

A case of lung, pleura, and lymph nodes metastases from basal cell carcinoma

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Introduction: Basal cell carcinoma (BCC) is the most common cutaneous malignancies. However, metastasis from this tumor is extremely rare and estimated to range from 0.003 to 0.05% of cases. The criteria for the diagnosis of metastatic basal cell carcinoma (MBCC) is that the primary tumor is from skin and not of mucosal or glandular tissue; metastasis must be at a distant site and cannot be a result of direct extension; the primary and metastatic tumor must share the same histologic subtype. To our knowledge, only a few cases of MBCC have been reported in Korea. We report a case of BCC metastasizing to the lung, pleura, and lymph nodes. **Case Report:** A 69-year-old man was referred to our hospital with left pleuritic chest pain for 3 months. The patient had a history of basal cell carcinoma involving right upper arm that was diagnosed 20 years earlier. He underwent excision of the primary tumor and reconstruction with split-thickness skin graft. The tumor had three local recurrences that required excisions and radiation treatment. He had no evidence of recurrence for 5 years before this presentation. A chest computed tomographic (CT) scan showed multiple nodules in the right middle lobe and both lower lobes and small amount of pleural effusion with pleural thickening in left hemithorax. Fluorine 18-labeled fluorodeoxyglucose (FDG)-positron emission tomography-CT scan revealed abnormal FDG uptake in the lung nodules and the subaortic and left retrocrural lymph nodes. He underwent video-assisted thoracoscopic surgical biopsy for lung nodule and pleural nodule. This biopsy specimens of the lung nodule and pleural nodule revealed basal cell carcinoma. He was transferred another hospital and received chemotherapy.

Three cases of endobronchial management in patients with advanced leiomyosarcoma

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Endobronchial metastasis of leiomyosarcoma is rare, but it can cause life-threatening complications such as dyspnea, massive hemoptysis, respiratory failure, or death. The development of new endoscopic modalities including cryoextraction allows effective endobronchial management. However, there is little information about interventional bronchoscopy for endobronchial metastasis from advanced leiomyosarcoma. We report three patients with endobronchial metastases from advanced leiomyosarcomas that caused bronchial obstruction. The bronchoscopic examinations revealed masses obstructing the left main bronchus in all three patients. Recanalization of malignant endobronchial obstruction was successful in all three patients using cryoextraction. Two of them required repeated bronchoscopic intervention, which was effective and seemed safe. After removing the endobronchial tumor via interventional bronchoscopy, there was symptomatic and radiologic improvement. Moreover, the patients could undergo additional palliative chemotherapy. The experiences with our three patients suggest that interventional bronchoscopy helps to alleviate respiratory symptoms and improves clinical status. It also provides an opportunity for further treatment. Therefore, endobronchial management should be considered in the treatment of endobronchial metastasis, even in patients with advanced malignancies.