A 74-year-old man presented with a 1-year history of dyspnoea and low volume mucoid sputum production, having had a previous right upper lobectomy 2 years ago for squamous cell lung cancer. He had a 20 pack-year smoking history. Examination was consistent with his previous chest surgery. His chest radiograph showed progressive volume loss and mediastinal enlargement as well as signs of his previous surgery. Computed tomography unfortunately confirmed significant mediastinal adenopathy suspicious of recurrence with right hilar and subcarinal nodes as well as evidence of his previous surgery (Figure 1). He underwent bronchoscopy that showed extrinsic compression from his adenopathy but no endobronchial lesion. Transbronchial needle aspiration was performed (Figure 2) which confirmed recurrent poorly differentiated squamous cell cancer from the subcarinal lymph node (broncho-alveolar lavage at the same time was non-diagnostic). He underwent palliative chemotherapy. Transbronchial needle aspiration can be particularly useful when there is no endobronchial lesion and radical treatment is not contemplated as broncho-alveolar lavage may be non-diagnostic. Moreover, endobronchial ultrasound is not always needed.

Figure 1. Computed tomography scan of chest (mediastinal windows) showing enlarged right hilar and subcarinal lymph nodes and evidence of previous right upper lobectomy.

Figure 2. Cytology smear from transbronchial needle aspirate of subcarinal node showing poorly differentiated squamous cell cancer.