Perspective

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Complex Diagnoses in Pulmonary and Hematological Disorders

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Description

The diagnosis of Intravascular Large B-cell Lymphoma (IVLBCL) is sometimes complicated by vague symptoms. This report describes the case of a 70-year-old man who developed severe respiratory failure due to exhaustion, dyspnea and weight loss. A random skin biopsy revealed that the man. After the respiratory symptoms initially improved, coronavirus illness developed. Elevated lactate dehydrogenase levels and the response to steroid therapy suggested IVLBCL, which was verified by a random skin biopsy. The respiratory condition was improved by the combination chemotherapy that included prednisolone, doxorubicin, vincristine, cyclophosphamide and rituximab. This example emphasizes the difficulty in diagnosing IVLBCL and the critical function of random skin biopsy. An immunosuppressive course of treatment for anti-MDA5 dermatomyositis with lung involvement in a 62-year-old male patient resulted in persistent cavitary pulmonary aspergillosis in the left upper lobe. The patient's history was exacerbated by a full pneumothorax resulting from an alveolar-pleural fistula that was caused by the pulmonary cavitation rupturing. A four-week period of pleural drainage did not result in the left lung expanding again. The patient had endobronchial valve therapy in the anterior segmental bronchus of the left upper lobe in addition to antifungal medication, which resulted in the closure of the aspergillosis cavitation, the cessation of air leaks and the enlargement of the left lung. The uncommon non-Hodgkin lymphoma known as extranodal natural killer/T cell lymphoma nasal type typically affects the upper respiratory system, including the nasal cavity, palate and nasopharynx. Additionally, extranasal locations such the epidermis, gastrointestinal tract, testicles, central nervous system and lungs are rare places where the primary lesion can originate. We report the hospital admission of an 82-year-old man smoker who had been experiencing fever, coughing up phlegm, chest tightness and chest pain for eight months.

Pulmonary pneumonia

On a Computed Tomography (CT) scan of the chest, a subpleural high-density shadow with hazy boundaries and a patchy ground-glass shadow surrounding it was visible in the right lung's lower lobe. Initially, the patient's right lower lobe lesion progressed after getting anti-inflammatory medication. He then had a bronchoscopy and two percutaneous transthoracic needle aspiration biopsies guided by Computed Tomography (CT), but no tumor cells were discovered. After engaging in multidisciplinary team discussions, the patient was sent to the cardiothoracic surgery department in order to undergo a right lower lobectomy. Finally, analysis of the surgical specimen indicated that the patient had nasal type extranodal T-cell lymphoma. When the patient was diagnosed and treated, the extrapulmonary location was the only source of evidence, leading to the diagnosis of primary pulmonary Extranodal NK/T-Cell Lymphoma (ENKTCL). In this instance, we provide insights into the disease by documenting a case of primary pulmonary extranodal T-cell lymphoma of nasal type presenting as pneumonia in the right lower lobe. An unusual subtype of Non-Small Cell Lung Cancer (NSCLC) called pulmonary Large Cell Neuroendocrine Carcinoma (LCNEC) is distinguished by its aggressive nature. This leads to a poor prognosis and involves rapid progression, extensive metastases and resistance to traditional therapies. As such, the management of pulmonary LCNEC continues to be quite difficult.

MAC infection and bronchiectasis

The RET (Rearranged During Transfection) kinase inhibitor was successfully used as a first-line treatment in this case report for a patient with advanced pulmonary LCNEC who carried a RET fusion gene. This instance highlights the significance of early genetic testing in patients with pulmonary LCNEC to properly customized targeted therapy, despite the extremely rare occurrence of RET fusion genes in this condition. A female patient acquired several intestinal perforations at 31 and 43 years of age. When came to our hospital at the age of 52, Ehlers-Danlos Syndrome (EDS) was suspected due to her family's history of intestinal perforation and pneumothorax. experienced bilateral external iliac artery dissection and was diagnosed with vascular Ehlers-Danlos Syndrome (vEDS). When the patient was admitted, a CT scan showed granular and infiltrative shadows in both lungs, indicating bronchiectasis. In addition, the patient's drug susceptibility to clarithromycin was verified and *Mycobacterium Avium* Complex (MAC) lung illness was diagnosed. Following the initiation of rifampicin, ethambutol and clarithromycin therapy, the respiratory symptoms showed some improvement after approximately one month and the acid-fast bacilli cultures obtained from sputum were negative.

Few cases of respiratory infections with vEDS have been reported, yet it is purported that vEDS is linked to lung conditions such pneumothorax and cystic lung lesions. Furthermore, no MAC disease-related problems have been reported. We describe a case of uncommon complications associated with vEDS and propose a potential mechanism of infection.