Ureterocolic fistula as an incidental finding after barium enema

Dear Editor,

A 42-year-old female patient who had undergone Hartmann's procedure for the treatment of colorectal carcinoma 7 months prior presented for preoperative evaluation before closure of the colostomy. She reported no clinical symptoms or comorbidities and stated that she had never received chemoradiotherapy. She was given a barium enema (Figure 1), after which there was opacification of the ureter and left renal collecting system, consistent with ureterocolic fistula. Although the fistulous tract was difficult to characterize, it appeared to be connecting the distal stump to the middle third of the left ureter. There was also late opacification of the bladder. Careful

Figure 1. X-rays obtained after barium enema. A: Lateral view showing initial opacification of the rectum, remaining distal colon, ureter, and left renal collecting system. B: Lateral view showing late opacification of the bladder. C: Posteroanterior view showing late opacification of the bladder.

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Lucas de Pádua Gomes de Farias1,a, Igor Gomes Padilha1,b, Carla Jotta Justo dos Santos2,c, Christiana Maia Nobre Rocha de Miranda2,d

1. Universidade Federal de Alagoas (UFAL), Maceió, AL, Brazil. 2. Clínica de Medicina Nuclear e Radiologia de Maceió (MedRadius), Maceió, AL, Brazil. Correspondence: Dra. Christiana Maia Nobre Rocha de Miranda, Clínica de Medicina Nuclear e Radiologia de Maceió (MedRadius), Rua Hugo Corrêa Paes, 104, Farol, Maceió, AL, Brazil. Email: maia.christiana@gmail.com.

a. https://orcid.org/0000-0001-5195-9818; b. https://orcid.org/0000-0002-7639-0397; c. https://orcid.org/0000-0001-7205-8656; d. https://orcid.org/0000-0002-7750-6638.

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Lymphocytic interstitial pneumonia and pulmonary amyloidosis in Sjögren’s syndrome

Dear Editor,

A 72-year-old male patient who was a former light smoker presented with a complaint of dyspnea. In 2014, he had been diagnosed with Sjögren’s syndrome during investigation of thrombocytopenia identified on a routine laboratory test. An X-ray performed prior to transurethral resection of the prostate showed pulmonary nodules. Further evaluation with computed tomography (CT) of the chest revealed multiple thin-walled pulmonary cysts in the peribronchovascular and subpleural regions of both lungs, predominantly in the middle and lower lung fields, together with solid, irregular, partially calcified nodules, some in close proximity to the cysts (Figure 1). A biopsy of the largest nodule revealed fragments of lung parenchyma with lymphocytic infiltrate and proteinaceous fibrin filling the alveolar spaces, with degenerated red blood cells (ghost cells), sometimes forming hyaline membranes. Complementary analysis of the material showed an light chain amyloidosis (kappa) peptide profile.

Sjögren’s syndrome is an autoimmune disease in which lymphocytes attack the glands that generate saliva and tears [1]. Many patients with Sjögren’s syndrome develop interstitial lung diseases such as lymphocytic interstitial pneumonia (LIP), amyloidosis, follicular bronchiolitis, and even lymphoma [1,2]. On CT, LIP can manifest as ground-glass opacity or consolidations, as well as septal thickening, centriflobular nodules, and cysts [3]. Cysts are believed to be formed by air trapping caused by a check-valve mechanism, with airway dilation distal to bronchiolar obstruction caused by lymphocytic infiltrate, and can be the only residual findings in chronic cases [3,4].

Amyloidosis occurs due to excessive formation and deposition of certain proteins in an abnormal fibrillar pattern, resulting in malfunction of the affected organ [3,4]. Pulmonary nodular amyloidosis typically manifests as multiple nodules, of varying attenuation, which can cavitate [3,4]. Some are associated with mucosa-associated lymphoid tissue lymphoma [3,4]. In the clinical context of Sjögren’s syndrome, calcification within a nodule is more consistent with amyloid nodules [2]. More rarely, amyloidosis can also lead to the formation of pulmonary cysts, of varying sizes [3,4]. The mechanism of cyst formation is uncertain and is believed to involve a check-valve mechanism secondary to narrowing of the airways, caused by the accumulation of inflammatory or amyloid cells or by capillary rupture due to amyloid deposition with alveolar destruction and cyst formation [5]. In alveolar-septal amyloidosis, the CT findings include septal thickening and ground-glass opacity, whereas CT shows circumferential thickening of the tracheobronchial wall in the more common form of the disease [1–3].

In the case reported here, the emergence of the ureterocolic fistula was iatrogenic, being attributed to previous surgical manipulation. A contrast-enhanced imaging examination was essential because it allowed the fistula to be corrected during the surgical procedure that was being planned, as well as allowing the patient to be referred to the nephrology department for the clinical monitoring of any renal dysfunction that might develop.

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