ELSEVIER

European Journal of Cardio-thoracic Surgery 21 (2002) 155–161

EUROPEAN JOURNAL OF CARDIO-THORACIC SURGERY

www.elsevier.com/locate/ejcts

Letters to the Editor

Letter to the Editor

Tracheal bronchus obliterated with bronchial carcinoid

Muzaffer Metin, Adnan Sayar, Akif Turna*, Atilla Gürses
Yedikule Hospital for Chest Disease and Thoracic Surgery, Zeytinburnu, Istanbul, Turkey

Received 11 July 2001; received in revised form 26 September 2001; accepted 1 October 2001

Keywords: *Tracheal bronchus*; *Typical carcinoid*; *Aberrant bronchus*; *Tracheoplasty*

Tracheal bronchus (TB) is an aberrant bronchus that usually arises from the right lateral wall of the trachea less than 2 cm above the major carina and it was first described by Chiari in 1889 [1]. Two types of the anomaly are described: 'supernumerary', which is associated with a normal trifurcating right upper lobe bronchus, and 'displaced' in which instance the ectopic bronchus supplies the apical segment of the upper lobe [2].

A 33-year-old man was admitted to the chest ward with a complaint of chest pain and a history of treated pneumonia initiated 1 month ago. The initial chest radiograph showed a patchy consolidation in the right upper lung field. Flexible bronchoscopy revealed a right-sided tracheal bronchus. It originated from the posterio-lateral wall of the lower trachea about 1 cm above the tracheal bifurcation. A purplish tumor growth obstructing the distal TB lumen was found and was causing nearly total occlusion of it. Only two segmental bronchi were identified arising from the right upper lobe bronchus. They were posterior and apical branches. Remaining bronchial anatomy was otherwise normal. Both biopsy and cytologic brushing of the tumor were performed and histology revealed a carcinoid tumor. Computed tomography of the thorax disclosed a spiculated 7 cm mass in the right upper pulmonary lobe near the right tracheal border and accessory TB.

Utilizing one-lung ventilation with a left-sided double lumen endotracheal tube, a right thoracotomy was performed. The tumor was completely resected by apical segmentectomy with tracheoplasty. Histology confirmed the diagnosis of typical carcinoid tumor with no mitosis, necrosis or nuclear hyperchromasia. Postoperatively he made a good recovery and was discharged home on day 5.

Contrary to the numerous variations of lobar or segmental bronchial subdivisions, abnormal bronchi originating from the trachea or main bronchi are rare. It occurs in approximately 2% of people [2]. Tracheal bronchus is a normal finding in sheep, swine, cattle, camels, goats, and giraffes, but a rare and usually incidental finding in humans [2]. TB is of no clinical significance, although some reports indicate that it is associated with recurrent pneumonia, chronic bronchitis, and bronchiectasis [3].

Carcinoid tumors are low-grade neoplasms of neuroendocrine cells, which constitute 1–2% of all lung tumors [4]. The preoperative knowledge of the histologic subtype of the tumor, the presence of lymph node involvement, and the intraoperative assessment of resection margins by frozen section examination could assist in therapeutic decision-making. The carcinoid tumor was completely resected by right upper lobe apical segmentectomy. We additionally performed tracheoplasty since, the tumor was protruded from the 'displaced' apical TB and the distance between TB and tracheal carina was barely 1 cm.

There is only one case of bronchial carcinoid developing from the tracheal bronchus [5] and we present a second case. Unlike ours, their report indicated a 'supernumerary' TB with otherwise normal right upper lobe branching. Although there is a lack of evidence that TB is more susceptible to malignancy, careful preoperative bronchoscopic and tomographic evaluation is warranted to exclude this possibility, thus permitting a conservative lung-sparing resection.

References

[1] Boyden EA. The distribution of bronchi in gross anomalies of the right upper lobe, particularly lobes subdivided by azygos vein and those containing prearterial bronchi. Radiology 1952;58:797–807.
[2] Rodgers BM, Harman PK, Johnson AM. Bronchopulmonary foregut malformations: the spectrum of anomalies. Ann Surg 1986;203:517–524.
[3] McCaughan BC, Martini N, Bains MJ. Bronchial carcinoids: review of 124 cases. J Thorac Cardiovasc Surg 1985;89:8–17.
[4] Carter D, Eggleston JC. Tumors of the lower respiratory tract. Atlas of tumor pathology, Second Series, Fascicle 17. Washington, DC: Armed Forces Institute of Pathology, 1980.
[5] Patrinou V, Kourea H, Dougenis D. Bronchial carcinoid of an accessory tracheal bronchus. Ann Thorac Surg 2001;71:1034–1035.

* Corresponding author. Cami Sok. Muminderesi Yolu. Emintas Camlik Sit. No: 32/22, Sahrayicedid, Kadikoy 81080 Istanbul, Turkey. Tel.: +90-216-411-3675; fax: +90-216-411-6651.
E-mail address: aturna@turk.net (A. Turna).

PII: S1010-7940(01)01029-6

Letter to the Editor

Posterolateral thoracotomy is behind limited thoracotomy and thoracoscopic surgery in terms of postoperative pulmonary function and walking capacity

Hiroaki Nomori*, Hirotoshi Horio, Tsuguo Naruke, Keiichi Suemasu

1010-7940/02/$ - see front matter © 2002 Elsevier Science B.V. All rights reserved.

Downloaded from https://academic.oup.com/ejcts/article-abstract/21/1/155/469094 by guest on 06 March 2020