

Superior Vena Cava Syndrome[☆]



Síndrome de vena cava superior

Dear Editor:

The differential diagnosis of facial edema and erythema is broad and includes diseases with variable outcome that may require urgent attention. We report 2 cases of patients in whom these clinical symptoms were signs of neoplastic disease.

The first patient is a 59-year-old woman with a past history of breast and lung cancer 6 years earlier, who presented palpebral and facial erythema and edema that had appeared 1 month earlier. The patient was being studied due to a probable angioedema and was receiving treatment with topical corticosteroids and antihistamines, with gradual worsening of the condition. The physical examination revealed an edema in the cervical region and upper chest, together with collateral circulation (Fig. 1). Computed tomography of the chest revealed an infiltrating mass enclosing and con-

stricting the superior vena cava (Fig. 2). Subsequent studies confirmed a recurrence of the patient's lung cancer.

The second patient is a 69-year-old woman with a past history of allergic rhinitis, who visited the emergency department with a palpebral and facial edema that had appeared 15 days earlier. She had undergone treatment with oral corticosteroids and antihistamines due to suspected angioedema, with no response. She reported weight loss of 5 kg in 6 months and stated that she was a smoker. Physical examination revealed edema of the face and neck, and right jugular vein distention (Fig. 3). A chest x-ray showed a hilar mass causing complete atelectasis of the right upper lobe (1B). Computed tomography of the chest confirmed a mediastinal infiltrate and obstruction of the superior vena cava. Subsequent studies confirmed the diagnosis of lung cancer.

In superior vena cava syndrome (SVCS), vascular infiltration by a mass (most frequently tumor) obstructs venous flow to the right atrium and causes gradual edema of the face and upper extremities, and may be associated with reddening.¹⁻³ Distention of veins in the torso and neck, which worsens in the supine position, makes it possible to differentiate it from

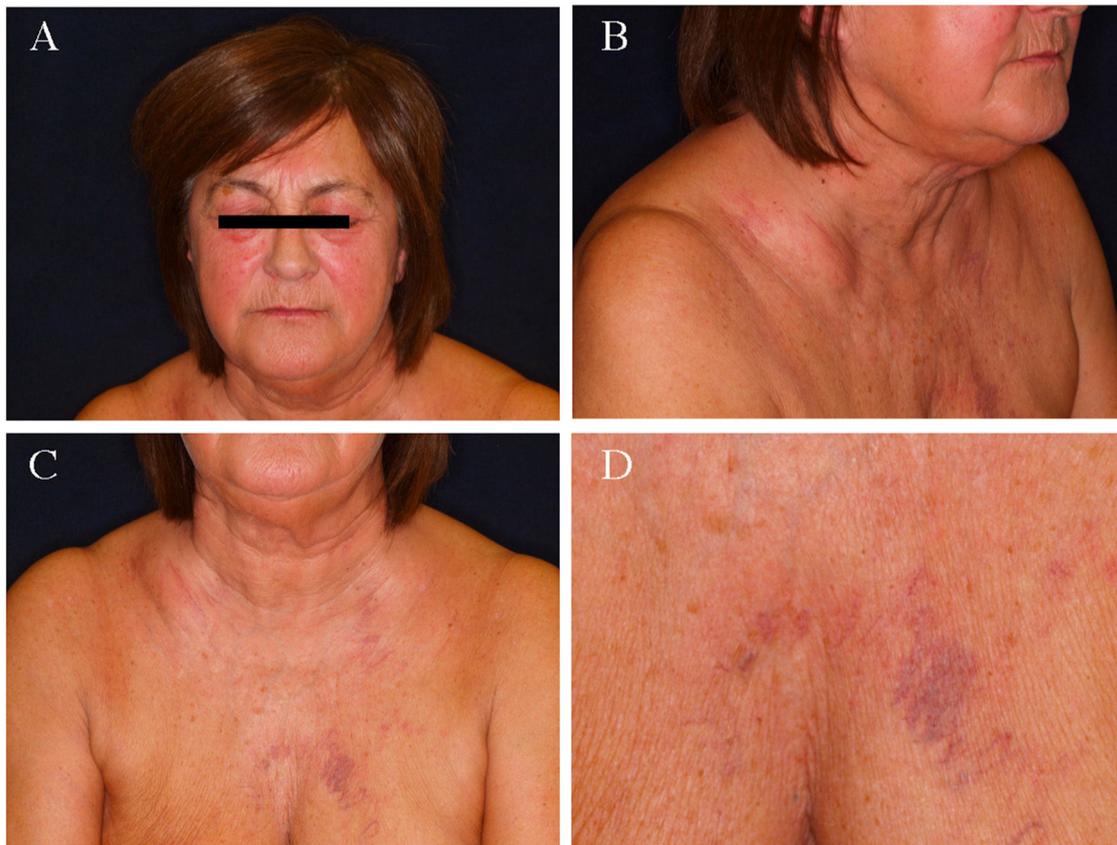


Figure 1 Clinical images. A, Periocular and bimalar edema and erythema. B and C, Edema of the face and neck, notable in the cervical and clavicular regions. D, Collateral venous circulation in the region of the sternum.

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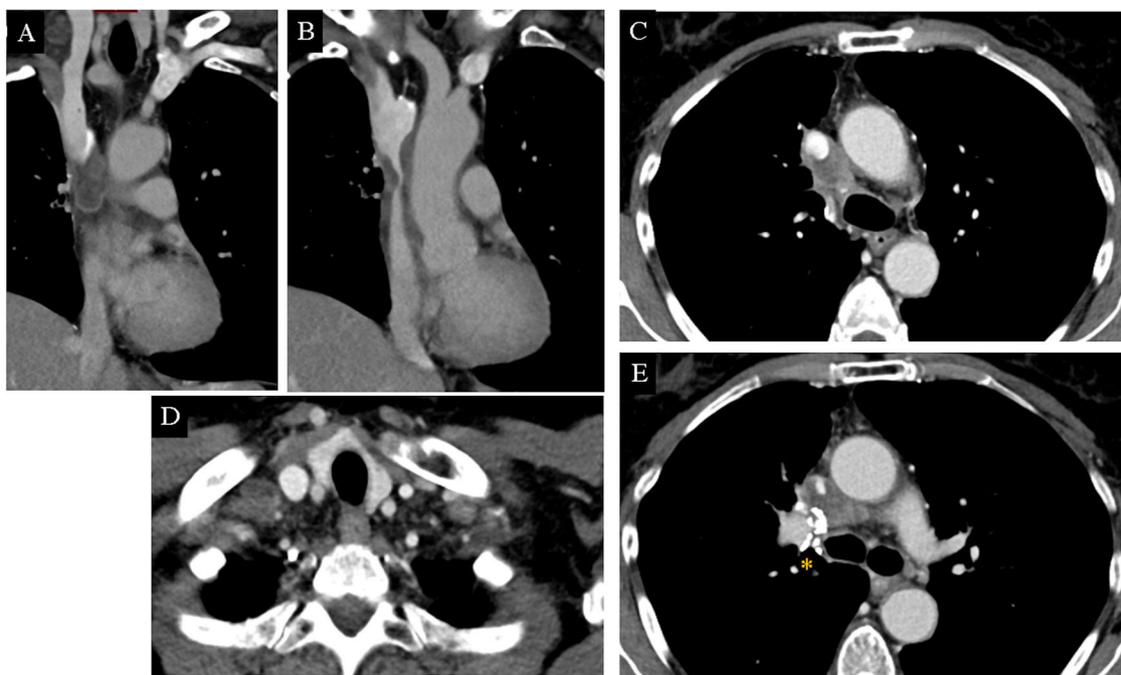


Figure 2 Computed tomography of the lungs in the first patient. Coronal (A and B) and axial (C-E) view of mediastinal window. An infiltrating mass can be seen, enclosing and constricting the superior vena cava from the arch of the azygos vein to where it enters the right atrium (yellow circles and arrows). Image D shows a hypodense diseased lymph node in the right supraclavicular fossa (arrow tip). Surgical clips from past right upper lobectomy (asterisk).

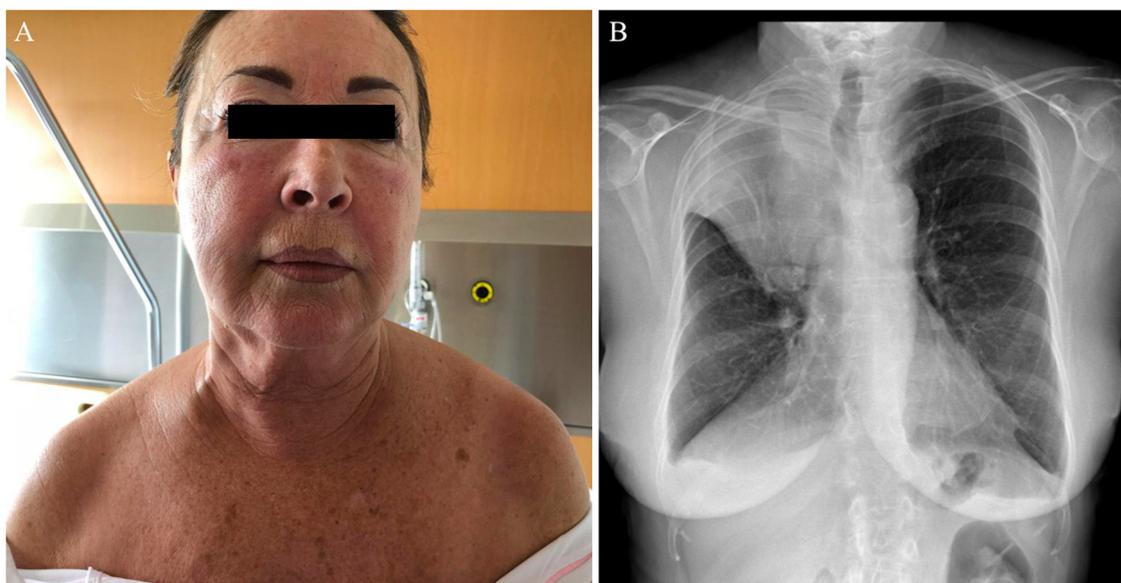


Figure 3 Clinical and radiologic image of the second patient. A, Facial erythema and edema of the face and neck. B, Posteroanterior chest x-ray. Golden S-sign. Obstructive atelectasis of the right upper lobe in the context of a right hilar lung mass. Right pleural effusion.

other diseases. Imaging tests usually confirm the diagnosis.³ This is an entity in which signs on the skin may indicate an internal tumor, as also occurs with other cutaneous manifestations in the context of lung cancer.⁴

In the 2 patients described, the first diagnosis was angioedema, a sudden inflammation of the skin, sub-

cutaneous tissue, or mucosa due to increased capillary permeability.^{5,6} Facial edema, however, usually persists for weeks and does not respond to antihistamines. It is not usually due to angioedema. Nevertheless, we have found this incorrect diagnosis of angioedema in SVCS repeated in the literature.⁷⁻⁹

Diagnostic failure in SVCS can lead to inappropriate treatment of the real disease, which may be severe in some cases, as in those reported here.

Other entities to consider in the differential diagnosis include dermatomyositis, which was another of the principal suspected diseases in the first case described and which was the reason for performing a skin biopsy and myositis antibody assay, with no findings. Heliotrope rash, shawl sign, and their potentially paraneoplastic nature may be similar to SVCS. But the other manifestations, such as myositis and Gottron papules, may help to differentiate it.

Other entities that should be considered due to their potential to cause facial erythema or edema include acute contact dermatitis, which typically affects the skin surface, and exanthema caused by drug reaction with eosinophilia and systemic symptoms (DRESS), in which skin involvement tends to be generalized. These and other diseases that rarely produce facial edema (such as rosacea, hypothyroidism, subcutaneous emphysema, orofacial granulomatosis, urticaria, hypocomplementemic vasculitis, systemic capillary leak syndrome, and histaminergic headache) must be considered in the differential diagnosis.³

In conclusion, we report 2 patients with SVCS secondary to a tumor, which illustrate the importance of considering this syndrome in the differential diagnosis of facial or cervical edema, in which a thorough patient history and complete examination are essential.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Switching From One Anti-IL-17 Antibody to Another: On Trying Again or Changing the Target[☆]



De un anti-IL-17 a otro: dar una segunda oportunidad o cambiar de diana

To the Editor,

Psoriasis is a chronic inflammatory skin disease that can be treated with several currently available drugs. Until November 2018, the 2 anti-interleukin (IL) 17 drugs available in

Spain were secukinumab and ixekizumab. There is little evidence on whether the lack of response to either of these drugs can also predict the response to other drugs with the same mechanism. The literature shows that affected patients could benefit from treatment with the other available drug,^{1–4} although there are no clear guidelines on which is the best treatment after failure of an initial biologic drug.⁵ The objective of our study was to determine whether the inefficacy or loss of efficacy of one of the anti-IL-17 drugs points to the failure of another one.

We designed a single-center, retrospective, longitudinal, observational study that included patients with moderate to severe plaque psoriasis. Patients were aged >18 years and had been treated with the 2 anti-IL-17 drugs available in Spain up to November 2018, namely, secukinumab and ixekizumab. Both drugs were administered according to the summary of product characteristics. All of the patients had reported that one of the drugs had proven ineffective and that they had subsequently received treatment with the other drug for at least 12 weeks. The patients' demographic

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