were detected on CT, described elsewhere as very unusual. The most common histopathological changes are airway inflammation and bronchiectasis. Our patient’s lung biopsy revealed foci of organizing pneumonia and necrobiosis nodules. These necrotic areas, seen on CT as abscesses, appeared sporadically during our patient’s clinical course. To date, flare-ups of organizing pneumonia associated with UC have been described, but necrobiosis nodules are rarer. Treatment of UC lung involvement is based on corticosteroids. Our patient’s response to corticosteroids was excellent, with complete clinical and radiological resolution after 2 weeks of treatment.

To conclude, this is a case of pulmonary involvement of UC, with an interesting presentation, due to exacerbations occurring with hemoptysis, respiratory failure and radiological images of migratory cavituated pulmonary nodules, with no associated clinical symptoms. Definitive diagnosis was based on lung biopsy results and response to steroid treatment was complete.

Conflict of Interests

The authors state that they have no direct or indirect conflict of interests with the contents of this manuscript.

References


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Mortality in Obesity-Hypoventilation Syndrome and Prognostic Risk Factors

Mortalidad en el síndrome de obesidad-hipoventilación y factores de riesgo pronóstico

To the Editor,

We read with interest the letter sent to ARCHIVOS DE BRONCONEUMOLOGÍA regarding our article “Noninvasive Mechanical Ventilation in Patients With Obesity Hypoventilation Syndrome. Long-term Outcome and Prognostic Factors”. We would like to thank the authors and venture to respond.

We agree that the lack of comorbidity data is the greatest limitation of this study, particularly since the main aim was to define prognostic factors for predicting mortality. However, this aspect was not taken into account in the preliminary design of the database, and we rejected the idea of a retrospective search in the clinical records that would have reduced the quality of our data. While including comorbidities in the analysis would have been interesting, this omission does not affect the results, namely, that patients with sleep apnea and those with better ventilatory function at the start of the ventilation program have the best prognosis.

With regard to the methodological concerns expressed by the authors of the letter, both initiation of ventilation and monitoring of ventilation mode comply with standard recommendations. Lowest pressure support (PS) was 10 cm H2O, gradually increasing to 16, depending on arterial blood gases and tolerance. If 90% saturation could not be achieved with the initial PS, oxygen supplements were added until saturation was 90%, while FiO2 was subsequently modified according to arterial blood gas and saturation achieved with the effective or maximum PS. The statistical tests for comparison were selected on the basis of the sample size and normal distribution, and nonparametric tests were used, assuming penalties.

Although all patients were included in the analysis of lung function and gas exchange outcomes until they left the ventilation program, the survival analysis was performed exclusively on patients who remained on ventilation until death (endpoint event). This means that patients who were withdrawn from the program due to poor compliance were not included in these analyses. As the authors of the letter rightly observe, and as confirmed in a
recently study,\textsuperscript{2} compliance is key to the success of noninvasive ventilation.

In our opinion, nighttime monitoring of patients is particularly important. While we agree that studies evaluating the benefits of polygraphy and/or polysomnography monitoring are needed, we are convinced that ventilator efficacy must be monitored in terms of PaCO\textsubscript{2}, the value directly related with alveolar ventilation. Our belief, corroborated by other authors,\textsuperscript{3} is that this type of monitoring is essential. It is a routine practice in our clinic, and early morning arterial blood gases are measured in the patient on ventilation both at the start of the ventilation program and in all follow-up visits.

In brief, although the study is limited by the lack of data evaluating the impact of comorbidity, we believe that it is important to have been able to show in a long term study that the severity of ventilatory impairment is a factor for poor prognosis in patients with obesity-hypoventilation syndrome requiring noninvasive ventilation, while concomitant sleep apnea constitutes a protective factor. PaCO\textsubscript{2} monitoring is essential for ensuring effective ventilatory support and obtaining good outcomes.

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References


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