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기관지를 침범한 외투세포림프종 1예

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서론: 외투세포림프종 (Mantle cell lymphoma) 은 비호지킨림프종 (Non-Hodgkin's lymphoma) 의 3~10 %를 차지하는 드문 질환으로, 진단 시 대부분 병이 진행된 상태로 림프절, 비장, 간, 위장관, 골수 등의 침범을 보인다. 하지만 외투세포림프종이 기관지를 침범하는 경우는 매우 드물어서 세계적으로 수 건의 증례만 보고 되었으며, 국내 문헌에서는 보고된 바를 찾기 힘들다. 저자들은 기관지내시경으로 기관내 종괴를 발견하고 조직검사를 통해 외투세포림프종을 진단한 1예를 경험하여 보고한다. **증례:** 72세 남자가 3일 전 발생한 호흡곤란으로 내원하였다. 흉부 컴퓨터 단층촬영상 우상엽 폐종괴 및 종격동 림프절 비대가 있어 경피적 폐생검 (Percutaneous Needle Biopsy) 을 시행하였으나 결과는 만성 염증이었다. 이후 시행한 기관지내시경 검사에서 우상엽 폐첨 분절을 막고 있는 종괴가 관찰되어 조직검사를 시행하였고, 병리 결과 lymphoma 로 보고되었으며, 면역조직화학 검사에서 CD20 양성, CD5 양성, Cyclin D1 양성으로 최종 mantle cell lymphoma 로 진단되었다. 이후 환자는 경부 및 복부 컴퓨터 단층촬영, 양전자 방출 단층촬영 및 골수 검사 등의 추가검사를 통해 종격동 림프절, 우측 비인두 및 골수 침범을 확인하여 병기 IV기 판정 후 Rituximab 을 기반으로 하는 항암 화학치료를 시작하였다. **고찰:** 외투세포림프종이 폐를 침범하는 것 자체도 매우 드물다고 알려져 있으며, 본 증례에서와 같이 기관내 침범을 보이는 경우는 진행된 병기에서도 거의 보고된 바가 없다. 이 환자에서처럼 호흡기계 증상 발현을 통해 폐에 국한된 종괴를 조직 검사하여 외투세포림프종이 발견된 증례는 매우 드물어 이를 보고하는 바이다.

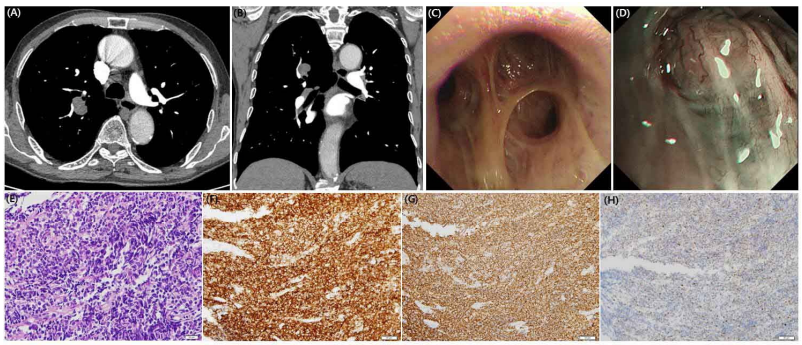

Figure 1. (A)(B) Chest CT shows well-defined nodule in RUL. **(C)** Bronchoscopy shows a mass obstructing bronchus, RUL apical segment. **(D)** Narrow band imaging of the mass. **(E)** Pathological findings of endobronchial biopsy. Atypical cells with a high nuclear cytoplasmic ratio and irregular nuclei formed sheet like lesions (H&E staining, x 400). Immunohistochemical staining revealed positivity for CD5 (x200) **(F)**, CD20 **(G)**, Cyclin D **(H)**.

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A rare case of micro pulmonary infarction due to an accidental cement injection into soft tissue

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Introduction Percutaneous vertebroplasty is a commonly used technique for painful vertebral compression fractures caused by osteoporosis. The procedure involve injection of bone cement into the desired vertebral body. However, serious complications, such as local cement leakage, adjacent vertebral fractures, and emboli into the vascular system, have been reported following this procedure. We report a case of pulmonary infarction and skin necrosis caused by iatrogenic cement injection into soft tissue. Case report A 73-year-old woman was tranferred to our emergency room with iatrogenic bone cement into soft tissue instead of local anesthesia. It was an accident caused by mistake during vertebroplasty. Her vital signs on admission were stable, she only complained mild dyspnea and lower back pain. She had hemorrhagic bullae on injection site. Chest computed tomography showed multiple wedge-shaped subpleural consolidation in both lower lobes and right middle lobes. She had no respiratory infection sign such as fever, cough, and sputum, so we thought that pulmonary infarction was more likely. After wound care and supportive management for pulmonary infarction, her symptoms and wound were improved. Discussion A pulmonary infarction caused by cement migration after this procedure is rare but it is major complication. Some of the injected cement had embolized and entered the paravertebral vascular system. We report a rare case of micro pulmonary infarction due to an accidental cement injection into a paraspinal muscle and soft tissue of the back during vertebroplasty. This patient was discharged from the hospital after 7 days of treatment with supplemental oxygen and clinical observation. Treatment of pulmonary cement embolization depends on patient's symptoms. Patients with mild symptome only require supportive care. For severe cement pulmonary emboli, anticoagulation, percutaneous removal, and surgical removal seem to be definitive treatment. If a patient has respiratory difficulty after the procedure, chest imaging studies should be performed immediately.