Malignant Pleural Mesothelioma in a Young Adult With No Known Exposure to Asbestos. Can Asbestos Exposure be Truly Ruled Out?☆

Mesotelioma pleural maligno en adulto joven sin exposición conocida al asbesto. ¿Se puede descartar realmente la exposición a asbesto?

Dear Editor,

We read with interest the scientific letter from Espinosa Muñoz et al., describing the case of a young woman with malignant mesothelioma.[1] The main message of the letter was to alert readers to the possibility of mesothelioma developing without known exposure to asbestos. Indeed, in all published series, this exposure cannot be confirmed in around 20% of patients.[2] In these cases, exposure to erionite in some areas of Turkey, the effect of the SV-40 virus, or previous radiation have been cited, as mentioned by the authors.

However, the possibility of inadvertent exposure to asbestos must also be taken into consideration. On the basis of this hypothesis, some data that would definitively rule out asbestos exposure in the case under discussion are missing. In the first place, the absence of environmental or domestic exposure should be confirmed, since mesotheliomas have been reported in association with proximity to several industries, such as fiber cement factories,[3] or in association with certain domestic appliances or installations. As there is no safe threshold for asbestos exposure in the development of mesothelioma, environmental or domestic exposure in the patient's early years of life could have caused the tumor 20 years later. We would also like to point out that, in an exceptional case such as this, an analysis of the asbestos content in the surgical resection piece would have been very illustrative. Our group is very familiar with this technique, which is used to determine the presence of asbestos bodies in the lung, expressed as number of bodies per gram of dry lung tissue. The number of asbestos bodies correlates well with the number of fibers and is an indication of the asbestos retained in the lung after inhalation, particularly in the case of the amphybole variety. Since this test is performed on lung tissue left over after the histological study, it is of great interest in cases such as the one discussed here, if sufficient sample material is available.

Indeed, study of the lung quite often provides evidence of exposure to asbestos that has gone unnoticed by patients themselves.[4] In asbestos-related diseases, diagnosis is based mainly on a history of patient-reported exposure, along with a suggestive clinical and radiological picture. However, in doubtful cases, like this one, in which radiological or histological findings conflict with the data obtained from the case history, it is interesting to obtain objective evidence of such exposure, which can have clear diagnostic and medicolegal repercussions.[5]

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New Year, New Challenges for Community Acquired Pneumonia

Nuevo año, nuevos desafíos respecto a la neumonía adquirida en la comunidad

Dear Editor:

The editorial about recent changes in pneumonia[1] addresses treatment as regards early antibiotics and dilemmas regarding steroids. However, there is one early step that needs further attention, and this has not even received a brief mention.

Deciding whether a patient is at high risk and in need of early hospitalization needs further consideration. Several different scales are used to assess risk, such as the PSI, SMARTCOP, CURB-65 and SOAR, but the use of these tools in primary care is considerably hampered by limited access to some parameters (for example urea/blood urea nitrogen, or partial arterial oxygen pressure to FIO2 ratio).

In the case of the PSI, which gives better results in low risk patients,[2] step 1 is easy enough to apply, but all patients over age of 50 will need further assessment, and this step alone is not enough. Step 2 can still produce scores up to 185 points (class V needs a score over 130, indicating highest risk), even without including the 110 points from laboratory or radiographic findings.

Community acquired pneumonia is still evaluated differently in primary and secondary care. Therefore, we need to work together to create a tool that can be used in the early stages of the disease, based on more than the patient's history, a clinical examination and bedside tests. This would prevent unnecessary admissions and also provide more input in patients at high risk, thus improving outcomes in these populations.

Clearly, existing guidelines must be updated,[1] and better assessment algorithms and tools are needed. There is little point in suggesting, for example, that C-reactive protein (CRP) be measured before considering antibiotics,[3] if this test, in the UK, is only available in hospitals, and the time spent awaiting results can delay a critical decision. Risk assessment in patients with community acquired pneumonia is already a challenge in general practice.