P16 ENDOSKOPSKI ASPEKTI SINDROMA SREDNJEG REŽNJA

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UVOD

Sindrom srednjeg režnja je termin koji se u pulmologiji koristi za označavanje brojnih patoloških stanja praćenih atelektazom i smanjenjem volumena srednjeg režnja. Prema različitim autorima, sindrom srednjeg režnja se javlja kod 0,33-6% plućnih bolesnika, a kod muškaraca se nalazi oko dva puta češće. Sindrom srednjeg režnja je preliminarna klinička i radiološka dijagnoza koja zahteva dalje razjašnjenje uzroka ovog patološkog procesa. Predlaže se da se iz ovog koncepta isključe slučajevi atelektaze uzrokovane tumorskom opstrukcijom bronha. U praksi, do diferenciranja dijagnoze i utvrđivanja etiologije, u ovaj termin se može skrivati i uključujući bronhogeni karcinom. Različite varijante sindroma srednjeg režnja treba razlikovati od centralnog karcinoma pluća, tuberkuloze i interlobarnog pleuritisa. Rjeđi diferencijalno dijagnosticki uzroci mogu biti perikardijalna cista i abdomenomedijastinalni lipom. Izolacija ovog sindroma je posljedica relativno visoke incidencije oštećenja ovog područja desnog pluća, što je povezano sa anatomskim karakteristikama. U poredjenju sa drugim lobarnim bronhima, srednji lobarni bronh ima najuži promjer i najveću dužinu, osim toga, kada se odvoji od intermediernog bronha formira akutni ugao od oko 30°. U neposrednoj blizini bronha srednjeg režnja nalazi se veliki broj bronhopulmonalnih limfnih čvorova čija hiperplazija vrsi spoljasnu kompresiju zida bronha. Obzirom na ove karakteristike lakse se desava hipoventiliranost srednjeg reznja. Cilj rada je analiza, procena i uporedjenje bronhoskopskih nalaza u slucajevima gde su indikacije za endoskopski pregled bile radiografski uocene promene (na posteroanteriornu i grafiju u lateralnom polozaju) u predeo anatomske projekcije srednjeg reznja (sifra po MKB R91 – „nenormalni nalazi kod dijagnostickog snimanja pluca" – Pulmones ad diagnosticam abnormales), bez obzira na ispoljavanju klinickih simptoma.

PRIKAZ SLUČAJA

Slucaj 1. AM, zena 48 godina starosti, sa anamnezom za nespecificne tegobe koje su se manifestovale nekoliko dana pre javljanja na pregled: dominira laksi bol u grudima i retki suvi kasalj. Nije dobiven podatak za povisenu temperaturu ili groznicu. Nepusac, bez komorbiditeta, negativna licna i porodicna anamneza. Standardne laboratorijske analize i tumorski markeri su bili u granicama referentnih vrednosti. Rentgengrafija je pokazala nalaz infiltracije u projekciji srednjeg reznja. CT toraksa je prikazao konglomerat limfoglandula u medijastinumu, konsolidacionu zonu u desnom hilusu sa anterobazalnom propagacijom, te pozitivni vazdusni bronhogram. Bronhoskopski pregled je utvrdio laku stenozu usca srednjeg reznja, submukoznu i mukoznu infiltraciju sa stenozom lumena, te potpunu neprohodnost lumena distalno

od infiltrirajuce mase sa hiperemicnom sluzokozom. Takodje je primecen difuzni edem sluzokoze (morfoloski podtip edematozni, hyperemic, fibrostenic). Histoloski nalaz je potvrdio granulomatoznu inflamaciju sa mnostvom epitelovidnih granuloma, deo sa prisutnom centralnom nekrozom, oko kojih su se videli nakupine limfocita. Definitivna histoloska dijagnoza je bila Inflammatio chronica granulomatosa, cime je bila potvrdjena klinicka dijagnoza endobronhijalne tuberkuloze. Mikrobioloski nalaz bronhoaspirata i sputuma nije povrdio psisustvo acidorezistentnih bacila (u direktnom preparatu i sa imunofluorescentnom tehnikom, kultrure po Lovenstein-Jensen-u i Bactec-u su ostale negativne). Dobijen je pozitivan nalaz molekularnog testa (GeneXpert). Antituberkulotska terapija je sprovodjena 9-to mesecnim rezimom (zbog produljene klinicke simptomatologije i prolongiranog radioloskog nalaza infiltrativnih promena, sto je upucivalo na produzenu aktivnost bolesti i usporene tkivne regeneracije, usled toga je bio sproveden i vremeni oralni steroidni rezim nakon cega se pratila srednje izrazena radioloska rezolucija (u daljem toku ce se pratiti stvaranje rezidua i sekudarnih bronhiektaticnih promena u srednjem reznju, sto ce se najverovatnije i klinicki manifestovati u sklopu „sindroma rednjeg reznja“). Terapijski rezim je zavrsen, pacijentkinja je se vratila na posao, fizicki je u solidnu kondiciju, ali se zapazaju povremeni simptomi u vidu slabo produktivnog kaslja, stezanja u grudima, povremenim osecajem grudnog diskomforta i opste nelagodnosti, te cescih „prehlada“, dok su laboratoriski parametri i plucna funkcija u normalnim granicima. Kontrolna bronhoskopija je pokazala difuzni edem sluzkoze lika submukozne infiltracije osobito u lingularnom bronhu (u biopsiji su nadjene fibrokolagene i hijaline promene, odgovor patologa je “fibrosis“). Usce srednjeg reznja je prohodno, distalno se prati stenoza lumena bronha te se ne mogu vizuelizirati segmentalna usca (komparativno sa nalazom pre UVODjenja terapije, prati se redukcija promena usca srednjeg reznja koje je sada prohodno, dok su promene u linguli skoro identicnog izgleda). Sveukupni izlged upucuje na posttuberkulozne sekvele (u daljem toku I visegodisnjeg pracenja bice procenjeno u pogledu definitivnih rezidua kao i ispoljavanju simptoma u sklopu „sindroma srednjeg reznja“). Slucaj 2. JV, u dobi od 72 godine, upucen pulmologu zbog opstih simptoma: osecaj malaksalosti, gubitak apetita i gubitak na telesnu tezinu, produzeni kasalj sa iskasljavanjem gustog sekreta, te bolova po celom telu osobito u ledjima (slabinskom i krstnom predelu kicme), bol u grudima sa desne strane. Tegobe traju vec 6 meseci unazad. Prethodno zbog simptoma parapareze postavljena je sumnja na paraneoplasticni sindrom. Pacijent je bio hospitalizavan na Neuroloskoj klinici gde je uradjen KT pregled LS kisme i vidjene su osteoliticke promene sa smanjenjem promera pojedinih prsljenskih tela. Iz licne anamneze: visegodisnji pusac. Auskultatorni nalaz na plucima pokazuje oslabljeni disajni sum s predne strane desnog hemitoraksa, nema uvecanih limfoglandula. Laboratorijske analize nisu karakteristicne. Radiografija je pokazala solidnu homogenu promenu trouglastog izduzenog oblika u projekciji srednjeg reznja (lobarna atelektaza). Bronhoskopski nalaz je bio tipican – iz usca srednjeg reznja prominira tumorska masa glatke sivkastobelicaste povrsine koja obturira u potpunosti usce bronha sa involviranjem interlobarne karine koja se ne moze raspoznati u tumorsku infiltraciju – endoskopska dijagnoza je bila: Infiltratio et obturatio bronchi lobi medii, Infiltratio carinae interlobaris. Patohistoloski nalaz iz biopsije je pokazao

sitnoceljski karcinom (histoloska i imunohistohemijska diferencijacija podtipa nije bila uradjena). U staging-u su utvrdjene metastaze u jetri i lumbalnih prsljena. Zbod opste loseg stanja (Karnofsky 50) kod pacijenta nije bio sproveden onkoloski tretman.

ZAKLJUČAK

Prikazani slucaji su nedvosmisleni u dijagnostickom pogledu. Algoritam ispitivanja kod radioloski uocenih promena u projekciji srednjeg reznja treba bezuslovno da ukljuci i endoskopski pregled. Detaljan bronhoskopski pregled je neizbezan kao jednostavan, pouzdan i pecizan dijagnosticki postupak. U prikazanih slucaja endoskopski nalaz je korelisao sa radioloskim i CT nalazom, sto je takodje pomoglo postavljanju dijagnoze, a i sam ishod lecenja je nadopunio dijagnozu.

KLJUČNE REČI

Srednji režanj, sindroma lobi medii, bronhoskopija, endobronhijalna tubekuloza

P16 ENDOSCOPIC ASPECTS OF MIDDLE LOBE SYNDROME

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INTRODUCTION

Middle lobe syndrome is a term used in pulmonology to denote a number of pathological conditions accompanied by atelectasis and a decrease in the volume of the middle lobe. According to different authors, middle lobe syndrome occurs in 0.33-6% of lung patients, and in men it is found about twice as often. Middle lobe syndrome is a preliminary clinical and radiological diagnosis that requires further clarification of the cause of this pathological process. It is suggested to exclude cases of atelectasis caused by tumoral obstruction of the bronchus from this concept. In practice, until the diagnosis is differentiated and the etiology determined, this term can be hidden and include bronchogenic carcinoma. Different variants of middle lobe syndrome should be distinguished from central lung cancer, tuberculosis and interlobar pleurisy. Rarer differential diagnostic causes can be pericardial cyst and abdominal mediastinal lipoma. The isolation of this syndrome is a consequence of the relatively high incidence of damage to this area of the right lung, which is related to anatomical characteristics. In comparison with other lobar bronchi, the middle lobar bronchus has the narrowest diameter and the longest length, moreover, when it separates from the intermediate bronchus it forms an acute angle of about 30°. In the immediate vicinity of the bronchus of the middle lobe, there is a large number of bronchopulmonary lymph nodes whose hyperplasia causes external compression of the bronchial wall. Due to these characteristics, hypoventilation of the middle section occurs more easily. The aim of the work is the analysis, assessment and comparison of bronchoscopic findings in cases where the indications for endoscopic examination were radiographically observed changes (on posteroanterior and lateral view) in the area of the anatomical projection of the middle section (code according to ICD R91 - "abnormal findings in diagnostic imaging of the lungs " - Pulmones ad diagnosticam abnormales), regardless of the manifestation of clinical symptoms.

CASE REPORT

Case 1. AM, a 48-year-old woman, with a history of non-specific complaints that manifested themselves a few days before appearing for an examination: light chest pain and a rare dry cough predominate. No data was obtained for elevated temperature or fever. Non-smoker, no comorbidities, negative personal and family history. Standard laboratory analyzes and tumor markers were within reference values. X-ray showed the finding of infiltration in the mid-section projection. Chest CT showed a conglomeration of lymphoglands in the mediastinum, a consolidation zone in the right hilus with anterobasal propagation, and a positive air bronchogram. Bronchoscopic examination confirmed mild stenosis of the mouth of the median incision, submucosal and mucosal infiltration with stenosis of the lumen, and complete impermeability of the lumen

distal to the infiltrating mass with hyperemic mucous membrane. Diffuse edema of the mucosa (morphological subtype edematous, hyperemic, fibrosthenic) was also observed. Histological findings confirmed granulomatous inflammation with many epithelioid granulomas, some with central necrosis, around which accumulations of lymphocytes were seen. The definitive histological diagnosis was Inflammatio chronica granulomatosa, which confirmed the clinical diagnosis of endobronchial tuberculosis. The microbiological findings of bronchoaspirate and sputum did not reveal the presence of acid-resistant bacilli (in the direct preparation and with the immunofluorescence technique, cultures according to Lovenstein-Jensen and Bactec remained negative). A positive molecular test result (GeneXpert) was obtained. Antituberculosis therapy was carried out with a 9-month regime (due to prolonged clinical symptoms and prolonged radiological findings of infiltrative changes, which pointed to prolonged disease activity and slowed tissue regeneration, as a result, a temporary oral steroid regime was also carried out, after which moderate radiological resolution (in the future, the formation of residual and secondary bronchiectatic changes in the middle section will be monitored, which will most likely manifest clinically as part of the "second section syndrome"). condition, but there are occasional symptoms in the form of a poorly productive cough, chest tightness, occasional feeling of chest discomfort and general discomfort, and frequent "colds", while laboratory parameters and lung function are within normal limits submucosal infiltration, especially in the lingular bronchus (in the biopsy, fibrocollagenous and hyaline changes were found, the pathologist's answer was "fibrosis"). The mouth of the median incision is passable, stenosis of the bronchial lumen is observed distally, and segmental orifices cannot be visualized (compared to the findings before the INTRODUCTION of therapy, the reduction of changes in the orifice of the median incision is monitored, which is now passable, while the changes in the lingula are almost identical in appearance). The overall appearance points to post-tuberculosis sequelae (in the further course of the multi-year follow-up, it will be evaluated in terms of definite residues as well as the manifestation of symptoms as part of the "middle cut syndrome"). Case 2. JV, aged 72, was referred to a pulmonologist due to general symptoms: a feeling of weakness, loss of appetite and weight loss, prolonged cough with expectoration of thick secretions, and pain all over the body, especially in the back (lumbar and sacral region of the spine). , pain in the chest on the right side. The problems have been going on for 6 months. Paraneoplastic syndrome was previously suspected due to symptoms of paraparesis. The patient was hospitalized at the Neurological Clinic, where a CT scan of the LS region was performed and osteolytic changes were seen with a decrease in the diameter of individual vertebral bodies. From personal history: long-term smoker. Auscultatory findings on the lungs show a weakened respiratory sound on the front side of the right hemithorax, there are no enlarged lymph glands. Laboratory analyzes are not characteristic. Radiography showed a solid homogeneous change of elongated triangular shape in the mid-section projection (lobar atelectasis). The bronchoscopic finding was typical – a tumor mass with a smooth grayish-white surface protrudes from the mouth of the median incision, which completely obturates the mouth of the bronchus with the involvement of the interlobar carina, which cannot be recognized as tumor infiltration – the endoscopic

diagnosis was: Infiltratio et obturatio bronchi lobi medii, Infiltratio carinae interlobaris . Pathohistological findings from the biopsy showed small cell carcinoma (histological and immunohistochemical differentiation of the subtype was not performed). During the staging, metastases in the liver and lumbar vertebrae were found. Due to general poor condition (Karnofsky 50), the patient was not treated oncologically.

CONCLUSION

The presented cases are unequivocal in terms of diagnosis. The examination algorithm for radiologically observed changes in the mid-section projection should unconditionally include an endoscopic examination. A detailed bronchoscopic examination is inevitable as a simple, reliable and accurate diagnostic procedure. In the presented cases, the endoscopic finding correlated with the radiological and CT findings, which also helped to establish the diagnosis, and the outcome of the treatment itself complemented the diagnosis.

KEYWORDS

Middle lobe, middle lobe syndrome, bronchoscopy, endobronchial tuberculosis