A 70-year-old female patient with multiple comorbidities presented to us with exertional breathlessness, night sweats, and weight loss of 5 kg in the last 1 year. She had type 2 diabetes, systemic hypertension, dyslipidemia, and cerebrovascular disease and was on drugs for the same. She did not have any history of pulmonary or cardiac illness in the past. All investigations were normal except for imaging which showed multiple mediastinal and para-aortic lymph nodes with apparently normal-looking lung parenchyma. She was extensively investigated considering the differential diagnoses such as tuberculosis, sarcoidosis, and lymphoma. She underwent a bronchoscopy, transbronchial needle aspiration, and transbronchial lung biopsy as a part of her evaluation. She developed chest pain and fever few hours after the procedure and was evaluated for the same. All her investigations for fever workup were normal. Only nonspecific alveolar opacities were noted on chest radiographs. She underwent computed tomography of the thorax postbiopsy on the same day as scheduled earlier, and to our surprise, we found multiple small sized cavitations/lacerations (9–11 mm) in different segments of the right lung [Figures 1-3].

Relatively large tissue samples are obtained from the lung with the biopsy forceps while performing a transbronchial biopsy and are supposed to result in lacerations in lung parenchyma. In general, these lesions will become small nodule by the second day (filled with clot) and are not seen in routine chest radiography. These lesions may get infected and become persistent cavities in few patients, especially immunocompromised patients. Our patient had four such lacerations of different sizes, from 9 to 11 mm in different segments of the right lung which were well correlated to four biopsy tissues obtained during the procedure. A thickened wall or surrounding alveolar reaction related to bronchoalveolar lavage or biopsy-induced hemorrhage was seen in the lesions. These simulated the appearances of lung abscess or invasive fungal disease. On review of literature, there were only limited data regarding this complication. Hartman[1] had described such lesion in post bronchoscopic biopsy patients in his book *Pearls and Pitfalls in Thoracic Imaging - Variants and Other Difficult Diagnoses*, and we could find only one case report by Daly et al.,[2] in post lung transplant patients with similar lesions.

However, to the best of our knowledge and experience, these lesions are self-resolving and no specific treatment is required.
Finanical support and sponsorship
Pearls and Pitfalls in Thoracic Imaging - Variants and Other Difficult Diagnoses (By Thomas Hartman), few case reports on the internet.

Conflicts of interest
There are no conflicts of interest.

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How to cite this article: Peringattuthodiyl Y, Rajamanickam T. A rare cause of lung cavity. Lung India 2016;33:702-3.