Aspergilloma Presenting with Lung mass

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Aspergilloma is a fungus ball composed of Aspergillus hyphae, fibrin, mucus, and cellular debris found within a pulmonary cavity, and may present with lung mass accompanying with hemoptysis. Although Chest PA sometime cannot confirm the existence of air-meniscus sign around lung mass, usually CT scanning can reveal whether there is air meniscus sign or not. A 40-year-old man was admitted via emergency room presenting with cough and sudden massive hemoptysis. He had smoked one pack a day for 20 years. He suffered from pulmonary tuberculosis 20 years ago, and then had treated for 1 years. Outside Chest CT scanning showed mass lesion in left upper lobe with slight contrast enhancement, but there was no evidence of air-meniscus sign. So differential diagnosis was needed. For bleeding control, bronchial artery embolization was performed. On CT scanning of PTNA for evaluation of mass, there was air-meniscus sign implying aspergilloma. Pathologic examination revealed Aspergillus hyphae with septation. In case of hemoptysis, the clot & bleeding can make it difficult to make a diagnosis of Aspergilloma. So we have to be careful, and consider follow-up CT scanning of lung mass after absorption of clot.

Focal and positional wheezing resulting from endobronchial lipomatous hamartoma

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Pulmonary hamartomas are the most common benign tumors of the lung, mostly occurring in the parenchyma. Endobronchial hamartoma is a rare form of pulmonary hamartoma and of these, lipomatous hamartoma are extremely rare. Here, we describe the case of a 39-year-old man who presented with a two-year history of dyspnea on exertion and wheezing over the left chest only while lying on his left side. A chest radiograph suggested the presence of a mass within the left main bronchus. A CT scan revealed a low-attenuation endobronchial mass, obstructing the superior bronchus of the lower lobe of the left lung and the left main bronchus with distal obstructive pneumonia and air trapping (Fig. 1A,B). Fiberoptic bronchoscopy confirmed a large polypoid mass occluding the distal part of the left main bronchus, which extended to the superior bronchus of the left lower lobe (Fig.2). Subsequently, the patient underwent a superior segmentectomy of the left lower lobe, which promptly relieved dyspnea and positional wheezing. At microscopic examination, the tumor consisted predominantly of mature fat cells with small areas of smooth muscles and an epithelial component consistent with the diagnosis of endobronchial lipomatous hamartoma (Fig. 3). To the best of our knowledge, there are only less than 10 other cases cited in the English literature, none of which presented with positional wheezing. This patient represents the first case of focal and positional wheezing resulting from endobronchial lipomatous hamartoma.