Antiplatelet therapy was discontinued, and the patient was treated with aminocaproic acid, prophylactic antibiotic therapy with amoxicillin and clavulanic acid and anticoagulant doses of low molecular weight heparin. He was discharged on remission of hemoptysis.

As this was an elderly patient with relapsed and disseminated disease, the chosen treatment was chemotherapy with chlorambucil and prednisolone, and local therapy (with bronchoscopy or radiotherapy) if he didn’t respond. He has so far completed 8 cycles of chemotherapy and remains asymptomatic. Follow-up chest CT showed complete resolution of the tracheal mass.

Although tracheal MALT lymphoma is extremely rare, it is associated with favorable prognosis and long term survival. Several different therapeutic options have been shown to be effective in this disease (surgical resection, radiotherapy, bronchoscopic therapy, chemotherapy, immunotherapy (rituximab) and immunochemotherapy). Given its rarity, there is insufficient data to compare the different options available.

In the case of disseminated disease, the treatment guidelines for non-gastric lymphoma recommend chemotherapy alone or in combination with immunotherapy. Local radiotherapy should be used only in localized stages or in palliation of local symptomatic disease.4,5

Given the prognosis and survival of this disease, this is an important differential diagnosis in tracheal lesions.2,3 According to the PubMed database, 20 cases have been reported worldwide; this is the first case described in Portugal.

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and after confirmation of bleeding control, sutures were placed at the entrance of the lung parenchyma.

New chest tubes were placed and the patient was transferred to the ICU. Following the intervention, chest X-rays showed bilateral infiltrates compatible with ARDS, and over the next few days the patient developed multiorgan failure. Finally, the patient died on the seventh postoperative day.

Several complications have been reported following chest tube insertion, including lung and diaphragm lacerations, intercostals artery bleeding and perforation of intraabdominal organs. Damage to cardiac structures has also been reported, such as right atrium perforation described by Meisel, Ram and Priel.

As previously reported, a chest X-ray showing the tip of the catheter passing across the midline and the withdrawal of fresh blood should raise the suspicion of pulmonary artery perforation, as was the case in our patient.

It has been described that pleural adhesions, as also found in this case, could play a role upon misplacing the thoracostomy tube, probably by leading to perforating the lung parenchyma or lacerating vascular structures.

For the management of pulmonary artery perforation, different approaches have been described including the progressive withdrawal of the chest tube during several days with no surgical intervention. However, it is accepted that the best option is to keep the tube clamped when there is suspicion of a great vessel rupture until the patient arrives to the operating room. It has been reported that the retrieval of the chest tube prior to arrival to the operating room may lead to a fatal outcome.

Finally, chest tube insertion is a procedure that saves lives and is commonly performed in everyday clinical practice. However, as in any medical/surgical procedure, complications may occur. In order to achieve the best treatment, it is important to quickly recognize them and to choose the most suitable treatment for each patient. In the case we present we believe that the immediate surgical approach may be the best choice.

References


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