

**Figure 1.** Ultrasound (A); sagittal T2-weighted MRI sequence (B); out-of-phase T1-weighted gradient-echo MRI sequence (C); and in-phase T1-weighted gradient-echo MRI sequence (D). Note the expansile cystic lesion with heterogeneous content, containing numerous oval formations that were hyperechoic on the ultrasound and showed intermediate signal intensity in the T1- and T2-weighted sequences, with no evidence of signal loss in the out-of-phase T1-weighted gradient-echo sequence.

MRI, the fat seen within the lesion produces a hyperintense signal on T1-weighted images and signal loss in fat-saturated sequences<sup>(3,5,7)</sup>. In rare cases, the presentation of MCT is atypical, which can be a diagnostic challenge for radiologists<sup>(2,6)</sup>. Multiple small floating spheres within a large cyst, as observed in the case presented here, is one of those rare presentations, known as the “floating ball” presentation<sup>(4,6)</sup>. Histologically, the spheres are composed of keratin, fibrin, hemosiderin, sebaceous debris, hair, and fat, in variable proportions<sup>(2,6,13)</sup>. Although the mechanism of formation of these spheres has yet to be clarified, it is speculated that it involves aggregation of sebaceous material around a nidus<sup>(2,4,14)</sup>. The mobility of the spheres is due to their low density relative to the other content of the cyst<sup>(2,4,6)</sup>. A finding of multiple floating spheres within a single large cyst has not been reported for other types of tumors and is therefore considered pathognomonic of MCT<sup>(2,4,6,14-16)</sup>.

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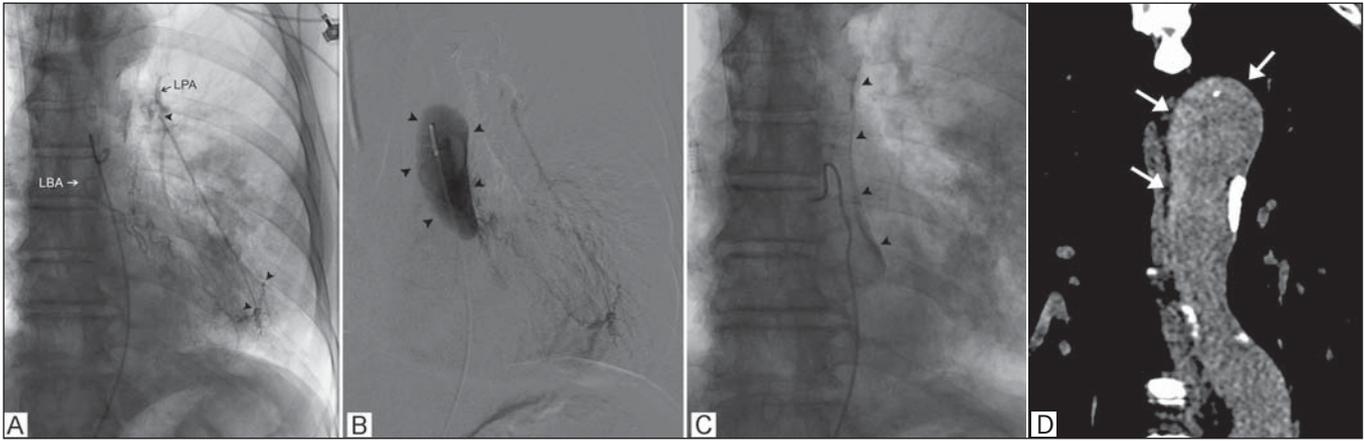
<http://dx.doi.org/10.1590/0100-3984.2015.0155>

**Self-limiting thoracic aortic dissection during bronchial artery embolization**

Dear Editor,

A 75-year-old woman presented with a 3-week history of intermittent hemoptysis related to a history of recurrent episodes of pneumonia. Chest computed tomography (CT) showed cylindrical bronchiectasis in the lingula, and bronchoscopy showed clots in the left bronchial tree. Bronchial arteriography was requested and revealed a shunt (Figure 1A) between the left bronchial ar-

tery and the left pulmonary artery. During manual-injection digital subtraction angiography, enhancement and stagnation of the contrast media were observed in a false lumen of the descending thoracic aorta (Figures 1B and 1C), consistent with iatrogenic aorta dissection. The iatrogenic aortic dissection extended to the left bronchial artery, leading to obstruction of blood flow to the shunt. However, there were no signs of hemodynamic instability, and the patient therefore received conservative therapy with clinical and radiological monitoring. A second CT scan, obtained 7 days later, showed that the iatrogenic aorta dissection was stable



**Figure 1.** **A:** Left bronchial arteriography showing a shunt (arrowheads) between the left bronchial artery (LBA) and the left pulmonary artery (LPA). **B,C:** Stagnation of the contrast media (arrowheads) can be seen at the false lumen of the descending thoracic aorta, indicating dissection. **D:** Coronal CT reconstruction at 7 days after bronchial arteriography showing persistence of the contrast media in the false lumen of the thoracic aorta (arrows), with no increase in the extent of the dissection.

(Figure 1D), and a third scan, obtained 5 months later, showed total resolution. During 7 months of follow-up, the patient reported no pain or new episodes of bleeding.

During endovascular procedures, iatrogenic aortic dissection can occur when the tip of the catheter is pushed into the vessel wall during catheterization, as well as when high-pressure jets of contrast media are directed toward the vessel wall. Although uncommon, iatrogenic aortic dissection accounts for approximately 5% of all thoracic aortic dissections<sup>(1,2)</sup>. In a review article, Ittrich et al.<sup>(3)</sup> showed rates of subintimal short segment dissection of the aorta during bronchial arteriography ranging from 1% to 6.3%<sup>(4,5)</sup>, although there are virtually no images of such dissections in the literature. There is no standard for the management of iatrogenic thoracic aorta dissection. Uncomplicated dissection of the descending thoracic aorta is a relatively benign process, and complete spontaneous resolution is observed in most cases. Pharmacological treatment to control pain and blood pressure is recommended, as is short-term follow-up with CT<sup>(6-8)</sup>.

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<http://dx.doi.org/10.1590/0100-3984.2015.0216>