

lung base, partial fissure separating it from the rest of the pulmonary parenchyma, irrigated by an artery originating in the thoracic artery, and venous drainage to the left atrium via the left lower pulmonary vein (Fig. 1B–D).

In view of the CT findings, the patient was referred to the reference thoracic surgery unit for surgical evaluation with a diagnosis of bilateral PS. Atypical ablation of the right lower lobe was performed by right video-assisted minithoracotomy with ligation of the artery originating in the abdominal aorta. In a second stage, 2 months later, atypical ablation of the left lower lobe was performed by left video-assisted minithoracotomy, with release of the sequestered artery and the inferior pulmonary vein. Intraoperative diagnoses were: right and left intralobar PS with accessory fissure in the left lower lobe, irrigated by a direct branch from the aorta. The pathology report described pulmonary parenchyma lined with visceral pleura, with isolated foci of pulmonary fibrosis and dilated bronchi, findings consistent with intralobar PS in the left lower lobe and right lower lobe.

PS is a rare malformation, and diagnosis is generally made early in life. The treatment of choice is segmentectomy by thoracotomy. Most intralobar PS are unilateral, and bilateral PS are very rare. The general incidence of PS ranges between 0.15% and 1.8%; the exact statistics of bilateral PS have not yet been determined, but it is known to be extremely rare.¹

The radiological image of intralobar sequestration can vary: it can be a well-defined homogeneous mass, an air- or fluid-filled cystic lesion, a hyperlucent and hypovascular region, or a combination of all of these.² Presentation may also be unusual, as in our case, manifesting with only a subtle area of tubular opacity in the lower lobe that might represent the systemic vessels or venous drainage associated with the lesion.³

Several case reviews published over the years have reported very few bilateral sequestrations, an example being the review published by Wei Y and Li F in 2011, in which only 3 of 2625 reviewed cases were bilateral; 2 patients both with intralobar PS, as in our case.⁴

With respect to treatment, surgical resection of the smallest amount of pulmonary parenchyma possible has been compared

with angiographic embolization in newborns: the safest and most effective method appears to be surgical resection,⁵ although there have been reports of asymptomatic patients successfully treated with embolization.²

Although many presentations of PS have been described in the literature, we must remember that slow-to-resolve pneumonias may conceal this entity, a fact that, along with the tubular opacity, guided us toward the diagnosis. Moreover, it is unclear how many cases of bilateral PS exist in Spain, and we believe that it would be of interest to make a larger case review study with the aim of furthering our knowledge of the topic.

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Kikuchi-Fujimoto Disease as a Differential Diagnosis for Lymph Nodetuberculosis. The First Case of Kikuchi-Fujimoto Disease in Peru*



Enfermedad de Kikuchi-Fujimoto como diagnóstico diferencial de tuberculosis ganglionar. Reporte del primer caso de enfermedad de Kikuchi-Fujimoto en Perú

To the Editor,

Tuberculosis (TB) is a highly prevalent disease in Peru.¹ Lymph node involvement presents a particular challenge, as it is often difficult to diagnose, and treatments unsupported by scientific evidence may sometimes be prescribed, given that this entity can be confused with Kikuchi-Fujimoto disease (KFD).

We report the case of a 7-year-old boy from Lima, in his second year of primary school, who was referred to the respiratory medicine department by his pediatrician for left axillary lymph node enlargement, with no previous history of respiratory symptoms or fever. He had been fully vaccinated according to the WHO

vaccination schedule, which in Latin America includes Bacillus Calmette-Guérin (BCG). He had no history of previous TB, but his mother reported a possible exposure 6 months before the episode, when she took the child along to a prison to visit a family member who was an inmate there. The family member did not have a diagnosis of TB, but in Peru the high prevalence of this disease among the prison population means that visiting one of these establishments is considered a risk factor.

No respiratory abnormalities were found on examination, but painful lymphadenopathies measuring ± 2 cm were observed in the region of the left axilla. The rest of the examination was normal and no abnormalities were found on blood tests. Imaging studies revealed increased bronchovascular markings, with no pathological lesions on chest radiograph, and axillary lymphadenopathies measuring 2.2 cm on ultrasonography. Sputum tuberculin testing (PPD) and sputum smear were negative for alcohol-acid resistant bacilli. A lymph node biopsy was performed, and the sample was sent for study. The biopsy was not cultured for *Mycobacterium tuberculosis*. After receiving the pathology study, which reported chronic, mildly granulomatous lymphadenitis, lymph node tuberculosis was considered as a first option, and admission to a TB program to start treatment was planned. However, as part of a special protocol, polymerase chain reaction (PCR) was performed on the lymph node biopsy for *M. tuberculosis* with sequence IS6110,

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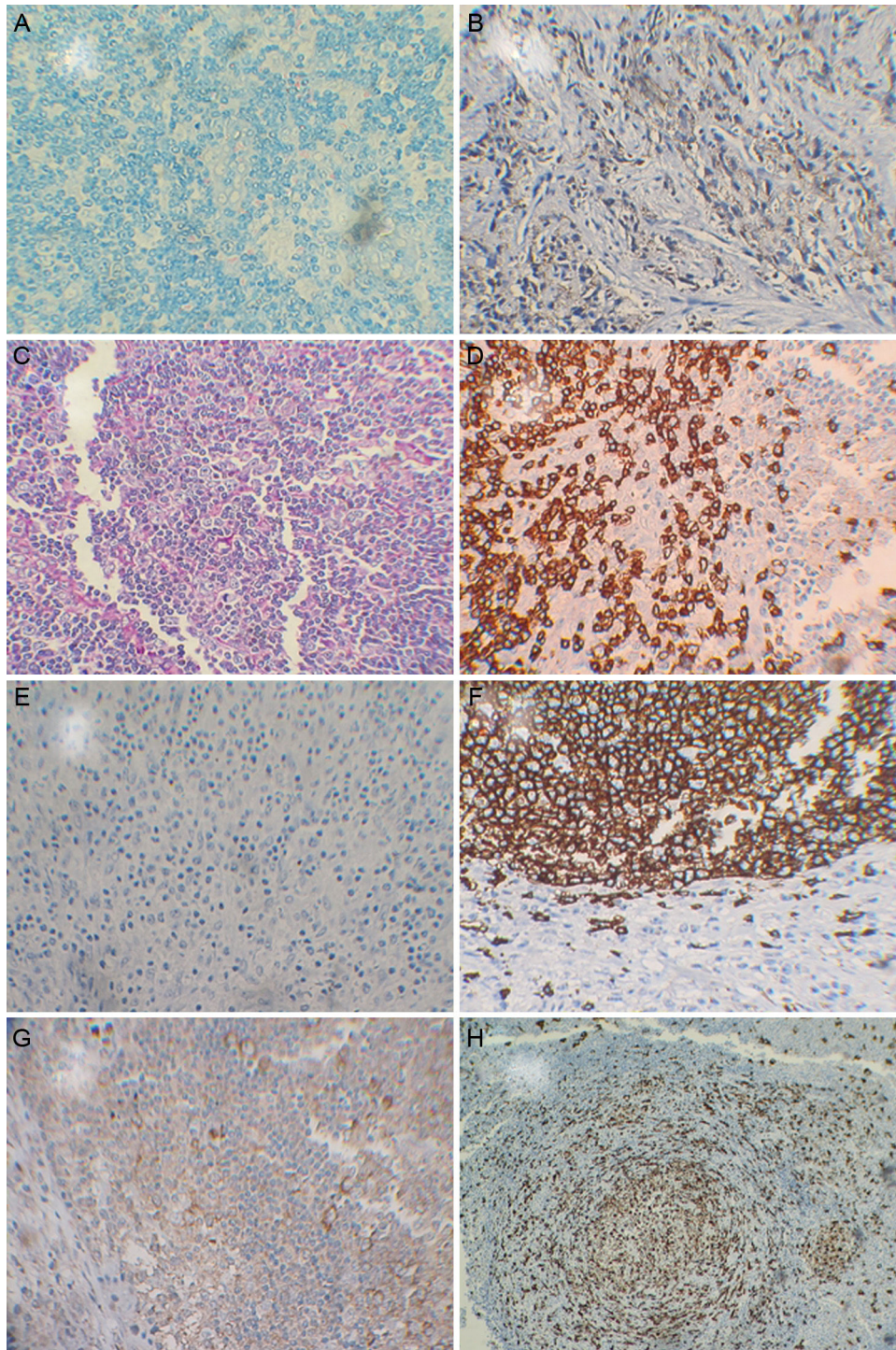


Fig. 1. (A) BK negative; (B) PAS negative; (C) EBV negative; (D) CD3 partially positive; (E) CD15 negative; (F) CD20 partially positive; (G) CD30 positive in reactive lymphocytes and (H) CD68 positive for histiocytes.

with negative results. Samples were sent for immunohistochemistry testing, with the results shown in Fig. 1.

The patient was diagnosed with KFD and did not receive anti-tuberculosis treatment. The clinical picture resolved after 3 weeks of symptomatic treatment.

Tuberculous cervical lymphadenitis is the most common manifestation of TB of the head and neck in our setting, and accounts for 15% of cases of extrapulmonary TB.² Both tuberculous lymphadenitis and KFD are diseases that form part of the differential diagnosis

of necrotizing lymphadenopathies.^{2–5} KFD is a rare disease that consists of histiocytic necrotizing lymphadenitis, and is generally self-limiting with a benign course. It affects mainly younger individuals, and is more common among females than males.³ Although it has been described mostly in Asian populations, cases have been reported worldwide. It generally presents in the form of enlarged, mainly unilateral cervical lymph nodes (70%–90%),^{5,6} accompanied in some cases by fever, fatigue, night sweats, and gastrointestinal and cutaneous changes.^{3,5,7,8} Laboratory and imaging data are not

characteristic, so diagnosis can be difficult: a lymph node biopsy is required for correct identification, since fine needle aspirates tend to be inconclusive.⁶

Pathogenesis remains unclear to date, but some authors have suggested that both interferon and interleukin-6 (IL-6) or cell apoptosis may play some role, pointing toward viral^{5,9,10} or autoimmune^{9,11} etiologies. It seems clear that KFD is an exaggerated T cell-mediated reaction to a variety of mostly infectious stimuli.^{5,7,8,12} The course is usually benign, and it resolves in a few months without specific treatment, although some more severe cases have occasionally been reported.^{5,7,13}

Histological findings correspond to 3 disease stages (proliferative, necrotizing and xanthomatous), representing progressive pathological changes.¹⁴ The typical immunophenotype of this disease consists of a predominance of CD8+ cells over CD4+ T cells. Consistent immunohistochemistry results shows CD68 and CD3+, CD20+/- and CD30-. Histiocytes expressing myeloperoxidase and CD68 are characteristic of this disease.¹⁴

Chest radiograph must be obtained from all patients to rule out the possibility of other causes such as neoplasms or TB. Multislice spiral tomography is of particular use in locating the most accessible lymph node for biopsy and for determining the extent of the disease.⁶

In Peru, a country with a very high prevalence of TB, lymph node involvement is found in a good number of cases. Lymph node biopsy studies are included in diagnostic protocols, and epidemiological factors and other laboratory findings are taken into consideration. However, antituberculosis treatment is sometimes prescribed without hard scientific evidence and before the other etiological options, which would include KFD, have been explored. We therefore hold that it is important to include this disease in the differential diagnosis of lymphadenopathies, particularly for lymph node TB, and appropriate studies must be conducted to avoid the prescription of costly drugs that might be unnecessary and carry significant risks for the patient.

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Actinomycosis Associated with Foreign Body Simulating Lung Cancer[☆]



Actinomicosis sobre cuerpo extraño que simula una neoplasia pulmonar

To the Editor,

Pulmonary actinomycosis is a necrotizing lung infection that can develop after aspiration of a foreign body. Approximately 50% of cases can mimic lung cancer.¹

We report the case of a 76-year-old woman diagnosed with right lower lobe (RLL) pneumonia in September 2014, treated with azithromycin 500 mg/24 hours for 1 week. After completing the course of antibiotics, she consulted due to dyspnea accompanied by cough with foul-smelling whitish sputum and fever.

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A chest computed tomography was performed (Fig. 1A), which showed heterogeneous pulmonary consolidation in the RLL, with no evidence of any obstructive central lesion. The patient received another cycle of antibiotics with amoxicillin/clavulanate acid (1000/200 tid) for 14 days.

In September 2015, she presented with hemoptysis, and fiberoptic bronchoscopy was performed, revealing a “fibrin plug in a medial subsegment of the RLL”. Bronchial angiogram revealed a hypervascularized lesion in the right hilum, irrigated by a right bronchial artery originating in an intercostal trunk. The study was completed with a PET/CT, which showed the lesion in the RLL with a maximum standardized uptake value (SUV) of 4. Given the high suspicion of malignancy and the episode of hemoptysis, we decided to perform a surgical intervention. In view of the location of the lesion, right lower lobectomy was performed by thoracotomy.

The pathology report described mixed acute and chronic inflammation, forming focal abscesses, associated with a foreign body (fish bone), with *Actinomyces* superinfection, fibrosis and perilesional reactive changes (Fig. 1B).