Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Antifungal susceptibility testing should be performed because of its frequent resistance to antifungal agents. Although there is no universally accepted treatment, case reports show that the use of voriconazole or posaconazole may be the best initial approach and an effective antifungal treatment in cases poorly responsive to other therapies.[1]

In conclusion, *P. lilacinum* is a rare cause of fungal keratitis and its treatment is usually challenging, therefore early microorganism detection is necessary. We describe a *P. lilacinum*-induced keratitis diagnosed with in vivo confocal microscopy, which can be useful in cases where microbiological investigations yield no results and correlates well with histopathology findings.

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IgG4-related lung disease. A case report☆

Enfermedad relacionada con IgG4 de afectación pulmonar. A propósito de un caso

Dear Editor,

The presence of lung lesions can be the first manifestation of multiple diseases. The aetiological range is very wide, from infectious causes to cancer disease and rheumatological diseases, among others. There are rare diseases, and their form of presentation may be atypical, making diagnosis difficult. If we add to this the fact that the onset of symptoms occurs in the middle of the SARS-CoV2 pandemic, it makes diagnosis even more difficult.

We report the case of a 51-year-old male who was admitted for a 5-day history of fever with nasal congestion, cough with purulent expectoration, without dyspnoea or chest pain. He reported asthenia with no other accompanying symptoms. A chest X-ray showed several bilateral nodular parenchymal consolidations suggestive of SARS-CoV-2 disease; so antiviral treatment with lopinavir–ritonavir and hydroxychloroquine was initiated with the patient's consent, even though the PCR results were negative for SARS-CoV-2. Given the lack of clinical and radiological improvement, a chest CT scan was performed, which reported the presence of multiple nodular images and lung masses, some with cavitation. Septic emboli were suggested as a first possibility, although the likelihood of tumour lesions could not be ruled out (Fig. 1). The antiviral treatment was discontinued and a laboratory, microbiological and pathological study was started.

Laboratory tests showed thrombocytosis (593,000/μl), leukocytosis (13,550/μl) with neutrophilia, elevated C-reactive protein (195.8 mg/l) with normal procalcitonin, high D-dimer (1520 ng/ml) and ferritin (887 ng/ml) levels, cANCA positive (positive for proteinase 3, negative for myeloperoxidase), elevated immunoglobulin (Ig) G subclass 4 (154 mg/dl) and IgE (246 kUA/l). The cultures of the samples obtained by core-needle biopsy of the lung lesions were negative for bacteria, fungi and mycobacteria. In the anatomical pathology study, the presence of lymphocytes, plasma cells, fusiform histiocytes, some giant cells and isolated eosinophils without evidence of polymorphonuclear cells or foci of necrosis were described. The methenamine silver technique detected foci of obliterative vasculopathy. With immunohistochemistry, spindle cells expressed CD-68 and cytoplasmic lysozyme, and plasma cells showed diffuse IgG deposition and many of them had IgG4 (up to 60 IgG4 plasma cells per high-power field). All of these findings corresponded to IgG4-related lung disease.

IgG4-related disease is the name given in the previous decade to a clinicopathological entity characterized by swollen lesions, a dense lymphoplasmacytic infiltrate with abundant IgG4-positive plasma cells, storiform fibrosis and, frequently, elevated serum levels of IgG4. The prevalence of the disease is estimated to be 2.63–10.2 cases per million inhabitants in Japan. It is usually diagnosed between the sixth and seventh decades of life and predominantly in males. The most affected organs are usually

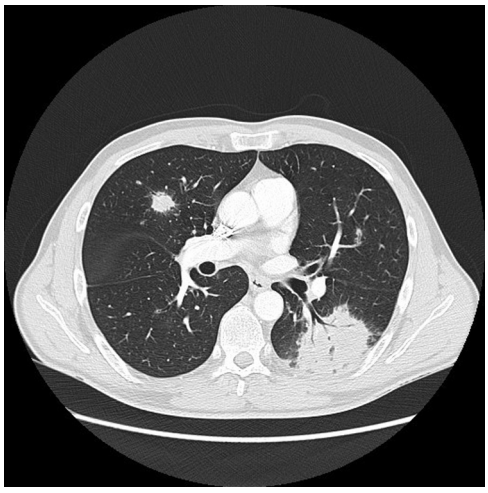

Fig. 1. Chest CT image: several nodules and a lung mass are seen.

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the pancreas, salivary glands and lymph nodes, but renal, aortic, retroperitoneal, meningeal, prostatic and pulmonary involvement have also been described.[1] In the latter organ involvement, symptoms are usually non-specific, such as cough, dyspnoea, fever or chest pain. Sometimes there may be no symptoms at all.[2] The radiological pattern of presentation can be remarkably diverse: localized parenchymal involvement, diffuse parenchymal involvement, presence of lymphadenopathy, diffuse interstitial pattern, bronchial thickening and pulmonary nodules, as in our case.[3] In terms of laboratory tests, elevated serum levels of total IgG (61% > 1800 mg/dl), IgG4 (84% > 135 mg/dl) and IgE (58% > 360 mg/dl) *stand out.* It may even be positive for antineutrophil cytoplasmic antibodies.[4] Histopathological findings include a diffuse lymphoplasmacytic infiltrate, vascular obliteration and fibrosis with occasional eosinophils and the presence of abundant IgG4-positive plasma cells.

The differential diagnosis with other diseases is very broad and varied: infectious diseases such as tuberculosis, rheumatological diseases such as Sjögren's syndrome or granulomatosis with polyangiitis and malignant diseases such as lymphoma. There are international diagnostic consensus guidelines for this disease which include clinical, serological and histological criteria that are classified as definitive, probable, or insufficient evidence.

The goal of treatment is to reduce inflammation and induce remission of the disease to preserve the function of the affected organs. There is no standardised treatment for this disease, as it is based on case series, but steroid treatment is usually initiated and, depending on the response, the addition of immunosuppressants or biological agents, especially rituximab, is considered. Relapses with steroids are quite common, so a second drug is usually associated with steroids. Despite the limited evidence, several case series have observed a better clinical response in the association of prednisone + rituximab compared to steroids in monotherapy or in association with immunosuppressants (azathioprine, methotrexate, mycophenolate mofetil, cyclosporine. . .).[1]

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Uterine pyometra by *Eggertella lenta*☆

Piometra uterino por Eggertella lenta

Dear Editor:

Eggertella lenta (E. lenta) is a gram-positive bacillus that was first isolated in 1935. Previously called *Eubacterium*, it has been reclassified under the bacterial genus Actinobacteria.[1,2] It has generally been associated with infections of the gastrointestinal and genitourinary tract and has been linked to polymicrobial infections (50%). Compared to other gram-positive bacteria, *E. lenta* is an important cause of bacteraemia, secondary to intestinal bacterial translocation, although it is rarely isolated from intra-abdominal fluid samples.

Risk factors include alterations in immunocompetence, diabetes mellitus, final stages of chronic kidney failure, ulcerative colitis or Crohn's disease, and neoplasms.[3] The mean age of presentation is 55 and it is more common in women.[2] Its mortality exceeds 35%.[1,3]

It is a slow-growing microorganism, hence the difficulty in its laboratory isolation. In recent years, the development of new techniques and the use of MALDI-TOF MS have allowed a fast and reliable diagnosis.

We report the case of a 70-year-old woman with a history of obesity surgery, difficult-to-control asthma, atrial fibrillation anticoagulated with apixaban, moderate degenerative aortic regurgitation, and acute urine retention, for which she was a permanent urinary catheterization patient.

She went to the emergency department due to sudden pain in the hypogastrium and in the left iliac fossa. In the previous days, she had reported dysuria, so her primary care doctor prescribed fosfomycin treatment.

During the first clinical assessment, she had developed a condition of shock with hypotension (BP 90/60), tachycardia and oliguria. Evidence of severe metabolic acidosis, exacerbated chronic renal failure and hyperlactacidemia, as well as significant elevation of inflammatory parameters in blood tests were observed. An abdominal computed tomography showed free perihepatic and perisplenic fluid between the loops and in the lesser pelvis, without other relevant findings.

She was admitted to the intensive care unit for stabilization, initiation of intense fluid therapy and vasoactive drug treatment. Once blood and urine cultures were taken, broad-spectrum antibiotic treatment with carbapenem and linezolid was started.

After evaluation by general surgery, an exploratory laparotomy was performed with the finding of uterine vault perforation and purulent peritonitis of the 4 quadrants, requiring hysterectomy and double adnexectomy. She experienced a had a good recovery during the following hours, with discontinuation of vasoactive drugs and improvement of renal function. *Enterococcus avium* susceptible to linezolid was isolated in the peritoneal fluid, while *E. lenta* sensitive to piperacillin/tazobactam isolates were found in blood cultures, with subsequent antibiotic treatment adjustment.

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