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Correspondence

Pulmonary Hamartoma

To The Editor: I read the article 'Pulmonary Hamartoma' by Garg K *et al* with great interest.[1] I appreciate the efforts of authors in highlighting the features of pulmonary hamartoma through this article but pained to see its publication under section "Radiology Forum", more so when the case under discussion is not showing all the typical radiological features of pulmonary hamartoma.

In "Radiology Forum", it will be more appropriate, if the radiological features of any given problem are highlighted and its differential diagnosis is discussed.

This lesion appears to be a solitary pulmonary nodule, *albeit* about 4 cm in size. The imaging features of this lesion need to be evaluated in greater details, more particularly the findings on thin section computed tomography (CT) and magnetic resonance imaging (MRI), both with and without contrast enhancement. The pre-test probability of malignancy also needs to be estimated on the basis of the detailed imaging findings, clinical history and other laboratory findings and discussed. Patel *et al*[2] have also suggested this approach.

I hope, all the respiratory physicians and the readers will appreciate this, alike.

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2. Patel VK, Naik SK, Naidich DP, Travis WD, Weingarten JA, Lazzaro R, *et al*. Practical algorithmic approach to the diagnosis and management of solitary pulmonary nodules. Part 1: Radiologic characteristics and imaging modalities. *Chest* 2013;143:825-39 and Part 2: Radiologic characteristics and imaging modalities. 840-6.

The Author's Reply: We appreciate and welcome Dr Gupta and colleague's comments that 'lesion appears to be a solitary pulmonary nodule (SPN)' and their suggestion for evaluation on thin section CT and MRI. As already described, the lesion was a single focal mass lesion, >3cm in size, better labelled as a lung mass than a SPN, the characteristics of which have already been detailed in the manuscript.[1] We need to consider focal pulmonary lesions more than 3cm in diameter as lung masses, being representative of bronchogenic carcinoma, until proven otherwise.[2]

To add to the description, the mass was round and non-spiculated with no gross intra-lesional calcification. A nodule with enhancement at greater than 25HU (Hounsfield units) is considered malignant,[3] but in our case it was 17HU.[1] Considering the size, we evaluated the mass with CT-guided needle aspiration cytology which confirmed the diagnosis of "benign chondroid hamartoma".

In view of younger age (37years) of the patient, asymptomatic profile and cytology report, the patient was judged to have low probability for malignancy. Hence, it was decided to keep him under regular follow-up, with no more investigations. The pre-test probability was not calculated but same factors, as mentioned in the study by Patel *et al*,[4] were considered. As mentioned by Dr Gupta, MRI, with or without contrast enhancement is a promising new modalitiy to differentiate between benign and malignant lesions,[4] but it was not carried out in our patient at the baseline due to above mentioned reasons. Rather dual time point ^{18}F-FDG PET (Flourine 18-fluorodeoxyglucose - positron emission tomography), being a cell proliferation tracer, usually does not concentrate in benign lesions, and, thus can rule out such chondroid hamartomas in a better way.[5] Moreover the diagnosis was confirmed pathologically. The patient was followed-up for more than a year (even if considering the possibility of false negative results pathologically[2]) and post one year, the chest radiograph did not show any change in the lesion and the same needs be followed up at the institutional level in the times to come to document the biological behaviour of such lesions.

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