Scientific Letters

Mature Cystic Teratoma of the Lung With a Somatic-Like Malignant Component in a Patient With Testicular Germ-Cell Tumor

Dear Editor:

In urological oncology, the diagnosis of teratoma with a somatic-like malignant component refers to the presence of a malignant neoplasm, e.g., carcinoma or sarcoma, either within a teratoma of the genital tract (usually the testis) or, more commonly, in a metastasis, following initial cisplatin therapy. The somatic-type malignancy (STM) most widely observed in germ cell tumors (GCT) is rhabdomyosarcoma; neuroendocrine carcinoma is extremely rare.

We report on a 40-year-old patient who had undergone surgery seven years earlier for a malignant mixed germ-cell tumor of the right testicle with pulmonary and retroperitoneal metastasis, and received cisplatin therapy. At recent check-up, CT scans revealed some enlargement of known lung lesions; blood alpha-fetoprotein levels were also slightly elevated (AFP: 9 ng/ML). Since needle-biopsy findings were inconclusive, lung nodules were all excised by videothoracoscopy. Histological examination of them revealed a multicystic lesion containing solid areas. The cystic component was lined by squamous, respiratory and intestinal epithelium, a finding consistent with a mature teratoma. The solid component comprised tumor cell nests displaying peripheral pallisading, an organoid arrangement with rosette formation, focal necrosis and a high mitotic rate (6/10 HPF) (Fig. 1A). No elements characteristic of immature teratoma were observed. Immunohistochemical analysis revealed patchy focal positivity for CK7, CK20, CDX2 and SOX2 in the cylindrical epithelial cells of the cystic component (Fig. 1B and C). Solid-component cells stained positive for cytokeratin (AE1/AE3), chromogranin-A (Fig. 1D), synaptophysin, and cytoplasmic OCT4, and negative for CD56. Staining for neural development transcription factors (TTF1, ASCL1 and POU3F2) was positive only for POU3F2 (nuclear). Since tests using a broad battery of antibodies (CDX2, TTF1, CK7 and CK20) yielded negative results, it was not possible to identify the original tissue of the neuroendocrine component.

The final pathological diagnosis was atypical carcinoid tumor in a metastatic mature cystic teratoma. Surgical margins were tumor free, and postoperative recovery was good, with no complications. Two histogenetic hypotheses have been put forward to account for this association. The first is that cisplatin therapy selectively excludes immature components, whilst chemotherapy-resistant mature components survive and in some cases grow. The second is that chemotherapy induces the transformation of immature malignant teratoma into mature teratoma, a phenomenon first reported...
A Rare Case of Incidental Tracheal Lipoma

Caso excepcional de un hallazgo casual de lipoma traqueal

Dear Editor,

Primary tracheal tumours are uncommon, with an incidence of 0.2/100,000 population.1 In adults, only 10%–20% of tracheal tumours are benign, including chondroma, papilloma, fibroma, haemangoma. Tracheal lipoma is extremely rare and only few cases have been reported in the literature.1–8 This tumour typically presents with non-specific symptoms and signs as dry cough and wheezing and infrequently with respiratory failure. Its resection is required and it can be achieved by both endoscopically and open surgery.

Here we report the case of an incidental tracheal lipoma successfully treated by rigid tracheobronchoscopy. A 79-year-old male, former smoker with a history of arterial hypertension, right Meckel’s cave meningoima and previous retroperitoneal non-Hodgkin’s lymphoma, was admitted to our Thoracic Surgery Unit to evaluate a broad-based polypoid tracheal lesion incidentally discovered during the endoscopic CO2 laser cordectomy performed for an in situ squamous cell carcinoma of the left true vocal cord. The patient reported no cough, dyspnoea, wheezing, stridor or haemoptysis. The physical examination was unremarkable. Chest X-ray was normal. Computed tomography (CT) scan showed an intratracheal polypoid growth arising from the anterolateral tracheal wall. Flexible tracheobronchoscopy confirmed the presence of a broad-based polypoid lesion growing from the anterior tracheal wall, in correspondence of the IV–V tracheal rings. The tumour was about 7 mm in diameter with a smooth and yellowish surface. It obstructed about 50% of the tracheal lumen (Fig. 1A). The uneventful endoscopic biopsy revealed chronic tracheitis with squamous hyperplasia and mild dysplasia. Despite the benign histological finding and the patient’s asymptomatic status, we decided to remove the lesion because of the recent history of glottis carcinoma. The patient underwent tumour excision with diode laser by rigid tracheobronchoscopy. Complete clearance of the airways was obtained. The postoperative course was unremarkable. Histopathological examination revealed

References


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