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Trakeobronchopathia Osteokondroplastica: A Rare Cause of a Chronic Cough

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Tracheobronkopatia Osteochondroplastica (TO); A rare benign disease characterized by a large number of osseous and cartilaginous nodules protruding into the lumen of the trachea and bronchus. The disease was first described by Rokitansky in 1855, by Luschka in 1856 and by Wilks in 1857. Although its definite etiology is unknown, chronic infections such as mycobacteria, chemical or mechanical irritations such as silicosis, metabolic abnormalities such as amyloidosis and genetic predisposition are thought to be involved in the etiology. Since most cases do not have complaints, the diagnosis is usually incidentally established by autopsy or bronchoscopy. Recently, multislice computed tomography (CT) has been used more frequently and the incidence of diagnosis has increased.

Our case; A 74-year-old female patient presented to the cardiology outpatient clinic with chest pain and dyspnoea. As a result of echocardiography, pericardial effusion was detected and the patient was hospitalized for medical follow-up and treatment. The patient who was complaining of dyspnoea and cough after hospitalization was consulted with our clinic. In the patient's history, it was learned that there was a dry cough in the winter and the cough continued during the year. In her history, she was on medication for hypertension. There was no smoking history. On physical examination, bronchospasm was present in both lungs. The thoracic CT revealed a trachea and a main bronchus and there were wall irregularities. In our case, there were nodular views on the trachea and large airways at the anterior and lateral walls. No nodules were observed in the trachea's posterior wall. Fiberoptic bronchoscopy could not be performed because of bronchospasm in our patient who was thought to be radiologically tracheobronkopatia osteochondroplastica (TO). TO is a benign condition, which is histopathologically defined as the calcified protein matrix and the cartilage, bone, and blood elements, which are devoid of histopathologically. Amyloidosis, endobronchial sarcoidosis, calcified tuberculosis, tracheobronchial calcinosis should be considered in the differential diagnosis. The prognosis of TO is generally good. The treatment is mostly in the form of antibiotic follow-up of infectious complications and for obstruction. We also organized the infection treatment of our patient and we have taken to follow-up. As a result, patients with TO are more common because of increased thorax CT imaging rate. For this reason, radiological examination of the characteristic appearance of TO is likely to be helpful in differentiating other possible pathologies and managing treatment.

Keywords: Dyspnoea, cronic cough, Torax CT