ship between clinical appearance of digital clubbing and radiological changes of the same fingers.

To our knowledge, digital clubbing associated with McCune Albright syndrome has not been reported previously. Since the patient had no disease known to be associated with digital clubbing, such as chronic obstructive pulmonary disease and cirrhosis. We think that clubbing of the fingers was due to bony lesions of McCune Albright syndrome.

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Endobronchial lipoma simulating bronchogenic carcinoma

Sir,

Endobronchial lipomas are rare benign neoplasms that account for about 0.1% of all pulmonary tumours.1 So far, fewer than 60 cases have been reported in the English literature.2 They are much more common in males, the male–female ratio being 45:7.3

A 68 year old man presented with a 3 month history of non-productive cough, left-sided chest pain, weight loss of 3 kg and one episode of haemoptysis. He was a chronic cigarette smoker. His chest X-ray taken 2 years earlier was normal. The patient was not obese and had no cutaneous lipoma.

The chest radiograph showed left upper lobe collapse. Computed tomography revealed atelectasis of the left upper lobe without any obvious mass lesion, hilar or mediastinal lymphadenopathy.

Routine laboratory tests were unremarkable except for an elevated erythrocyte sedimentation rate of 83 mm/hour. At fibreoptic bronchoscopy the left upper lobe bronchus just after branching off of the lingular bronchus was completely occluded by a pink round smooth-surfaced endobronchial tumour. Bronchoscopic biopsy specimen revealed normal intact bronchial epithelium covering mature adipose tissue. The histological diagnosis was endobronchial lipoma.

The endobronchial lipoma which measured 1 cm in diameter was removed by a left upper lobectomy.

Endobronchial lipomas arise from the submucosal or interstitial adipose tissue of the large bronchi. They consist of histologically normal adult fat cells.4 Diagnosis of these tumours is often by bronchoscopic biopsy but the usually intact epithelium and fibrous capsule may render such a biopsy difficult and non-diagnostic, in which case the diagnosis can only be made after bronchotomy or thoracotomy. The majority of patients with endobronchial lipoma present in the sixth and seventh decades. The common presenting symptoms include cough, chest pain and fever.1 Our patient also had haemoptysis which tends to be a late symptom occurring in about 30% of cases.3 Haemoptysis is related to distal lung disease such as bronchiectasis rather than directly to the tumour. Our patient also had weight loss which is only seen in 8% of cases.

Chest X-rays may show enlarged hilar shadows, as endobronchial lipomas are more commonly found in the large bronchi.4 Distal collapse of a lobe secondary to bronchial obstruction, as in this case, may be seen.2 Such radiological appearance and our patient’s symptoms are similar to those of bronchogenic carcinoma, and a confident diagnosis of endobronchial lipoma from an adequate biopsy is essential as the two tumours tend to affect the same age group.

This case illustrates that symptoms and chest radiograph abnormality highly suggestive of bronchogenic carcinoma in an elderly smoker may occasionally be due to a benign lesion like endobronchial lipoma.

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