

The patient was then referred to our hospital for a definitive diagnosis. The test for antineutrophil cytoplasmic antibodies was negative. The patient tested positive for rheumatoid factor, although the remaining laboratory tests revealed no significant alterations. Bronchoscopy with bronchoalveolar lavage was performed, and the bronchoalveolar lavage fluid tested negative for fungi by periodic acid-Schiff staining as well as for acid-fast bacilli by Ziehl-Neelsen staining; cultures were also negative. An open lung biopsy showed a cavitory subpleural nodule with extensive central necrosis and fibrosis with a hyaline aspect at the periphery, containing histiocytes and fibroblasts, consistent with a pulmonary rheumatoid nodule. The adjacent pulmonary tissue showed a moderate amount of interstitial mononuclear inflammatory infiltrate, with pneumocyte hyperplasia and mild interstitial fibrosis, consistent with nonspecific interstitial pneumonia. During hospitalization, the patient developed respiratory failure secondary to bacterial pneumonia, and she died in the intensive care unit.

Rheumatoid arthritis is a chronic, systemic inflammatory autoimmune disease, which is characterized by persistent inflammation of the diarthrodial joints with synovial hyperplasia that, if persistent, results in progressive joint destruction<sup>(1,2)</sup>. Approximately 40% of affected patients present extra-articular manifestations, pulmonary involvement being the second most common cause of death in such patients<sup>(1-3)</sup>.

Many recent studies published in Brazil have emphasized the importance of radiology in diagnosing thoracic diseases<sup>(4-8)</sup>. Rheumatoid nodules, usually subcutaneous, are the most common manifestation of rheumatoid arthritis. They are most common in male smokers and occur in approximately one third of HIV-infected patients. Although the nodules are typically found in periarticular areas exposed to pressure, they can also be found in other organs<sup>(3,9)</sup>. Pulmonary rheumatoid nodules are identical to the nodules found in subcutaneous tissue. They usually measure 0.5–5.0 cm in diameter, are located in peripheral areas of the upper or middle zones of the lungs, can undergo cavitation or calcification, can increase in size, and can even be spontaneously reabsorbed<sup>(1,2)</sup>. In most cases, they are asymptomatic and do not require specific treatment<sup>(3,9,10)</sup>.

Histologically, pulmonary rheumatoid nodules are similar to their extrapulmonary counterparts, with central necrosis, palisading of epithelial cells, mononuclear infiltrate, and vasculitis<sup>(2,9)</sup>. Pulmonary rheumatoid nodules should be differentiated from malignant and infectious processes, especially when there is only a solitary nodule. Therefore, radiological follow-up and occasionally a biopsy may be necessary to exclude malignancy<sup>(2,9)</sup>.

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#### Spontaneous dissection of the left gastric artery: a rare cause of abdominal pain

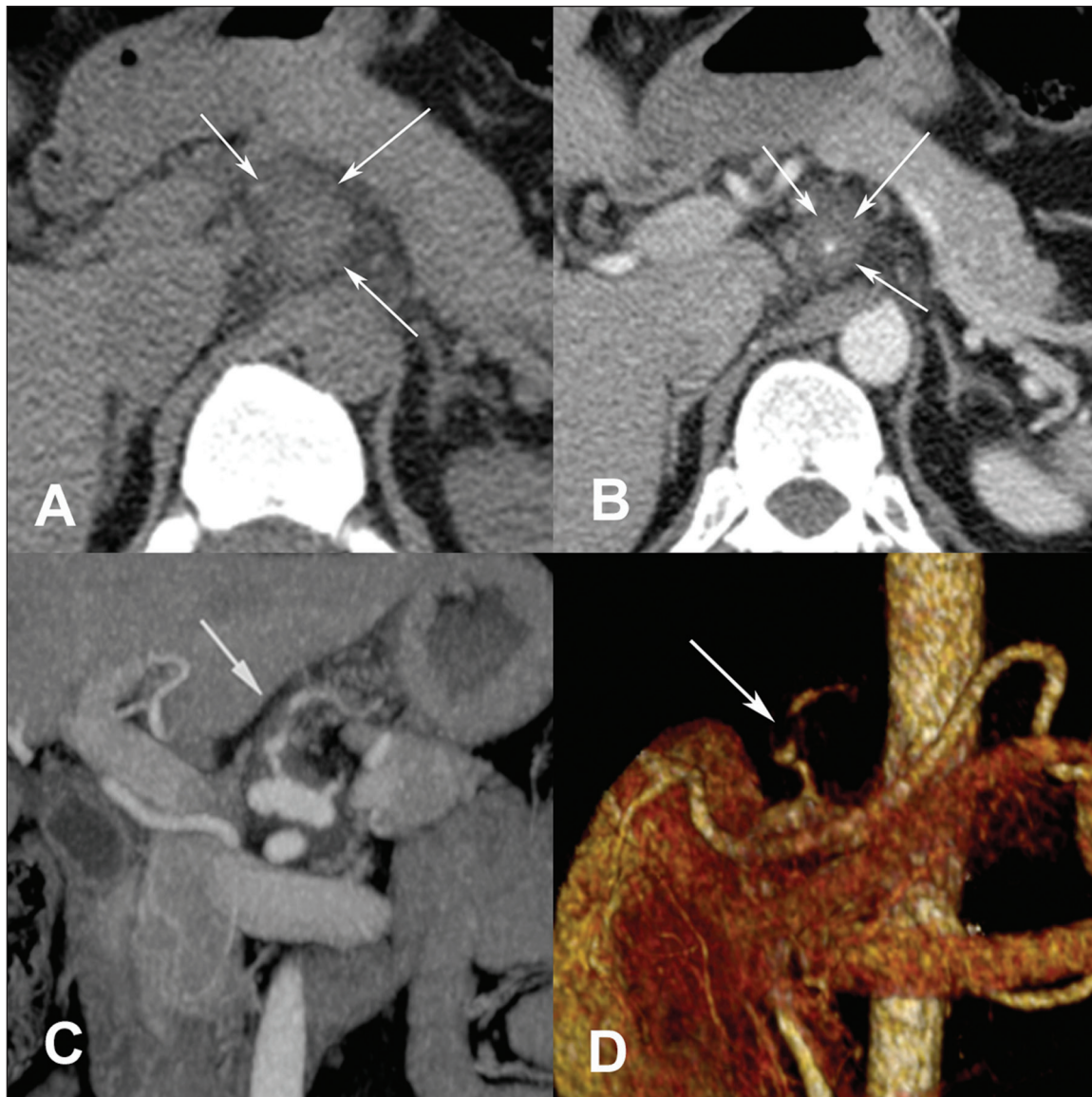
Dear Editor,

A 44-year-old man was admitted to the emergency department with a 12-h history of severe epigastric pain. He reported no history of trauma or fall. Physical examination revealed a flaccid abdomen, pain on deep palpation of the epigastrium, and no signs of peritoneal irritation. The results of laboratory tests, including a complete blood count, together with the determination of the levels of amylase and transaminases, showed no relevant changes. Upper gastrointestinal endoscopy showed signs of mild non-erosive distal esophagitis and moderate erosive antral gastritis, as well as some sessile hyperplastic polyps in the gastric body. An abdominal ultrasound did not show any changes. Because of persistent pain, the patient underwent abdominal computed tomography (CT) angiography, which showed high attenuation of the tissue before contrast administration (Figure 1A). Contrast-enhanced axial CT showed diffuse irregular thickening of the left gastric artery (Figure 1B). Multiplanar reconstruction

demonstrated eccentric thickening suggestive of false lumen thrombosis (Figure 1C). Three-dimensional (3D) reconstruction revealed diffuse irregular thickening of the left gastric artery (Figure 1D). These findings are consistent with a diagnosis of spontaneous dissection of the left gastric artery. No aneurysm formations or relevant anatomical variations were found in the evaluated arteries. A multidisciplinary group recommended conservative treatment (with anticoagulant/antiplatelet therapy and analgesics), hospital discharge, and outpatient follow-up.

Spontaneous dissection of a splanchnic artery is a rare event. Although several possible causes, including fibromuscular dysplasia, congenital connective tissue disorders, cystic medial necrosis, trauma, and hypertension, have been proposed, no strong association has yet been established<sup>(1,2)</sup>. Dissection of the superior mesenteric artery has been the most often described, although its incidence is estimated at only approximately 0.06%. To our knowledge, there has been only one reported case of isolated left gastric artery dissection without aneurysm formation<sup>(3)</sup>.

Acute abdomen has been the subject of recent publications in the radiology literature of Brazil<sup>(4-8)</sup>. CT angiography is the



**Figure 1.** **A:** CT showing high attenuation (50 HU) of the tissue before contrast administration, consistent with hepatic thrombosis. **B:** Contrast-enhanced axial CT showing diffuse irregular thickening of the left gastric artery. **C,D:** 3D multiplanar reconstruction showing eccentric thickening suggestive of false lumen thrombosis.

modality of choice for diagnosing cases with clinical suspicion of vascular pain. It is a rapid, noninvasive method that clearly shows vascular changes and possible anatomical variations<sup>(9)</sup>. New 3D reconstruction techniques help evaluate the extent of vascular involvement and improve the definition of a morphological pattern. Although considered a pathognomonic finding of spontaneous dissection, an intimal flap is not always clearly visualized in the images. Therefore, the diagnosis of dissection in such cases depends on a finding of false lumen thrombosis or eccentric mural thrombi.

There are several available treatment approaches to spontaneous dissection of a splanchnic artery, including conservative therapy with anticoagulation and blood pressure control; percutaneous endovascular interventions such as stent placement, embolotherapy, and intralésional thrombolytic therapy; and surgical interventions such as artery ligation, endoaneurysmorrhaphy, resection by laparotomy, and aortomesenteric bypass. Conservative management with anticoagulation is recommended as the first-line therapy. Endovascular treatment is indicated in cases

of progression of the dissection, luminal thrombosis, increasing aneurysmal dilatation of the artery, or persistent symptoms despite anticoagulation. Emergency laparotomy with surgical repair should be performed in patients with suspicion of low blood flow and bowel necrosis or ruptured artery<sup>(10-13)</sup>.

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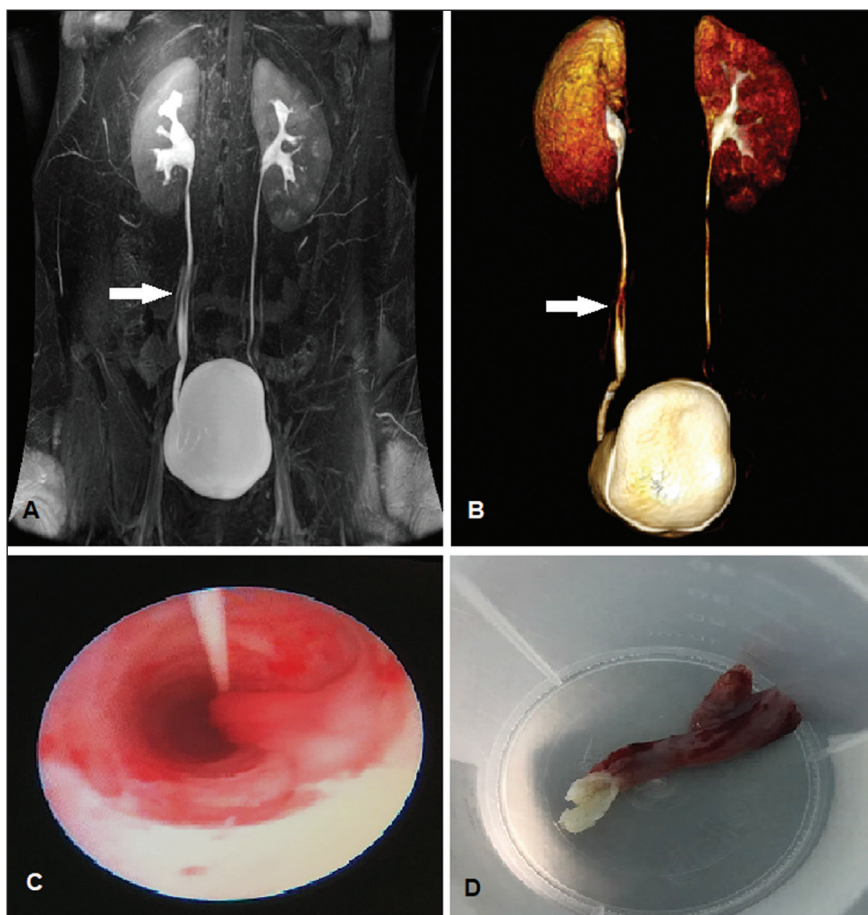
**Fibroepithelial polyp of the ureter: the value of magnetic resonance imaging of the urinary tract in diagnosis and therapeutic planning**

Dear Editor,

A 33-year-old woman presented with a five-month history of intermittent lumbar pain radiating to the suprapubic region. She reported no dysuria or hematuria. Computed tomography showed ureterolithiasis, and the patient was treated conservatively, which resulted in partial improvement. She evolved to worsening of the intensity and frequency of pain, together with pollakiuria. Physical examination revealed no significant alterations. A rapid urine test demonstrated erythrocytes in the urinary

sediment. Magnetic resonance imaging revealed an elongated polypoid formation, likely originating from the middle ureter, with inferior displacement, measuring approximately 4.8 cm in length (Figures 1A and 1B). Ureterscopy showed an intraluminal ureteral polyp (Figure 1C). The patient underwent endoscopic resection (Figure 1D), which was successful, resulting in improvement of the signs and symptoms. The pathology report confirmed the presumed diagnosis of fibroepithelial polyp (FEP).

Although tumors of the genitourinary tract are not uncommon<sup>(1–4)</sup>, primary tumors of the ureter are rare, accounting for only 1% of all tumors of the upper urinary tract. Benign lesions are even rarer, accounting for only 20% of all tumors of the ureter,



**Figure 1.** Coronal magnetic resonance imaging of the urinary tract (A) and three-dimensional reconstruction (B), showing an elongated polypoid formation with a probable origin in the middle ureter (arrow). C: Ureterscopy showing an intraluminal polyp. D: Macroscopic aspect of the lesion.