

Pulmonary artery sarcoma masquerading as subchronic pulmonary thromboembolism

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1 | CASE PRESENTATION

A 50-year-old male presented with increasing shortness of breath. A chest computed tomography (CT) scan showed extensive filling defects involving the main pulmonary artery (PA) and its major and segmental branches (Figure 1). The patient was started on intravenous heparin but there was no change in the size of the mass on a transthoracic echocardiogram. In view of this, the patient was taken to the operating room to make a definitive diagnosis, and was placed on cardiopulmonary bypass via a median sternotomy with central aortic and bicaval cannulation. The mass was seen invading the left, lateral inferior portion of the PA (Figure 2). Following cardioplegic arrest, a longitudinal incision was made in the main PA and a solid mass was noted to extend proximally

through the pulmonary valve into the right ventricular outflow tract and distally to beyond the bifurcation of the right and left PA (Figure 3). A tumor debulking procedure was performed, as it was not possible to resect this infiltrating mass. The PA was closed with a running 4-0 prolene suture. The patient tolerated the procedure well and had an uncomplicated postoperative course. The final pathology was consistent with a pleomorphic sarcoma (Figure 4). The patient was referred for adjuvant therapy.



FIGURE 1 CAT scan showing mass infiltration of the pulmonary artery on the level of the bifurcation

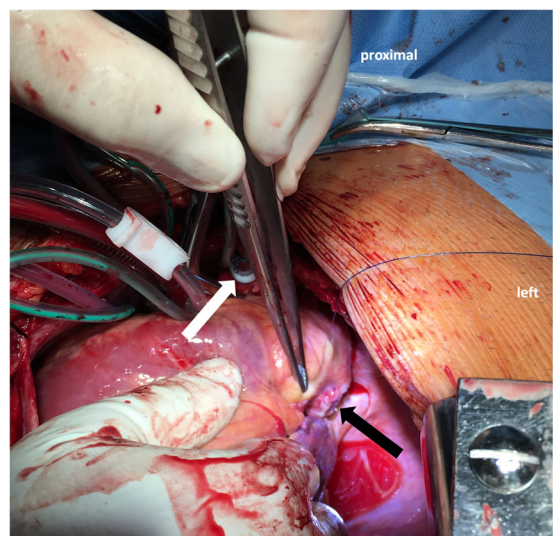


FIGURE 2 Intraoperative image of inferior wall infiltration of the pulmonary artery (black arrow); white arrow = the aortic cannulation

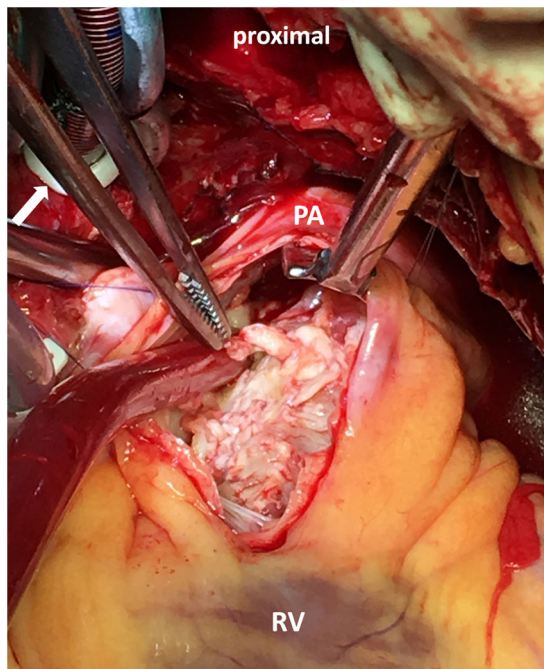


FIGURE 3 Intraoperative image showing the longitudinally opened pulmonary artery with mass formation. PA, pulmonary artery; RV, right ventricle

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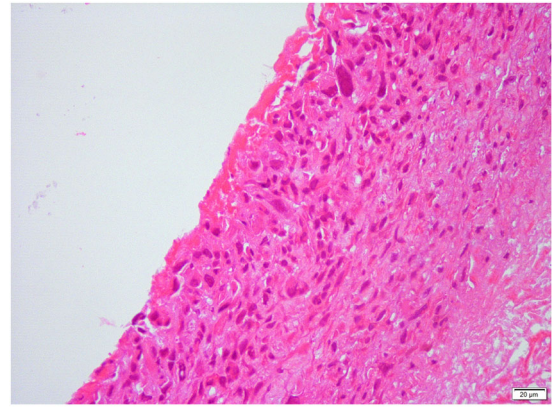


FIGURE 4 Hematoxylin and eosin stain study of the intraoperative biopsy

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CONFLICT OF INTEREST

The authors acknowledge no conflict of interest in the submission.