A worsening dyspnea

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A 52-year-old postmenopausal woman presented because of a progressive dyspnea, non-productive cough and right side chest pain that worsened with deep inspiration. She had a history of breast carcinoma 2 years earlier and subsequent left segmental mastectomy, axillary dissection, adjuvant chemotherapy and local radiotherapy (RT). One year later she underwent to a T-8 balloon vertebroplasty and local RT for symptomatic bone metastases. Afterward, her disease remained well controlled by treatment with trastuzumab and systemic chemotherapy.

Physical examination revealed shortness of breath and bibasilar crackles on lung auscultation; otherwise, examination was unremarkable. A chest radiography (Figure 1A) showed mild bilateral reticulonodular interstitial infiltrates, T-8 balloon vertebroplasty (black arrows) and pathologic fracture of the right seventh rib (white arrow).

A high-resolution computed tomography of the chest showed irregular, sometimes nodular thickening of the interlobar septa with prominent centrilobular structures. A transbronchial lung biopsy specimen revealed small foci of breast carcinoma.

Figure 1. A This chest radiography (above in antero-posterior view and below in lateral view) showing mild bilateral reticulonodular interstitial infiltrates, T-8 balloon vertebroplasty (black arrows) and pathologic fracture of the right seventh rib (white arrow). B This chest radiography showing a right-side pleural effusion and a progression of the previously noted infiltrates with placed chest tube (arrowheads). C This radiograph showing considerable worsening findings with increased diffuse bilateral reticulonodular opacification, and recurrent right-side pleural effusion.
within lymphatic channels (Figure 2). These findings were compatible with diagnosis of lymphangitic carcinomatosis.

She was treated with oxygen, morphine and corticosteroids but the dyspnea progressed over a month period; another chest radiography (Figure 1B) showed a right-side pleural effusion and a progression of the previously noted infiltrates; a chest tube was placed (arrowheads).

One month later the patient’s condition worsened rapidly despite high doses of corticosteroids, and an additional radiograph (Figure 1C) of the chest showed considerable worsening findings with increased diffuse bilateral reticulonodular opacification.

The patient chose not to receive further care and died one month later from respiratory failure.

Lymphangitis carcinomatosis is usually the result of hematogenous metastases to small pulmonary capillaries, with secondary invasion of peripheral pulmonary lymphatics. Breast, lung, stomach, pancreas and prostate cancers are the most common tumors that result in lymphangitis. It generally has a very poor prognosis and optimal treatment of the patient with this disease is not well defined.1,2

Conflict of interest: None declared.

References
