

Introduction

How do we interpret the appearance of lung nodular lesions after upper right lobectomy 8 months ago for a large cell neuroendocrine lung carcinoma ?

Case Summary – History

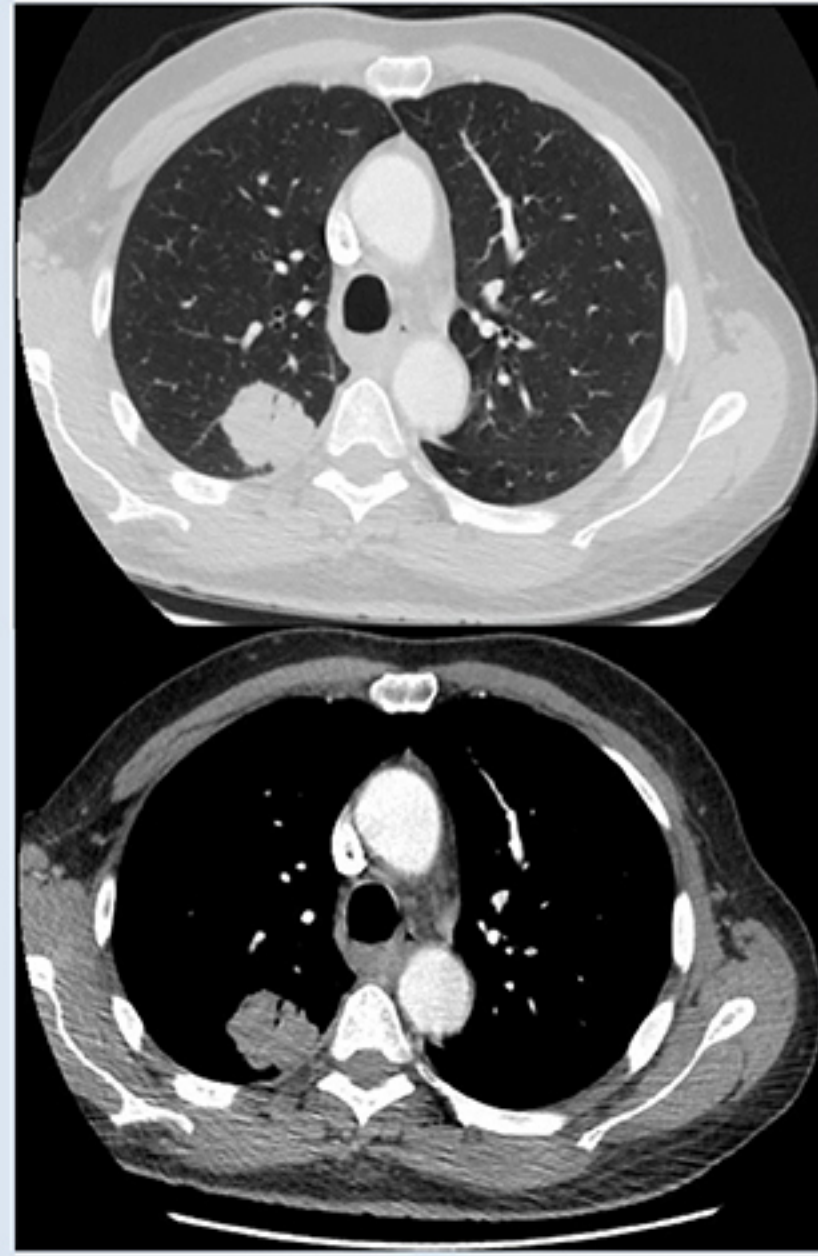
- 64-year-old male
- Ex-smoker (~20 YP) for over 10 years
- Without occupational exposure to respiratory toxins

- January 2017 – right anterior hemithorax chest compression – Chest X-Ray



- Recommendations: Toracic CT Scan with contrast.

- Toracic and Abdominal CT scan with contrast and bronchoscopy with bronchoalveolar lavage were performed in the same month.



- Conclusion: Upper right lobe malignant tumor.

- February 2017 – right upper lobectomy with mediastinal lymphadenectomy – HP exam: Large cell neuroendocrine lung carcinoma staged T2aN0M0



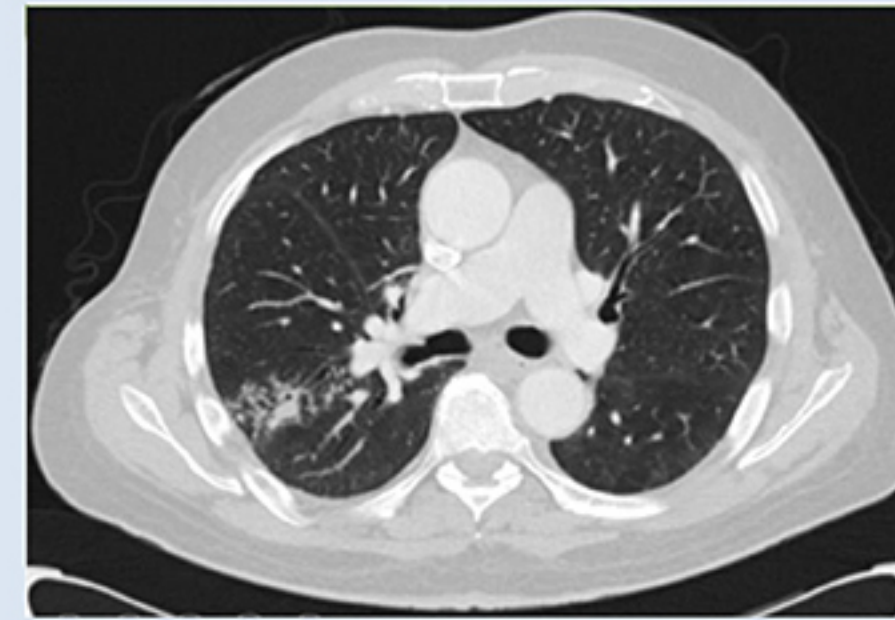
- March – July 2017: 4 chemotherapy courses.
- July 2017: Oncological re-evaluation – Stained glass at the LIS level, favorable CT appearance (no signs of tumor recurrence, no secondary determinations)



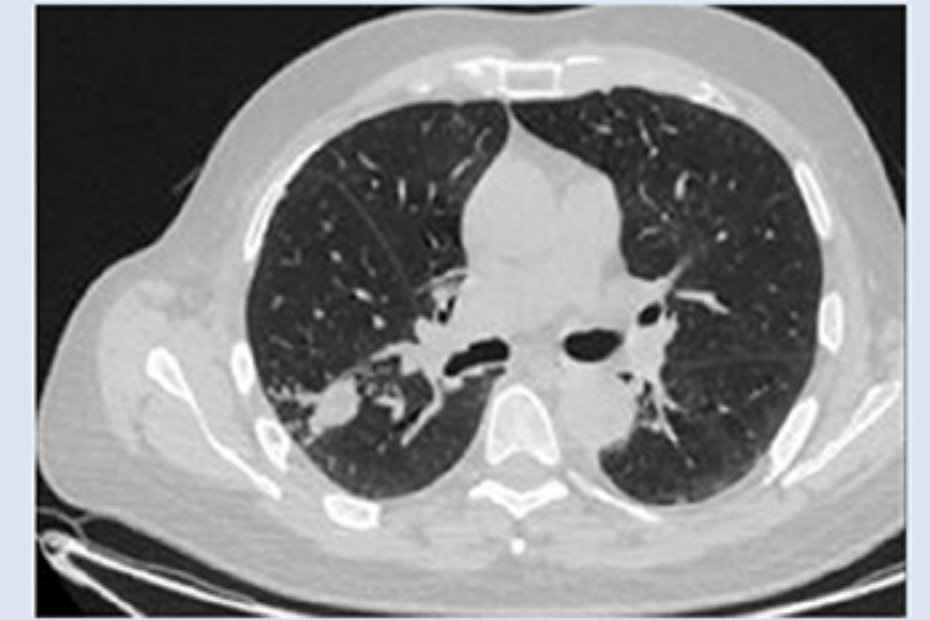
Case Summary

- Presentation: September 2017: chest pain on the right side, persistent febrile syndrome – antibiotic treatment is initiated with the recommendation of complete diagnostic investigations by Chest CT scan and TB sputum examination
- Evolution: Unfavorable – patient with precarious general status

- October 2017 – Right basal chronic pneumonia

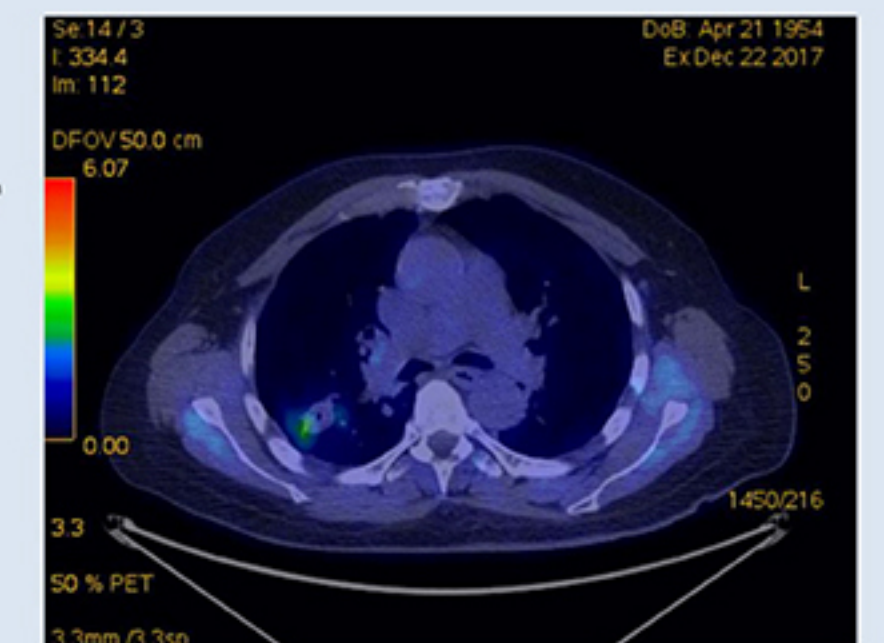


- November 2017 – Condensation and homolateral adenopathy



- December 2017

- Bronchoscopy + BAL – GeneXpert MTB : Detected "Very Low"
- PET CT – Partially metabolically active LID lung lesion
- CT – guided biopsy puncture: Necrosis
- Exploratory thoracoscopy: Casified epithelioid granuloma.
- January 2018: Positive diagnosis – TB treatment initiation



- Favorable evolution since the positive diagnosis

Conclusions:

- ✓ Complex patient, the association of two distinct pathologies with a possible mutual causal relationship.
- ✓ Although the patient underwent multiple high-standard investigations: 3 bronchoscopies, 4 native and contrast tomographic examinations and 1 PET-CT, the positive diagnosis was a difficult one - something that does not show the limitations of paraclinical investigations.
- ✓ Always keep in mind the possible association of NBP with Tuberculosis due to several causes:
 1. The pre-existence of tubercular lesions that can degenerate malignantly
 2. Reactivation of latent tuberculous lesions due to immunosuppression caused by both the malignant tumor and chemostatic treatment.
 3. Simultaneous evolution of separate pathologies

Discussion

- Therapeutic attitude:
 - The patient was treated with 2 courses of antibiotic therapy, initially broad-spectrum, later ultra-broad with the almost complete disappearance of the symptoms.
 - Due to the unfavorable evolution of the patient - it is necessary to obtain a diagnosis of certainty.
- The particularity of the case:
 - The difficulty of establishing a diagnosis of certainty, even in the conditions of increased accessibility to high-quality investigations.
- Key points:
 1. Paraclinical investigations guide our clinical attitude, but they cannot always provide the answer we are looking for.
 2. In order to maximize the quality of the medical service, they must use every resource to help us establish the diagnosis of certainty - endoscopies, imaging investigations, surgical interventions and laboratory examinations.
 3. The therapeutic attitude must be dictated by a multidisciplinary team so that the patient's benefit is maximal - in the present case: Pneumology-Oncology-Thoracic surgery-Infectious diseases.

References

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4. The effect of anti-cancer and anti-tuberculosis treatments in lung cancer patients with active tuberculosis: a retrospective analysis
5. Cancer or Tuberculosis: A Comprehensive Review of the Clinical and Imaging Features in Diagnosis of the Confusing Mass