Characteristics of Patients with Lymphangioleiomyomatosis and Pleural Effusion: A Systematic Review

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Key Words
Chylothorax · Pleurectomy/decortication · Lymphangioleiomyomatosis · Pleural effusion · Pleural fluid · Sirolimus · Tuberous sclerosis complex

Abstract
The characteristics of patients with lymphangioleiomyomatosis (LAM) are poorly defined, as they may present with or without pleural effusion (PE). We performed a systematic review across four electronic databases searching for studies reporting clinical findings, PE characteristics, and the most effective treatment of LAM. Case descriptions and retrospective studies were included, unrestricted by year of publication. The review consisted of 94 studies (199 patients) spanning a period of nearly 55 years. The median age was 38 years (range: 1 month to 69 years), and 79.7% were between 21 and 50 years old. All cases had dyspnea, 95% had a cough, and 87.5% had chest pain. PE was exudative chylothorax, usually unilateral (76%) and right-sided, predominantly lymphocytic, and with proportionately higher levels of proteins than lactate dehydrogenase. Sirolimus was effective in all cases, completely in 87%, and partially in 13%, although the number of patients receiving sirolimus was small. The present study confirmed that LAM and PE mainly occur in women of childbearing age (third to fifth decade of life). PE was usually unilateral and presented as a lymphocyte-predominant chylous exudate. The most effective treatment for PE seems to be sirolimus, although studies with larger series are needed to confirm this.

Introduction
Pulmonary lymphangioleiomyomatosis (LAM) is a rare disease that almost exclusively affects women of childbearing age. It is characterized by abnormal proliferation of smooth muscle cells in different regions of the lung. This myeloproliferative process is often associated with proportionately higher levels of proteins than lactate dehydrogenase. Sirolimus was effective in all cases, completely in 87%, and partially in 13%, although the number of patients receiving sirolimus was small. The present study confirmed that LAM and PE mainly occur in women of childbearing age (third to fifth decade of life). PE was usually unilateral and presented as a lymphocyte-predominant chylous exudate. The most effective treatment for PE seems to be sirolimus, although studies with larger series are needed to confirm this.
with diffuse cystic changes in the lung parenchyma, with the possible appearance of pneumothorax, and the disruption or obstruction of the thoracic duct or one of its branches, causing chylous pleural effusion (PE) [1]. LAM can occur sporadically (noninherited form) or be associated with the tuberous sclerosis complex (TSC), a hereditary neurocutaneous syndrome (autosomal dominant) characterized by the formation of hamartomas in multiple organs including the skin, eyes, central nervous system, abdominal organs (especially the kidney), and lungs. About a quarter (26%) of women with TSC present with LAM [2].

Most patients have a sporadic form of the disease (sporadic LAM) that is not associated with germline mutations of TSC genes. However, they may present with some of the extrapulmonary manifestations found in TSC (renal angiomyolipoma, lymphadenopathy, and abdominal lymphangiomyoma) but not with others (eye, skin, or central nervous system involvement), which are necessary to establish the diagnosis of TSC [3]. While LAM, diagnosed by biopsy, may occur in some men with TSC [4], pulmonary involvement in patients with sporadic LAM has almost exclusively been reported in women [2].

The diagnosis of definite LAM may be made in the presence of a characteristic CT scan and a transbronchial, thoracoscopic, or open lung biopsy showing the characteristic histological features of LAM and reactivity with monoclonal antibody (human melanin black antibody-45). Alternatively, the presence of a characteristic lung CT and angiomyolipomas, chylous effusions, lymphangiomyoma, or TSC are sufficient to establish the diagnosis [5, 6].

About 55% of patients with sporadic LAM or TSC-LAM have a pneumothorax during the course of the disease and 21–28% have a PE [1, 7]. However, the characteristics of these patients are not well established since no large studies have been performed. Using a systematic review, our aim was to describe the characteristics of patients with LAM or TSC-LAM and PE, to analyze the characteristics of the pleural fluid (PF) and to evaluate the most effective treatment options of the recurrent PE that occurs in these cases.

**Material and Methods**

The method employed was that outlined in the PRISMA statement (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) [8]: in the absence of large studies which could provide answers to the study questions, the material comprised cases previously described in the literature.
Results

Ninety-four studies involving 199 patients were selected for review, spanning a period of nearly 55 years. Figure 1 presents a flowchart showing the complete breakdown of the steps used in the identification of appropriate studies [9–102]. They correspond to isolated case reports (between 1 and 4 per article) and 12 retrospective series [16, 25, 38, 43, 55, 57, 63, 67, 68, 86, 95, 100].

Demographic and Clinical Characteristics

Clinical and demographic characteristics of the 199 patients included in the study are shown in table 1, and their age group distribution is shown in figure 2. The median age was 38 years (range: 1 month to 69 years). The disease occurred mainly during the reproductive age (21–50 years; 106/133, 79.7%). Age was not available for 66 patients. Gender was not available for 10 patients. Of the final study population, 186/189 (98.4%) were women. Only 3 patients were male (2 TSC [37, 77] and 1 lymphangiomyomatosis [62]; ratio 62/1).

Table 1. Demographic and clinical findings of patients with LAM and PE

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age, years</td>
<td>38</td>
</tr>
<tr>
<td>Males/females</td>
<td>3/186</td>
</tr>
<tr>
<td>Smokers or ex-smokers/nonsmokers</td>
<td>5/29</td>
</tr>
<tr>
<td>Dyspnea, yes/no</td>
<td>76/0</td>
</tr>
<tr>
<td>Cough, yes/no</td>
<td>38/2</td>
</tr>
<tr>
<td>Chest pain, yes/no</td>
<td>28/4</td>
</tr>
<tr>
<td>Chyloptysis, yes/no</td>
<td>6/10</td>
</tr>
<tr>
<td>Hemoptysis, yes/no</td>
<td>17/4</td>
</tr>
<tr>
<td>Prior pneumothorax, yes/no</td>
<td>16/3</td>
</tr>
<tr>
<td>Simultaneous pneumothorax, yes/no</td>
<td>15/5</td>
</tr>
<tr>
<td>Prior or simultaneous pneumothorax, yes/no</td>
<td>28/4</td>
</tr>
<tr>
<td>Ascites, yes/no</td>
<td>44/25</td>
</tr>
<tr>
<td>Abdominal lymphadenopathy, yes/no</td>
<td>48/15</td>
</tr>
<tr>
<td>Renal angiomyolipoma, yes/no</td>
<td>20/13</td>
</tr>
<tr>
<td>LAM/STC/LAM-STC</td>
<td>178/7</td>
</tr>
<tr>
<td>Family history, yes/no</td>
<td>1/16</td>
</tr>
</tbody>
</table>

Values in parentheses represent percentage. 1 Range: 1 month to 69 years.

Pleural Effusion

PE was unilateral in 95 patients (76%), right-sided in 60 (63.2%), and left-sided in 35 (36.8%). In 30 patients, PE was bilateral (24%). In 74 cases the authors did not specify whether it was unilateral or bilateral. Of the 158 cases of patients with PE and descriptions of its appearance, 155 (98.1%) were chylous, 1 opaque fluid (triglycerides: 3,898 mg/dl) [80], and 2 serous-hematic [21, 48], although in a subsequent thoracentesis in 1 of them, the PF was described as ‘pink creamy’ [21]. Triglyceride levels were not specified in serous-hematic cases.
Biochemical characteristics and cellular differentiation of PF are described in only a few cases (table 2). The question of whether the PE was transudate or exudate was only addressed in 14 cases, and all corresponded to the latter. PF triglyceride levels were reported in 20 cases [23, 25, 29, 32, 37, 47, 49, 60, 63, 74, 77, 81–84, 87, 88, 91, 101], and all had values higher than 110 mg/dl (range 190–4,600 mg/dl). The presence of chylomicrons was only specified in 3 cases [46, 83, 101]. The PF culture was negative in the 16 cases where this was reported [10, 21, 30, 33, 37, 39, 45, 46, 49, 62, 65, 74, 80, 81, 83, 93], as was cytology for malignancy in the 25 cases where this parameter was described [11, 12, 16, 21, 22, 27, 30, 35, 37, 39, 46, 48, 57, 61, 63, 66, 79] (thoracentesis, chest tube pleurodesis, pleurectomy, and oophorectomy) with favorable results [33, 40, 42, 45, 48, 49, 57, 63, 66, 74] in 13 cases (56.5%). Lung transplantation (unilateral or bilateral) was performed in 7 patients with poor response in all cases [44, 52, 79, 94, 101], although in 1 case the disease took 5 years to reappear [79]. In another case, chylothorax appeared after bilateral lung transplant [76]. PE was not treated in 7 cases [16, 20, 28, 44, 57, 69], and the choice of treatment was not specified in another 75 patients with PE.

Discussion

Publications on LAM and PE involve isolated case reports and some small series, so key issues such as clinical course, characteristics of PE, or the most effective treatments are not well known. These questions were addressed using a systematic review of the literature relating to this disease.

Although LAM and PE can occur at any age, the largest number of cases (79.7%, 106/133) occurred during the reproductive age (21–50 years) (fig. 2). Most series of LAM with PE reflect the fact that it almost exclusively affects women, although some case reports involving men were found [37, 62, 77]. Two of them [37, 77] were in fact

Table 2. Descriptive analysis of the parameters determined in pleural fluid

<table>
<thead>
<tr>
<th>Parameter</th>
<th>n</th>
<th>Values 1</th>
<th>Range</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nucleated cells, cells/mm³</td>
<td>5</td>
<td>2,900</td>
<td>2,100–7,000</td>
<td></td>
</tr>
<tr>
<td>Differential count, % lymphocytes</td>
<td>6</td>
<td>94</td>
<td>74–97</td>
<td>Predominantly lymphocytes: 100% (6/6 cases)</td>
</tr>
<tr>
<td>Proteins, g/dl</td>
<td>20</td>
<td>4.7</td>
<td>2.5–8</td>
<td>95% of cases (19/20) ≥3 g/dl</td>
</tr>
<tr>
<td>LDH, IU/l</td>
<td>7</td>
<td>360</td>
<td>142–474</td>
<td>Low values: only 1 case with values &gt;400 U/l [86]</td>
</tr>
<tr>
<td>Cholesterol, mg/dl</td>
<td>14</td>
<td>91</td>
<td>29–199</td>
<td>2 cases with cholesterol values ≤30 mg/dl [45, 80]</td>
</tr>
<tr>
<td>Triglycerides, mg/dl</td>
<td>20</td>
<td>1,606</td>
<td>190–4,600</td>
<td>High values: all levels &gt;110 mg/dl</td>
</tr>
<tr>
<td>Chylomicrons, yes/no</td>
<td>3</td>
<td>3/0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose, mg/dl</td>
<td>8</td>
<td>99.5</td>
<td>91–144</td>
<td>High values</td>
</tr>
<tr>
<td>pH</td>
<td>4</td>
<td>7.46</td>
<td>7.42–9</td>
<td>No case with low pH; 1 case with high values [74]</td>
</tr>
</tbody>
</table>

LDH = Lactate dehydrogenase. 1 Values are given as median or number.

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cases of TSC without characteristics of LAM. However, these studies were included because there is disagreement about whether LAM and TSC lung lesions represent opposite ends of a continuum or whether LAM is a distinct entity. The third case corresponded to LAM with bilateral chylothorax [62], a characteristic already reported (LAM in a man) [4] but without PE. The typical patient, thus, would be a woman (98.4% of cases) aged 21–50 years (79.7%), nonsmoker (85.3%), presenting with dyspnea (100%), cough (95%), chest pain (87.5%), hemoptysis (81%), abdominal lymphadenopathy (76.2%), ascites (63.8%), renal angiomyolipoma (60.6%), and no family history (94.4%). Conversely, the presence of simultaneous or prior chyloptysis and pneumothorax is less frequent (37.5 and 37.3%, respectively) (table 1). The frequency of these characteristics is not always similar to that of patients with LAM, so those with PE have more frequently dyspnea (100% vs. 73%), cough (95% vs. 30.9%), chyloptysis (37.5 vs. 7%), hemoptysis (81% vs. 30.4%), ascites (63.8% vs. 4.3%), and renal angiomyolipoma (60.6% vs. 37.8%) and are less frequently smokers (14.7% vs. 39.6%) or have prior or simultaneous pneumothorax (37.3 vs. 55.5%) [1].

PE occurred in roughly a quarter (21–28%) of LAM cases during the course of the disease [7], more frequently in sporadic LAM than in TSC-LAM [1]. Three mechanisms may be involved in the development of chylothorax in LAM: (1) chyle leaking from the thoracic duct or its tributary branches due to proximal lymphatic obstruction or direct involvement; (2) chyle oozing from pleural lymphatics or collateral vessels, and (3) a transdiaphragmatic flow occurring from chylous ascites [63]. In our series, 98.1% (154/157) of the cases in which PE was described were chylous; in 2 cases the PF was described as opaque fluid (triglycerides: 3,893 mg/dl) [81] and as creamy pink at the second thoracentesis (no triglyceride data) [21], suggesting that they were also chylothorax, and only 1 case with PE was not (serous-hematic appearance). It therefore appears that PE secondary to LAM is indicated by exudative chylothorax (triglycerides >110 mg/dl in all cases described), usually unilateral, mainly right-sided, and predominantly lymphocytic with higher levels of proteins than lactate dehydrogenase (table 2). This characteristic PF analysis is representative of an increased capillary permeability or lymphatic dysregulation rather than pleural space inflammation. Measurements of pH and glucose can be useful to rule out other diseases but not to confirm the diagnosis. Cytology and culture of PE were negative in all cases. In 44 of 69 patients (63.8%) in whom ascites was described, PE was accompanied by this condition [9, 11, 16–18, 24, 26, 28, 30, 39, 48, 52, 55, 58, 63–65, 68, 73, 75, 76, 78, 82, 84–86, 88, 95], and in 97.3%

| Table 3. Established treatments for the control of PE associated with LAM |
|-------------------------------|-----------------|----------------|-----------------|
| Treatment                        | n   | Favorable | Unfavorable | Unknown |
| Therapeutic thoracentesis<sup>2</sup> | 62  | 7 (11.3)  | 53 (85.5)  | 2 (3.2)  |
| Pleurodesis<sup>3</sup>         | 44  | 25 (56.8) | 15 (34.1)  | 4 (9.1)  |
| Thoracic drainage<sup>4</sup>   | 32  | 8 (25)    | 23 (71.9)  | 1 (3.1)  |
| Decortication/pleurectomy<sup>5</sup> | 11  | 9 (81.8)  | 2 (18.2)   | 1 (0)    |
| Thoracotomy + thoracic duct ligation | 20  | 12 (60)   | 7 (35)     | 1 (5)    |
| Sirolimus                        | 23  | 23 (100)<sup>6</sup> | 0 (0) | 4 (9.1)  |
| Medroxyprogesterone<sup>7</sup>  | 23  | 13 (56.5) | 9 (39.1)  | 1 (4.4)  |
| Lung transplant                  | 7   | 0 (0)     | 7 (100)    |           |

Values represent the patient number with the percentage given in parentheses. 1 Favorable: full or partial control of PE or its symptoms; unfavorable: no control of PE or its symptoms, or recurrence. 2 Includes once-only evacuating thoracentesis, repeated thoracentesis, thoracentesis plus a free- or low-fat diet, thoracentesis plus treatment with medroxyprogesterone, octreotide, tamoxifen, or luteinizing hormone. 3 Includes pleurodesis with bleomycin, doxycycline, talc, povidone iodine, nitrogen mustard, OK-432, KE OK-432 (0.1 mg dehydrated preparation of Streptococcus pyogenes), mechanical pleurodesis, and pleurodesis plus thoracic duct ligation. 4 Chest drainage plus diet, tamoxifen, sirolimus, progesterone, octreotide, or antibiotics. 5 Includes pleurectomy alone and pleurectomy plus thoracic duct ligation, progesterone, or radiotherapy. 6 Partial resolution in 2 cases, and PE in 1 other case was stabilized. 7 Alone or combined with other treatments (thoracentesis, chest drainage, pleurodesis, pleurectomy, and oophorectomy).
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in 1 case [79]. Furthermore, in a series of 13 patients
(only 3 chylothorax), all had posttransplant complica-
tions [52], and in another patient, chylorrhox was ap-
ppeared after a double lung transplant [76]. Treatments with lute-
inizine hormone [58], triptorelin [60], tamoxifen [84],
ocotretide [87, 94], or chylovenous shunt [39, 76] seem
rather anecdotal since the number of cases in which they
have been used is very small, and in general results have
not been good. Spontaneous improvement of chylothro-
rax has also been described [31].

Our review has some limitations. The most important
is the reliance on descriptions of case reports instead of
case series or comparative trials. Therefore, the evalua-
tion of the quality of the reported literature could limit
internal validity, generalizability, and accuracy. In addi-
tion, some articles highlight the clinical characteristics of
the patients, while others stress diagnostic and therapeutic
aspects. Due to the heterogeneity of the reported infor-
mation, it is not possible to provide the details re-
quired, making it difficult to correctly classify some effu-
sions or evaluate the response to a particular treatment.
As in all rare diseases, the publication bias would be an-
other limitation to consider since the successfully treated
cases or atypical cases are more likely to get published.
Finally, the significant variation in the diagnosis and
management of chylothorax in LAM. Experts believe
that treatment should be identified based on the size of
the PE, its recurrence, the respiratory status of the pa-
tient, and existing comorbidities [6]. The most frequent-
ly used treatments are therapeutic thoracentesis (62 pa-
tients) and pleurodesis (44 patients), with a favorable re-
sponse in 11.3% [18, 21, 37, 42, 48, 83] and 56.8% [15, 16,
24, 27, 29, 53, 56, 57, 61, 63, 65, 66, 71–73, 85, 88, 101],
respectively. However, the best response is obtained with
sirolimus (100%). This drug (rapamycin), by binding to the
protein FKBP12, inhibits the pathway of the mam-
salian target of rapamycin, a protein that regulates the
growth, proliferation, motility, and cell survival, and the
addition of protein synthesis and transcription. Sirol-
mus has been shown to improve lung function [103] and
the resolution of chylous effusions in all patients with
LAM, although in some only partially [86, 95]. There-
fore, some authors considered it the standard treatment
for LAM [5]. Other treatment modalities have been de-
corticosteroid/pleurectomy (11 patients), chest tube (32 pa-
tients), ligation of the thoracic duct (20 patients), and
medroxyprogesterone (23 patients) with favorable re-
sponses in 9 (81.8%) patients [10, 13, 45, 57, 63], 8 (25%) 
patients [30, 33, 57, 63, 87], 12 (60%) patients [10, 12, 15,
24, 27, 57, 70, 73, 93, 96, 99], and 13 (56.5%) patients [33,
40, 42, 45, 48, 49, 57, 63, 66, 74], respectively. However,
these, possibly very optimistic, results should be inter-
preted with caution, since in the majority of these studies
they were associated with various treatments, and some-
times it is difficult to know which treatment led to the
favorable outcome. Furthermore, the follow-up period
was generally short in the majority of cases. Lung trans-
plant does not appear to be useful, since there were no
favorable outcomes in any of the cases, although a tem-
porary remission of 5 years in the disease was observed
(36/37) of the cases it was chyloous. The only case of non-
chyloous ascites corresponded to the already mentioned
patient that had a hemipereitoneum and a serous-hematic
PE [48]. It is possible that in these cases the source of chy-
lothorax was more likely due to the passage of fluid from
the abdominal cavity than to the pulmonary involvement
of the disease. Although this is the normal behavior of PE,
there are exceptions, such as observing a predominance of
eosinophils [21], values of protein and cholesterol that
could suggest the existence of a transudate [45, 81, 87], or
a pH outside the normal range [74]. The pleural biopsy
findings are nonspecific; therefore, it seems to be an un-
necessary test for the diagnosis of LAM [99].

The optimal method of managing chylothorax in
LAM has not seemed clear. There is no agreement on the
management of chylothorax in LAM. Experts believe
that treatment should be identified based on the size of
the PE, its recurrence, the respiratory status of the pa-
tient, and existing comorbidities [6]. The most frequent-
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sponse in 11.3% [18, 21, 37, 42, 48, 83] and 56.8% [15, 16,
24, 27, 29, 53, 56, 57, 61, 63, 65, 66, 71–73, 85, 88, 101],
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patients [30, 33, 57, 63, 87], 12 (60%) patients [10, 12, 15,
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favorable outcome. Furthermore, the follow-up period
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porary remission of 5 years in the disease was observed

Financial Disclosure and Conflicts of Interest

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References


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Erratum

Erratum to Table 6b in the paper by Slebos D-J et al. entitled ‘Bronchoscopic coil treatment for patients with severe emphysema: a meta-analysis’ [Respiration 2015;90:136–145] should read:

Table 6. Minimal clinically important difference

<table>
<thead>
<tr>
<th></th>
<th>ΔFEV₁&gt;0.1 liters</th>
<th>ΔSGRQ score&gt;-4 points</th>
<th>Δ6MWD &gt;26 m</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6-m FU</td>
<td>12-m FU</td>
<td>6-m FU</td>
</tr>
<tr>
<td>ΔRV &gt;0.4 liters</td>
<td>37 (31)</td>
<td>26 (28)</td>
<td>47 (38)</td>
</tr>
<tr>
<td>ΔFEV₁ &gt;0.1 liters</td>
<td>32 (26)</td>
<td>20 (22)</td>
<td>35 (30)</td>
</tr>
<tr>
<td>ΔSGRQ total score &gt;-4 points</td>
<td>54 (45)</td>
<td>38 (41)</td>
<td></td>
</tr>
</tbody>
</table>

Data are presented as n (%). Numbers in square brackets behind variables in table 6a are references supporting the MCID cutoffs. 6-/12-m FU = 6-/12-month follow-up; TLC = total lung capacity.