Archivos de Bronconeumología 58 (2022) T433

Sociedad Española de Neumología y Cirugía Torácica SEPAR

ARCHIVOS DE
Bronconeumología

www.archbronconeumol.org

Clinical Image

[Translated article] Placental Transmogrification of the Lung

Transmogrificación placentaria del pulmón

Giovanna Foschini*, Carmen M. Rodríguez, Matilde M. Rubio, Xavier Baldo

Departamento de Cirugía Torácica, Hospital Universitari de Girona Dr. Josep Trueta, Girona, Spain

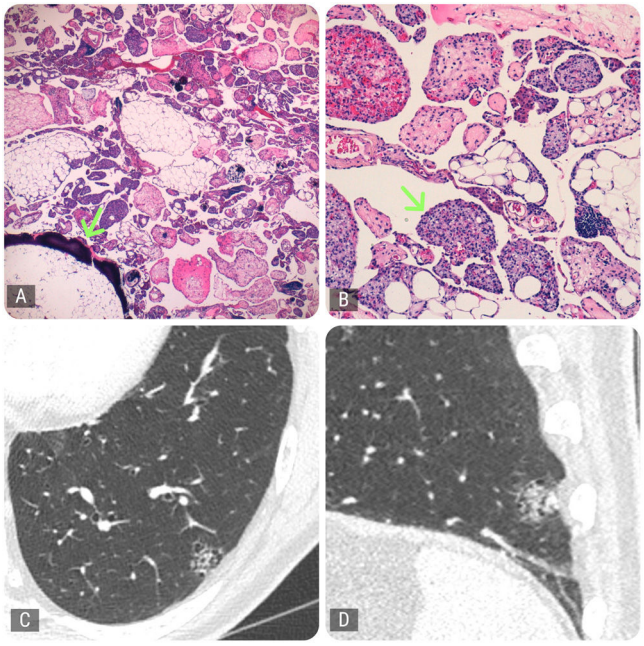

Fig. 1. Histology and radiology. (A) Optical microscopy (OM): non-encapsulated lesion composed of papillary structures within hyperaerated cystic spaces and significant presence of adipose tissue with occasional foci of bone metaplasia (arrow) (H&E 2×). (B) OM: a proliferation of capillaries is seen in the interior of papillary structures (arrow) along with abundant mast cells (H&E 10×). (C) CT axial slice: ground glass opacity measuring 19 mm in its maximum diameter, located in the left lower lobe. (D) CT sagittal slice: the lesion combines a solid, cystic, and trabeculated component.

Placental transmogrification of the lung (PTL) is a rare benign lesion of unknown etiology that occurs more frequently in men. It was first described in 1978 as a lesion that has a topography resembling chorionic villi but no placental biological properties.[1,2] Presentation varies from asymptomatic forms to respiratory failure, depending on the presence or absence of underlying disease.[1] Lesions have occasionally been described as incidental masses seen on X-ray, but the most common finding is unilateral bullous emphysema and lipomatosis. PTL is often associated with pulmonary fibrochondromatous hamartomas.[2]

We report the case of a 63-year-old male smoker with an incidental finding of a ground-glass opacity measuring 19 mm with a solid component in the left lower lobe. At follow-up, the lesion had not grown, but a cystic, trabeculated component and an increase in the solid component were identified, so a thoracoscopic transsegmental resection of the lesion was performed, giving a diagnosis of PTL with marked lipomatosis. The patient was discharged 48 h after surgery. Our case is the first reported case of PTL beginning as a ground glass opacity (Fig. 1).

Conflict of interests

We have no conflict of interest or funding to declare and all authors contributed equally to this work.

References

1. Ferreti GR, Kocier M, Moro-Sibilot D, Brichon PY, Lantuejoul S. Placental transmogrification of the lung: CT – pathologic correlation of a rare pulmonary nodule. AJR. 2004;183:99–101.
2. Ortiz S, Tortosa F. Pulmonary placental transmogrification: the last 16 years in a reference centre. Rev Port Pneumol. 2006;23:164–6.

DOI of original article: https://doi.org/10.1016/j.arbres.2021.04.004
* Corresponding author.
E-mail address: gfvm86@gmail.com (G. Foschini).

https://doi.org/10.1016/j.arbres.2021.04.033