Unexplained dyspnoea in a patient with idiopathic myelofibrosis

A 41-year-old with idiopathic myelofibrosis was referred to the chest clinic with a 1-month history of progressive dyspnoea and intermittent wheeze. There was no history of haemoptysis and the patient was a lifelong non-smoker. On examination, the patient was afebrile, cachectic and had hepatosplenomegaly. Haemoglobin was 6.0 g/dl, white cell count $3.6 \times 10^9/l$, platelet count $98 \times 10^9/l$. Blood smear showed marked anisopoikilocytes, prominent tear drop cells and polychromasia. Bone marrow aspirate was hypercellular, showed reduction in the degree of maturation, and a marked decrease in the proportion of erythroid cells. There was no evidence of acute leukaemia or metastatic malignancy. Microbiologic analysis of the sputum and blood for pulmonary infection was negative. Lung function test showed a restrictive pattern and a DLco of 32% predicted. Chest radiography demonstrated diffuse bilateral reticular interstitial infiltrates and bibasal septal lines. A subsequent CT of the chest demonstrated diffuse bilateral smooth and nodular interlobular septal thickening with centrilobular nodules (figure 1). There was no echocardiographic or radiologic evidence of pulmonary hypertension.

On the basis of the patient’s unexplained progressive dyspnoea, impaired gas transfer and CT findings, an open VATS-assisted lung biopsy was performed. Histology demonstrated pulmonary congestion and haemorrhage (figure 2) and numerous dark-staining hyperchromatic cells with multilobated nuclei within alveolar capillaries. On CD42B immunostain and high power (inset figure 3), these cells were confirmed as megakaryocytes (figures 2 and 3). The absence of CD34 expression (inset figure 2) in the peribronchiolar immature myeloid precursor cells and lymphoid cells excluded leukaemic infiltration. There was no evidence of interstitial fibrosis. The histology was consistent with pulmonary extramedullary haemopoiesis (EMH). The patient was started on cytoreductive hydroxyurea and referred to the local bone marrow transplant unit.

EMH is the development and growth of haematopoietic tissue outside of the bone marrow. Although essential in foetal life, its occurrence after birth is abnormal. As in physiologic foetal
EMH, the liver, spleen and lymph nodes are the most common sites of pathologic EMH, however, thoracic EMH has been described. Pleural-based tumours and paraspinal masses are the most common thoracic manifestations of EMH, while pulmonary interstitial EMH is rare and usually occurs in patients with an antecedent haematologic disorder. In suspected pulmonary EMH, surgical lung biopsy is required to allow immunohistochemical staining for erythroid, myeloid and megakaryocyte precursors, which typically follow the pulmonary lymphatics. The CT findings of pulmonary EMH are non-specific. However, when this pattern of interlobular septal thickening and centrilobular nodules is encountered in a patient with a haematological malignancy, the diagnosis of pulmonary interstitial EMH should be considered.

Learning points

- Pulmonary EMH is an uncommon and typically late manifestation of myelofibrosis.
- Unexplained dyspnoea, diffuse interstitial infiltrates on chest radiograph, and diffuse interlobular septal thickening on CT in patients with haematological malignancies should prompt the clinician to consider pulmonary EMH.

Praveen Pissay Gopala Rao, Rachel Buxton-Thomas, Brendan Tinwell, Adrian Draper, Johnny Vlahos, Simon L F Walsh

1Department of Radiology, St George’s Hospital, London, UK; 2Department of Respiratory Medicine, St George’s Hospital, London, UK; 3Department of Histopathology, St George’s Hospital, London, UK; 4Department of Radiology, Royal Brompton Hospital, London, UK

Correspondence to Dr Praveen Pissay Gopala Rao, Department of Radiology, St George’s Hospital, Blackshaw Road, Tooting, London SW17 0QT, UK; drpgrpraveen@gmail.com

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

Received 16 February 2012
Accepted 26 May 2012

Thorax 2012;67:1—2. doi:10.1136/thoraxjnl-2012-201783

REFERENCES

Unexplained dyspnoea in a patient with idiopathic myelofibrosis

Praveen Pissay Gopala Rao, Rachel Buxton-Thomas, Brendan Tinwell, Adrian Draper, Johnny Vlahos and Simon L F Walsh

Thorax published online July 6, 2012

Updated information and services can be found at:
http://thorax.bmj.com/content/early/2012/07/05/thoraxjnl-2012-201783

These include:

References
This article cites 4 articles, 0 of which you can access for free at:
http://thorax.bmj.com/content/early/2012/07/05/thoraxjnl-2012-201783#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections

- Thorax Images in Thorax (149)
- Screening (oncology) (407)
- Lung infection (97)
- Pulmonary hypertension (205)
- Lung cancer (oncology) (670)
- Lung cancer (respiratory medicine) (670)
- Lung neoplasms (608)
- Hemoptysis (80)
- Respiratory cancer (104)
- TB and other respiratory infections (1273)
- Transplantation (184)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/