中文題目：一位有雙側腋下及腹股溝淋巴結病人合併氣管內腫瘤

英文題目：A endobronchial tumor in the patient with bilateral axillary and inguinal lymph nodes

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Case Report

The 46-year-old male labor with a history of diabetes mullitus was presented to our outpatient department because of chest tightness for one week.

One week ago, cough and whitish sputum developed. Then, he suffered from chest tightness that exacerbated when lying down. There was no fever, dyspnea, radiation pain, cold sweating or body weight loss. The body temperture On physical examination, his body weight was 108 Kg and body higeht was 174cm. The body temperture 36.9 ℃, blood pressure 159/87 mmHg, regular pulse rate 99 per minute, and smooth respiratory pattern were noted on physcial examination. Palpable lymph nodes over bilateral axillary and ingunal area were found. The breath sounds was clear and abdomen was soft without tenderness. Chest radiograph revealed focal density superimosed with left hilar region. (Figure 1) The chest computer tomograph (CT) showed a mass lesion (6.3 cm) over left hilar region (Figure 2) and enlarged lymph nodes in both sides of neck, mediastinum, axillary regions, hilar regions. Bronchoscopy was performed and a endobronchial tumor in the orifice of left ligunal lobe was found. (Figure 3) Forces biopsy to the tumor was performed and the psthology report showed atypical medium sized lymphoid cells with angulated nuclei and distinct nucleoli are seen focally. The immunohistochemical study reveals positive for CD10, CD20 and bcl-6; negative for CK, TTF-1, p40, CD3, MUM-1 and EBER-ISH, that diffuse large B cell lymphoma is favor. The patient was referred to hematology department for further staging and treatment.

Discussion

Diffuse large B-cell lymphoma (DLBCL) is the most common subtype of non-Hodgkin lymphoma (NHL). Most symptoms and signs of DLBCL included mediastinal lymphadenopathy, B symptoms (fever, weight loss, and night sweats). The most common site of DLBCL with extranodal involvement is gastrointestinal tract. Non-Hodgkin lymphoma generally affects the thorax in nearly half of the cases, but endobronchial non-Hodgkin lymphoma is rare. Endobronchial NHL occurs in the presence of disseminated disease. It develops from a variety of mechanisms such as direct bronchial invasion from a parenchymal or mediastinal mass, lymphatic spread to

peribronchial connective tissues, transbronchial aspiration of tumor emboli, and direct hematogenic spread. Bronchoscopic examination with biopsy is essential for the diagnosis. To classify the types of endobronchial NHL, immunohistochemistry is necessary, and gene rearrangement and cytogenetic examination are the alternative.

Conclusion:

In conclusion, endobronchial NHL is rare and requires a high degree of suspicion to establish the diagnosis. Endobronchial biopsy for histologic examination and immunohistochemistry are required to confirm the diagnosis.

Figure

Figure 1. Chest radiograph showed a mass lesion over left hilar region.

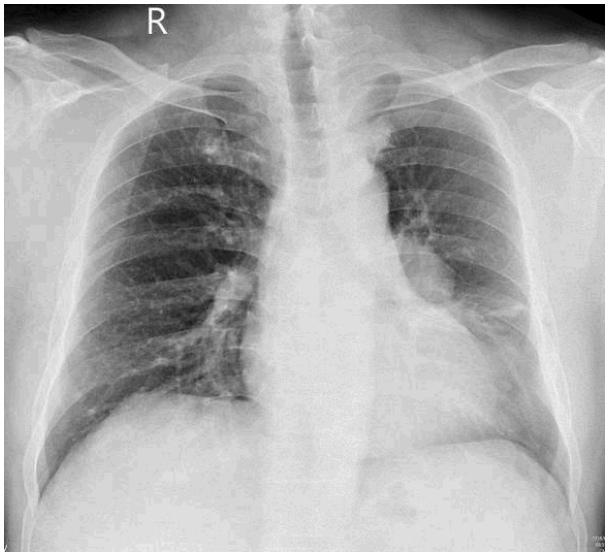

Figure 2. CT revealed a mass lesion (6.3 cm) over left hilar region

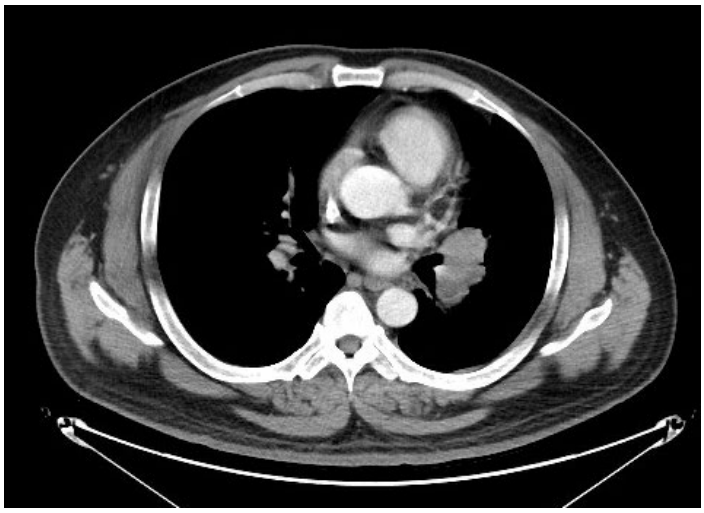

Figure 3. Bronchoscopy showed endobronchial tumor in the orifice of left lingual lobe.