ANEXOS

Tabla n°1. Etiologías más comunes del NPS

NODULO PULMONAR SOLITARIO	
FRECUENTES	
1. Granuloma	
a. Tuberculosis	(50-60 %)
b. Inespecífico	
2. Carcinoma broncogénico	(10-30 %)
3. Metástasis solitaria	(3-10 %)
4. Quiste hidatídico	
5. Adenoma	(0.5-2 %)
6. Hamartoma	(5-10 %)
MENOS FRECUENTES	
1. Tumores benignos	
2. Carcinoma broncoalveolar	
3. Fistula arteriovenosa	
4. Quiste broncogénico	
5 Hematoma pulmonar	
6. Infarto	

Fuente: Pedrosa C, Casanova R. Diagnóstico por imagen. Compendio de Radiología clínica. Ed. Interamericana – McGraw-Hill, 2º ed. Madrid 2001.

Tabla n°2. Riesgo de malignidad según los factores que presenta el individuo.

Baja (<5%)	**Intermedia (5-65%)**	**Alta (>65%)**
No fumador	Características de los dos grupos	Fumador de >30 paquetes/año
> 40 años		> 60 años
Sin antecedentes de cáncer		Antecedente de cáncer
Bordes lisos		Bordes espiculados
Lóbulos medios o inferiores		Lóbulos superiores

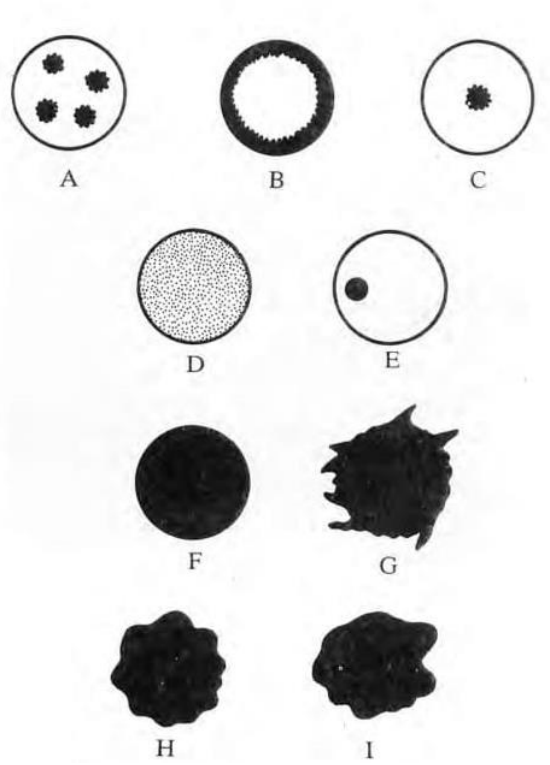
Fuente: Trinidad López C, Delgado Sáenz-Gracián C, Utrera Pérez E. Nódulo pulmonar incidental: caracterización y manejo. Sociedad Española de Radiología Médica. 2019; 61(5):357-369.

Tabla n°3. Guía de la Sociedad Fleischner 2017 para el seguimiento del NPS.

Pulmonary Nodule Size	Lung Nodule Type	Single vs. Multiple	Low Risk Patient	High Risk Patient
< 6mm (< 100mm³)	Solid	Solitary	No Follow-Up If suspicious morphology or upper lobe location, consider 12-month follow-up.	Optional CT in 12 months
		Multiple	No Follow-Up If suspicious morphology or upper lobe location, consider 12-month follow-up.	Optional CT in 12 months
	Part-Solid (Subsolid)	Solitary	No Follow-Up	
		Multiple	CT in 3 to 6 months. If unchanged, consider CT at 2 and 4 years.	
	Ground-Glass	Solitary	No Follow-Up If suspicious, consider follow-up at 2 and 4 years. If grows or increasingly solid, consider resection.	
		Multiple	CT in 3 to 6 months. If unchanged, consider CT in 2 and 4 years.	
6 to 8mm (100-250mm³)	Solid	Solitary	CT in 6 to 12 months, then **consider** CT in 18 to 24 months.	CT in 6 to 12 months, then **obtain** CT in 18 to 24 months.
		Multiple	CT in 3 to 6 months, then **consider** CT in 18 to 24 months	CT in 3 to 6 months, then **obtain** CT in 18 to 24 months
	Part-Solid (Subsolid)	Solitary	CT in 3 to 6 months to confirm persistance. If unchanged and solid component below 6mm, CT annualy for 5 years. **Persistent part-solid nodules containing a solid componment > 6mm are highly suspicious.**	
		Multiple	CT in 3 to 6 months. Then management based on most suspicious nodule(s).	
	Ground-Glass	Solitary	CT in 6 to 12 months to confirm persitance, then CT every 2 years until 5 years. If grows or increasingly solid, consider resection.	
		Multiple	CT at 3 to 6 months. Then management based on most suspicious nodule(s).	
> 8mm (> 250mm³)	Solid	Solitary	In 3 months consider either CT, Biopsy, or PET-CT (however, negative PET-CT does not exclude low-grade malignancy, FDG uptake may be underestimated in small nodules < 1cm, or those close to diaphragm)	
		Multiple	CT in 3 to 6 months, then **consider** CT at 18 to 24 months	CT in 3 to 6 months, then **obtain** CT at 18 to 24 months
	Part-Solid (Subsolid)	Solitary	CT in 3 to 6 months to confirm persistance. If unchanged and solid component below 6mm, CT annualy for 5 years. **Persistent part-solid nodules containing a solid componment > 6mm are highly suspicious.**	
		Multiple	CT at 3 to 6 months. Then management based on most suspicious nodule(s).	
	Ground-Glass	Solitary	CT in 6 to 12 months to confirm persitance, then CT every 2 years until 5 years. If grows or increasingly solid, consider resection.	
		Multiple	CT at 3 to 6 months. Then management based on most suspicious nodule(s).	

Fuente: Guidelines for magagement of incidental pulmonary nodules detected on CT images: From the Fleischner Society 2017. Radiology 2017; 284:228-243.

Fig. 1. Características del NPS; Las calcificaciones A, B C Y D representan lesiones benignas. La E representa atrapamiento de una calcificación previa por un nódulo maligno. El contorno nítido, redondeado de la F lo suele producir lesiones benignas. Las espiculadas y umbilicados la lesiones malignas (G, H, I).



Fuente: Pedrosa C, Casanova R. Diagnóstico por imagen. Compendio de Radiología clínica. Ed. Interamericana – McGraw-Hill, 2º ed. Madrid 2001.