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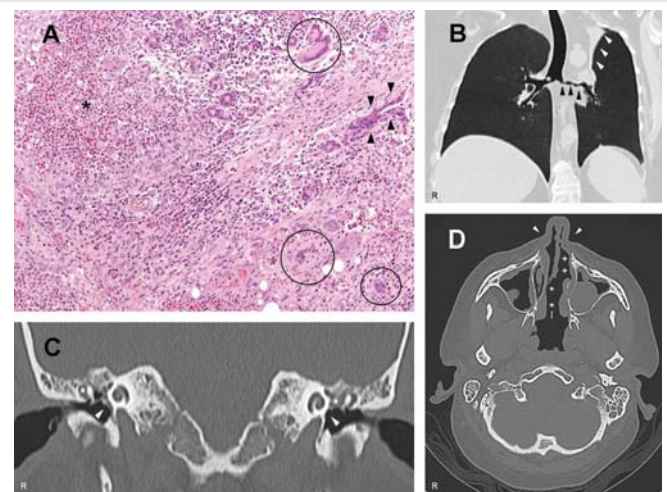
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Clinical Image

Granulomatosis with Polyangiitis: an Atypical Presentation

acquired mesotympanic cholesteatoma that requires periodic debridement. Paranasal sinuses computed tomography (Figure D) showed wide perforation of the nasal septum (*), absence of the anterior half of the left inferior turbinate (+), and atrophy of the upper lateral cartilages (white arrowheads). Fiberoptic rhinoscopy documented the presence of extensive crusting rhinitis. The patient was put under oral prednisone 1 mg/kg daily and cyclophosphamide monthly pulse therapy, with progressive improvement of breast and nasal lesions. She has currently reached a clinically stable NYHA Class II and is treated with prednisone 15 mg daily, methotrexate 15 mg weekly, and n-acetylcysteine 600 mg daily. She needs periodic endoscopic dilatations of bronchial stenosis.

A 45-year-old female came to our attention with a 6-month history of ulcerative mass in her right breast, cough, shortness of breath, nasal obstruction with hematic discharge, and hearing loss. The patient underwent excision biopsy of breast lesion. Definitive pathology (Figure A) documented the presence of a granulomatous mastitis with suppurative necrotic foci (*), giant multinucleated cells (circles), and normal breast ducts trapped by neutrophilic-eosinophilic infiltrate (arrowheads). Blood tests revealed high levels of antineutrophilic cytoplasmic antibodies with cytoplasmic pattern (c-ANCA). These findings were consistent with diagnosis of Granulomatosis with polyangiitis. Chest computed tomography (Figure B) showed marked wall thickening of the right main bronchus (*), severe stenosis of the left main bronchus (black arrowheads), and segmental atelectasis in the upper lobe of the left lung (white arrowheads). Petrous bone high resolution computed tomography (Figure C) showed atelectasis of the tympanic membranes (white arrowheads) with soft-density tissue filling the epitympanum (*). Otomicroscopy documented a bilateral



Figures 1A-D: