INTRODUCTION

Tracheobronchopathia Osteochondroplastica is a rare benign disorder of the lower part of the trachea and large airways. It is associated with the development of multiple osseous and cartilaginous nodules in the sub-mucosa of the airways. Patients commonly present with cough, hemoptysis and recurrent respiratory tract infections. The diagnosis is usually made with the help of CT scan and bronchoscopy. Bronchoscopic biopsy reveals the presence of cartilage and bone tissue. This condition usually remains stable for many years or progresses very slowly. There is no specific treatment described for this condition. Only a minority of patients develop significant upper airway obstruction and require invasive treatment. We report a case of Tracheobronchopathia Osteochondroplastica in a 53-year-old man from South India.

Keyword: Tracheobronchopathia Osteochondroplastica

Abstract: Tracheobronchopathia Osteochondroplastica is a rare disorder of the trachea and large airways. It is associated with the development of multiple osseous and cartilaginous nodules in the sub-mucosa of the airways. Patients commonly present with cough, hemoptysis and recurrent respiratory tract infections. The diagnosis is usually made with the help of CT scan and bronchoscopy. Bronchoscopic biopsy reveals the presence of cartilage and bone tissue. This condition usually remains stable for many years or progresses very slowly. There is no specific treatment described for this condition. Only a minority of patients develop significant upper airway obstruction and require invasive treatment. We report a case of Tracheobronchopathia Osteochondroplastica in a 53-year-old man from South India.

A 53-year-old man, who was a non-smoker, presented with a history of persistent cough and breathing difficulty for 4 months. A chest X-ray showed multiple nodules in the sub-mucosa of the trachea and main bronchi. CT scan of the chest revealed multiple nodules in the sub-mucosa of the trachea and main bronchi. Bronchoscopic biopsy revealed the presence of cartilage and bone tissue. The patient was diagnosed with Tracheobronchopathia Osteochondroplastica. He was treated with oral medications and his symptoms improved. The patient has been followed up for a period of 2 years and there has been no progression of the disease.

CASE REPORT

A 53-year-old man, who was a non-smoker, presented with a history of persistent cough and breathing difficulty for 4 months. The cough was associated with minimal white mucoid expectoration. The breathing difficulty was present only after prolonged exertion. There was no history of fever, hemoptysis, diurnal variation or wheezing. There were also no features suggestive of allergic rhinitis or gastro-oesophageal reflux disease. He was diagnosed with diabetes mellitus 1 year back and was on oral medications. On clinical examination, there

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DISCUSSION

This condition was first described by Rokitansky in 1855. As this condition is benign in a majority of patients, the exact incidence is not well known. Incidence has been reported to be between 1 in 125 and 1 in 6000 as per bronchoscopy based studies. The exact etiology and pathogenesis remains unknown. However, various hypotheses have been proposed. The submucosal nodules are characteristically confined to the anterior and lateral walls, sparing the posterior wall. Histologically, the nodules are composed of cartilage and bone. Most patients remain asymptomatic. The common symptoms include cough, hemoptysis and recurrent respiratory infections. The chest radiograph is usually normal. CT scan may reveal calcified nodules in the anterior and lateral walls of the trachea-bronchial tree that protrude into the lumen. Bronchoscopy is the gold standard for diagnosis. The classical description is the presence of multiple sessile nodules with a normal overlying mucosa causing a beaded appearance of the trachea-bronchial tree. The diagnosis is confirmed with histology of the bronchial biopsy. The lung function tests are usually normal, except in the severe cases and are usually helpful in the follow up evaluation. The prognosis is usually good. Treatment is usually conservative and consists of management of respiratory infections. Asthma and COPD, if coexistent, should be treated appropriately. Invasive procedures are needed only in a minority of patients with severe disease.

REFERENCES
