Images

Young woman with dyspnoea

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This is the case of a 30-year-old woman with a history of melanoma surgically removed 3 years previously, who presented at the Emergency Department with chest pain and progressive dyspnoea. She had undergone a fine-needle aspiration puncture (FNAP) 18 days previously in order to study a segment 6 mass in the lower lobe of the left lung, after which she began to experience slight discomfort in the chest which had subsequently increased. Physical exploration showed good overall health with normal vital signs (Temp: 37ºC, BP 130/80) and an oxygen saturation of 93% with fraction of inspired oxygen (FiO_2: 28%). Cardiac auscultation was normal and pulmonary auscultation showed hypoventilation in left hemithorax. No significant results on blood analysis. A chest radiography showed minimal apical pneumothorax (A, Figure 1), naked spine sign due to leftward mediastinal deviation and atelectasia of practically the entire left lung with predominance in the lower left lobe. An abrupt shortening of the main left bronchus was also observed (arrows).

Urgent surgical intervention was decided, leading to discovery of a tumoral endobronchial growth occluding the entrance to the bronchus in the upper left lobe causing lung collapse. A diagnosis of metastatic endobronchial sarcomatoid melanoma was confirmed by anatomical pathology.

Metastatic endobronchial melanoma secondary to extrapulmonary solid tumours are rare, and the primary tumours which usually cause them are those of a renal or mammary origin, although there are a few cases describing malignant melanoma. The importance of anatomopathological study is therefore underlined, as treatment options may vary depending on the primary origin of the metastases.

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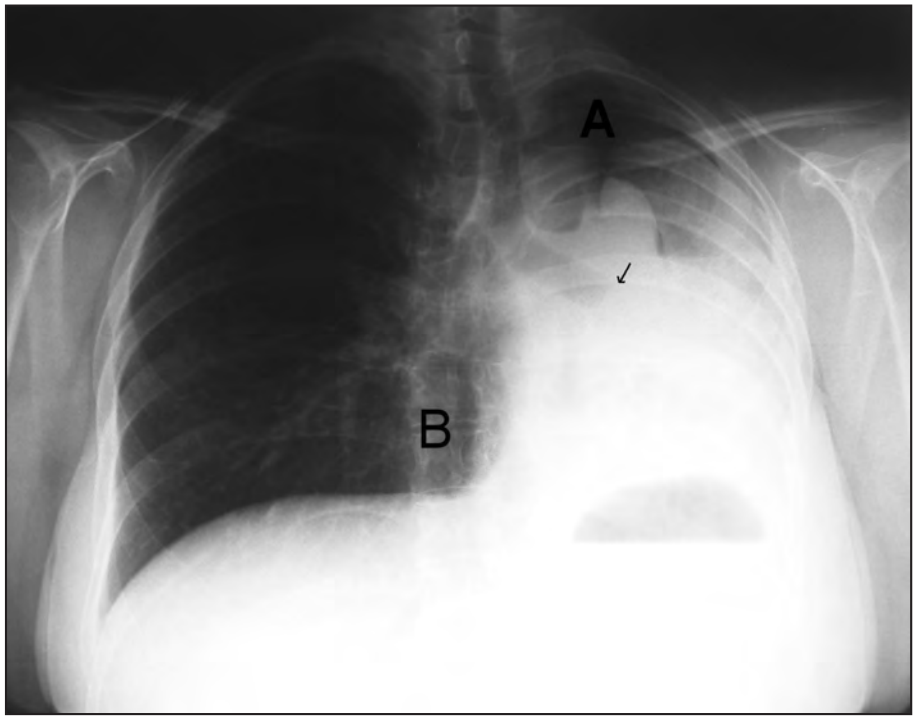

Figure 1. Radiography of posteroanterior thorax showing left lung, left apical pneumothorax (A) and sign of naked spine (B).