student confidence in essential surgical skills acquisition and increase interest in surgery as a career. Medical schools and student surgical societies should work together to improve undergraduate BSS training.

Christopher TJ. Madden-McKeea, Dharmesh V. Valandb, Joshua M. Clementsb

aSchool of Medicine, Dentistry and Biomedical Sciences, Queen’s University Belfast, University Road, Belfast, BT7 1NN, Northern Ireland, UK

bUlster Hospital Dundonald, Upper Newtownards Road, Belfast, BT16 1RH, Northern Ireland, UK

Corresponding author:
Christopher Madden-McKee, Queen’s University Belfast, University Road, Belfast, BT7 1NN, Northern Ireland, UK,
Email: cmaddenmckee01@qub.ac.uk

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A CURIOUS CASE OF GRANULOMATOSIS WITH POLYANGITIS

Editor,
A 65-year-old male non-smoker presented with a 2-month history of weight loss, fever and back pain. Bloods noted normocytic anaemia, elevated ESR (130mm/hr) and normal renal indices. To exclude malignancy, a CT chest, abdomen and pelvis was requested. This revealed a paravertebral mass extending from T6-T11 with significant uptake on subsequent CT-PET (Figure 1). CT guided biopsy was not possible due to the location of the mass. Endobronchial ultrasound guided biopsy of the mass was negative for malignancy, yet this remained likely. Spinal referral was made for consideration of a biopsy/removal of the mass.

The patient was readmitted with acute kidney injury (urea 16.5mmol/L, creatinine 123μmol/L, eGFR 51ml/min). Presuming pre-renal failure, intravenous fluids were given with no improvement. Renal tract ultrasound was normal. Urine dipstick demonstrated significant blood and protein. Vasculitis screen showed PR3 ANCA of >8.0 and cANCA 20, prompting a presumptive diagnosis of granulomatosis with polyangitis (GPA). On renal biopsy, focal segmental glomerulosclerosis, active crescents and C3 positivity on immunofluorescence confirmed the diagnosis (Figure 2). Patient was pulsed with methylprednisolone before commencing oral cyclophosphamide and prednisolone. At 4 month follow up the patient’s renal function had normalised and repeat imaging showed complete resolution of the mass.

Figure 1: CT-PET showing uptake in the prevertebral and bilateral paravertebral region, (SUV max 11.92), PET avid right hilar nodes (SUX max 6.7) with encasement of the descending aorta, associated with increased uptake.
GPA is a potentially lethal multisystem disorder of unknown aetiology which typically presents as a small-vessel vasculitis and necrotising granulomatous inflammation of the kidneys and respiratory tract. Anomalous manifestations exist with cutaneous, ocular, musculoskeletal, neurological and cardiac presentations previously described. GPA presenting as tumour like masses is less well documented. To date, GPA tumour like lesions have been noted in the orbits, nasal passages, lungs and right ventricle with a predilection for the lung, and normal kidneys. Within the literature there exists only one previous case of GPA presenting as a paraspinal mass with this patient exhibiting synchronous renal and paraspinal masses. To the authors knowledge, our case represents the only description of a solitary GPA paraspinal mass.

Those with suspected GPA require serum anti-neutrophil cytoplasmic antibody (ANCA) testing. Whilst not wholly pathognomonic, elevated cANCA and PR3 levels strongly support a diagnosis of GPA in patients with moderate/high probability scores. A negative ANCA does not exclude the diagnosis therefore ANCA testing is not advised for monitoring disease activity. Definitive diagnosis requires evidence of necrotising vasculitis on biopsy. Many biopsy sites exist however renal samples are considered superior. As per the European Renal Association and European Vasculitis Society, management of GPA is in accordance with symptom severity at diagnosis. ‘Non organ threatening disease’ requires treatment with methotrexate and glucocorticosteroids. Glucocorticoids with either cyclophosphamide or rituximab are recommended in "organ or life threatening disease" which includes tumour like lesions given their potential to compress surrounding structures. Plasma exchange is only required in the event of pulmonary haemorrhage or rapidly progressive renal failure. This case highlights the diagnostic difficulty surrounding GPA and its ability to present as tumour like masses. In such cases it is imperative to exclude malignancy, yet this may generate diagnostic delays. The authors therefore argue GPA should be considered in any patient with a mass and evidence of multi-system disease.

Patient consent was obtained for the publication of this case.

E Keelan1, A McCorkell1, M Kelly1, G Shivashankar2, D O’Rouke3

Respiratory Department, Altnagelvin Hospital, Glenshane Road, Derry.
Renal Department, Altnagelvin Hospital, Glenshane Road, Derry.
Queen’s University Belfast, Belfast.

Correspondence: Dr Emma Keelan, Department of Respiratory, Royal Victoria Hospital, Belfast

Email: (ekeelan01@qub.ac.uk)

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THINKING OUTSIDE OF THE LUNGS

Editor,

A 29-year-old female presented to the emergency department with increasing dyspnoea, a productive cough and pleuritic chest pain. She was a known intravenous drug user. On examination she was pyrexic with a temperature of 39.5°C and significantly hypoxic with PaO2 of 8.6 kPa on FiO2 of 0.6.

Admission blood test results showed a raised white cell count of 22.3 (10^9/l), accompanying neutrophilia and raised C-reactive protein of 345.6 (mg/l). Liver function tests were also deranged.

Initial chest x-ray (Figure 1a) reported patchy opacification in the right mid zone, suggestive of infection and subsequent computed tomography (CT) of the chest revealed a patchy distribution of nodules and confluent pseudo-mass showing signs of cavitation with associated evidence of bilateral pleural effusions and reactive nodes in the right hilum and in mediastinum (Figure 1b).

She was commenced on broad spectrum antibiotics with