

ratio of the intervention, providing a better understanding of the infectious complications.

Funding

No funding was required.

Conflict of interests

The authors state that they had no conflict of interests.

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Blindness and Deafness as Initial Manifestation of Non-small Cell Lung Cancer[☆]



Ceguera y sordera como manifestación inicial de un cáncer de pulmón no microcítico

To the Editor,

Meningeal carcinomatosis (MC) is an uncommon and devastating entity characterized by malignant infiltration of the leptomeninges and subarachnoid space. Although it is usually a later finding in patients with known disseminated disease, it can also be the initial manifestation.

We report the case of a 71-year-old woman, non-smoker, with *situs inversus totalis* who was admitted to a neurology department

due to a 2-month history of progressive visual and hearing loss. Physical examination showed bilateral amaurosis and hypoacusia. Brain computed tomography (CT) showed no intracranial lesions (Fig. 1A) and gadolinium-enhanced magnetic resonance imaging (MRI) of the brain showed no focal or diffuse leptomeningeal enhancement or tumoral lesions. A lumbar puncture was performed and pathological analysis of the cerebrospinal fluid (CSF) revealed adenocarcinoma cells with immunohistochemistry showing positivity for TTF-1 and cytokeratin 7, indicative of a pulmonary origin. A chest CT showed a 3 cm lobulated mass in the right lower lobe (RLL) (Fig. 1B). A percutaneous CT-guided core biopsy was conducted in an attempt to obtain additional tumor tissue to perform *EGFR* mutation sequencing. Histology showed pulmonary parenchyma occupied by neoplastic structures with

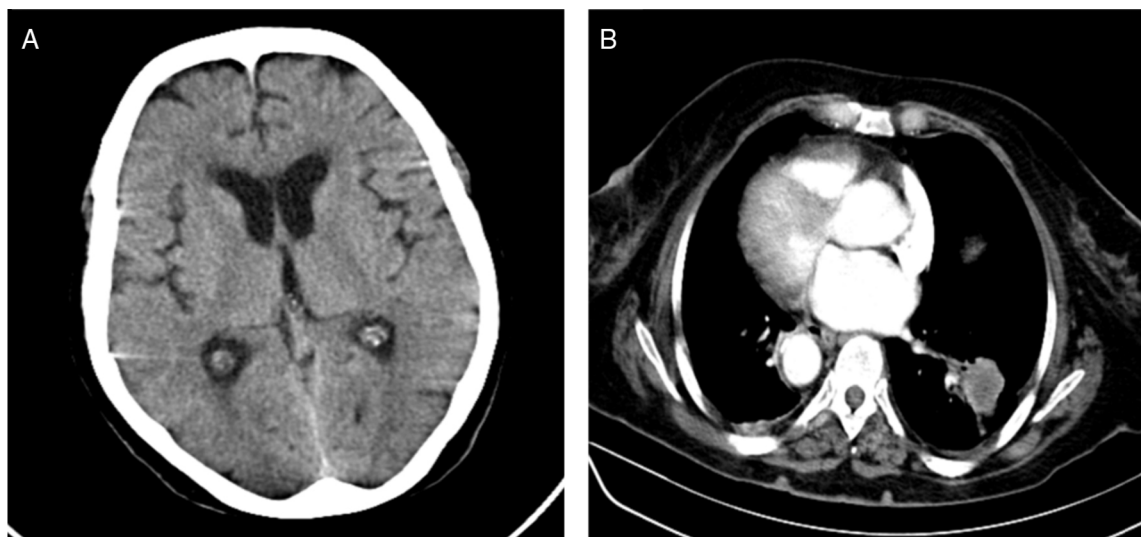


Fig. 1. (A) Brain CT with no intracranial lesions; (B) chest CT showing a 3 cm lobulated mass in the right lower lobe.

[☆] Please cite this article as: Nascimento LM, Reis R, Fernandes A. Ceguera y sordera como manifestación inicial de un cáncer de pulmón no microcítico. *Arch Bronconeumol*. 2016;52:115–116.

adenocarcinoma features which stained diffusely for TTF-1 and cytokeratin 7. The patient died during hospital admission due to aspiration pneumonia. One week later the biopsy of the RLL mass showed that the tumor harbored *EGFR* G719C mutation in exon 18.

MC is more commonly diagnosed in patients with hematological tumors followed by breast and lung cancer.¹ Of the latter, small cell lung cancer has the highest rate of meningeal dissemination.² Non-small cell lung cancer (NSCLC) presenting with MC and without brain parenchymal metastasis is an extremely rare event. Furthermore, simultaneous presentation of blindness and deafness has been exceptionally reported in the literature.³

Prognosis is extremely poor and an optimal treatment modality is difficult to determine since most performed studies are small and retrospective and often include multiple concomitant regimens. In our case, the use of EGFR tyrosine kinase inhibitors (TKIs) could have had a relevant impact in the patient's evolution, as these agents seem to be particularly effective, improving performance status and survival in patients with EGFR positive NSCLC.⁴

Our report illustrates an extremely rare case of a NSCLC presenting with MC, itself with an exceptional clinical manifestation – simultaneous blindness and deafness – in the absence of brain parenchymal metastasis and brain MRI changes.

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An Unusual Foreign Body[☆]



Un cuerpo extraño insólito

To the Editor,

A 63-year-old non-smoking, asthmatic man, employed as a manual worker in a timber factory, presented with 3-day history of productive cough associated with greenish sputum, wheezing, shortness of breath and left-sided pleuritic chest pain. On examination, he was pyrexia (38 °C) and hypoxic (oxygen saturation 87% on room air). Bilateral wheezing and coarse crackles were heard at the left base of his lung on auscultation.

Chest radiograph showed a moderate amount of left-sided pleural effusion. A chest drain was subsequently inserted, as the pH of the exudative fluid was 6.8. Interestingly, chest computed tomography revealed a metallic foreign body within the main bronchus with collapse of the left lower lobe (Fig. 1). Bronchoscopy confirmed the presence of a metal stent-like object overlain by granulation tissue in the left main bronchus. The granulation tissue was firmly embedded into the foreign body making it hard to extract the foreign body. We therefore referred the patient to the cardiothoracic surgeon for removal of the foreign body via rigid bronchoscopy under general anesthesia. The foreign body turned out to be a pigeon foot



Fig. 1. Foreign body 2.

[☆] Please cite this article as: Kooball M. Un cuerpo extraño insólito. *Arch Bronconeumol.* 2016;52:116-117.