Atelectasis in the ICU: An unexpected finding

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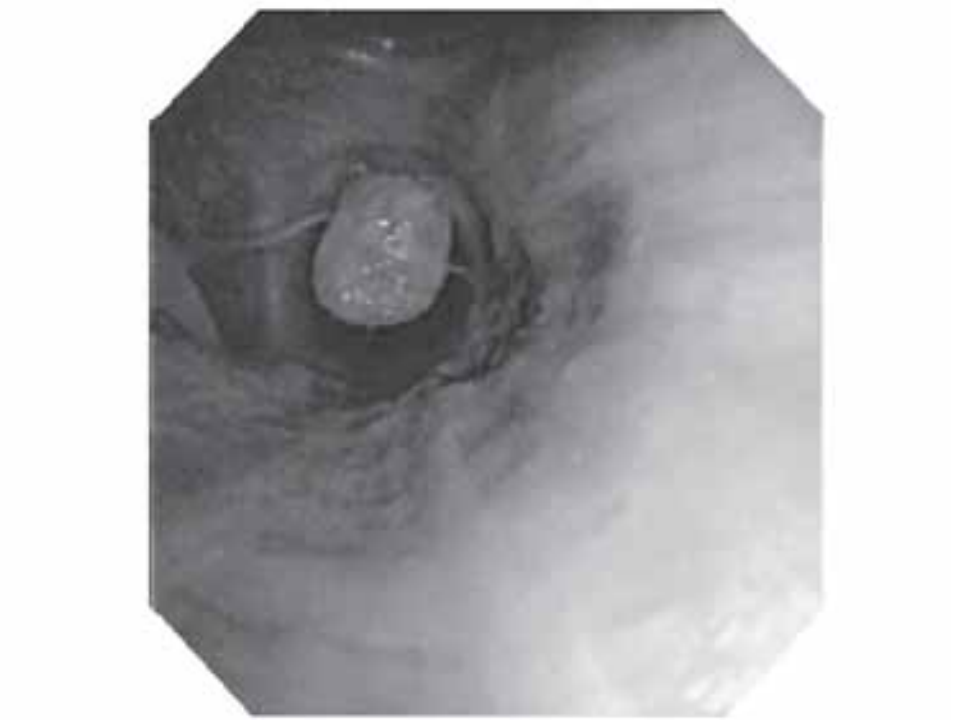
An 81 year-old male with a history positive for coronary artery disease, chronic hypertension and rheumatoid arthritis presented to the hospital complaining of diffuse chest pain. Chest x-ray on admission did not reveal lung masses, atelectasis, signs of infection or any other radiologic abnormality. Cardiac catheterization revealed multi-vessel disease. He underwent coronary artery bypass graft surgery on 5 vessels. On the first postoperative day the patient developed atelectasis of the entire right upper lobe. An emergency bronchoscopy revealed diffuse mucous plugs causing atelectasis of right upper lobe, which were suctioned until clear. In addition, an endobrochial polypoid glistening lesion accidentally found at the entrance of left lower lobe. (**Figure**)

The biopsy of this lesion revealed large fragments of hyaline cartilage with fibromyxoid stromal changes consistent of an endobronchial hamartoma. These tumors are the most frequent benign tumors of the lung. Its endobronchial location is very rare. Lung hamartomas usually occur in a 0.3% of the general population, with a higher incidence during the sixth decade of life being the male gender more oftenly affected than females. Pulmonary hamartomas are usually benign, peripheral, well-circumscribed single lesions, in the lung parenchyma. Our patient had the hamartoma endoscopically resected and had no additional postoperative complications.



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