Letters to the Editor

The differential diagnoses include other diseases affecting the trachea, not only those presenting localized involvement—such as primary tracheal neoplasms, injuries of traumatic origin, and some infectious diseases—but also those presenting diffuse involvement—amyloidosis, tracheobronchopathia osteochondroplastica, relapsing polychondritis, laryngotracheobronchial papillomatosis, tracheobronchomegaly, neurofibromatosis, Wegener’s granulomatosis, lymphoma, and paracoccidioidomycosis(5,7–12).

Imaging studies have become increasingly important in the evaluation of chest diseases, as recently noted in the radiology literature of Brazil(13–19). In the study of the trachea, imaging studies comprise X-rays and, primarily, CT of the chest, which can show irregular, circumferential narrowing of the lumen, with or without mediastinitis. In fibrotic disease, the lumen is smoother and the wall is not thickened. Lymphadenopathy is generally associated with active tuberculosis(4,6).

Bronchoscopy can reveal inflamed mucosa, submucosal granuloma or polyp, ulceration, hypertrophy, or cicatricial stenosis; histologically, tracheobronchial tuberculosis can be identified if the presence of giant cell granuloma and caseous necrosis(10). Although the gold standard for the diagnosis of tracheobronchial tuberculosis is the finding of granulomas in the tracheal/bronchial mucosa, a diagnosis based on imaging findings and sputum positivity is accepted and enables immediate treatment(2).

Making a diagnosis of tracheobronchial tuberculosis requires suspicion, and it is necessary to correlate the clinical manifestations with the radiological findings. Early diagnosis and treatment can avert the complications of the disease.

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Imune reconstitution inflammatory syndrome, with pulmonary and neurological cryptococcosis, in an HIV-negative patient

Dear Editor,

A 26-year-old male presented with complaints of cough and fever for a few days. He reported having followed a weight loss program for the last four months, having lost 20 kg. He reported no comorbidities.

Chest X-ray showed pulmonary consolidation in the left lung. A complete blood count showed leukocytosis and a lymphocyte count at the lower limit of normality. Subsequent X-rays, during antibiotic therapy, showed an increase in the consolidation. Computed tomography of the chest showed left lung consolidation with air bronchogram and a partially rounded hilar opacity, both containing areas of hypointense signals (Figure 1A), raising the hypothesis of an infectious or neoplastic process. Because he developed mental confusion, seizures, and postural instability, the patient was submitted to magnetic resonance imaging (MRI) of the brain, which showed multiple intraparenchymal cystic lesions (Figure 1B), with no enhancement and minimal edema at the borders.

Pathological examination of a biopsy sample obtained from the pulmonary consolidation revealed fungal infection with characteristic of deep cryptococcal mycosis. Staining with mucicarmine showed a mucin-positive capsule. The serology was negative for HIV, as well as for hepatitis B and C. Treatment was started with fluconazole, alternated with amphotericin B. During hospitalization, the general status of the patient became unstable and he was submitted to tracheostomy, subsequently developing tracheal candidiasis. After clinical improvement, he was discharged to outpatient follow-up, with home therapy and attention to an appropriate diet.

Five weeks after discharge, the patient was readmitted to the hospital with worsening neurological status. Another MRI of the brain showed the development of marked, progressive perilesional vasogenic edema (Figure 1C) and significant enhancement of
positive patient, probably developing immunosuppression due to nutritional restriction for weight loss.

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Neurocutaneous melanosis

Dear Editor,

A 12-year-old male patient presented with a delay in neuropsyomotor development that had been diagnosed in the first year of life. Two years prior (at 10 years of age), he had undergone ventricular shunt placement because of hydrocephalus. Six months prior to the visit reported here, he had experienced episodes of seizures. Physical examination revealed multiple cutaneous nevi (Figure 1A). Cerebrospinal fluid examination showed an elevated level of protein (1359.7 mg/dL; reference range: 15.0–45.0 mg/dL) and revealed the presence of epithelioid cells. Magnetic resonance imaging (MRI) of the brain (Figures 1B, 1C, and 1D) showed extensive, bilateral, asymmetric leptomeningeal thickening.