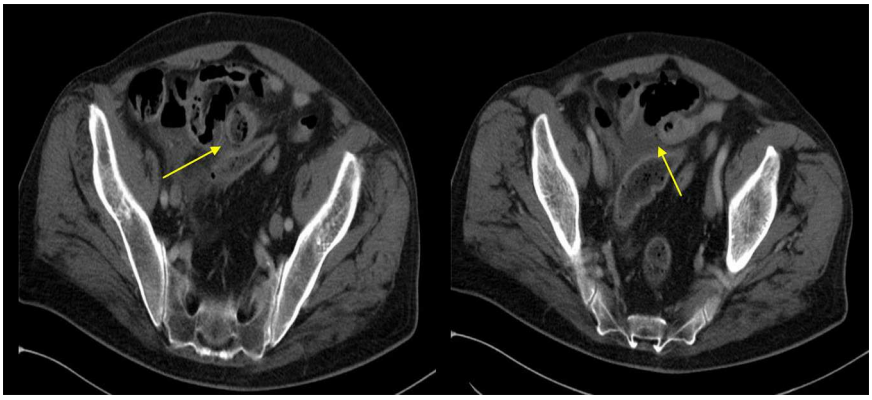

Fig. 1. Abdominal computed tomography: thickening of a segment of the small intestinal wall (jejunum), inflammatory changes, and adjacent extraluminal air bubbles.

Discussion

A search of the Medline database (1974–2013) retrieved 4 cases of malignant pleural mesothelioma metastasis involving the small intestine[1–4] and 1 case presenting as acute jejunal perforation.[5] Our patient is the second case with acute presentation described in the literature. Malignant pleural mesothelioma generally manifests as a locally invasive chest tumor, while cases of gastrointestinal metastases are rare, probably because diagnosis is difficult. Abdominal symptoms tend to be unspecific and are often interpreted as side effects of chemotherapy, and the sensitivity of ultrasound and computed tomography (CT) techniques for detecting intestinal tumors is poor. PET/CT and the combination of capsule endoscopy and double-balloon enteroscopy may overcome difficulties in detecting this type of metastatic implant.

In our opinion, the possibility of metastasis to the small intestine must be taken into account in patients with a history of malignant pleural mesothelioma and clinical symptoms consisting of acute abdominal pain, occult fecal blood, and intermittent unspecific abdominal pain.

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María Inmaculada Navarro García,* Ainhoa Sánchez Pérez, José Luis Vázquez Rojas

Cirugía General y del Aparato Digestivo, Hospital General Universitario Santa Lucía, Cartagena, Murcia, Spain

* Corresponding author.
E-mail address: macu844@hotmail.com (M.I. Navarro García).

Extensive Endobronchial Lesions in a Patient With Stage 0 Sarcoidosis☆

Lesiones endobronquiales extensas en un paciente con sarcoidosis en estadio 0

To the Editor,

We report the case of a 61-year-old Causasian man with a history of NYHA grade II dyspnea and unproductive cough lasting several months. He was a former smoker (20 pack-years, with cessation 20 years previously). Lung function tests (Fig. 1A) showed mild obstruction (forced expiratory volume in 1 s [FEV_1] 2.43 l, 74% predicted, Tiffeneau index 61%, residual volume [RV] 2.29 l, 94% predicted, total lung capacity [TLC] 6.2 l, 89% predicted, RV/TLC 37%) and slightly reduced gas exchange (DLCO 53% predicted, KCO 75% predicted, alveolar volume 4.94 l, 71% predicted). Chest X-ray was normal (stage 0) and chest CT (Fig. 1B) showed mainly bronchiectasis in the left lower lobe, with no mediastinal or hilar lymphadenopathies. Miniscule disseminated granulomatous lesions spreading from the upper trachea to the segmentary and sub-segmentary bronchi on both sides with circular distribution in all membranous and cartilaginous parts of the airways were observed on bronchoscopy. Lymphocytosis (45%) with a raised CD4/CD8 ratio (4.5) was observed in bronchoalveolar lavage

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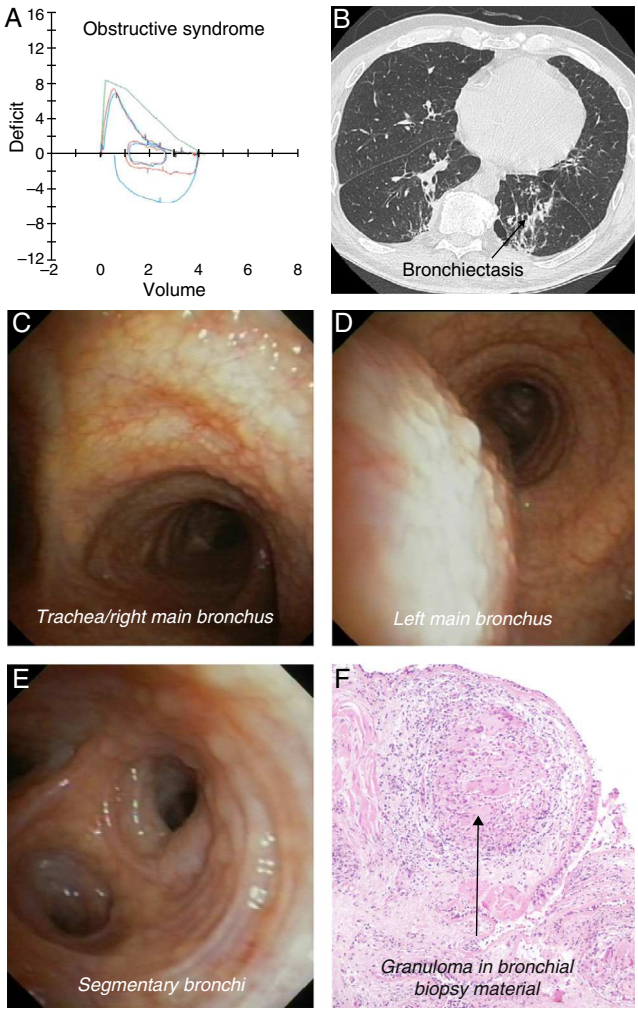

Figure 1. (A) Lung function tests showing mild obstruction. (B) Chest computed tomography showing mainly bronchiectasis in the left lower lobe. (C)–(E) Bronchoscopy showing miniscule disseminated lesions, spreading from the upper trachea to the segmentary and sub-segmentary bronchi on both sides, with circular distribution in all membranous and cartilaginous parts of the airways. (F) Non-caseating epithelioid cell granulomas.

fluid. Non-caseating epithelioid cell granulomas were identified in bronchial biopsy material (Fig. 1F). Staining and cultures for acid-resistant microorganisms and mycoses were negative.

Extensive endoluminal sarcoidosis with mild parenchymal involvement and no lymph node involvement is very uncommon.[1,2] The treatment of disseminated endoluminal disease is challenging and is aimed at preventing fixed obstruction. Inhaled corticosteroids and bronchodilators were initiated, with clinical and endoscopic monitoring of the patient's progress and lung function.

Conflict of Interests

The authors have no conflict of interests with the contents of this article.

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Alban Lovis,[a,*] Leslie Noirez,[a] Igor Letovanec,[b] Alexandre Walker[c]

[a] *Department of Respiratory Medicine, University Hospital of Lausanne, Lausana, Switzerland*
[b] *Department of Pathology, Lausanne University Hospital, Lausana, Switzerland*
[c] *Lungen- und Schlafzentrum, Lindenhofspital, Bremgartenstrasse, Berna, Switzerland*

* Corresponding author.
E-mail address: alban.lovis@chuv.ch (A. Lovis).