An unusual pulmonary mass

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A 23-year-old woman smoker complained of right-sided chest pain. The patient had no significant personal or family history. She was asymptomatic, and physical examination was unremarkable.

Her chest X-ray and thoracic computed tomography (CT) scan are shown in figures 1 and 2. Blood biochemical and haematological examinations were normal, as was abdominal ultrasonography. A tuberculin purified protein derivative (5 IU) skin test was 10 mm in diameter. Several sputum samples were negative for malignant cells and for Mycobacteria.

Appropriate microbiological and cytological examinations of a bronchoalveolar aspirate obtained by fiber-optic bronchoscopy were non-diagnostic. A transthoracic fine-needle aspiration of the pulmonary mass yielded abundant necrotic material with clumped histiocytic cells, epithelioid cells, lymphocytes and rare neutrophils. A diagnostic thoracotomy was performed. The histological section is shown in figure 3.

Questions
1 What is the radiological differential diagnosis in this patient?
2 What is the most likely diagnosis?
Answers

QUESTION 1
Radiological differential diagnosis of a pulmonary mass in a young patient includes many lesions and diseases, summarised in the box.

QUESTION 2
Microscopic examination of the surgical specimen revealed necrotizing epithelioid granulomas with multinucleated giant cells (arrow) and abundant acid-fast bacilli surrounded by normal lung parenchyma. Mycobacterium tuberculosis grew in Löwenstein’s culture. Anti-tuberculous drugs were begun.

Discussion

Pulmonary infection by Mycobacterium tuberculosis is still a widespread clinical problem. Its radiological manifestations are very diverse, although usually its diagnosis can be clinically and/or radiologically suspected. Unusual forms of pulmonary tuberculosis include pleural effusions, mediastinal or hilar lymphadenopathies and pulmonary nodules; the presence of a large mass is an extremely rare form of presentation.

Tuberculomas are defined as solitary, round or oval pulmonary nodules which are surrounded by normal lung parenchyma, and are caused by M tuberculosis. They usually range from 0.5 to 4 cm in diameter.1 Radiologically they show calcifications in 50%, satellite lesions in 80%, and cavitation in one-third of cases. They are preferentially found in upper lobes and in the right lung, and are most frequently seen in women.5 Tuberculomas comprise 3–9% of all cases of pulmonary tuberculosis.3–4 Most patients are asymptomatic, and the diagnosis is difficult to establish unless X-ray findings are suggestive of pulmonary tuberculosis (cavitation, calcification, satellite lesions), since sputum samples and bronchoalveolar aspiration fluid are usually negative for acid-fast bacilli.3–4 In these cases the diagnosis is made by thoracotomy and tumorectomy3–5; conventional antituberculous treatment is still necessary.

The case described herein is interesting for several reasons. First of all the patient presented with a large lesion consistent with a pulmonary mass, which is an extremely rare form of pulmonary tuberculosis. Secondly, the absence of clinical manifestations, the non-specific thoracic X-ray and CT scan findings and the left lower lobe location of the mass were not suggestive of pulmonary tuberculosis. It was necessary to perform a thoracotomy and tumorectomy to make the diagnosis. Although the fine-needle aspiration could have suggested the diagnosis of an infectious necrotizing lesion, the absence of infecting organisms made it necessary to rule out a necrotic neoplastic lesion. Magnetic resonance imaging with gadolinium-DTPA might help in the diagnosis of pulmonary tuberculosis by showing the epithelioid granulomas as a reinforced peripheral halo,4 but the validity of this technique needs to be confirmed.

Final diagnosis

Pulmonary tuberculosis presenting as a large mass.

Keywords: tuberculosis, pulmonary mass, tuberculosis, Mycobacterium tuberculosis

3 Miller WT, MacGregor RR. Tuberculosis frequency of unusual radiographic findings. AJR 1978; 130: 867–75.
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