



## CASE REPORT OF BRONCHOGENIC CARCINOMA

## Paediatrics

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## ABSTRACT

Primary pulmonary neoplasms are uncommon in children and represent a wide spectrum of pathology from benign to malignant. They are quite different in their histopathologic distribution from that of adults.

## KEYWORDS

## INTRODUCTION-

Primary pulmonary neoplasms are not common in children. Amongst the malignant pulmonary lesions in children, secondaries from osteogenic sarcomas, Wilms' tumors, and rhabdomyosarcomas are more commonly encountered. The pediatric primary pulmonary neoplasms represent a wide range of pathology from benign to malignant end of the spectrum. They are quite different in their histopathologic distribution from that of adults. Amongst the variety of benign and malignant tumors arising in adults, majority are carcinomas; squamous cell carcinomas and adenocarcinomas constitute the bulk. However, in children, inflammatory myofibroblastic tumors, chondromatous hamartomas, granular cell myoblastomas, leiomyomas, bronchial chondromas and teratomas constitute the major bulk of benign tumors, whereas carcinoids, mucoepidermoid carcinomas, pleura-pulmonary blastomas (PPBs), pulmonary blastomas (PBs), adenoid cystic carcinomas, sarcomas like fibrosarcomas, leiomyosarcomas, rhabdomyosarcomas constitute the list of malignant lung tumors.

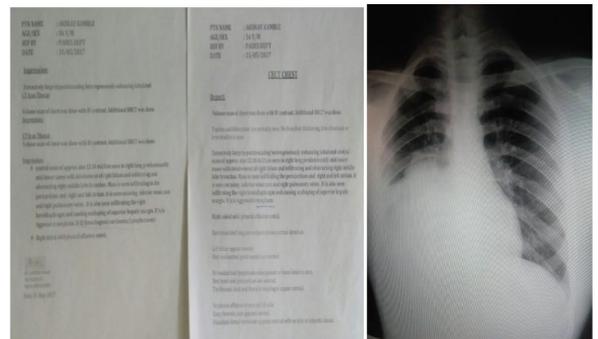
Bronchogenic carcinoma is a malignant lung tumor characterized by uncontrolled cell growth in tissues of the lung. This growth can spread beyond the lung by the process of metastasis into nearby tissue or other parts of the body. Most cancers that start in the lung, known as primary lung cancers, are carcinomas. The two main types are small-cell lung carcinoma (SCLC) and non-small-cell lung carcinoma (NSCLC). The most common symptoms are coughing (including coughing up blood), weight loss, shortness of breath, and chest pains.

## CASE REPORT-

A 16 year old male patient was brought with complaints cough since 1 month which was productive in nature, non-purulent, non-blood tinged, no diurnal variations. He also had complaints of right sided chest pain which relieved on lying on same side. No h/o fever or breathlessness. On examination patient was conscious, co-operative, heart rate -90 beats/min, respiratory rate-24 breaths/min, B.P-110/78 mm hg, no pallor, clubbing or lymphadenopathy. On palpation chest movements were reduced in right infra-mammary area. On percussion stony dull note present on right infra-mammary, infra-axillary & infra-scapular areas. On Auscultation air entry was absent in right infra-mammary, infra-axillary & infra-scapular areas.

On admission CBC-Hb-13.3 gm%, WBC-11,400 cumm, Platelets-5,42,000 cumm, ESR-8 mm/hr, chest x-ray was done which showed cardio-phrenic, cardio-thoracic angles were obliterated and obliterated opacity was seen in mid-zone. patient was started on antibiotics and symptomatic treatment. Ultrasonography of chest was done in the afternoon which showed minimal pleural effusion on right side (approx. volume-59 cc). Diagnostic pleural tapping done showed reddish, turbid, exudative fluid. ADA was within normal limits. pleural fluid culture showed no growth. On Day 2 of admission CBNAT of pleural fluid was sent, sMTB not detected. On day 3 of admission HRCT Chest was done, it showed central mass of approx. size-12\*10.4\*11 cm in right lung in mid-lower zone involving right hilum and infiltrating and obstructing right middle lobe bronchus, peri-cardium, right and left atrium. It was seen encasing inferior vena cava and right pulmonary veins. F/S/O Aggressive neoplasm. D/D Bronchogenic carcinoma/Lymphoma.

On day 4 of admission patient was referred to cancer centre for further management.



**Conclusion:** Bronchogenic carcinoma is major cause of cancer mortality in adults, but remains as unusual disease in children, bronchogenic carcinoma is associated with short asymptomatic periods, frequent metastasis in children, hopefully early diagnosis and treatment may result in improved prognosis and prevent life threatening complications.