extraluminal extension of the tumor. The prognosis is poor, with mean survival time of approximately one year and a half after symptoms onset. Due to pulmonary artery occlusion and acute symptoms, surgical resection is generally the treatment of choice.

In conclusion, the present case reinforces the important role of the imaging methods in the differentiation between pulmonary artery intimal sarcoma and chronic PTE. The relevant aspects for this differentiation, such as contrast enhancement, dissection of the affect vessels and extraluminal extension, allow for a correct diagnosis, avoiding delay in the required surgical approach.

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Central nervous system involvement in sarcoidosis

Envolvimento do sistema nervoso central na sarcoidose

Dear Editor,

A 51-year-old female patient complained of mild frontotemporal headache of insidious-onset for two years. One year ago, she had an episode of focal, tonic-clonic seizures (with right lower limb paresthesia) and was prescribed carbamazepine. Cerebrospinal fluid demonstrated increased protein levels and intrathecal immunoglobulin (IgG) synthesis, suggesting an inflammatory component. Magnetic resonance imaging was performed (Figure 1).

Sarcoidosis is a multisystem disease of unknown etiology characterized by noncaseating granulomatous inflammation. There is a genetic predisposition, with T-lymphocyte receptor activation by some unknown antigen. The disease affects preferentially the respiratory system. In the lungs, granulomas are observed in the interstitial compartment, showing a perilymphatic distribution along the peribronchovascular sheaths, interlobular septa and pleural surface.

It is estimated that in about 5% to 15% of cases sarcoidosis affects the central nervous system. Rarely the patient presents with exclusively neurological manifestations like in the present case. Most commonly, neurosarcoidosis is observed in cases of disseminated disease.

The clinical manifestations of neurosarcoidosis are pleomorphic. Cranial nerve compromise, visual alterations, headache, weakness, paresis, paresthesia, psychiatric alterations and signs of meningeal irritation may be observed. Although rare, symp-
Femoral artery injury during aneurysm coiling
Lesão da artéria femoral durante embolização de um aneurisma

Dear Editor,

Endovascular artery reconstruction with low-profile stents, flow-diverters and flow-disrupting devices represent a significant progress in the endovascular therapy of intracranial aneurysms. Despite the improvement in technical expertise and developments in device technology, endovascular treatment still has inherent risks(4). In the literature, most reports are focused on neurological complications during procedures(2), however, reports on access vessel complications are scarce. Some of the well known access-related complications include: arterial pseudoaneurysms, arteriovenous fistulae, hematomas, arterial dissection leading to acute vessel occlusion(5), intracavitary bleeding, and retroperitoneal hematoma following femoral artery puncture(6). The authors report the case of a large groin hematoma caused by a hypodermic needle connected with the black cable of the detachable coil power supply (Boston Scientific; Natick, MA, USA) and its endovascular management.

Local compression is the first line treatment for femoral access complications(6), but such strategy may fail when indicated for patients under combined antiplatelet and anticoagulation regimens. Open surgery is effective in the treatment of groin complications(7). However, the endovascular approach is a safe and effective minimally invasive alternative to surgery in the management of other complications.

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