4. Granda Orive JI, Villanueva Serrano S, Aleixandre Benavent R, Valderrama Zurián JC, Alonso Arroyo A, García Río F, et al. Redes de colaboración científica internacional en tabaquismo. Análisis de coautorías a través del Science Citation Index durante el período 1999–2003. Gac Sanit. 2009;23: 222.e34–e43
5. Granda Orive JI, Alonso Arroyo A, Jareño Esteban J, Campos Téllez S, Aleixandre Benavent R, García Río F, et al. ¿Ha aumentado la producción española en tabaquismo en los últimos dos quinquenios?. Arch Bronconeumol. 2009;45: Espec Congr:140
6. Granda Orive JI. Algunas reflexiones y consideraciones sobre el factor de impacto. Arch Bronconeumol. 2003;39:409-17

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Primary Lung Sarcoma

Sarcoma pulmonar primario

Dear Editor,

Primary lung sarcoma (PLS) is a very rare lung tumour , found rarely in the literature and has different varieties: angiosarcoma, leiomyosarcoma, rhabdomyosarcoma, the sarcomatoid variant of mesothelioma and the primary Ewing's sarcoma/primitive neuroectodermal lung tumour,[1] which are different from pulmonary metastases from extrathoracic sarcomas.[2] Radiology techniques (computerised tomography and magnetic resonance) try to define the origin of the tumours, as well as the relationship with and invasion of neighbouring structures.[3]

We present the case of a 61-year-old smoker male. After showing common cold symptoms, he presented a nodule in the left lower lobe (posterior-anterior [Fig. 1a] and lateral [Fig. 1b] chest radiographs). A thoracic computerised tomography scan without intravenous contrast showed a mediastinal window with solid and homogenous nodule (Fig. 2a), with spiculated edges and pleural tail signa and a parenchymal window, as indicative signs that the tumour was malignant (Fig. 2b). After having carried out a lobectomy and left lymphadenectomy, the definitive anatomopathologic diagnosis was an intermediate grade PLS with fusocellular and epithelioid areas, type malignant fibrous histiocytoma, which was infiltrating the visceral pleura at pT2 N0 M0 stage. It presented positive immunohystochemical reaction with S-100 protein, EMA (epithelial cells of ducts trapped due to neoplasm), enolase (epitheloid-like isolated tumour cells), Bcl-2, CD-34 and pan-CK (epithelial cells of ducts).

PLS is a rare malignant entity, that affects young people and often starts with chest pain, coughing and haemoptysis. Radiographs often show a lung mass in the pleural cavity. The anatomopathologic diagnosis is based on microscopic visualisation of the epithelioid and fusiform cells, as well as positive immunohystochemical reactions to epithelial membrane antigens and to cytokeratin and vimentine.[4] Protein expression levels of SYT-SSX1 are related with a worse prognosis.[5] Treatment is a combination of surgery and polychemotherapy. Economic resection of the lung is performed to prevent future relapses. 5-year survival rates are estimated at 40-57% and 10-year at 30%, being good prognostic factors for tumours smaller than 5cm. as well as a histology of epithelial predominance and peripheric localisation.[6]

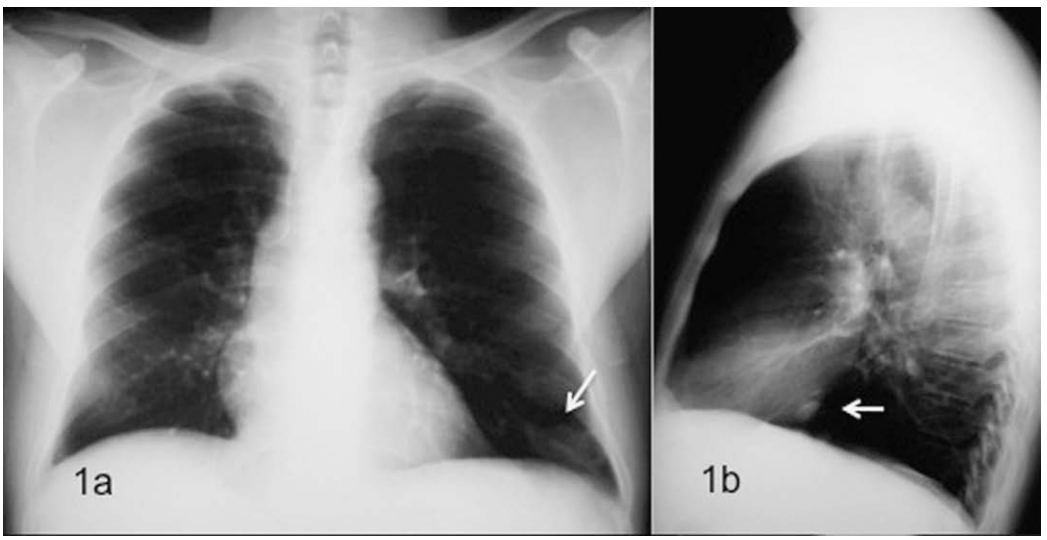

Figure 1. Posteroanterior *(a)* and lateral *(b)* chest radiographs, where a nodule (white arrows) can be seen in the left lower lobe.

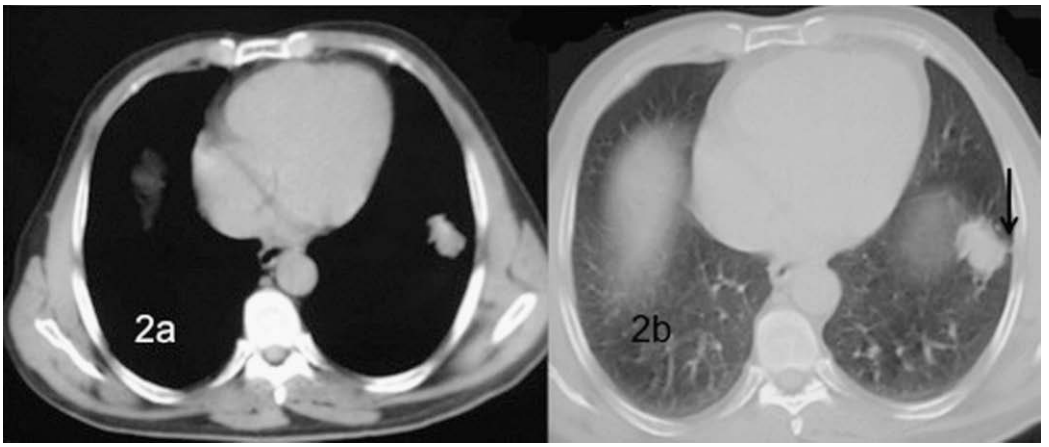

Figure 2. Computerised tomography without intravenous contrast, mediastinal window showing a solid and homogenous nodule *(a)*, parenchymal window showing the spiculated edges and pleural tail sign (black arrow) with *(b)*.

References

1. Suárez J, Rodríguez C, Montero C, Verea H. Sarcoma de Ewing pulmonar/tumor neuroectodérmico primitivo (PNET): aportación de un caso y revisión de la bibliografía. Arch Bronconeumol. Available in press.
2. Montero C, Valiño P, Souto A, Fernández MD, Suárez J, Verea H. Tratamiento endoscópico de metástasis en bronquis principales de sarcoma: aportación de 2 casos. Arch Bronconeumol. 2009. doi:10.1016/j.arbres.2009.03.009
3. Cakir O, Topal U, Bayram AS, Tolunay S. Sarcomas: rare primary malignant tumors of the thorax. Diagn Interv Radiol. 2005;11:23-7.
4. Jiang J, Zhou J, Ding W. Primary pulmonary synovial sarcoma, a rare primary lung neoplasm: two case reports and review of the current literature. Respirology. 2008;13:748-50.
5. Hosono T, Hironaka M, Kobayashi A, Yamasawa H, Bando M, Ohno S, et al. Primary pulmonary synovial sarcoma confirmed by molecular detection of SYT-SSX1 fusion gene transcripts: a case report and review of the literature. Jpn J Clin Oncol. 2005;35:274-9.
6. Haro M, Baldo X, Rubio M, Sebastián F, Viñas G, Bernadó L. Sarcoma sinovial pulmonar primario. Presentación y diagnóstico de dos casos. Arch Bronconeumol. 2003;39:136-8.

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Pulmonary inflammatory myofibroblastic tumour: a confusing diagnosis

Tumor miofibroblástico inflamatorio pulmonar: un diagnóstico confuso

To the Editor:

Although malignant carcinomas constitute the majority of lung malignancies, a wide variety of rare tumours occur sporadically in the lungs. Among these, inflammatory myofibroblastic tumours (IMT) have been described as single lesions usually well-defined, benign-appearing[1] which appear more frequently in the paediatric age.[2,4] By describing 2 cases of atypical radiological presentation, we discuss its wide range of radiological presentation and the occasional aggressive behaviour.

Figure 1a shows the initial study of a chest computerized tomography (CT) of a 51 year old male with recurrent pneumonia. There is a spiculated right hilar mass producing discreet extrinsic compression on the middle lobe bronchus and left lower lobe. There were low right paratracheal lymphadenopathies (not shown). The fine needle aspiration guided transthoracic CT showed only the presence of inflammatory cells. A pneumonectomy was conducted, with subsequent pathologic diagnosis of IMT. Nine months later a contralateral lung recurrence was detected, which was controlled with corticosteroids (Fig. 1b). In a long series of thoracic IMTs, Agrons et al[1] described that only 20% of them had spiculated margins. Bronchial affectation secondary to parenchymal lung injury occurs in 10% of cases, and lymphadenopathy in only 7%. In another series[4] of 23 patients, no cases were described with mediastinal lymphadenopathy. The differential diagnosis of a spiculated mass is extensive. In the adult, primary malignancy or metastasis must be first discarded. In a child, an injury of this kind more likely represents an IMT, especially if there are no other signs of malignancy.[1] From the radiological point of view, a spiculated lesion with arterial supply may be indistinguishable from an intralobular pulmonary sequestration.[1]

Figure 1c shows an axial CT scan of a 30 year old man with history of cough and expectoration of 5 months. In the bronchus of the right lower lobe a partially calcified endobronchial lesion is observed that produces a partial lobar atelectasis with bronchiectasis. The biopsy showed a non-specific inflammatory reaction. Following a right lower lobe lobectomy a diagnosis was obtained of an IMT (Fig. 1d). The thoracic endobronchial IMT are extremely rare[1] not the presence of intralesional calcium, which can occur in up to 15% of parenchymal lesions. IMT may simulate an endobronchial carcinoid tumour, adenoid cystic carcinoma or mucoepidermoid carcinoma. The presence of calcifications in lung injury points to a granuloma or hamartoma.[1]

Some authors think that the IMT is a non-neoplastic process resulting from the uncontrolled proliferation of inflammatory cells.[2,5] The cause