Intrapulmonary lipoma in children: A case report and literature review
Chunmei Zhu, Ling Cao. The Capital Institute of Pediatrics, Beijing, China

Objective: To help early diagnosis of lipoma in children by reporting a rare case of intrapulmonary lipoma in a child.

Case presentation: A 13-month-old boy was hospitalized because of cough and fever. Physical examination revealed rales and wheezing over his lungs. Chest
radiograph showed patchy infiltration and consolidation near his left hilar. Chest CT scan showed patchy infiltration and round-shape, hypodense homogeneous lesions located in the lower lobe of right lung without any calcification. After 19 days of antibiotics treatment, his clinical symptoms and signs disappeared, he underwent chest CT scan (Figure 1) again after treatment, and the result showed the patchy infiltration dissolved, however, the lesions in the lower lobe of right lung remained without any change. He was discharged. One month and one year later he was examined by chest MRI. The lesions were diagnosed as intrapulmonary lipoma by T2 weighted MRI images (Figure 2) with fat suppression.

Conclusions: Intrapulmonary lipoma can also be identified in children. Chest CT scan and MRI are very important for making correct diagnosis.

P3500
Munchausen syndrome by proxy presenting as unexplained hemoptysis: A report of two cases
Suleyman Tolga Yavuz1, Guzin Cine1, Ugur Ozcok1, Ebru Yalcin2
Deniz Dogrua2, Nural Kiper2. 1Department of Pediatrics, Pediatric Asthma and Allergy Unit, Hacettepe University, Ankara, Turkey; 2Department of Pediatrics, Pediatric Chest Diseases Unit, Hacettepe University, Ankara, Turkey

Hemoptysis is a serious symptom in early childhood and further investigation may be required in some cases. Munchausen syndrome by Proxy (MSBP) must be kept in mind particularly when suspicious behaviors of the supervisors are observed.

Case 1: A thirteen-month-old boy was admitted with recurrent hemoptysis. He was hospitalized because of persisting symptoms for four months, however no reason was found and he was subsequently discharged. Detailed history revealed that hemoptysis had occurred only in times when he was alone with his mother. Despite comprehensive diagnostic evaluation including laryngoscopy, Computerized Tomography, bronchoscopy and endoscopy, no definitive etiology was diagnosed. During his hospitalization, the mother reported new bleedings of the child and blood stained clothes were noticed. Examination of security footage revealed that the mother was sneakily obtaining the blood samples of another patient and deceiving medical staff.

Case 2: An-eight-month old girl was admitted with a history of having vomited blood for two months. Reluctance of her mother was noticed by the physician during history taking. Upper endoscopic investigation revealed linear hemorrhagic lesions at pharynx and tonsils. No definitive etiology was diagnosed despite comprehensive investigations. During hospitalization, the doctor witnessed that her mother was injuring the child with her finger and making her bleed. She was warned about security footage of the room and her complaints resolved spontaneously.

Munchausen syndrome by proxy is an unusual and difficult to identify cause of child abuse. It must be taken into consideration particularly in conditions with secondary gain of family members.

P3501
Thoracic splenosis – Case series and review of the literature
Nissim Arish1, Ariel Rockach1, Naama Bogot2, Irith Hadas-Halperen2, Gabriel Izhaki1. 1Pulmonology, Shaare-Zedek Medical Center, Jerusalem, Israel

Introduction: Splenosis is a rare finding of ectopic splenic tissue found within the thoracic cavity, abdomen or peritoneal cavity. In thoracic splenosis the splenic tissue most often grows in the form of a nodule and the auto-transplantation is usually caused by a previous penetrating or blunt trauma to the thoracic-abdominal region, resulting in splenic rupture.

Cases: We present three cases of thoracic splenosis. All the patients were Caucasian males aged 40-63 presenting with pleural masses that mimicked malignancy, who were eventually diagnosed as thoracic splenosis. All of them had a history of traumatic event to their upper abdomen which occurred 13-40 years ago resulting in splenectomy.

Methods: We made a Medline search in order to find all the cases of thoracic splenosis. We reviewed the cases in order to specify this rare condition.

Results: We found 39 case reports of patients diagnosed with thoracic splenosis. In the majority of the cases the patients are asymptomatic and are incidentally diagnosed with left hemithorax pulmonary lesions found via chest radiography or thoracic computed tomography. The average period of diagnosing thoracic splenosis from the time of trauma is roughly 21 years and ranges from 6 to 46 years. The diagnosis is challenging and the patients usually undergo extensive workload including surgical biopsy.

Conclusion: We conclude that splenosis is a rare entity but one should think about this possibility in a patient with a left thoracic mass and a history of abdominal trauma, splenic rupture and splenectomy.

Abstract P3502 – Table 1: Diagnosis, location, origin of arterial vessel, and symptoms

<table>
<thead>
<tr>
<th>Patient</th>
<th>Diagnosis</th>
<th>Location</th>
<th>Origin of Vessel</th>
<th>Follow up yrs</th>
<th>Exacerbations</th>
<th>Life threatening events</th>
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<tbody>
<tr>
<td>1</td>
<td>MDCTA, MRA, Gallium Scan, CT guided Biopsy</td>
<td>LLL</td>
<td>TA</td>
<td>11</td>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>MDCTA</td>
<td>RLL</td>
<td>TA</td>
<td>5</td>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>3</td>
<td>MDCTA, PET-CT</td>
<td>LLL</td>
<td>Abdominal Aorta/Celiac trunk</td>
<td>6</td>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>4</td>
<td>MDCTA, PET-CT</td>
<td>LLL</td>
<td>TA</td>
<td>1</td>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>5</td>
<td>MDCTA</td>
<td>LLL</td>
<td>TA and Celiac Trunk</td>
<td>6</td>
<td>2</td>
<td>None</td>
</tr>
</tbody>
</table>

CTA, computer tomography angiography; PET, Positron Emission Tomography; LLL, Left lower lobe; RLL, Right lower lobe; TA, Thoracic Aorta.

P3502
Pulmonary sequestration in asymptomatic adults; a plea for conservative observation
Artemios Dimirou, Yehudit Rozensen, Issahar Ben Dov. Pulmonary Department, Sheba Medical Center, Tel Aviv; Israel Radiology Department, Sheba Medical Center, Tel Aviv; Israel Pulmonary Department, Sheba Medical Center, Tel Aviv, Israel

Background: Pulmonary sequestration (PS) is a rare congenital anomaly. Due to recurrent infections, the treatment in children is surgical removal of the sequestrated lung and this recommendation expands to adulthood.

Objective: To test if asymptomatic or mildly symptomatic adults with PS could be offered conservative follow up instead of surgery.

Methods: We conducted a case series analysis of all patients above 20 yrs old, with sequestration seen in our institute from 2000-2012. Diagnosis, symptoms, patient characteristics, natural course and treatment were reviewed.

Results: During a median follow up of 7.8yrs, no major infection occurred and the lesion size remained unchanged in 4/5 patients while mild infection that resolved with oral antibiotics was noted in 1/5.

Conclusion: In asymptomatic or mildly symptomatic adult patient with lung sequestration, conservative follow up instead of surgery is a legitimate option.

P3503
Acquired tracheoesophageal fistula – A rare cause of chronic episodic cough
Amishesh Gupta1, Saurabh Kansal2, A.P. Kansal1, Bidhi Chandel1. 1Chest and Tuberculosis, Govt. Medical College, Patiala, Punjab, India; 2ENT, Dayanand Medical College, Ludhiana, Punjab, India

Introduction: Acquired tracheoesophageal fistula (TOF) is a rare entity and occurs as a result of trauma, malignancy, granulomatous infection, any previous surgery of trachea and esogastros. Symptoms include uncontrolled coughing after swallowing. The majority of acquired fistulas occur at cervico-thoracic junction.

Case report: We report a case of 55 yr female who presented to us with cough and regurgitation particularly after intake of liquids since two mths. There was no history of tuberculosis or malignancy. Patient was on antihypertensive agent for four mths but not on ACE inhibitors. On routine investigations TLC and ESR were rased but chest xray was normal.

Sputum was negative for AFB. Patient was managed on lines of Gastro Esophageal Reflux Disease with no improvement. CECT chest showed consolidative changes. Nothing significant found in upper GI endoscopy. Barium swallow revealed the passing of contrast into trachea and in bronchi, showing the presence of tiny fistula at C3-C4 vertebral level. Due to higher position of fistula, patient was advised to undergo surgery.

Discussion: An acquired TOF bypasses the laryngeal protection and leads to repeated aspiration. We are reporting a rare case of acquired TOF possibly of infective etiology which is a rare occurrence at such a age. It was also the cause of chronic episodic cough in this patient which was not relieved with various treatments. Malignant and traumatic causes have now superseded infection. Barium swallow will demonstrate the defect in 70% of lesions. The management of acquired TOF involves minimizing further aspiration to prevent pulmonary infections. Definitive management involves stenting or surgical repair with treatment of underlying cause.

Conclusion: In asymptomatic or mildly symptomatic adult patient with lung sequestration, conservative follow up instead of surgery is a legitimate option.
P3504
An unusual cyst of posterior mediastinum: Mullerian cyst
Mehmet Dukak1, Barış M. Poyraz2, Safak Bulut3, Cihan Özger4, Selçuk Bilgin1, 1Thoracic Surgery Department, Private TOBB ETU Hospital, Ankara, Turkey; 2Chest Diseases Department, Private TOBB ETU Hospital, Ankara, Turkey; 3Pathology Department, Private TOBB ETU Hospital, Ankara, Turkey; 4Intensive Care Unit, Private TOBB ETU Hospital, Ankara, Turkey

In this case, we report a newly categorized mediastinal cyst called Mullerian cyst, which was reported for the first time by Hattori et al in 2005. A 51-year-old female patient was admitted to our hospital with the complaint of dysphagia. T2-weighted chest magnetic resonance imaging (MRI) showed a cystic lesion attached to the vertebral column in the posterior mediastinum.

The patient underwent right thoracotomy. The cyst was tightly attached to esophagus and corpus of the 5th thoracic vertebra. The intact cyst was freed from posterior mediastinum.

It was lined by a ciliated tubal-type epithelium and had a thin wall composed of smooth muscle. The epithelium showed estrogen and progesterone receptor expressions immunohistochemically. Mullerian cysts arise from remnants of the Mullerian duct and can be located anywhere along the path of Mullerian duct regression. Pelvis is the most common localization and their occurrence in the mediastinum is extremely rare. However mediastinal mullerian cyst is newly known entity, it should be kept in mind for the differential diagnosis of posterior mediastinal cysts.

P3505
First presentation of a case of pulmonary alveolar microlithiasis with spontaneous pneumothorax
Nashe Sigari1, Shilan Mohammadi2, 1Internal Medicine, Kurdistan University of Medical Sciences, Sanandaj, Kurdistan, Islamic Republic of Iran; 2Pediatric Medicine, Kurdistan University of Medical Sciences, Sanandaj, Kurdistan, Islamic Republic of Iran

Pulmonary Alveolar Microlithiasis (PAM) is a rare disease of unknown etiology. It is characterized by the presence of small calcified nodules within the alveolar space. Clinical features vary and some patients may be asymptomatic for a long time with subsequent occurrence of dyspnea, dry cough, chest pain, and ultimately, respiratory failure. Recurrent spontaneous pneumothorax is a late complication of the disease. Herein we report a case of alveolar microlithiasis in a 42-year-old male whose first presentation was the symptoms of pneumothorax. He was admitted with sudden onset dyspnea and right sided pleural chest pain. After treatment of pneumothorax with insertion of chest tube, pulmonary function revealed normal indices. The chest radiograph demonstrated diffuse confluence of dense micronodular infiltrate. High-resolution CT scan revealed diffuse ground glass attenuation and calcifica-

P3506
Benign metastatic leiomyosarcoma of uterus with lung damage
Ivetta Dvorakovskaya, Dali Dzadzua, Irina Platonova. Laboratory of Pathomorphology, Research Institute of Pulmonology, St. Petersburg, Russian Federation

Benign metastasizing leiomyosarcoma of uterus is difficult to diagnosis extrauterine metastatic leiomyomatous lung lesion without histologic signs of malignancy. Aim: To present a rare case of uterus leiomyosarcoma metastasizing into the lungs that shows difficulties in diagnosis and choice of adequate treatment.

Materials and methods: The woman, 46 year, was subjected to hysterectomy with uterine appendages in 2004. Through 5 years multiple masses were observed on the thorax x-ray that interpreted as lung metastases. With videothoracoscopic marginal resection of S4 on the right was performed. Histological sections were stained with hematoxylin-eosin and van Gisone. Immunohistochemical study was performed.

Results: Histological study revealed leiomyosarcoma consisting of many small nodules of leiomyomatosis proliferation with multicellular foci, tendency to myxomatosis, and nuclear changes (polymorphism, blurred nuclear membranes, variety of chromatin content). Mitoses were absent. The histological structure of nodes removed from lungs and uterus was identical. High expression of antibodies to smooth muscle actin (SMA), expression of receptors ESR and PR in uterine and pulmonary nodes indicated histological identity of the process that allows us to estimate changes in the lungs as metastasis. The patient was recommended hormone therapy (aminoestrin drugs in combination with tamoxifen).

Conclusion: Immunohistochemical study is necessary to determine the exact diagnosis of benign metastasizing leiomyosarcoma of uterus with lung damage.

P3507
Hyper eosinophilic syndrome in a young female – A rare disorder
Yamawar Anand1, Ram Chopra1, Nita Mundhi1, Nuti Wadekar2, Vaibhav Pandhurkar, Chintan Patel, Sharad Patil1, Manisha Bhole1, 1Chest Medicine, Ruby Hall Clinic, Pune, Maharashtra, India; 2Pathology, Ruby Hall Clinic, Pune, Maharashtra, India

Hyper eosinophilic syndrome (HES) is characterized by blood eosinophilic count 1500 or more for 6 months & eosinophilic infiltrations of multiple organs like heart, bone marrow, skin, CNS. We report a unique case, rare in a female Case report: 20 years old female had progressive dyspnoea since 1 year. One report with her showed peripheral eosinophilia of 27% Respiratory system revealed signs of left pleural effusion with fluid eosinophilia Evaluated for this presentation Absolute eosinophilic count was 2750 cells. PFT/ECG were normal CT thorax revealed RA thrombus & RV infiltrations and cardiac MRI showed typical endomyocardial fibrosis in RV. Echo showed RA thrombus & apical fibrosis in RV. HES was considered strong possibility. Bone marrow showed 37% eosinophils, no blast cells.

Other causes of eosinophilia were ruled out. Diagnosis of HES was confirmed. BCR-ABL & FIP1L1-PDGFRα-a fusion gene were negative. Patient responded to oral steroids & azothoprime.

Discussion: Multiple organ involvement with eosinophilia is an important diagnostic criterion of HES. Malignant transformation is known. Early diagnosis, identification of disease variant are required to prevent fatal outcome.
A rare cause of hemoptysis: Munchausen syndrome

Guzen Cinel1, Salehman Tolga Yavuz2, Ugor Ozcelik3, Ebubakir Yakcin4

Hemoptysis is a serious and sometimes life-threatening symptom that requires broad evaluation, including invasive procedures. Nevertheless, in a group of patients, the cause of hemoptysis may not be elucidated despite extensive investigations. Factitious hemoptysis is a manifestation of Munchausen syndrome that describes a group of patients who intentionally produce or feign symptoms or disabilities; and it must be kept in mind in the differential diagnosis of unexplained hemoptysis.

We report 5 patients diagnosed as Munchausen syndrome who complained of severe, sudden-onset hemoptysis. Here we describe patients No. 1 and No. 2, who were referred to our institution due to severe, sudden-onset hemoptysis.

Patient No. 1: A 35-year-old female was admitted to our institution with a history of severe, sudden-onset hemoptysis. She had a history of panic disorder and was treated with benzodiazepines and selective serotonin reuptake inhibitors. Despite this, her symptoms persisted and she was referred to our institution. On examination, she was found to have a normal lung examination, with no signs of infection. Chest X-ray and CT scan revealed no abnormality. Pulmonary function tests were normal. Arterial blood gas analysis showed a normal pH and oxygen saturation. Bronchoscopy showed no abnormality.

Patient No. 2: A 28-year-old male was admitted to our institution with a history of severe, sudden-onset hemoptysis. He had a history of panic disorder and was treated with benzodiazepines and selective serotonin reuptake inhibitors. Despite this, his symptoms persisted and he was referred to our institution. On examination, he was found to have a normal lung examination, with no signs of infection. Chest X-ray and CT scan revealed no abnormality. Pulmonary function tests were normal. Arterial blood gas analysis showed a normal pH and oxygen saturation. Bronchoscopy showed no abnormality.

Conclusion: Munchausen syndrome should be considered in the differential diagnosis of hemoptysis of unclear etiology, especially when accompanied by changing symptoms and in patients with a calm demeanor despite dramatic complaints.

Eosinophilic pneumonia – Our own experience with diagnosis and treatment

Jan Plutinsky, Ivan Margret, Stanislav Majernik, David Magula, Frantisek Dvorak. 2nd Pneumology, Specialized Hospital of St.Zoerardus, Nitra, Slovakia (Slovak Republic)

Eosinophilic pneumonia (EP) is a rare disease. Some EP could be caused by concomitant diseases (CD), while in others the cause is unclear (idiopathic). EP is divided into acute (AEP) and chronic (CEP) forms.

The aim: The authors share their own experience with EP diagnosis and treatment.

Methods: EP was diagnosed in 23 patients (pts). Clinical examination, X-ray, CT, laboratory examinations with a peripheral blood count of eosinophils (Eo), microbiology, mycobacteriology, fiberobronchoscopy or histology were used. The pts were divided into two groups: AEP and CEP Statistical analysis was performed.

Results: 15 F, median age 66 yrs (36-87) and 8 M, median 67 yrs (55-85) had one of the two forms: AEP in 7 pts and CEP in 16 pts. The main clinical symptoms were dyspnoe in 20 pts (95.2%), cough in 19 pts (90.5%), fever in 17 pts (80.9%), pain in 5 pts (23.8%). AEP or CEP was the result of CD in 3 pts (toxoplasmo- sis), in 1 pt with sarcoidosis, rhinitis and in 2 with allergic bronchopulmonary aspergillosis. In 17 pts CD was identified. A statistical significance was found between the age of pts with AEP (56.1±12.2) and CEP (67.6±12.9) (p<0.05). There were no statistically significant differences between the groups of AEP and CEP in the expression of the CD such as: bronchial asthma (43.6 % vs 43.1%), COPD (21.4% vs 18.2%), Pneumocystis carinii pneumonia (6.7% vs 12.5%) and in the groups of AEP (860.7±976.7) and CEP (570.6±429.3). 11 pts have been continually treated with corticosteroids, 8 pts temporally. The longest treated patient has been receiving corticosteroid for more than 13 yrs.

Conclusions: EP is a very interesting disease. Treatment with antibiotics is unsuccessful, but corticosteroid treatment leads to a dramatic improvement. Dividing EP into AEP and CEP is not so clear cut.
Case: A 38-year old female with no relevant medical history was referred to internal medicine with clinical features comparable with Cushing’s syndrome. Laboratory results suggested ectopic adrenocorticotropic hormone (ACTH) production. The pituitary gland had a normal aspect on magnetic resonance imaging but computed tomography of the chest showed a smooth, oval mass in the posterior mediastinum and a node in the left upper lobe. Differential diagnosis consisted of carcinoid, small cell lung cancer or neurogenic tumor. Bronchoscopy showed no endobronchial lesions but both lesions could not be reached with fluoroscopic guidance. On 18F-deoxyglucose positron emission tomography (18F-FDG-PET) increased 18F-FDG uptake was seen in the mediastinal mass and in the right gluteal region, but not in the left upper lobe. Somatostatin scintigraphy showed uptake in the left upper lobe, but not in the other masses. Histological biopsy of the gluteal mass showed a desmoid type fibromatosis. Wedge resection with peroperative frozen section of the left upper lobe mass was performed and a typical carcinoid metastases was found. The mediastinal mass appeared to be a schwannoma.

Conclusion: Cushing’s syndrome caused by ectopic ACTH in a T1aN2M0 typical carcinoid. Furthermore, the two PET-positive lesions appeared to be a schwannoma and a desmoid type fibromatosis. This case stresses the importance to link presenting condition with imaging features and to obtain histological confirmation.

Conclusion: ECD should be considered in the differential diagnosis of interstitial lung diseases. As there is no standard treatment for this disorder, interferon-alpha can be effective in the treatment of Erdheim-Chester disease.

P3514 Three tumors in a young woman with Cushing’s syndrome Lizza Hendriks1, Remy Mostard1, Eric van Haren1, Linda van de Winkel1, Patrick van Battum1, Wendy Schreurs1, 2Pulmonary Medicine, Atrium Medical Centre, Heerlen, Netherlands; 2Internal Medicine, Atrium Medical Centre, Heerlen, Netherlands; 3Nuclear Medicine, Atrium Medical Centre, Heerlen, Netherlands.

Background: A 38-year old female with no relevant medical history was referred to internal medicine with clinical features comparable with Cushing’s syndrome. Laboratory results suggested ectopic adrenocorticotropic hormone (ACTH) production. The pituitary gland had a normal aspect on magnetic resonance imaging but computed tomography of the chest showed a smooth, oval mass in the posterior mediastinum and a node in the left upper lobe. Differential diagnosis consisted of carcinoid, small cell lung cancer or neurogenic tumor. Bronchoscopy showed no endobronchial lesions but both lesions could not be reached with fluoroscopic guidance. On 18F-deoxyglucose positron emission tomography (18F-FDG-PET) increased 18F-FDG uptake was seen in the mediastinal mass and in the right gluteal region, but not in the left upper lobe. Somatostatin scintigraphy showed uptake in the left upper lobe, but not in the other masses. Histological biopsy of the gluteal mass showed a desmoid type fibromatosis. Wedge resection with peroperative frozen section of the left upper lobe mass was performed and a typical carcinoid metastases was found. The mediastinal mass appeared to be a schwannoma.

Conclusion: Cushing’s syndrome caused by ectopic ACTH in a T1aN2M0 typical carcinoid. Furthermore, the two PET-positive lesions appeared to be a schwannoma and a desmoid type fibromatosis. This case stresses the importance to link presenting condition with imaging features and to obtain histological confirmation.

P3515 The treatment of a non-Langerhans-cell histiocytosis, Erdheim-Chester disease: A case report Dane Ediger1, Asli Gerek Dilektasli1, Ahmet Ursavas1, Duygu Koprucuoglu1, Saduman Balaban Adım1, Cengizhan Gokalp1, Ugur Yayla2, Ercument Ege1.

1Department of Pulmonary Diseases, Uludag University Faculty of Medicine, Bursa, Turkey; 2Department of Pathology, Uludag University Faculty of Medicine, Bursa, Turkey; 3Department of Radiology, Uludag University Faculty of Medicine, Bursa, Turkey; 4Department of Ophthalmology, Uludag University Faculty of Medicine, Bursa, Turkey.

Erdheim-Chester disease (ECD) is a rare, non-Langerhans histiocytosis with multi-system involvement. Pulmonary involvement is uncommon. We present a 46-year-old woman who presented with chronic cough, dysnea and yellowish plaques in the peribronchial area. She was previously diagnosed as diabetes insipidus. Chest radiographs showed bilateral diffuse interstitial infiltrates. Symmetric sclerotic bone lesions, dural nevre thickening were defined on imaging studies. Histopathologic examination of the skin lesions revealed infiltration of CD68 positive foamy histocytes. She was diagnosed as ECD with pulmonary, pituitary, skeletal, orbita, central nervous system and skin involvement. Follow first-line treatment with corticosteroids her syptoms worsened. Treatment of infections and immunoglobulin replacement therapy. Results: The only viable option of airway management. An MRI scan of the neck revealed a right sided cervical mass of 7x3cm, as well as an enlarged lymph node in the right supraclavicular region (R1). Biopsy was performed both of the lymphnode (core needle biopsy) and the laryngeal mass (EBUS-TBNA). The histological and immunohistochemical findings were consistent with metastasis of the known multiple myeloma. Extramedullary metastasis of multiple myeloma is a rare complication of the disease occurring. Laryngeal stenosis due plasmocytoma has been described in pediatric patients, but never in adult patients before.

P3517 Urinary incontinence in adult bronchiectasis patients: Common but treatable Jonathan Miller1, Hilary Tedd1, Jackie Rees2, Anthony DeSoyza1.

1Bronchiectasis Service, Newcastle NHS Foundation Trust, Newcastle, United Kingdom; 2Continence Service, Newcastle NHS Foundation Trust, Newcastle, United Kingdom.

Background: Patients suffering from urinary incontinence (UI) often avoid seeking medical attention, due to embarrassment, consequently remaining untreated. UI negatively impacts of quality of life, psychological health and relationships. In patients with non-CF bronchiectasis, it may also reduce adherence to chest physiotherapy. UK Physical therapy guidelines (2009) suggests screening for UI in patients with non-CF bronchiectasis.

Methods: Screening at new specialist bronchiectasis clinic for symptoms of UI and referral onto Continence specialist services. Results: Of the initial 116 patient referred to the bronchiectasis service, 76 were female. 55% of female patients had UI (UI-Br). 87.5% of UI-Br patients reported symptoms for over 5 years, with 40% of patients describing symptoms of over 10 years duration. 37% reported UI as having a terrible impact on quality of life. Patients were assessed by a Continence Nurse Consultant. A personalised UI management plan was formulated, including education on pelvic floor strengthening, urge suppression and voiding techniques. Other techniques used included bladder retraining (40%) and toilet reschuling (40%). Over 60% of patients have been discharged by the Continence Service, following symptom improvement.

Conclusions: In asking about UI, in line with UK guidelines, we identified symptomatic patients and referred them onto an appropriate specialist service. We identified a high prevalence of UI in female patients with non-CF bronchiectasis. Patients suffered symptoms for a prolonged period with a significant impact on quality of life. Through appropriate specialist input, these distressing symptoms have been improved in the majority of our patient group.

P3518 Hypogammaglobulinemia, reduced B cell count and recurrent sinopulmonary infections: Good’s syndrome Murat Türk, Nurdan Köşkütür, Numan Ekim. Pulmonary Medicine, Gazi University School of Medicine, Ankara, Turkey

A 62-year-old woman with a history of thymectomy for capsule-invasion-free, type AB thymoma, presented with cough, dyspnea and fever. She had frequent respiratory tract infections for 9 months. Her initial physical examination was normal. Abnormal laboratory studies on admission were anemia, leukocytosis, proteinuria, elevated erythrocyte sedimentation rate, C-reactive protein and procalcitonin levels. On chest tomography, multiple mediastinal and hilar lymph nodes, bilateral traction bronchiectasis and milimetric nodules were seen. E.Coli was isolated in bronchoalveolar lavage. TBNA and TBB were negative for probable thymoma metastasis.

For the probability of Good’s Syndrome, serum immunoglobulin levels were measured and found normal for IgA, low for IgG and high for IgM. Flow cytometry demonstrated 8% of CD19+, 12% of CD56+, 14% of CD57+, 30% of CD4+, 37% of CD8+ cells in total lymphocytes; consistent with B-cell immunodeficiency. With the diagnosis of Good’s Syndrome, intravenous immunoglobulin treatment was started. During her follow-up, she was hospitalized twice for respiratory tract infections. Now she is on ciprofloxacin prophylaxis. Good’s syndrome is a rare cause of combined B or T cell deficiency. Its main characteristic is hypogammaglobulinemia, reduced or absent B cells, reduced serum levels of IgA, IgG and IgM, recurrent sinopulmonary infections caused by encapsulated microorganisms. Management of syndrome includes surgical resection of thymoma, treatment of infections and immunoglobulin replacement therapy. Good Syndrome is a rare but treatable condition and it should be considered in patients with the diagnosis of thymoma and frequent respiratory tract infections.