Small-cell lung cancer often presents as an extensive cancer, and rarely as a solitary tracheal tumor. We report a 41-year-old male smoker with dyspnea and wheezing that was initially diagnosed as asthma and treated with bronchodilators. He was later intubated for acute respiratory failure, and computed tomography revealed a tracheal mass. Solitary primary small-cell lung cancer was diagnosed via bronchoscopic biopsy. The patient received bronchoscopic electro-surgery and was successfully extubated. Concurrent chemo-radiotherapy was performed due to the stage IV small-cell lung cancer. Key words: tracheal tumor; small-cell lung cancer; acute respiratory failure; bronchoscopic electro-surgery. [Respir Care 2010;55(7):929–932. © 2010 Daedalus Enterprises]
squamous metaplasia of the overlying bronchial mucosa. The tumor cells had small hyperchromatic nuclei, scanty cytoplasm, and marked crushing artifact, which was highly suggestive of small-cell carcinoma. Multiple immunohistochemical stains were performed to confirm the diagnosis. The stain for CD45 was negative, which excluded lymphoma (Fig. 3A). The stain for CK5/6 was also negative, which excluded poorly differentiated squamous-cell carcinoma (see Fig. 3B). The stain for TTF-1 was weakly positive (see Fig. 3C), which is compatible with but not specific for small-cell carcinoma. The stain for neuron-specific enolase (a marker for neuroendocrine tumor) was negative (see Fig. 3D), which could rule out carcinoid tumor but not small-cell carcinoma. Since small-cell carcinoma is a poorly differentiated neuroendocrine carcinoma, negative staining for neuroendocrine markers is not uncommon. In summary, the histology and immunohistochemical stains all supported the diagnosis of small-cell carcinoma.

The patient then underwent fiberoptic bronchoscopic electrocautery of the tracheal tumor. Electrocautery was initially done at 20W/20W, and then 35W/35W. Heat probe, knife, snare-loop, and heat forceps were used for tumor extraction. After electrocautery the patient was successfully extubated and there was complete resolution of the wheezing and dyspnea. He was then transferred to the general ward in stable condition.

Further tumor staging via bone scan revealed bony metastasis of the right 6th rib. Moreover, there was 27-mm right supraclavicular lymphadenopathy that also showed small-cell lung cancer on biopsy, for a tumor clinical stage of 4 (T4N3M1). However, surgery for the tracheal small-cell lung cancer was not performed. The patient received monthly systemic chemotherapy with 25 mg/m² of cisplatin (Pharmachemie, Israel) and 100 mg/m² of etoposide (Nippon Kayaku, Japan). Concurrent chest irradiation (6,000 cGy in 30 fractions) to the trachea and mediastinum was also performed.

After radiotherapy and 3 cycles of chemotherapy, computed tomogram and bronchoscopy revealed only tracheal
mucosal thickening, without visible tracheal tumor (see Fig. 2B). One year after treatment, the patient was well and had no evidence of recurrence.

Discussion

Patients with tumors in the upper respiratory tract presenting with dyspnea, wheezing, and cough are frequently misdiagnosed as having asthma or COPD. However, tracheal tumor with central airway obstruction should be included in the differential diagnosis, particular in those who are refractory to treatment for presumed COPD or asthma.2 Tracheobronchial obstruction from malignant or benign lesions can cause important complications, such as acute respiratory distress, post-obstruction pneumonia, atelectasis, hemoptysis, asphyxia, or even death.4

Primary malignant neoplasms of the trachea are rare and account for fewer than 0.1% of malignant diseases.2 Primary tracheal tumors can arise from the respiratory epithelium, salivary glands, and mesenchymal structures of the trachea. In adults, 90% of primary tumors are malignant,5 compared to 10–30% in children.6 In adults, squamous-cell carcinoma and adenoid cystic carcinoma account for two thirds of adult primary tracheal tumors.2,5 Tracheal tumors are often a diagnostic and therapeutic challenge. Although patients present with signs and symptoms of central-airway obstruction, the definitive diagnosis of these tumors is commonly delayed, so most patients present with advanced disease.2

Among lung malignant neoplasms, small-cell lung cancer has the worst prognosis and usually grows and disseminates very rapidly,1 so early detection and correct diagnosis are very important. Small-cell lung cancer often presents as an extensive disease and rarely as a primary tracheal mass.1,2 The diagnosis of tracheal small-cell lung cancer is quite challenging, and in a patient with acute respiratory failure, solitary tracheal small-cell lung cancer should be considered, even with normal chest radiography.

Chemotherapy is the cornerstone of treatment.7 Cisplatin plus etoposide and concomitant radiotherapy is the standard treatment for patients with extensive small-cell lung cancer.7 This achieves high response rate (60–70%), but small-cell lung cancer has a high recurrence rate and a median survival time of 8–10 months.7 Our patient suffered respiratory failure from tracheal occlusion by the tumor, so immediate surgery was required. Fiberoptic bronchoscopic electro-surgery is an effective option for immediate intra-luminal tumor debulking.8

There are many modalities to treat tracheal and bronchial lesions. Laser photo resection, electro-surgery, cryotherapy, argon plasma coagulation, and brachytherapy can be used to remove endobronchial tissue.8,10 Laser photoresection is the application of laser energy via rigid or flexible bronchoscope.10 It is effective for rapid tissue de-
Endobronchial brachytherapy places a radioactive source within or near an endobronchial malignancy to deliver local irradiation. It is a relatively new form of electro-surgery. Argon plasma coagulation is a relatively new form of electro-surgery. Argon gas is ionized by electric current to create a non-contact, homogeneous region on the target tissue. Coagulated tissue has higher resistance and drives the ionized argon gas flow away to nearby tissue. Argon plasma coagulation is suitable for treating bronchial segments that have an acute angle from the major airways, such as apical and posterior segments of the upper lobes, and apical lower-lobe segments. Endobronchial brachytherapy places a radioactive source within or near an endobronchial malignancy to deliver local irradiation. The disadvantage of brachytherapy is its delayed effects. The first effects can be seen one week after treatment, and the maximum effect is achieved after 3 weeks. However, brachytherapy has a longer-lasting effect and greater tissue penetration than other techniques. It may be curative for very early superficial cancers.

There are many interventional modalities to treat tracheal and bronchial lesions, and each method has its advantages and disadvantages. The choice of modalities depends on the patient’s clinical condition, the operator’s training, the availability of equipment, and the weighed benefits and risks. Laser photo resection and electro-surgery allow rapid removal of endobronchial tissue, while cryotherapy and brachytherapy have delayed response and are not indicated for obstructive tumors in an emergency setting. In patients with acute respiratory failure in need of immediate relief, laser photo resection and electro-surgery are indicated.

However, these treatments are often palliative procedures that are usually combined with other treatments, such as radiotherapy and chemotherapy. In our patient, electro-surgery removed the major part of a tracheal small-cell cancer tumor and restored air passage. The patient was successfully extubated and had complete resolution of dyspnea and wheezing. As the small-cell cancer was extensive, he was further treated with chemo-radiotherapy, and he remains loco-regionally controlled on follow-up.

REFERENCES