Table 1
(A) Diseases Identified in the 138 Fiberoptic Bronchoscopies Performed for Stridor; in 43 Patients (31%), Multiple Findings Were Found on Fiberoptic Bronchoscopy. (B) Underlying Diseases in the 138 Patients Undergoing Fiberoptic Bronchoscopy.

(A) Fiberoptic Bronchoscopy Findings	Percentage	(B) Underlying Disease of Patients Undergoing Fiberoptic Bronchoscopy	Percentage
Laryngomalacia	46	Laryngitis and recurrent wheezing ($n=50$)	36
Subglottic stenosis	20	Gastroesophageal reflux ($n=36$)	26
Non-specific inflammation	17	ALTE/choking/apneas ($n=11$)	8
Extrinsic tracheal/bronchial compression	10	Congenital malformations ($n=11$)	8
Tracheomalacia	10	- Tracheomalacia (4)	
Arytenoid paralysis	5	- Tracheal stenosis	
Vocal cord paralysis	3	- Vascular ring due to right-sided aortic arch with aberrant left subclavian artery associated with Kommerell diverticulum (1)	
Granulation tissue	3	- Tracheal bronchus	
Epiglottis malformation	2	- Hypoplasia of right lung with pulmonary sequestration (3)	
Pharynogmalacia	2		
Mucocele	1	Prematurity ($n=9$)	6.5
Subglottic hemangioma	1	Epilepsy ($n=8$)	6
Bronchomalacia	1	Interventricular communication ($n=7$)	5
Epiglottic edema	0.7	Hypotonia ($n=6$)	4.3
Vocal cord dysfunction	0.7	Coarctation of the aorta ($n=6$)	4.3
Vocal cord synechia	0.7	Vascular ring ($n=5$)	3.6
Vocal cord nodule	0.7	Patent ductus arteriosus ($n=5$)	3.6
Arytenoid dislocation	0.7	Tracheoesophageal fistula ($n=5$)	3.6
Vallecular cyst	0.7	Cutaneous hemangioma ($n=4$)	2.9
Cyst on uvula	0.7	Down syndrome ($n=4$)	2.9
Tongue compressing epiglottis	0.7		
Middle lobe bronchial hypoplasia	0.7		

ALTE, apparent life-threatening event.

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Raquel Plácido-Paias,[a,*] Isabel Delgado-Pecellín,[b] Juan Pedro González-Valencia[b]

[a] *Servicio de Pediatría, Hospital de Mérida, Mérida, Badajoz, Spain*
[b] *Unidad de Neumología Pediátrica, Hospitales Universitarios Virgen del Rocío, Sevilla, Spain*

* Corresponding author.
E-mail address: raquelpaias@gmail.com (R. Plácido-Paias).

Reactivation of *Mycobacterium bovis* Infection and Tumor Necrosis Factor Inhibitors. A Mexican Case☆

Reactivación de infección por Mycobacterium bovis*, e inhibidores del factor de necrosis tumoral. El caso de México*

To the Editor,

In Mexico, the number of patients receiving tumor necrosis factor (TNF) blockers continues to grow. We report the case of a 32-year-old man with a history of rheumatoid arthritis, treated with methotrexate, folic acid, hydroxychloroquine and diclofenac for 3 months. Disease activity continued, so we decided to add infliximab (3 mg/kg intravenously at weeks 0, 2 and 6, then every 8 weeks), after ruling out suspected latent tuberculosis with negative tuberculin testing and chest X-ray. These 2 aspects, along with the absence of criteria for immunosuppression, and his denial of contact with tuberculosis patients, were taken into account in the decision to not administer isoniazid prophylaxis. After receiving 7 infliximab infusions, the patient moved to New Zealand. Two weeks later he presented in a clinic with a 5-day history of fever 39 °C, chills, mainly at night, accompanied by abdominal pain and distension, moderate constipation, and sensation of fullness. Abdominal tomography showed extensive ascites, nodular thickening in the serous membrane, and small mesenteric lymphadenopathies requiring a differential diagnosis with peritoneal cancer and lymphoma. Chest tomography revealed a small right pleural effusion. Ascitic fluid was obtained by abdominal needle aspiration, and incubated for 2 weeks in Mycobacterial Growth Indicator Tube (MGIT) medium. The culture grew an auramine-negative microorganism from the *M. tuberculosis* complex (MPT64 antigen-positive), later identified on polymerase chain reaction as pyrazinamide-resistant *Mycobacterium bovis* (*M. bovis*). QuantiFERON®-TB Gold determination was positive, and adenosine deaminase concentration in ascitic fluid was 66.3 U/l. The patient improved after 2 months of treatment with isoniazid, rifampicin and ethambutol, and 7 months of rifampicin and isoniazid, and currently is free of signs and symptoms of active tuberculosis.

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Drinking unpasteurized milk contaminated with *M. bovis* has been associated with tuberculous infection in humans,[1] and most cases of peritoneal tuberculosis occur as a result of the hematogenous spread of latent TB.[2]

Tuberculosis is significantly under-reported in Latin America.[3] In Mexico, 10% of cases of mycobacterial infection in immunosuppressed patients seen in tertiary hospitals are caused by *M. bovis*.[4] A recent epidemiological study[5] showed that the number of cases of tuberculosis caused by *M. bovis* in California, USA, rose from 3.4% in 2003 to 5.4% in 2011. It is interesting to note that between 2010 and 2011 either 1 or both parents or caregivers of children with *M. bovis* infection included in this study were born in Mexico.[5]

The prevalence of *M. bovis* in the vulnerable Mexican population must be determined, related risks must be identified, and these risks must be taken into account when deciding on the use of anti-TNF treatments.

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Alain R. Rodríguez-Orozco[a,b]

[a] *Facultad de Ciencias Médicas y Biológicas Dr Ignacio Chávez, Universidad Michoacana de San Nicolás de Hidalgo, Morelia, Michoacán, Mexico*
[b] *Instituto de Investigación Científica en Temas de Familia, Alergia eInmunología, Morelia, Michoacán, Mexico*
E-mail address: rodriguez.orozco.ar.2011@gmail.com

Acute Respiratory Distress due to Post-tracheostomy Tracheal Rupture Treated With Venovenous Extracorporeal Membrane Oxygenation and Endotracheal Prosthesis☆

Síndrome de distrés respiratorio agudo secundario a rotura traqueal postraqueostomía tratado con membrana de oxigenación extracorpórea venovenosa y prótesis endotraqueal

To the Editor,

We report the case of a 36-year-old man with a history of mild mental retardation and esophageal atresia with tracheoesophageal fistula operated at birth, who was admitted to the intensive care unit with symptoms of intestinal obstruction, probably caused by medications, and generalized respiratory failure caused by bronchoaspiration, requiring orotracheal intubation (OTI).

Twelve days after admission, percutaneous dilatational tracheostomy was performed. Forty-eight hours after the procedure, the patient presented significant subcutaneous emphysema and pneumomediastinum (Fig. 1A), so the tracheal cannula was removed and the patient was reintubated. The patient's general condition worsened progressively, with respiratory acidosis, hypercapnia >100 mmHg, PaO_2/FiO_2 <200 mmHg, severe respiratory difficulties, and incipient arterial hypertension. The chest X-ray showed bilateral alveolar-interstitial infiltrates and bronchoscopy

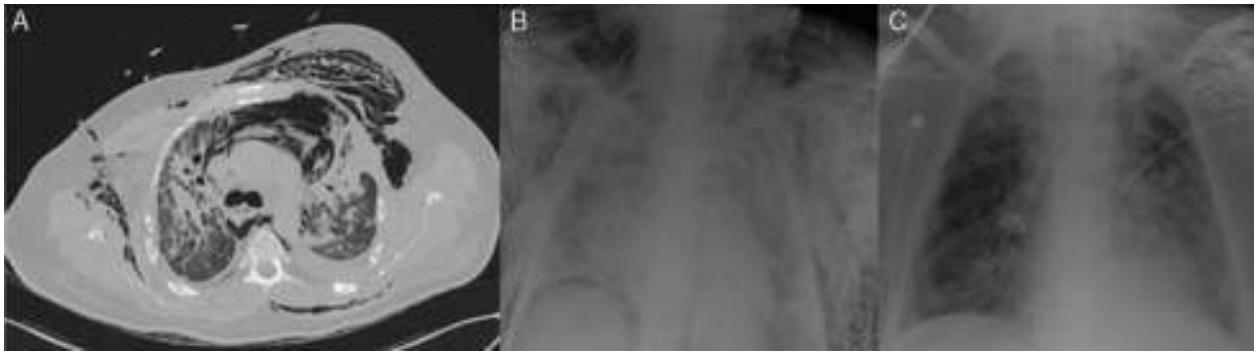

Fig. 1. (A) CT image, showing significant subcutaneous emphysema and pneumomediastinum. (B) Portable chest X-ray showing subcutaneous emphysema, bilateral alveolar-interstitial infiltrate and selective right intubation. (C) Portable chest X-ray, several days after placement of tracheal stent.

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