

classical concept of the myositis-associated autoantibodies causing a recognizable pattern of disease. Even so, the evident pathogenic role of these antibodies (between 43% and 88% of the patients positive for anti-PM/Scl antibodies are diagnosed as having a myositis/scleroderma overlap syndrome) (Rajimakers et al, 2004) and the absence of other concurrent serological findings may strengthen the diagnosis. Further studies in larger cohorts are needed to define the clinical significance of anti-PM/Scl antibodies in autoimmune diseases. **BJHM**

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Vanderghelyst F, Ocmant A, Sordet C et al. Anti-pm/scl antibodies in connective tissue disease: clinical

LEARNING POINTS

- Anti-PM/Scl conditions, also called scleromyositis, usually combine features of myositis and scleroderma.
- Although clinical phenotypes are usually linked to specific serological markers, sometimes the clinical appearance does not match the expected picture.
- An inflammatory myopathy should be suspected and treated when the clinical picture and laboratory findings are consistent, even in the absence of biopsy findings.

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Images in Medicine

Hydropneumothorax and intrapulmonary metastases secondary to breast cancer recurrence

A 48-year-old woman, who had previously been treated for stage IIB progesterone-positive breast cancer, presented with a 3-month history of cough and worsening breathlessness. Examination revealed percussion dullness and reduced air entry in the right lung. Plain chest radiograph showed right-sided hydropneumothorax and multiple left-sided pulmonary nodules (*Figure 1*). Despite chest drain insertion, the right lung failed to re-expand.

Subsequent chest computed tomography revealed loculated hydropneumothorax and pleural thickening (*Figure 2a*). Additionally, the right lung was collapsed with ipsilateral areas of reduced enhancement, suggestive of a large metastasis occluding the right main bronchus and impinging the right pulmonary artery (*Figure 2b*).

Pleural aspirate analyses revealed an exudative effusion with no malignant cells or microorganisms. Biopsy of a distant metastasis and the lung pleura during

subsequent video-assisted thoracoscopy both showed breast adenocarcinoma confirming disease relapse. The lung was 'trapped' and decortication was inappropriate. The patient was offered palliative chemotherapy and PleurX drain for symptomatic control. **BJHM**

Figure 2. Chest computed tomography scans (chest drain in situ) showing (a) hydropneumothorax with multiple air–fluid levels and pulmonary nodules and (b) narrowed pulmonary artery and occluded right main bronchus as a result of a large metastasis (arrow).



Figure 1. Plain chest radiograph showing hydropneumothorax and multiple pulmonary nodules. Note artefacts from previous mastectomy visible in the right upper zone.



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