

any other type of renal tumor confirmed that it was indeed an AML. The patient remains asymptomatic as regards the renal mass, and is undergoing checkups.

The second case is that of a 38-year-old woman in whom suspected cancerous ovarian cysts were detected during a gynecological examination. On the abdominal CT for staging and diagnosis, multiple round cystic lesions were observed in the retroperitoneum and pelvis (Fig. 1c). Pulmonary cysts were seen in the lung bases. The patient had no respiratory symptoms. Radiologically, the retroperitoneal and pelvic cysts were consistent with lymphangioliomyomas, and the finding of cysts in the lung parenchyma confirmed the diagnosis of LAM. In this case, the disease presentation was the abdominal findings.

AMLs are benign tumors that are characterized radiologically by the existence of fat; however, this is absent in 5% of tumors, making them more difficult to diagnose. Treatment is conservative unless complicated by bleeding, which may require surgery or embolization. It has been reported that its association with LAM is so strong that, as in this case, when a renal mass is identified in a patient with LAM, an AML should be suspected.<sup>2</sup>

Lymphangioliomyomas are cystic dilations of the lymphatic system that are produced by proliferation of the atypical cells of the LAM. Size may vary depending on gravitational factors or diet, the patient may be asymptomatic or report non-specific abdominal discomfort, and the condition can be confused with other processes such as lymphadenopathies or neoplasia, as in the case presented. There is no effective treatment.

In conclusion, we believe that physicians should be aware of the abdominal symptoms associated with LAM, as these may help diagnose the disease and obviate the need for more aggressive tests. Knowledge of the clinical importance of these findings may also avoid unnecessary surgery. We suggest that abdominal CT scans be performed in cases of chest CT consistent with LAM.

### Conflict of Interests

The authors declare that they have no conflict of interests.

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### Stenosing Esophageal Carcinoma Diagnosed by Endobronchial Ultrasound<sup>☆</sup>



#### Carcinoma estenosante esofágico diagnosticado por ecobroncoscopia

To the Editor,

Stenosing tumors of the esophagus occasionally pose a diagnostic challenge to digestive endoscopists due to the difficulty of access through the esophageal lumen. We describe a case of stenosing esophageal carcinoma diagnosed by endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA).

The patient was a 71-year-old man, smoker, with an alcohol intake of 30g/day, who presented with a 2-month history of dysphagia associated with constitutional syndrome. Physical examination was normal. Laboratory tests were unremarkable, apart from a total bilirubin of 1.3 mg/dl. Computed tomography (CT) detected a 33 mm × 26 mm × 48 mm mass in the upper third of the

esophagus (Fig. 1 A). Gastroscopy showed stenosis of the cervical esophagus, apparently extrinsic, that prevented advancement of the endoscope. During the transesophageal endoscopic ultrasound (EUS), stenosis of the esophageal lumen made it difficult to introduce the endoscope, and sampling by fine needle aspiration was not optimal. Aspiration performed in the area most proximal to the lesion showed only atypical cells.

Since a diagnosis could not be made through the digestive tract, the possibility of a diagnostic approach using transtracheal ultrasound-guided fine needle aspiration (EBUS-FNA) was studied. Following endoscopic examination, we detected a protrusion of the pars membranacea in the upper third of the trachea. Using ultrasound, a 25 mm × 32 mm retrotracheal mass was identified 2 cm from the vocal cords (Fig. 1B), which was aspirated twice. After histopathological study of the samples, including immunohistochemistry studies (positive for cytokeratin 5 and p63 and negative for cytokeratin 7 and TTF1), esophageal squamous cell carcinoma was diagnosed.

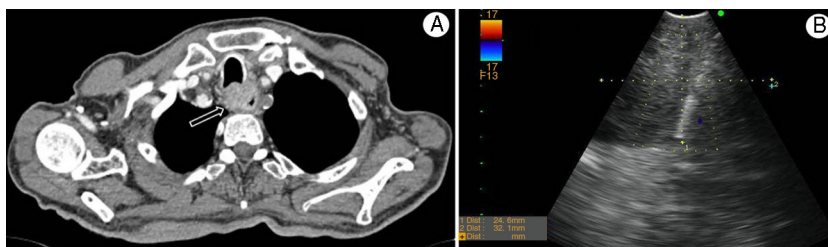


Fig. 1. (A) Chest CT image in which a mass situated in the upper third of the esophagus can be seen (indicated with an arrow). (B) Endoscopic ultrasound image of the esophageal mass needle aspiration.

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Stenosing cancer of the esophagus has a poor prognosis and sometimes poses a diagnostic challenge. Interventionist endoscopy and surgery have been proposed in the literature.

EBUS-TBNA is a useful, safe tool for the diagnosis of hila-mediastinal lymphadenopathies. It is essential in the diagnosis and staging of lung cancer. However, there is less data in the literature on its usefulness in the diagnosis of pulmonary or middle mediastinal masses.<sup>1</sup> Anantham et al. published 2 cases in which bronchogenic cysts were diagnosed,<sup>2</sup> and Chalhoub and Harris described the first case in which a thyroid nodule was sampled,<sup>3</sup> both using EBUS-FNA. Thus, EBUS-FNA can be used to diagnose other, non-adenopathic, mediastinal disease, thereby obviating the need for more invasive procedures.

In addition, EBUS-TBNA can be performed by the bronchoscopist during endobronchial ultrasound. Turner et al. reported a case of a stenosing esophageal tumor diagnosed by EUS-FNA.<sup>4</sup> In the patient described, the lesion, being stenotic, could not be properly accessed via the esophageal tract. Recently, Liberman et al. demonstrated the usefulness of EBUS-FNAB in the staging of esophageal carcinoma.<sup>5</sup>

EBUS and EUS are therefore complementary, minimally invasive techniques for the study of mediastinal disease, hence the importance of close collaboration between both specialties.

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## Unilateral Congenital Atresia in Adults. A Case Report and Review of the Literature<sup>☆</sup>



### Atresia congénita unilateral de venas pulmonares en adultos. Descripción de un caso y revisión de la literatura

To the Editor,

Congenital unilateral pulmonary vein atresia with no other cardiac abnormalities is a very rare entity.<sup>1,2</sup> It usually presents in childhood or adolescence as recurrent episodes of lung infection or hemoptysis, and is an exceptional finding in adults. We have only found 11 cases in the literature to date (including our own).

We present the case of a 43-year-old man, who we examined after admission for pneumonia. His medical history included type 1 diabetes and congenital right pulmonary venous atresia diagnosed in childhood, with no subsequent follow-up. This was the third episode of pneumonia in the right upper lobe in 2 years. He also reported small-volume hemoptysis daily, and dyspnea on major exertion. Decreased breath sounds were observed throughout the right hemithorax on auscultation, with persistent wheezing in the anterior axillary line.

Chest radiograph showed a resolving consolidation together with decreased right lung volume with a mediastinal shift to that side. The computed tomography (CT) scan is shown in Fig. 1. Bronchoscopy was performed, with the following findings: absence of right upper lobe bronchus; in its place was the opening of 2 accessory bronchi that prevented the bronchoscope from advancing. The opening of the apical and paracardiac bronchus of the right lower lobe could not be seen either. Spirometry revealed a moderately restrictive pattern, while the echocardiogram showed mild aortic stenosis with no pulmonary hypertension findings.

Finally, an angiography was performed. This confirmed all the findings described in the CT and also showed that part of the collat-

eral system formed to supply the right lung came from an inferior phrenic artery (Fig. 1).

After the study was completed, the case was discussed in a meeting with the thoracic surgery and vascular surgery departments, where it was decided that the most appropriate therapeutic option was pneumonectomy.

Unilateral pulmonary vein atresia occurs due to failure of incorporation of the common pulmonary vein into the left atrium. It is associated with other cardiac abnormalities in up to 50% of cases, and may occur in either lung.<sup>1,2</sup>

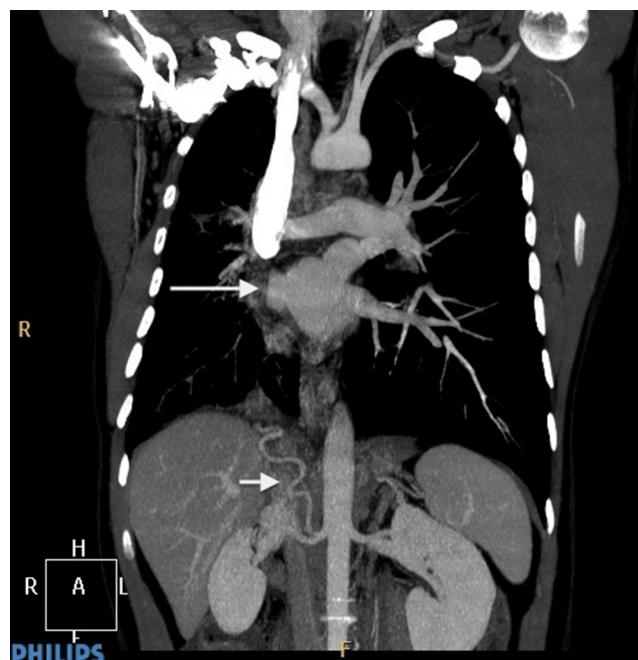


Fig. 1. The CT scan shows absence of right pulmonary veins draining into the left atrium, as well as the inferior phrenic artery with origin in the right renal artery.

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