PS 1236 Pulmonology

A Case of Primary Pulmonary Amyloidosis

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Background: Amyloidosis is a systemic disease of unknown origin which is characterized by extracellular deposit of proteins with a specific structural conformation hat gives them a characteristic apple-green birefringence when stained with Congo-red. Isolated pulmonary amyloidosis is a rare localized form of amyloidosis, characterized by amyloid deposits restricted to the lungs.

Case: A 79-year-old male was admitted due to hemoptysis and dyspnea for several months. On physical examination, he had crackes in both lungs. The chest tomography showed multiple nodular consolidations and nodules in both upper and right middle lobes and consolidations in both lower lungs. Pulmonary function test revealed moderate restrictive pattern of ventilation. Bronchoscopy showed infiltrative mucosal lesion and partial obliteration of lateral segmental bronchus of right middle lobe. Pathologic evaluation of the bronchial mucosal biopsy revealed apple-green birefringent amyloid on Congo-red staining. There was no hypergammaglobulinemia on protein electrophoresis and bone marrow biopsy sections showed normocellular. The patient was diagnosed isolated pulmonary amyloidosis with endobronchial involvement.

Conclusion: We report a rare case of primary pulmonary amyloidosis presenting with hemoptysis.

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A Case of Pulmonary Hyalinizing Granuloma: A Rare Pulmonary Disease

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Background: Pulmonary hyalinizing granuloma (PHG) is a rare, non-infectious, and benign fibrosing lesion of the lung. It is found with solitary or multiple bilateral nodules and may occur in any lobe. Ocassionally, it mimics metastatic pulmonary malignancy or tuberculosis. The authors report a typical case of PHG that was diagnosed upon histopathological examination via Wedge resection through Video-assisted thoracoscopic surgery (VATS) in a patient with lesions suspecting multiple metastatic lung malignancy.

Case summary: A 30-year-old female patient with mild dyspnea of exertion and chronic cough lasting for a year visited our hospital. The patient had no specific underlying disease and was a non-smoker. There were no abnormalities found on physical examination. The chest radiography (X-ray) revealed bilateral multiple pulmonary nodules. Multiple lung nodules in both lung with subcarinal lymphadenopathy was found on contrast enhanced chest computed tomography (CT). Hence, Positron emission tomography (PET) scan was done and multiple hypermetabolic nodules in both lung and fludeoxyglucose (FDG) uptake at left supraclavicular area were found. Such findings from chest CT and PET-CT strongly suggested metastatic lung malignancy. Accordingly, CT-guided percutaneous needle biopsy was performed and chronic inflammation was revealed. So, Wedge resection through VATS was performed for diagnosis and deposition of hyaline tissues composed of hypocellular collagen lamellae was the main finding in such histopathological examination through lung biopsy. Hence, this patient was diagnosed as pulmorary hyalinizing granuloma.

Conclusions: Based on histopathology and immunohistochemistry, we have diagnosed this patient as pulmonary hyalinizing granuloma. This is a very rare disease and it may present lesion mimicking metastatic lung cancer on radiography. Therefore, clinicians should keep in mind the existence potential of PHG when encountered patients presenting metastatic pulmonary nodules or masses.

Key Words: Pulmonary hyalinizing granuloma, Pulmonary nodule, Lung biopsy

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A Case of Interstitial Pneumonitis in a Prostate Cancer Patient Treated with Bicalutamide

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Introduction: There is a rare method to diagnose drug-induced pneumonitis so that can be diagnosed by careful documentation of the past medical history without other causes of pneumonitis. Non-steroidal anti-androgen, which is an important treatment for prostate cancer, rarely induces interstitial pneumonitis. In addition, bicalutamide-induced interstitial pneumonitis has rarely been reported. This paper reports the case of a prostate cancer patient who had been treated with bicalutamide, and then expired due to complications from interstitial pulmonary infiltrates and respiratory failure.

Case: A 77 year-old man was admitted in emergency room for dyspnea for one month. He was diagnosed prostate cancer 7 years ago and had undergone radical retropubic prostatectomy. After the operation, two years ago he was treated with casodex® (bicalutamide) for a period of 3 months followed by an additional treatment with bicalude®(bicalutamide) for 4 months. Lung auscultation revealed bilateral fine crackles, and arterial blood gas showed pH 7.4, PCO2 29.5 mmHg, PO2 37.3 mmHg, SaO2 72.5%, which revealed acute respiratory failure. Chest radiography showed diffuse infiltration in bilateral peripheral and lower lung fields (Fig.1). Likewise, computed tomography showed diffuse ground glass opacities and some patchy consolidation with interlobular septal thickening in bilateral peripheral and lower lung fields(Fig.2). No bacterium was identified, and the patient did not respond to empirical antibiotic therapy. Since the patient's diagnosis were suspected as a bicalutamide-induced interstitial pneumonitis, bicalutamide was stopped and methylprednisolone was started. However, after a temporary improvement, the patient suffered a rapid respiratory failure along with sepsis complications which led to his expiry.

Conclusion: In comparison to the other cases, this is a special case involving severe respiratory failure which required ventilator care. Therefore, the patient did not fully recover; rather complications occurred which resulted in the expiry.