Pulmonary sequestration is divided into intralobar and extralobar types. Intralobar sequestration is surrounded by the normal lung tissue without separate pleura whereas extralobar type has its own pleura. Intralobar pulmonary sequestration is the more common type, presents in older children and adolescents. Usually, intralobar pulmonary sequestration has a single feeding artery; however, multiple systemic arterial supply can be seen. Arterial supply of pulmonary sequestration commonly originates from thoracic aorta followed by abdominal aorta and less commonly from intercostal artery, phrenic artery, subclavian artery, pulmonary artery, left gastric artery, coronary artery, and celiac trunk. Arterial supply from renal artery is very rare, only few cases have been reported.

CT angiography is the noninvasive diagnostic modality of choice as it can show the abnormal lung parenchyma as well as one or more abnormal arterial supply to the sequestration. Surgical removal of the sequestrated segment is the treatment of choice as the sequestrated lung remains to be a source of infection. It is important to identify the arterial supply and venous drainage preoperatively to prevent the injury of unidentified vessels leading to massive intraoperative hemorrhage. Preoperative embolization of the anomalous vessels may be helpful in reducing intraoperative blood loss.

Factors influencing severe community-acquired pneumonia
few points to ponder

Sir,

We read with great interest the article by Mahendra et al. and would like to highlight a few pertinent points.

1. The authors have studied the potential factors responsible for severe community-acquired pneumonia (SCAP) and have used CURB-65 to decide on the site of care, as well as label cases as “severe” or “nonsevere”
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Staphylococcus aureus

3. This study was part of the international Global Initiative for Methicillin-resistant *Staphylococcus aureus* (MRSA) Pneumonia (GLIMP) study to evaluate MRSA; however, no MRSA was isolated in this particular study. Interestingly, in the GLIMP study, the incidence of MRSA pneumonia was reported as 1.4% in India. If the mortality data are available, it would perhaps be also meaningful to determine factors related to death (an endpoint of prime importance and on the basis of which the severity scores of pneumonia are formulated)

3. This study was part of the international Global Initiative for Methicillin-resistant *Staphylococcus aureus* (MRSA) Pneumonia (GLIMP) study to evaluate MRSA; however, no MRSA was isolated in this particular study. Interestingly, in the GLIMP study, the incidence of MRSA pneumonia was reported as 1.4% in India. It appears that the relatively small sample size of the present study (which is also mentioned by the authors) was probably the primary reason for nondetection of MRSA cases as studies with larger number of patients have reported on the incidence of MRSA in India.

4. Finally, among the risk factors reported by the authors, smoking and alcohol usage were the important determining factors for severity of pneumonia. In this regard, it would be useful to know the exact definition used by the authors as the same are often reported casually by patients/study subjects and may have lesser value if stringent objective definitions are not used.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

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