

**Fig. 1.** (Top right) hematoxylin–eosin (HE), 400×. (Top left) hematoxylin–eosin (HE) with monoclonal antibody CD163, 400×. (Below) hematoxylin–eosin (HE) with para-aminosalicylic acid (PAS), 400×.

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## Thoracic Cystic Lymphangioma in an Elderly Patient<sup>☆</sup>



### *Linfangioma quístico intratorácico en paciente de edad avanzada*

To the Editor,

Cystic lymphangiomas are focal collections of slow-growing benign lymphatic tissue. They are caused by altered embryonic development, or are secondary to chronic obstruction after surgery, infection or exposure to radiation.<sup>1,2</sup> The most common sites are the head, neck (75%), or axilla (20%), although they may also occur in the chest (1%).<sup>2,3</sup> They can remain asymptomatic for long periods, although compression of adjacent structures may produce

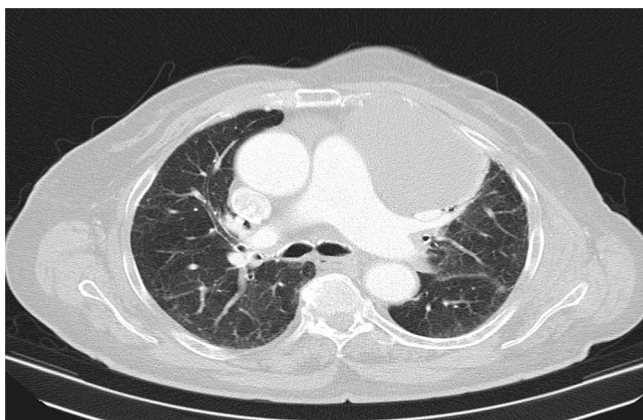
chronic cough, dyspnea, dysphagia, or even pneumothorax and pleural effusion.<sup>2,4</sup>

We report the case of an 80-year-old woman with a history of arterial hypertension, hypothyroidism, paroxysmal atrial fibrillation, for which she was receiving anticoagulants, breast cancer in 2006, treated with resection and adjuvant radiotherapy with no subsequent recurrence, and pulmonary embolism in 2009.

The patient was admitted to the respiratory medicine department for a 2-year history of repeated respiratory infections, with wheezing on inhalation, predominantly in the left hemithorax. Chest computed tomography (CT) revealed a cystic lesion measuring 10×9 cm causing partial atelectasis of the left upper lobe and compression of the mediastinal structures (Fig. 1). This lesion was biopsied using a CT-guided technique and the cytological study reported cystic lymphangioma.

The patient was evaluated in collaboration with the thoracic surgery department, and surgery was proposed. The lymphangioma was resected via anterior thoracotomy. The immediate

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**Fig. 1.** Chest computed tomography, showing cystic lymphangioma in the anterior mediastinum before surgery.

post-operative period was complicated by respiratory failure with rales and accumulation of secretions that required reintubation and transfer to the intensive care unit. The follow-up X-ray also revealed elevation of the left hemidiaphragm, indicative of post-surgical phrenic nerve palsy. After extubation breathing support continued with non-invasive mechanical ventilation.

In the following days the patient presented several episodes of partial and total atelectasis of the left lung, requiring repeated fiberoptic bronchoscopic procedures and placement of an endobronchial stent. Finally, due to prolonged weaning, a surgical tracheostomy was performed and the endobronchial stent was removed. The patient was stabilized and ventilatory support and oxygen requirements could be gradually reduced. The patient made good progress during her hospital stay, and some days later daytime respiratory cannulas could be withdrawn, although nocturnal non-invasive support continued.

Intrathoracic cystic lymphangiomas are rare benign tumors that generally occur in children and young adults.<sup>2,4</sup> Imaging tests are required for diagnosis (CT or magnetic resonance) and histological confirmation can be obtained with CT-guided biopsy or mediastinoscopy.<sup>2-4</sup> The most effective treatment is resection, although incomplete resection can be associated with a risk of recurrence.<sup>2,3</sup> Other therapeutic options include aspiration and drainage of the cysts for emergency decompression, injection of sclerosing agents, such as bleomycin or OK-432, or low-dose radiation therapy.<sup>2</sup>

Our case is of particular interest due to both the low incidence of this entity in elderly people and the intrathoracic site. Although surgical treatment is the most widely accepted option, due to its good prognosis and lower risk of recurrence, the procedure can involve considerable morbidity. Such was the case in our patient, who presented multiple complications after surgery.

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## The Exception Proves the Rule<sup>☆</sup>



### La excepción prueba la regla

To the Editor,

I share the authors<sup>1</sup> interest in clarifying the popular saying “the exception confirms the rule”; however, the proof of its falsity is not the proof put forward, nor does the warning originate in the eccentric winner of the Nobel prize in Physics, Richard Feynman. The problem is much older, bears no relationship whatsoever to physics, but stems from a poor knowledge of Latin in our field. Marcus Tullius Cicero (106-43 B.C.), in one of his marvelous speeches delivered during the defense of Lucius Cornellius Balbus, stated: “*exceptio probat regulam in casibus non exceptis*”, the literal translation of which would be “the exception proves the rule in cases not excepted”. The Latin verb “*probare*” means to prove, and from thence comes “to confirm”. But *probare* not only means “to prove” or “to confirm”; it also means “to verify”, “to test”. That is, the real

translation of the phrase would be “the exception tests the rule”. Or, in other words, the exception is the verification that there is a rule. Never, therefore, that the rule is false.

I will leave the issue of whether medicine is a descriptive or probabilistic science, or both, to others who venture to criticize the editorial and put the physicists in their place. In the case of the exception and the rule, we humbly render unto to Caesar what is Caesar's, and to Cicero what is his.

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