due to apparently diffuse alveolar haemorrhage. Both cases had recurrent symptoms after drug use, profound neutropaenia, one had positive ANA, but other serologies were negative. Infections were thoroughly discarded.

**Discussion.**—Presence of neovascularisation as prominent feature in case 2, without vessel wall inflammation, seldom reported [1], was found. Interestingly also, the patient had internal organ involvement, not previously reported.

**Conclusion.**—Additional histologic features can be present in levamisole-adulterated cocaine-induced vasculitis, which can also present with severe vital organ involvement.

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**Figure 1**

**Reference**


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**Severe diffuse alveolar haemorrhage after TAVI with CoreValve in patient with AAV and Horton disease in remission. An immuno-allergic reaction?**

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**Introduction.**—Transcatheter aortic valve implantation (TAVI) has recently emerged as alternative treatment for symptomatic aortic stenosis in pts at high surgical risk. Two bioprosthesis valves are commonly implanted nowadays, one is the self-expanded valve – Medtronic CoreValve, a valve in porcine pericardium mounted on a nitinol stent. Usually a transient increase of inflammatory indices and mild fever are observed 24–48 h post-TAVI.

**Results.**—A 81-year-old male patient (pt) was admitted to cardiology Department in October 2012 for a planned TAVI with CoreValve. At admission he was afebrile, the chest X-ray showed no lesions, CRP and ANCA were negative. He only presented new slight anemia (Hb 10.3 g/dl) (FOB repeatedly positive, pt on OAT). Since January 2007 pt was seen at the vasculitis clinic because of anti-MPO positive MPA. Pt was treated with steroids and ev cyclophosphamide and then with Methylprednisolone until February 2010. In May 2010 he started to

Mycobacterium tuberculosis (MT) infections. Histopathologic examination often demonstrates non-specific granulomatous inflammation. We present three patients with EIB and evidence of cutaneous vasculitis associated with visceral tuberculosis.

**Methods.**—We have retrospectively reviewed the clinical, laboratory, and histological data of these cases.

**Results.**—The review included three females aged 29, 35, and 80 years, which presented with erythematous painful nodules predominantly involving the skin of the lower limbs. The onset was acute in 2 patients and chronic in one case. A Mantoux test was strongly positive in all patients, and their histological examination of skin-lesion specimens showed granulomatous inflammation without caseum in the deep dermis and subcutaneous tissue, with lymphocytic vasculitis. Cultures of the skin lesions specimens were negative for Mycobacterium species. Cervical tuberculosis lymphadenitis was observed in two patients and thoracic in the other case. All patients received combination anti-tuberculous treatment with complete resolution of the lesions.

**Discussion.**—The pathogenesis of the erythema induratum with vasculitis is not fully understood, but they are commonly considered to be cutaneous hypersensitivity eruptions to M. tuberculosis that occur in patients with a moderate or high levels of immunity against the organism.

**Conclusion.**—Clinicians should consider in the differential diagnosis of patients with cutaneous granulomatous and lymphocytic vasculitis the possibility of a cutaneous hypersensitivity vasculitis associated with visceral tuberculosis. Resolution of the lesions may be achieved with antitubercular therapy, and no immunosuppressive treatment is needed.

**Further reading**


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