Pulmonary Hamartoma Syndrome

To the Editor:

I read with interest the report on pulmonary hamartoma syndrome by Gabrail and Zara. The authors state: "To our best knowledge there have been no previous reports of association between pulmonary hamartoma and other benign tumors or congenital anomalies, with one possible exception, which was a case report of a patient with multiple gastric leiomyomas, islet cell tumor of the pancreas, and thyroid adenoma." In their article, the authors document 24 cases of an association between pulmonary hamartoma and numerous benign tumors and congenital anomalies.

I would like to recall the Carney triad of pulmonary chondroma, extra-adrenal paraganglioma, and gastrointestinal leiomyosarcoma. In 1979, Carney published 15 cases, four of his own cases from the Mayo Clinic and 11 cases from the literature, including our case after reviewing the clinical data and available histology of that case. The follow-up course of our patient was described outside the English language literature.

In 1958 a mediastinal tumor was discovered in a 31-year-old asymptomatic woman. Additionally, an esophageal abnormality was discovered, but the patient refused any investigation or treatment of the esophagus. The mediastinal tumor was resected and diagnosed as a nonchromaffin chemodectoma. At subsequent follow-up, the mediastinum never appeared normal, and the heart size progressively increased. In 1974 a small opacity appeared in the left lung. Radiologically, the esophagus still presented the same multiple filling defects. In 1975 the patient was operated on again; a pulmonary osteochondroma, pericarditis and an intrapulmonary aortopulmonary chemodectoma were discovered. As discussed with the patient, the esophagus was not explored. In July 1979 an inoperable epidermoid carcinoma of the left main bronchus was discovered, and the patient died in September 1979. There was no hypertension and no catecholamine excess. Unfortunately a post-mortem examination was refused by the relatives, so that the histology of the esophageal anomalies is still unknown. We feel that our patient may have had the Carney triad and that the esophageal tumor could have been a benign leiomyoma.

In the series of 24 cases reported by Gabrail and Zara we noticed in one case the association of pulmonary hamartoma, cancer of the esophagus, squamous cell carcinoma, and glomus pulmonale. There is one case of lung cancer, but in total there are five cases with various cancers.

In conclusion, we agree with the authors that the clinical significance of pulmonary hamartoma is in the workup and follow-up of those patients. It is important to be aware of the possible associated anomalies or tumors as certain tumors may become malignant, and the increased susceptibility to develop malignant tumors seems suggestive.

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REFERENCES
1 Gabrail NY, Zara BY. Pulmonary hamartoma syndrome. Chest 1990; 97:562-65
4 Carney JA. The triad of gastric epithelioid leiomyosarcoma, functioning extra-adrenal paraganglioma and pulmonary chondroma. Cancer 1979; 43:574-82

Psychobiologic (and Pharmacologic) Aspects of Asthma and the Consequent Research Implications

To the Editor:

The relationship between psychologic factors and activity of asthma is an increasingly important area for investigation. In this