There is no defined treatment for PVT[1,3], and possible treatment strategies include use of anticoagulant drugs[1–4,6], NSAIDs[1,3,6], elastic socks[3,6] and rest[6]. However, the different therapies have shown similar results.

The most important complications of PVT include thrombosis extension into deep veins in the leg[7] and occurrence of pulmonary embolism[1].

Amongst the differential diagnosis of PVT, plantar fasciitis[2,4,5], tendinous involvement[3,5], bursitis[5], Morton's neuroma[4,5], stress fractures[2,4,5], sesamoiditis[5] and ganglion cysts[5]. No description of death associated with PVT is found in the literature.

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Maurício Fabro[1], Sara Raquel Madalosso Fabro[1], Rafael Santiago Oliveira Sales[1], Cesar Augusto Machado[1], Gustavo Lopes de Araújo[1]

1. Hospital Santa Catarina de Blumenau, Blumenau, SC, Brazil. Mailing Address: Dr. Maurício Fabro. Rua Tobias Barreto, 266, ap. 304, Vila Nova. Blumenau, SC, Brazil, 89035-070. E-mail: mauriciofabro@hotmail.com.

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Pulmonary neoplasia mimicking fungus ball

Neoplasia pulmonar simulando bola fúngica

Dear Editor,

We report the case of a 74-year-old man smoking 80 cigarette packages per year, with history of pulmonary tuberculosis for 50 years. Two years ago, the patient underwent chest computed tomography that demonstrated centrilobular and paraseptal emphysema, besides sparse bullae, the largest one located in the right lower lobe, with a small nodular mass inside, measuring about 0.8 cm in diameter (Figure 1A).

The patient didn't return for follow-up and after two years presented with progressive dyspnea whose onset had occurred two months ago, in association with cough, weight loss and pain in the lower third of the right hemithorax. A new chest computed tomography demonstrated a mass with spiculated margins, adjacent to the posterior portion of the largest bulla, occupying the whole bulla where the nodular mass had been seen at the previous computed tomography images (Figure 1B). Also, interstitial thickening suggestive of carcinomatous lymphangitis was observed, besides bilateral pleural effusion.

Pericardium biopsy and cytological analysis of pleural effusion revealed adenocarcinoma, raising the hypothesis of lung adenocarcinoma with metastasis to the pleura and pericardium. A chemotherapy protocol with gemcitabine and carboplatin was initiated. The patient presented worsening of the respiratory condition, progressing to death after two months.

Lung cancer frequently presents like a nodule or solitary lung mass[1,2]. However, the disease presentation forms are quite variable and some typical findings may be observed. One of such findings is growth from a preexisting cystic mass, mimicking a fungus ball. Thus, a cystic image showing either focal or diffuse wall thickening progressing to a nodular mass should include lung tumor in the differential diagnosis[3], particularly in cases where the nodule is attached to the wall and does not move with change in decubitus.

Other conditions which may present the finding of fungus ball include Rasmussen aneurysms, hydatid cysts, abscesses and intracavitary hematomas, besides fungal diseases themselves (aspergillosis, nocardiasis, actinomycosis, candidiasis, coccidioidomycosis)[2,4].

As the neoplasm develops in previous pulmonary lesions, it is found especially in fibroatelectatic or granulomatous areas result-

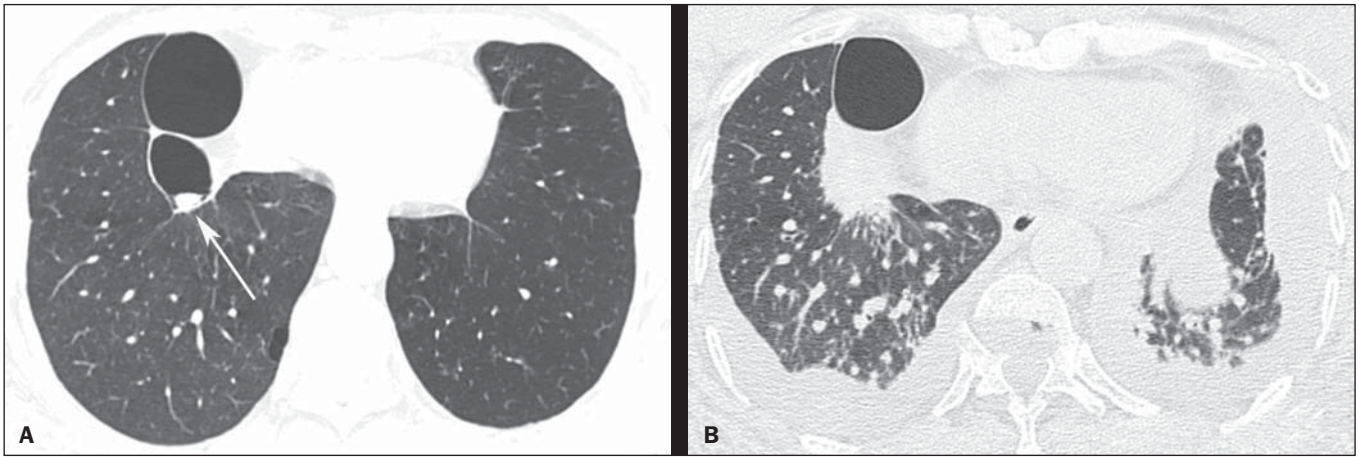

Figure 1. HRCT scan at the level of the lung bases (**A**) showing two bullae at right, with a small nodular mass measuring about 0.8 cm in diameter inside the small bulla (arrow). On **B**, scan acquired two years later, with a section of the same region, showing the presence of a mass with spiculated borders, adjacent to the posterior portion of the largest bulla, occupying the small bulla where the nodular mass had been seen at the previous CT images. Also, observe the presence of interstitial thickening suggestive of carcinomatous lymphangitis, besides bilateral pleural effusion.

ing from sequelae, generally associated with tuberculosis. The occurrence of lung cancer in cavities mimicking fungus ball or air crescent sign is quite rare[1,2,5]. The tumor tends to infiltrate in the adjacent pulmonary parenchyma causing a paracicatricial effect, and may lead to emphysematous or cystic changes adjacent to the neoplastic process[1].

In conclusion, lung cancer must be considered in the differential diagnosis for patients who present with a fungus ball-like lesion, particularly in cases where the nodule is fixed to the cavity wall.

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Bruno Fernandes Cavalcante[1], Gláucia Zanetti[1], Edson Marchiori[1]

1. Department of Radiologiy – Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro, RJ, Brazil. Endereço para correspondência: Dr. Edson Marchiori. Rua Thomaz Cameron, 438, Valparaíso. Petrópolis, RJ, Brazil, 25685-120. E-mail: edmarchiori@gmail.com.

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Extramedullary plasmacytoma in the right pulmonary hilum

Plasmocitoma extramedular no hilo pulmonar direito

Dear Editor,

A 53-year-old black, asymptomatic man, driver, being assessed to be released for physical activity. The patient denied smoking as well as having comorbidities.

Chest radiography performed on February 1st, 2011 showed ovoid opacity in the right hilar region, with no other abnormality (Figure 1A). Chest computed tomography (CT) performed on March 13, 2011 identified circumscribed round opacity with soft parts attenuation in the right hilar region, presenting enhancement after intravenous contrast agent injection, adjacent to the ipsilateral main pulmonary artery and its branches. Absence of other findings (Figures 1B and 1C).

Lesion biopsy result: *macro/microscopy* – hypercellular light-brownish fragments showing well-differentiated plasmacytoid cells with small, eccentric and hyperchromatic nuclei; *immunohistochemical analysis* – positive for CD138 and lambda antibodies; and negative for CD3, CD20, AE1/AE3 and kappa antibodies.

The investigation proceeded with abdominal CT (on May 16, 2011) that showed the presence of a liver cyst and signs of fat infiltration into the liver; normal blood count; negative Bence-Jones proteinuria; protein electrophoresis with no abnormalities; absence of noteworthy findings at bone scintigraphy and bone marrow aspiration.

Radiotherapy was the treatment of choice, with satisfactory response.

Chest CT performed on November 9, 2012 (Figure 1D) and other radiological studies with no suspect finding of disease recurrence/progression until May 20, 2015.

Diagnosis: extramedullary plasmacytoma (EMP) in the pulmonary hilum.

Plasmacytoma are primarily classified into solitary bone marrow/bone plasmacytoma (solitary myeloma), extramedullary plasmacytoma or one of multiple myeloma components[1,2]. Such

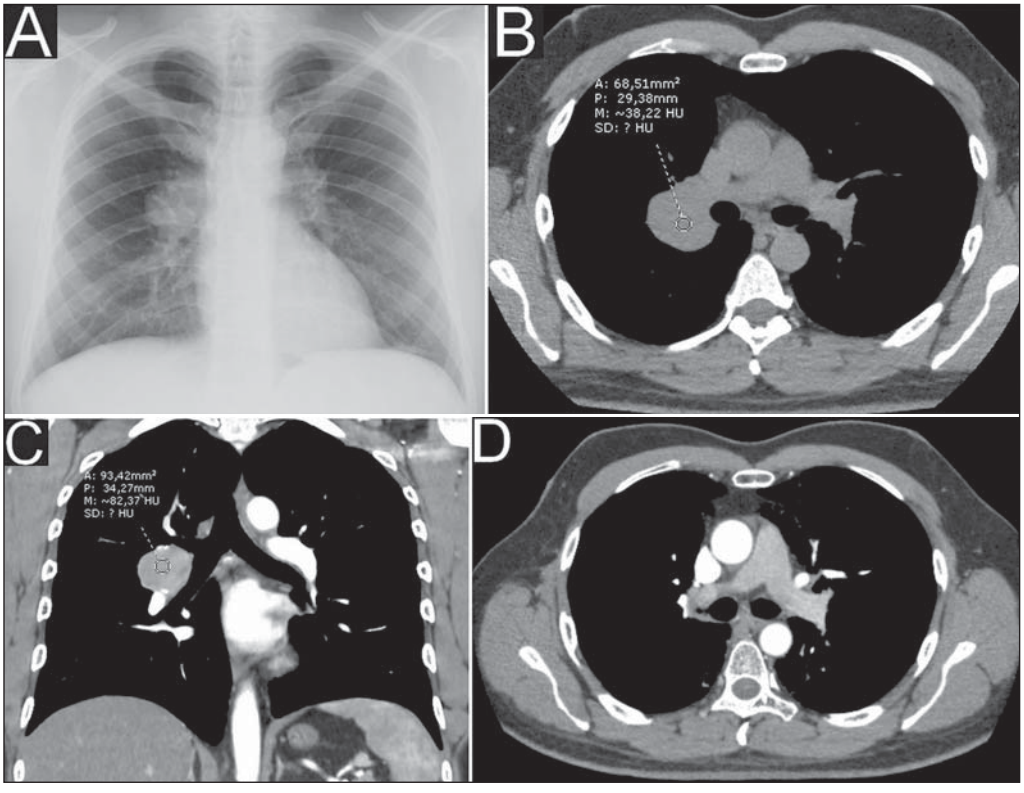

Figure 1. Chest radiography (**A**) showing ovoid opacity in the right hilar region. Axial chest CT section (**B**) at precontrast phase demonstrating circumscribed, round opacity with soft parts attenuation in the hilar region at right, and presenting enhancement after intravenous contrast agent injection, observed at coronal tomographic reconstruction (**C**). Contrast-enhanced axial chest CT section (**D**) after radiotherapy, where the previously described opacity is not characterized anymore, suggesting a good therapeutic response.