

Histological diagnosis was mature teratoma. Positive estrogen and progesterone receptors were detected in resected tumor tissue.

Sixty percent of teratomas are located in the anterior mediastinum, and 88% are mature.¹ Mature teratoma is often asymptomatic and protrudes from one hemithorax. On CT, it is seen as a mass containing fat, calcifications or cystic changes. The benign nature of these lesions is confirmed by lack of activity on FDG-PET.² MRI is useful for obtaining an accurate map of surrounding anatomical structures for surgical resection of the tumor.

The only curative treatment available for teratoma is surgical intervention, usually performed via sternotomy or thoracotomy, to relieve symptoms of compression and prevent transformation to malignancy.

Correct diagnosis and treatment are based on total tumor resection, although complete resection is not essential, since the local recurrence rate is low.³ Adjuvant treatment is unnecessary, as prognosis for mature teratoma is good.⁴

In pregnant women, radiation applied to the chest is considered safe if the abdomen is protected,⁵ so chest X-ray is formally indicated to avoid misdiagnosis of unexplained dyspnea in a pregnant woman.

This large chest tumor causes decline in lung function, and pleural effusion may increase due to hormone changes and mechanical factors associated with pregnancy.

To conclude, the appearance of these tumors during pregnancy is likely to involve real diagnostic and therapeutic issues.

Conflict of Interest

The authors have no conflict of interests to declare.

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Talking About Endobronchial Lipoma[☆]



A propósito del lipoma endobronquial

With reference to the article “Endobronchial Lipoma: A Rare Cause of Bronchial Occlusion”,¹ we report the case of a 64-year-old man with a previous diagnosis of severe obstructive sleep apnea-hypopnea syndrome receiving CPAP therapy, who presented with a clinical picture of long-standing productive cough. Increased density with upper right paratracheal rounded mass was observed on chest X-ray; chest computed tomography showed partial atelectasis of the right upper lobe (RUL); bronchoscopy showed a soft, rounded, pinkish, vascularized lesion in the entrance to the RUL; biopsy revealed metaplastic bronchial mucosa; and pathological contrast uptake was seen on positron emission tomography (PET). With a diagnosis of a RUL lesion with uptake on PET, a thoracotomy with upper right lobectomy and lymphadenectomy was performed. Pathology report revealed endobronchial lipoma with focal osseous metaplasia, alveolar hemorrhage, areas of bronchopneumonia and obstructive architectural distortion.

Discussion

Endobronchial lipoma is a very rare tumor, accounting for only 0.1% of all lung tumors.² They are usually located in the first 3 divisions of the tracheobronchial tree. The most common symptoms

are cough, expectoration, hemoptysis, fever and dyspnea, although 25% of cases may be asymptomatic.³ The lipoma consists of mature fatty tissue covered with normal bronchial epithelium or—as in our case—squamous metaplasia.⁴ Fibrous, glandular tissue, areas of cartilage or osseous metaplasia can also be found in the lipoma; pathologist must use differential diagnosis to rule out atypical lipomatous tumors and well-differentiated liposarcomas.⁵ Treatment of choice is bronchoscopic resection, while thoracotomy should be considered in difficult-to-diagnose cases, when there is parenchymal destruction due to atelectasis and long-standing pneumonitis, extrabronchial growth, or if bronchoscopy cannot be used for technical reasons.⁶ Nevertheless, in view of the possibility of long-term relapse, we recommend regular follow-up of patients undergoing bronchoscopic resection.

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Paraneoplastic Neuropathy With Positive Anti-Hu. A Case Report[☆]



Neuropatía paraneoplásica con anti-Hu positivo. A propósito de un caso

To the Editor,

We report the case of a 73-year-old man, active smoker with a history of 60 pack-years, a former alcohol habit, hypertension and ischemic heart disease, with acute myocardial infarction 15 years previously. He was seen for a 12-month history of pain, weakness and paresthesia in the lower limbs, and lumbago. He also reported cough, mucopurulent expectoration and dyspnea on slight exertion, with no associated toxic syndrome. Physical examination revealed mild tachypnea and generalized bilateral diminished breath sounds with no adventitious sounds. Neurological examination showed no changes in campimetry or cranial nerves, and functional tests were normal. Gait was cautious, with proximal weakness of the lower limbs and loss of triceps, patellar and Achilles reflexes. The patient was referred

to the neurology department, from where he was admitted to hospital.

General laboratory tests showed no significant findings. Protein levels and cerebrospinal fluid were normal, as were tumor markers AFP, CEA, Ca 125, Ca 19.9, Ca 15.3 and PSA. No pathological findings were seen on chest X-ray. The neurophysiological examination suggested demyelinating polyneuropathy. Head computed tomography (CT) showed bilateral frontotemporal atrophy, and the initial chest CT was normal. Magnetic resonance imaging of the cervical, dorsal and lumbar spine revealed only a foraminal disc protusion with no radicular involvement. An antibody study was negative for antigangliosides and anti-MAG (anti-myelin-associated glycoprotein) and positive for anti-Hu antibodies.

In view of the strong suspicion of a neoplastic process, PET-CT was performed, revealing a slightly hypermetabolic focus over a small infiltrate in the right subpleural lung base, and a large hypermetabolic focus in the subcarinal mediastinum, 3 cm × 2 cm in size (Fig. 1).

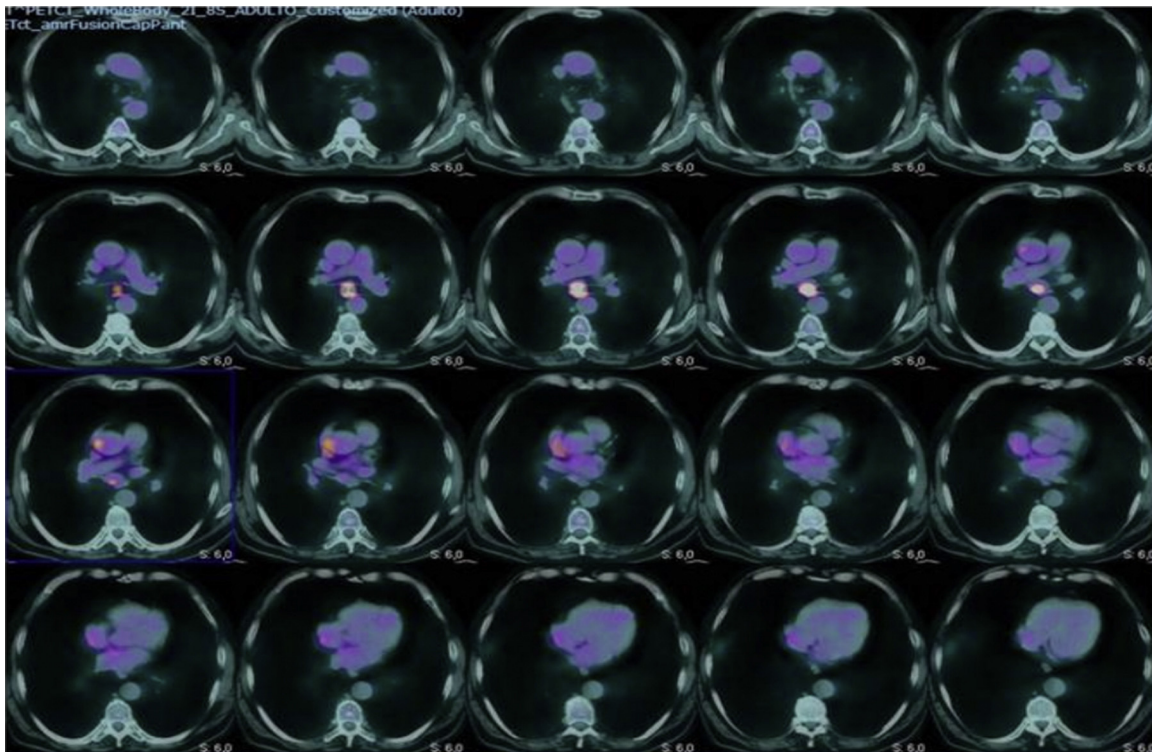


Fig. 1. Chest PET-CT image. A large hypermetabolic focus is seen in the subcarinal lymph node station (G7).

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