Pulmonary hamartomas are benign lesions, usually asymptomatic and incidentally discovered on a routine chest radiograph; occasionally, however, this benign lesion may cause life threatening symptoms due to its location and diffuse vascular involvement. We report the case of a 27 year-old male, non-smoker, who presented with dyspnea, cough, hemoptysis and weight loss. He was found to have a mass in the right hilar region which also involved the right main bronchus, pulmonary artery and esophagus. Surgical biopsy of the lesion led to the diagnosis of diffuse vascular hamartoma. Although it was a benign lesion, due to the size and location, surgical removal was not possible and patient died 10 years after being diagnosed with the condition.

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chronic inflammatory process. No signs of malignant cells were found in bronchial lavage. Ziehl-Neelson, Giemsa and Gram stain did not reveal any micro-organisms.

The patient was subjected to transthoracic needle aspiration guided by the computed tomography. There were no signs of malignancy.

A right thoracotomy, a lung biopsy and decortication of the pleural process were performed due to the important thickening of pleura. Gross examination of the specimen revealed thickening of the vessel walls and pleura with chronic inflammatory changes. Histological examination of the biopsy revealed - pulmonary parenchyma with large, irregular vessels with thickened heterogenic, irregular walls related to the hamartomatous nature of the disease (Fig. 3a-b) and pleural thickening with chronic inflammatory infiltrate and fibrosis. Diagnosis of vascular hamartoma was established.

Total surgical removal of the lesion was not possible due to the vascular invasion of the pulmonary artery and esophagus. The patient underwent radiation therapy, with stabilization of the lesion size. He had several episodes of hemoptysis, associated with progressive exertional dyspnea and developed respiratory insufficiency. Flexible bronchoscopies were performed trying to achieve control of hemoptyses with argon plasma coagulation on several occasions. Patient refused to undergo heart-lung transplantation.

Ten years after being diagnosed with the condition the patient died of the chronic illness and worsening respiratory insufficiency.

2. Discussion

Pulmonary hamartomas are usually found in adults with a peak incidence in the sixth decade of life with a male preponderance; male: female ratio being 2:1 to 3:1 [5]. These benign lesions are often asymptomatic and are typically discovered as an incidental coin lesion on a routine chest film. Pulmonary hamartomas characteristically appear as well-defined, solitary pulmonary nodules. Radiologically, hamartomas account for 7%–14% of pulmonary coin lesions [6–8]. PH can occur in all parts of lung, but most often, they are found in the periphery and rarely near the hilar regions. Our patient had an atypical radiologic presentation along with histological findings of a mainly vascular component; the latter also being less frequent than chondromatous type [5].

Today, despite the advances in medical therapy pulmonary resection remains the curative treatment for patients with pulmonary hamartoma. Controversy, however, still exists related to the indication and timing of the surgery [5]. Since most pulmonary hamartomas are nonexpanding or slowly growing neoplasms, some authors believe that surgery is necessary only when expansion is recorded in young or middle aged patients or accompanying by
obvious pulmonary symptoms. In spite of the benign nature of the disease, in this case it behaved as a malignant one, by invading the right pulmonary artery and esophagus, to which surgery and lung transplant were not treatment options [9], making this case a very rare one with no similar prior descriptions in the English literature.

**Conflict of interest**

We declare no conflicts of interest.

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