ities and in 75% of cases with bone alterations. The coexistence of chylothorax and lytic bone lesions may direct the diagnosis. The definitive diagnosis should be histological, as the evidence on radiological images coincide with other alterations of the lymphatic system, and mediastinal affection is rare. In the case of recurring chylothorax, drainage and pleurodesis are indicated, with the option of thoracic duct ligation to prevent complications such as malnutrition, pulmonary fibrosis and deteriorated respiratory function. In our case, we opted for ligation using a video-assisted thoracoscopic approach, which has not previously been reported in the literature in this pathology. Other treatments described are: radiotherapy, which causes sclerosis and fibrosis of the dilated lymphatic vessels, with good results; INTalpha2b; and bilateral lung transplantation. It is a progressive disease with a high rate of relapse and poor prognosis, and the main cause of death is lung function deterioration secondary to infection or pleuroperticardial effusion.

The case presented is especially unusual due to the age at which it debuted, which is the highest seen in the literature. It is also uncommon due to its clinical expression, with mediastinal lymphadenopathies and pleuroparenchymal affection from its onset, unlike the majority of the published cases. Minimally invasive surgery was used for the diagnosis as well as for the treatment with positive results, and it has been shown to be an effective technique with minimal morbidity and mortality. Despite the poor prognosis of the disease, 5 years after the treatment the patient has not presented new episodes of pleuroperticardial effusions, nor has he required hospitalization for other symptoms, currently presenting only exertional dyspnea.

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**References**


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**Letters to the Editor / Arch Bronconeumol. 2011;47(9):473–478**

**Bronchial Stenosis After Lung Transplantation**

*Estenosis bronquial postrasplante pulmonar*

To the Editor:

We have read with great interest the article recently published by Dr. Fernández-Bussy et al. about the treatment of airway complications after lung transplantation. The authors describe their experience over the course of 8 years and suggest a treatment algorithm to follow. In our opinion, the study deals with a topic that is currently of great relevance since, first of all, there has been an important growth in lung transplantation activity and, secondly, the possible airway complications that may occur in these patients are not always treated in centers that are specialized in such airway affections.

As the authors report, given stenosis of the bronchial anastomosis, endoscopic therapy using balloon dilation can be the first option for treatment, requiring the implantation of an endobronchial stent when, after 3 or 4 sessions, definitive results are not obtained. In our group, the most severe stenoses are treated with pneumatic dilation after previously performing radial cuts with electrocauterization in the fibrotic area of the stenosis, followed by the implantation of a stent in selected cases. In previous papers, our group has suggested that the local use of topical mitomycin C, after radial cuts with electrocautery and high-pressure balloon dilation, can avoid this latter measure in a selected sub-

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Fig. 1. Endoscopic treatment of post-lung transplantation bronchial stenoses in our center.

References


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