An unusual cause of bronchial dilation: Mounier–Kuhn syndrome

A 54-year-old previously healthy woman presented to the department of respiratory medicine with complaints of a productive cough. Thoracic computed tomography showed obviously dilated trachea and both main bronchi – the trachea measured 39 mm in diameter and the right and left main bronchi measured 25 mm and 23 mm respectively (*Figure 1*). In the absence of any secondary causes, Mounier–Kuhn syndrome was diagnosed.

Mounier–Kuhn syndrome or tracheobronchomegaly is a rare congenital anomaly characterized by distinct dilation of the trachea and main bronchi as a result of atrophy of the elastic fibres and smooth muscle cells of the trachea and main bronchi (Govindaraj et al, 2016). Thoracic computed tomography can confirm the diagnosis. Diagnostic criteria are diameters of the trachea greater than 30 mm, and of the right main and the left main bronchus more than 20 mm and 18 mm respectively (Celik et al, 2011). There is no specific treatment for Mounier–Kuhn syndrome. BJHM

Dr Tingting Wu, Resident Doctor, Department of Respiratory Medicine, Affiliated Hospital of Ningbo University Medical College, Ningbo 315020, China

Dr Yiming Yu, Vice Director, Department of Respiratory Medicine, Affiliated Hospital of Ningbo University Medical College, Ningbo 315020, China

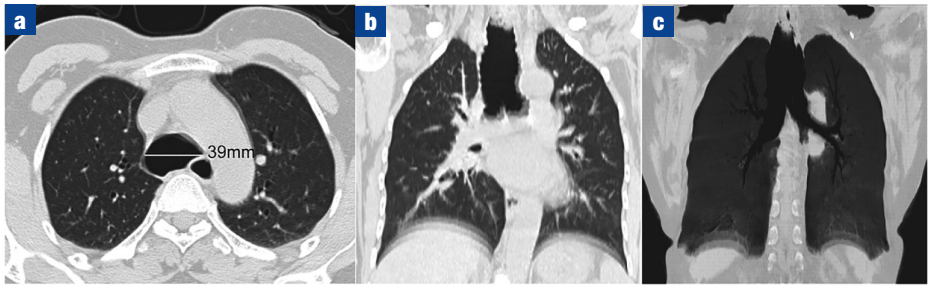
Professor Zaichun Deng, Consultant, Department of Respiratory Medicine, Affiliated Hospital of Ningbo University Medical College, Jiangbei District, Ningbo 315020, China

Correspondence to: Professor Z Deng (dzcrespiratory123@163.com)

Celik B, Bilgin S, Yuksel C (2011) Mounier-Kuhn syndrome: a rare cause of bronchial dilation. *Tex Heart Inst J* **38**(2): 194–196.

Govindaraj V, Mohanty Mohapatra M, Nagamalli Kumar B, Narayanasami S (2016) Tracheobronchomegaly as a cause of bronchiectasis in an adult. *Case Rep Pulmonol* **2016**: 1–4. https://doi.org/10.1155/2016/5049406

Figure 1. Chest computed tomography scan showing (a, b) obviously dilated trachea and (c) main bronchi.



Leg swelling: an important differential to consider

An 87-year-old man presented with a 6-month history of worsening right swollen lower leg and ankle pain. X-ray of his right ankle, showed metastatic erosive and lytic lesions (*Figure 1*). A computed tomography scan of the thorax, abdomen and pelvis with contrast showed a right hilar mass lesion with bulky mediastinal lymphadenopathy and a right-sided pneumothorax likely as a result of the malignancy (*Figure 2*).

A radiological diagnosis of probable T2a N2 M1b metastatic carcinoma of the lung was made. The lung cancer multidisciplinary team felt that he would not be a candidate for further investigations and chemotherapy. He was discharged back to his nursing home.

This case illustrates the importance of considering metastatic malignancy as a differential diagnosis in patients presenting with a painful swollen leg and ankle to ensure a prompt diagnosis. BJHM

Dr Muhammad JH Rahmani, Consultant Physician, Department of Health and Ageing, Conquest Hospital, East Sussex Healthcare Trust, St Leonards on Sea, East Sussex TN37 7RD

Dr Laurenda Obeng, CT1, Department of Health and Ageing, Conquest Hospital, East Sussex Healthcare Trust, St Leonards on Sea, East Sussex

Dr Shobayo Sholotan, FY1 Department of Health and Ageing, Conquest Hospital, East Sussex Healthcare Trust, St Leonards on Sea, East Sussex

Correspondence to: Dr MJH Rahmani (m.rahmani3@nhs.net)

Figure 1. Metastatic erosive and lytic changes in the distal fibula and tibia, calcaneus, talus and navicular.

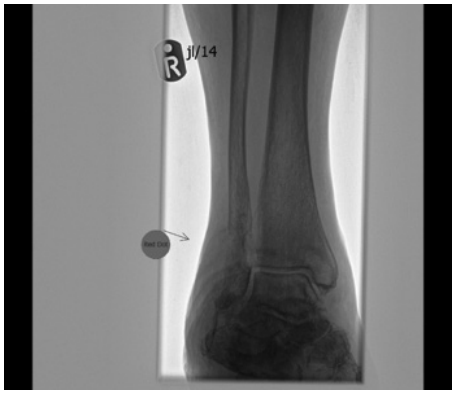


Figure 2. Primary lung carcinoma, with right-sided pneumothorax (arrows).