Chronic Obstructive Pulmonary Disease Mismatch: A Case of Tracheal Hamartoma

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Keywords
Tracheal neoplasms · Chronic obstructive pulmonary disease · Hamartoma · Computed tomography

Abstract
Objective: To demonstrate the diagnostic challenge of tracheal hamartoma in a patient with chronic obstructive pulmonary disease (COPD). Clinical Presentation and Intervention: A 65-year-old man with COPD was admitted with sudden onset of asphyxia attacks related to the position of his body. Computerized tomography (CT) of the neck showed a soft tissue mass with calcification, which occluded more than two-thirds of the proximal part of the trachea. The tumor was completely removed, and histopathology confirmed hamartoma. Conclusion: This case report showed the detection of a primary tracheal tumor on CT. This finding enabled the correct diagnosis and led to appropriate treatment in the form of surgery.

Case Report

A 65-year-old male patient was admitted to the clinic for thoracic surgery due to asphyxia attacks related to the position of his body. Computerized tomography (CT) of the neck showed a soft tissue mass with calcification, which occluded more than two-thirds of the proximal part of the trachea. The tumor was completely removed, and histopathology confirmed hamartoma.

Introduction

Primary tracheal tumors comprise <1% of all tumors and benign tumors are less common than malignant tracheal tumors [1]. Hamartoma, a benign tumor of mesenchymal origin, is extremely rare, with <20 adult cases to be found in the literature [2]. Due to signs and symptoms that mimic chronic obstructive pulmonary disease (COPD), there is usually a delay in diagnosing this tumor [3]. A common localization is the margin of the membranous and cartilaginous part of the tracheal wall. Here, we report a case that arose completely from the cartilaginous tracheal wall.
mass with calcification, approximately 2 cm in diameter, with a broad base abutting the anterior and left side of the tracheal cartilage (arrows) and occludes more than two-thirds of the initial lumen. Rigid preoperative bronchoscopy using general anesthesia showed a pale pink tumor that involved 4/5 of the tracheal lumen and a broad base connected with the third tracheal ring, while the membrane wall was completely free of it. During dissection of the trachea, it was determined that the tumor neither protruded the tracheal wall nor infiltrated the surrounding tissue. Partial resection of the trachea was done in block, and the tumor involved 2 tracheal rings which corresponded to hamartoma in its macroscopic features. T-T anastomosis of the trachea was done with individual stitches. On histopathologic examination, it was seen that the tumor was growing with its wide petiole from the cartilaginous tracheal wall. The presence of mesenchymal structures confirmed the diagnosis of tracheal hamartoma with chondromatous and lipomatous components (Fig. 2).

The postoperative course was uneventful and clinical and radiographic signs of tracheal obstruction were not seen at regular follow-up appointments. Three months after surgery, postoperative spirometry showed no physiologically significant narrowing of the upper airways but there were still signs of moderately expressed obstruction, which supported the previous diagnosis of COPD, with FVC 87% (3.36 L) and FEV₁ 59% (1.79 L).

Fig. 1. a Contrast-enhanced multidetector CT of the neck reveals a soft tissue mass with calcification, approximately 2 cm in diameter (arrows) at the proximal part of the trachea. b The mass, with a broad base, abuts the anterior and left side of the tracheal cartilage (arrows) and occludes more than two-thirds of the initial lumen.

Fig. 2. The cartilaginous part of the hamartoma protrudes into the tracheal lumen. a Tracheal glands are seen in the lower right corner. b Detail of the tumor. The hamartoma is settled in tracheal mucosa and covered by intact respiratory epithelium.
Discussion

The patient in the case presented here had had a history of progressive dyspnea for 2 years and had been treated without benefit according to a diagnosis of COPD. His unresponsiveness to bronchodilator therapy led us to consider fixed main airway obstruction and to conduct other diagnostic tests. Spirometry with the expected flow/volume curve [3, 4] findings of a calcifying soft tissue mass on imaging modalities and bronchoscopy confirmed the diagnosis [5].

If obstructive tracheal lesions are masked by the presence of COPD or asthma, as in this and previously reported cases, they are very difficult to diagnose. Conventional chest radiography as a first diagnostic test can lead to a tracheal tumor being overlooked due to its coexistence with COPD [6–8]. Sudden onset of shortness of breath and wheezing related to the position of the body should arouse suspicion of obstruction of the central airways, as in our case. Due to the slow-growing nature of hamartoma, the symptoms can be mild and negligible for years [7, 8]. Benign tracheal tumors, such as hamartoma, have a heterogeneous histological appearance and do not occur after complete resection [6]. Therefore, only surgical treatment is performed.

Conclusion

This case report showed detection of a primary tracheal tumor on CT. This finding enabled correct diagnosis and led to appropriate treatment in the form of surgery.

Acknowledgement

The authors dedicate this paper to the late Radoslav Jakovic, Professor of Thoracic Surgery, Faculty of Medicine, University of Belgrade, Belgrade, who inspired and encouraged us to aim for greater heights.

References