IMAGES IN THORAX

Pulmonary artery aneurysms and thrombi

C M J Steendam,^{1,2,3} A L Diederik,^{4,5} A Dendooven,^{6,7} R J Snijder,¹ G J Herder¹

¹Department of Pulmonology, St. Antonius Hospital Nieuwegein, Nieuwegein, The Netherlands

²Department of Pulmonology, Amphia Hospital, Breda, The Netherlands

³Department of Pulmonology, Erasmus MC, Rotterdam, The Netherlands

⁴Department of Radiology, St. Antonius Hospital Nieuwegein, Nieuwegein, The Netherlands

⁵Department of Radiology, Gelderse Vallei Hospital, Ede, The Netherlands

⁶Department of Pathology, St. Antonius Hospital Nieuwegein, Nieuwegein, The Netherlands

⁷Department of Pathology, University Hospital Antwerp, Edegem, Belgium

Correspondence to

CMJ Steendam, Department of Pulmonology, Amphia Hospital, Molengracht 21, Breda 4818 CK, The Netherlands; cmjsteendam@gmail.com

Received 20 November 2016

Revised 12 January 2017

Accepted 13 January 2017

Published Online First

7 February 2017

A 19-year-old previously healthy boy was referred to our hospital with fever, progressive coughing, dyspnoea and haemoptysis for 2 weeks. He had lost weight (3 kg) and was experiencing night sweats.

In the past 6 months, he had experienced that his overall condition and training capacity in sports had decreased noticeably.

On examination, he was tachypnoeic and tachycardic with normal blood pressure. Oxygen saturation was 90% with 15 L of oxygen delivered by Venturi mask. There were diminished breathing sounds in the basal segments of the right lung and in the upper paravertebral region. No other abnormalities were identified.

The laboratory results included a mild microcytic anaemia, leucocytosis and elevation of C reactive protein.

CT and conventional studies showed a central mass in the right upper lobe (figure 1A, B).

Positron emission tomography-CT (PET-CT) and magnetic resonance angiography (figure 1C) demonstrated (pseudo-) aneurysms of the pulmonary arteries in both lungs, ranging in size from 1 up to 6 cm in diameter, with thrombus lining the walls and in the central pulmonary arteries. The vascular walls showed enhancement after gadolinium admission and fludeoxyglucose (FDG) uptake.

There were no lesions found elsewhere in the body.

The differential diagnosis of pulmonary artery aneurysms includes infection (eg, TB, syphilis, bacterial, viral or fungal), structural cardiac abnormalities, pulmonary hypertension, idiopathic vasculitis syndromes (Hughes-Stovin syndrome and Behçet's disease), trauma and miscellaneous.^{1 2}

There were no signs of structural cardiac abnormalities, pulmonary hypertension, trauma, infection, neoplasm, autoimmune disorders causing

vasculitis or signs of Behçet's disease. We diagnosed Hughes-Stovin syndrome after consultations at a multidisciplinary team meeting and with international experts.

We started immunosuppressive therapy with methylprednisolone (1000 mg a day, during 3 consecutive days) and cyclophosphamide (750 mg/m²). After the first cycle, the patient developed signs of infection, for which broad-spectrum antibiotics was given in combination with prednisone maintenance therapy.

Follow-up FDG-PET-CT showed progression, and his clinical condition deteriorated with progressive haemoptysis. We performed extensive embolisation of the aneurysms without success. During the procedure, pulmonary artery pressure was 65/31 mm Hg (mean 44 mm Hg) with normal wedge pressure (7 mm Hg).

The patient was admitted to the intensive care unit, where he developed respiratory failure and exhaustion. The patient died approximately 6 weeks after admission.

The autopsy revealed multiple bilateral aneurysms and thrombi. Although not macroscopically evident, microscopic examination revealed that the thrombi were composed of a pleomorphic, intravascular-located tumour process consistent with high-grade pulmonary intima sarcoma (figure 2).

DISCUSSION

Hughes-Stovin syndrome is a rare vasculitic disorder of unknown aetiology. As such, it does not yet have formally described diagnostic criteria and is a diagnosis of exclusion. This disorder induces thrombophlebitis, followed by the formation of large pulmonary and/or bronchial artery aneurysms, and eventually leads to aneurysmal rupture with massive haemoptysis and death.²

Figure 1 (A) The mass in the right upper lobe on conventional posterior-anterior study, (B) on coronal reconstruction of CT. (C) Magnetic resonance angiography showing the aneurysms in coronal reconstruction.

CrossMark

To cite: Steendam CMJ, Diederik AL, Dendooven A, et al. *Thorax* 2017;**72**:1167–1168.

Figure 2 (A) The macroscopic view of the right lung from the hilus with evident aneurysms and thrombi. (B) The microscopy with growth of the tumour in the lumen of a branch of the pulmonary artery and pulmonary angiosarcoma (H&E stain).

Pulmonary artery sarcoma is a rare disease.³ It is known to resemble thromboembolic disease, but this aneurysmatic presentation is even more rare.⁴

This case shows how difficult diagnosis on pulmonary artery aneurysms is in an unstable clinical condition and confirms the poor prognosis of pulmonary angiosarcoma as described in literature.³

Contributors All authors wrote, revised and approved the final manuscript.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

- 1 Theodoropoulos P, Ziganshin BA, Tranquilli M, *et al.* Pulmonary artery aneurysms: four case reports and literature review. *Int J Angiol* 2013;22:143–8.
- 2 Khalid U, Saleem T. Hughes-Stovin syndrome. *Orphanet J Rare Dis* 2011;6:15.
- 3 Blackmon SH, Rice DC, Correa AM, *et al.* Management of primary pulmonary artery sarcomas. *Ann Thorac Surg* 2009;87:977–84.
- 4 Terra RM, Fernandez A, Bammann RH, *et al.* Pulmonary artery sarcoma mimicking a pulmonary artery aneurysm. *Ann Thorac Surg* 2008;86:1354–5.