A young male with left hilar mass

Tarun Krishna Boppana[1], Saurabh Mittal[2], Karan Madan[2], Anant Mohan[2]

[1]Department of Emergency Medicine, All India Institute of Medical Sciences, New Delhi, India, [2]Department of Pulmonary Medicine and Sleep Disorders, All India Institute of Medical Sciences, New Delhi, India

Address for correspondence: Dr. Saurabh Mittal, Department of Pulmonary Medicine and Sleep Disorders, All India Institute of Medical Sciences, Ansari Nagar, New Delhi - 110 029, India. E-mail: saurabh_kgmu@yahoo.co.in

A 34-year-old male presented to pulmonary medicine outpatient department with complaints of cough for 1 month. Cough was associated with minimal mucoid sputum production as well as streaky hemoptysis for the past 15 days. There was no history of fever, appetite loss, or weight loss. He was a lifelong nonsmoker and had no previous history of tuberculosis. He was diagnosed to have hypertension 2 years back, but was not receiving any treatment. He had a history of acute-onset central chest pain 6 months back for which he was admitted in cardiology and had undergone some interventional procedure. On examination, he had mild pallor and vital parameters were stable. Systemic examination was also unremarkable. His sputum for acid-fast bacilli was negative. His chest radiograph was performed outside [Figure 1] based on which the patient was referred to our department.

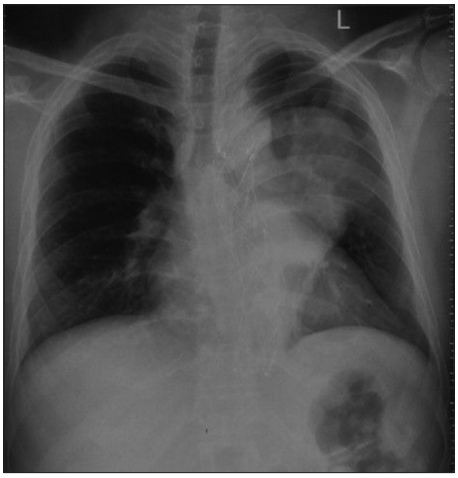

Figure 1: Posteroanterior chest radiograph raising a suspicion of left hilar mass

QUESTION

What is the diagnosis?

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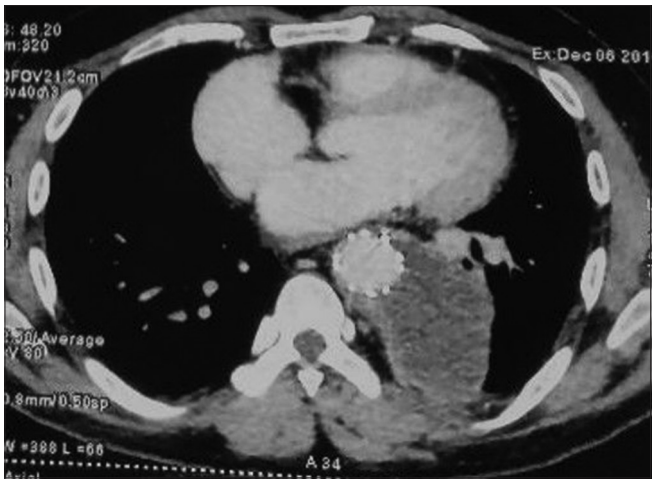

Figure 2: Computed tomography thorax demonstrating thrombosed dissection of descending aorta with metallic stent *in situ*

ANSWER

Thrombosed descending aortic dissection with metallic stent in descending thoracic aorta.

Subsequently, computed tomography (CT) scan of the thorax was performed [Figure 2] which demonstrated large thrombosed descending aortic dissection. The thrombosed aorta was compressing the left lower lobe bronchus causing distal obstructive pneumonia. The patient improved after treatment with amoxicillin–clavulanic acid combination for 1 week.

DISCUSSION

This patient was suspected to have a left hilar mass and was referred to our clinic for the same. It is essential to understand the anatomy of hilum to interpret a chest radiograph. On a posteroanterior chest radiograph, hilum is formed by pulmonary arteries with minor contribution from the pulmonary veins.[1] Hilum overlay sign (that is hilar vessels can be clearly seen through the lesion as seen in our case) helps in identifying whether the abnormality is at hilum or anterior/posterior to it. Second, lateral radiograph can help in localizing the abnormality. In Figure 1, it is evident that the left hilar abnormality continues till the diaphragm and appears to enter the abdomen, suggesting its posterior location and likely being an aortic shadow. Posterior mediastinal masses or prevertebral tubercular abscess may give a similar appearance.

This case highlights the importance of accurate interpretation of plain chest radiograph wherein additional imaging in the form of CT scan could be avoided in view of associated significant radiation exposure risk.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

REFERENCE

1. Jash D, Maji A, Patra A, Sarkar S. Approach to unequal hilum on chest X-ray. J Assoc Chest Physicians 2013;1:32.