An 82 year old male with transfusion-dependent myelodysplastic syndrome treated with Decitabine was admitted to hospital for an upper GI bleed. Chest radiogram (Panel A) revealed a cavitary infiltrate in the right lower lobe (RLL) and dense infiltrate without air bronchograms in the left lower lobe (LLL). Scant hemoptysis occurred and chest computed tomography (Panel B) demonstrated a 7 x 7 cm intraparenchymal hematoma in the LLL and a 4 x 6 cm thick walled cavitary lesion in the RLL.
Bronchoalveolar lavage was positive only for aspergillus antigen. Intravenous Amphotericin B and broad spectrum antibiotics were administered. Due to ongoing hemoptysis, a pulmonary artery angiography (Panel C) was performed and in the area of intraparenchymal hematoma in the LLL a giant 6 x 9 cm pulmonary artery pseudoaneurysm was noted. A second smaller pulmonary artery pseudoaneurysm was found adjacent to the first and both were successfully coiled and embolized (Panel D).

**Key Points**

Pulmonary artery pseudoaneurysms are parenchymal hematomas that form as a result of a leaking artery. They have non-specific radiologic features, including solitary pulmonary nodule(s) or focal consolidation [1].

CT may show central enhancement within a hematoma or consolidation, however definitive diagnosis requires pulmonary angiography which can be both diagnostic and therapeutic.

Pulmonary artery pseudoaneurysms are rare. The most common causes are infections; such as tuberculosis, endocarditis, pyogenic or mycotic infections, neoplasms, medium to large vessel vasculitis, trauma, or iatrogenic endovascular intervention [2]. High mortality may result from rupture leading to exsanguination and death [3].

**References**