphadenopathies were found on palpation, cardiopulmonary auscultation was normal. She had diffuse pain on palpation of the abdomen, which was soft, depressible and with no signs of peritoneal irritation. Musculoskeletal examination revealed palpable purpura on the lower legs, with some lesions on the thighs, nail clubbing in both the fingers and toes (Fig. 1), and no pain, joint limitation or synovitis. Clinical laboratory test results showed: Hb 12.7 g/dl,



Fig. 1. Palpable purpura lesions on the legs and nail clubbing in the toes.

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