REDUCTASE C677T POLYMORPHISM WITH NORMAL RANGE OF PLASMA HOMOCYSTEINE LEVEL
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The 5,10-Methylenetetrahydrofolate Reductase (MTHFR) locus is mapped to chromosome 1. The MTHFR converts 5,10-methylenetetrahydrofolate to 5-methyletetrahydrofolate and is a key enzyme in the metabolism of folate. Mutation in genes encoding MTHFR may account for reduced enzyme activity and has been identified to possess 14 rare mutation. Especially MTHFR C677T polymorphism is associated with elevated plasma homocysteine and increased risk of cardiovascular diseases. Also there were many reports on the association of MTHFR C677T polymorphism and various diseases.

We experienced a case with recurrent pulmonary thromboembolism associated with MTHFR C677T polymorphism with normal range of plasma homocysteine level developed in the patient with schizophrenia and thyroid cancer and then here report and this interesting case.

A RARE CASE OF PULMONARY HEMANGIOMA
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Introduction: Haemangioma is a benign neoplasm of vascular proliferation. Although it typically presents in skin and liver, it could be found within the thorax, most often in the subglottic area of the respiratory tract. Pulmonary haemangioma is a rare disorder of alveolar capillary proliferation which is a rare type of benign lung tumour.

Case: An 11-year-old boy was referred to our institution for recurrent haemoptysis in the last 2 years. In August 2017 at the previous hospital, he was diagnosed clinically tuberculosis based on the results of negative sputum AFB smear, Klebsiella pneumoniae in culture sputum, no parasite in feces. Thoracic CT Scan showed inflammation in apical and posterior segments of the right upper lobe and there was no sign of lung tumour and mediastinum. In April 2019 patient underwent bronchoscopy and showed apical and posterior segment of the right upper lobe was the source of bleeding. From the bronchial washing revealed MTB not detected, Klebsiella pneumoniae detected, no parasite and the pathological examination revealed no signs of malignancy. In May 2019 thoracic CT angiography showed a mass on the right middle lobe, suspect pulmonary haemangioma of the right middle lobe. From multidisciplinary expert discussion due to the limitations of our hospital facilities, the patient was referred to the pulmonary center hospital to consult with a thoracic surgeon and interventional radiologist for further treatment.

Conclusion: Pulmonary haemangioma is a rare case. The most complaint of pulmonary haemangioma is recurrent haemoptysis.

Keywords: pulmonary haemangioma, bronchoscopy, haemoptysis

A RARE CASE OF CONGENITAL ABSENCE OF LEFT PULMONARY ARTERY PRESENTING IN LATE ADULTHOOD
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Background and Aims: Unilateral absence of pulmonary artery (UAPA) is a rare congenital anomaly. It is mostly diagnosed in younger patients; associated symptoms are exercise limitation, pulmonary infections and haemoptysis. The natural progression of UAPA is not well known. We aim to present a rare case of UAPA presenting in late adulthood and describe the associated radiological and physiological abnormalities.

Figure 16011

Figure 1. A) Erect chest radiograph, B) axial CT thorax cut showing double aortic arch and C) axial CT thorax cut showing absence left pulmonary artery.

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The patient remained stable with relatively mild symptoms on follow up. A diagnosis of UAPA with obstructive airway disease (Figure 1a), according to patient, these findings were present on previous health screening. Computed tomography of the thorax revealed absent left basal crepitations but otherwise unremarkable. Pulmonary function tests showed a fixed obstructive abnormality with gas trapping (FEV1 of 1.10L [44%predicted], FVC of 1.73L [56%predicted], FEV1/FVC ratio of 0.63), total lung capacity of 5.16L [103%predicted] and mildly reduced gas transfer (DLCO [0.63], total lung capacity of 5.16L [103%predicted] and residual volume of 1.10L [44%predicted], FVC of 1.73L [56%predicted], FEV1/FVC ratio of 0.63). Chest CT Scan done showed 15-20% pneumothorax on the right. Air cysts are noted in the left postero-basal region and middle lobe. Bullae is noted in the middle lobe measuring 5.5 X 3.2 X 7.4 cm. Patient underwent video-assisted thoracoscopic surgery with intraoperative findings noted 6-7 cm bullae middle lobe, adhesions on the apical area. Closure of bronchopulmonary fistula (bullectomy), with mechanical pleural abrasion done. Histopathology report showed a cystic lesion internally lined and infiltrated by sheets of round to polygonal cells with atypical nuclei and abundant pale eosinophilic cytoplasm with indistinct cell border. These cell shows focal weak positive expression to CD1a, negative to S100, HMB45, and cailretin. Cailretin positive mesothelial cells are noted lining the external surface of the cyst. Findings are in favour of Pulmonary Cystic Langerhans Cell Histiocytosis.

Case Description: Mr. A is a 65-year-old Chinese man, never-smoker, who was referred for evaluation of cough when exposed to cold air and mild exertional dyspnoea (MRC dyspnoea scale 2). He is a Taxi driver by occupation, an avid martial art practitioner and is relatively healthy with no significant past medical history. Clinical examination revealed left basal crepitations but otherwise unremarkable. Pulmonary function tests showed a fixed obstructive abnormality with gas trapping (FEV1 of 1.10L [44%predicted], FVC of 1.73L [56%predicted], FEV1/FVC ratio of 0.63), total lung capacity of 5.16L [103%predicted] and residual volume of 2.71L [131%predicted] and mildly reduced gas transfer (DLCO [0.63], total lung capacity of 5.16L [103%predicted] and residual volume of 2.71L [131%predicted]) and mildly reduced gas transfer (DLCO 6.0 mmol/min/kPa [72%predicted]). Chest radiograph showed left lung volume loss, left-sided tracheal deviation and a right sided aortic arch (Figure 1a), according to patient, these findings were present on previous health screening. Computed tomography of the thorax revealed absent left main pulmonary artery with collateral vessels supplying left lung, ipsilateral volume loss, emphysema, fibrosis and bronchiectatic changes (Figure 1b, c and 2). A diagnosis of UAPA with obstructive airway disease was made. He was initiated on inhaled bronchodilator and corticosteroid.

Conclusion: We present a rare case of UAPA presenting in late adulthood with associated ipsilateral parenchymal changes and impaired ventilatory capacity. We hypothesize that these findings may be a sequela of prior infections or chronic systemic collateral supply to the affected lung, which may not be adequate.