serious consequences for public health, simply because they do not follow a standard diagnostic protocol. Indeed, standard diagnostic procedures were not ignored, they were only improved under the specific conditions of our clinical investigation. We are convinced that our study, and both the reflections that arose *a posteriori* and the general hypotheses generated from our initial findings are ethically correct, do not involve any conflict of interest, and respond to society's expectations of scientists. In this respect, one of the aims of the article was to combine our efforts with those of other clinicians and researchers interested in broadening our understanding of both the disease and the multiple interventions needed to reduce the impact of this form of silicosis in synthetic stone workers,[7] some of which have already been put into practice. We hope that these additional clarifications will be useful for advancing on both fronts.

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Bloody Expectoration as First Manifestation of Bilateral Kidney Cancer☆

Expectoración hemoptoica como primera manifestación de un cáncer renal bilateral

To the Editor,

Endobronchial metastasis (EBM) is rare and has been associated with breast, colon, kidney and pancreatic cancers. It can be asymptomatic or manifest as cough, hemoptysis or dyspnea, and is generally diagnosed during the course of the initial disease. We report the case of a patient with 3 bilateral renal tumors that first manifested as bloody expectoration.

A 76-year-old man with no toxic habits, coal-miner. Clinical history included left pleuritis as a young man, arterial hypertension, and diabetes. No significant family history was reported. He was referred to the respiratory medicine department due to 4–5 daily episodes of expectoration of red blood for some days, after cough. The patient was negative for fever, chest pain, dyspnea, extrathoracic symptoms, loss of weight and hematuria. Physical examination: good general condition, with mildly reduced breath sounds in the left hemithorax, no lymphadenopathies or masses. Clinical laboratory test results showed glucose 125 mg/dl and microhematuria. Lung function values were normal. Chest X-ray revealed aortic atheromatosis and left calcified pachypleuritis. Thoracoabdominal computed tomography (CT) revealed an intraluminal nodular lesion measuring 7 mm at the entrance of the right main bronchus (RMB), an expansive heterogeneous lesion of 6.6 cm in the upper pole of the right kidney, and another measuring 3.7 cm in the lower pole. Another lesion (2.6 cm) was observed in the upper pole of the left kidney. Fiberoptic bronchoscopy showed 2 vascularized polypoid lesions, one in the anterior aspect of the RMB (Fig. 1) and the other at the entrance of the right lower lobar bronchus. Biopsy results reported metastasis from clear cell carcinoma. Urine cytology testing was negative for malignancy. In view of the extension of the disease, no diagnostic procedures of the renal masses were initiated, and the patient was referred to the oncology department for treatment.

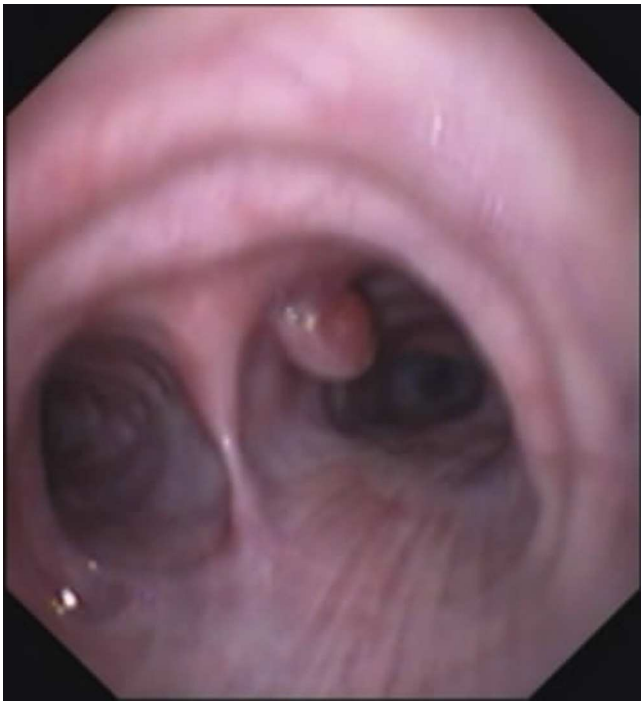

Fig. 1. Fiberoptic bronchoscopy, showing the lesion in the right main bronchus.

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Kidney cancer (KC) represents 3% of all tumors. Renal cell carcinoma is the most common subtype (85%). It often occurs between the ages of 50 and 60, mostly in men (2:1). It appears as hematuria (60%), lower back pain (40%) or masses (30%–40%). Other manifestations include polyglobulia, hypercalemia or Stauffer's syndrome. In 0.4%–6% of cases of KC, presentation is bilateral. Tumors can exist in a hereditary (in younger patients) or sporadic form. The latter account for 2% of bilateral synchronous tumors.[1] Between 25% and 30% of KCs present metastasis on diagnosis, and the lung is the second most common site of distant disease (36%). Endobronchial metastases, described in several extrathoracic tumors, are rare (2% in the autopsies of patients who have died from solid organ tumors).[2] The clinical manifestation of this type of tumor is no different from that of primary lung tumors (cough, hemoptysis, dyspnea, or asymptomatic, in up to 60% of cases).[3] The mean time to diagnosis is generally 41 months.[4,5]

This case has several unusual features: hemoptysis led to a diagnosis of primary renal cancer, with the peculiarity of presenting in the form of 3 bilateral synchronous tumors. One of the sites of metastasis could be detected with chest computed tomography (which has little sensitivity for distant disease), but the bronchial biopsy obtained by FB was decisive in the final diagnosis. The absence of family history and the patient's age suggest they were sporadic renal tumors.

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Lipoid Pneumonia due to Accidental Aspiration of Paraffin in a "Fire-Eater"☆

Neumonía lipoidea por aspiración accidental de parafina en un «comedor de fuego»

To the Editor

Exogenous lipoid pneumonia is a rare entity. It was first characterized in 1925, when Laughlen published a case of lipoid pneumonia caused by a nasopharyngeal injection of oil.[1] As this phenomenon is rare, we would like to report a new case of lipoid pneumonia, presenting in this case in a "fire-eater" who accidently inhaled paraffin during a circus act performed in the street.

A 19-year-old man, presented with dry cough, dyspnea, general malaise, and right rib pain after an episode of choking on paraffin during a fire-eating act. He smoked 2 cigarettes/day (accumulated smoking history of 3 pack-years) and worked as an amateur circus street performer. Physical examination revealed temperature 38.5 °C, and disperse wheezing on exhalation on auscultation. Clinical laboratory test results included 27 100 leukocytes/μl (91% neutrophils) and CRP 298 mg/l. Chest X-ray showed bilateral alveolar infiltrates and computed tomography (CT) revealed 3 cavities, the largest being 35 mm in diameter, in the middle lobe, and 1 in the left lower lobe, with partial fluid occupation and remains of low-density material (−3 to −50 HU) of lipid origin. Fiberoptic bronchoscopy was normal, and bronchoalveolar lavage fluid revealed 59% neutrophils, 17% lymphocytes, and 24% histiocytes; cultures for bacteria, mycoses and mycobacteria were negative. Sputum cytology showed numerous macrophages with clear, foamy cytoplasm, consistent with aspiration of foreign matter (Fig. 1). Antibiotic treatment was started (amoxicillin-clavulanate acid for 2 weeks) and corticosteroids (methylprednisolone 60 mg/day/i.v. for 1 week, followed by prednisone, tapered over a 10-day period). The patient showed clinical and radiological improvement. In the follow-up in the outpatient clinic, he was asymptomatic and chest X-ray and lung function tests were normal (FVC 4370 ml, 84% predicted; FEV_1 4100 ml, 93%; FEV_1%/FVC 94; DLCOsb 82%; DLCO/VA 100%).

Our patient presented with an acute form of lipoid pneumonia. This is of interest due to the unusual nature of its origin: accidental aspiration of paraffin in a street performer during a circus act in the street. Clinical presentation, unlike chronic forms, develops with sudden onset of dyspnea, fever, coughing fits, chest pressure, and, in some cases, hemoptysis. To our knowledge, the first case of lipoid pneumonia in a fire eater dates from 1984[2] and some isolated cases have been reported since then.[3,4]

Areas of homogeneous condensation with a diffuse or localized air bronchogram can been seen on chest X-ray. The extension of parenchymal damage can be documented with CT, and in our case, cavities occupied with low density material, consistent with lipid origin,[4] were seen with this technique. These cavities were pneumatoceles, which can take more than 2 months to resolve.[3]

The diagnosis is based on a finding of macrophages containing lipid vacuoles, as observed in the sputum samples of our patient.[5]

In conclusion, this was a case of lipoid pneumonia due to aspiration of paraffin in an amateur fire-eater. It is a very rare disease, but incidence rates may rise in the near future.

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