Pleomorphic carcinoma of the trachea after chemoradiotherapy for laryngeal cancer

Hirotaka Saikawa,1 Noriyuki Uesugi,2 Tamotsu Sugai,2 Makoto Maemondo1

SUMMARY
A 66-year-old male patient who had received chemoradiotherapy (CRT) for laryngeal cancer 2 years ago visited a local doctor complaining of dyspnoea and wheezing. CT scan showed narrowing of the trachea caused by a tumour. We intubated the trachea over the tumour using a bronchoscope. A week later, the truncated tracheal tumour obstructed the tracheal tube, compromising the patient’s breathing. We removed the obstructed tube and inserted a new one. We submitted the tissue from the tube to a pathologist. Histopathological diagnosis was pleomorphic carcinoma, a subtype of sarcomatoid carcinoma. The mechanism of epithelial–mesenchymal transition (EMT) occurring after CRT was detected in the tumour. Because he had undergone CRT for laryngeal cancer, surgery was not indicated, and we started radiation therapy. Sarcomatoid carcinomas including pleomorphic carcinoma of the trachea are extremely rare, with few reported cases, and EMT is associated with this histological type and CRT.

BACKGROUND
Primary tracheal tumours are rare. One report found only two primary tracheal tumours detected in 9000 autopsy cases.1 Pleomorphic carcinoma, a subtype of sarcomatoid carcinoma, is rare in any organ. To date, only three cases of sarcomatoid carcinoma in the trachea have been reported.2–4 Epithelial–mesenchymal transition (EMT) is related to metastasis and resistance to therapy.5 Generally, surgical resection is considered useful for tracheal tumours. We searched the literature, but did not find any cases of a primary tracheal tumour developing after CRT for a head and neck tumour. We report a case of a rare primary tracheal tumour related to EMT.

CASE PRESENTATION
A 66-year-old male patient received chemoradiotherapy (CRT) (intensity modulated radiation therapy: IMRT, 66 Gy/33Fr, and docetaxel) for squamous cell carcinoma of the larynx 2 years before this event. He was a former smoker with a history of two cerebral haemorrhages. He developed dyspnoea and wheezing lasting about a month, and visited a local otolaryngologist. His vital signs were normal. On auscultation, wheezing was heard. The doctor suspected bronchial asthma, and performed blood tests and a CT scan to exclude other diseases. Blood tests showed no significant abnormal findings, including tumour markers. The CT scan showed a tumour causing narrowing of the trachea, so the doctor consulted a respiratory physician in the same facility. The situation was considered life-threatening and the patient was intubated using a bronchoscope and placed on a mechanical ventilator. The tumour obstructing the trachea was identified using a bronchoscope (figure 1). The large tumour had a stalk and bled easily. The next day, the patient became feverish and developed hypoxaemia. Bilateral consolidations of the base of the lungs were observed by chest X-ray. Blood tests showed elevated inflammatory markers including C-reactive protein. The patient was diagnosed with ventilator-associated pneumonia (VAP) and antibiotic treatment by intravenous drip of tazo-bactam/piperacillin 13.5 g/day was initiated. Four days later, the patient was sent to our hospital for intensive treatment for VAP and treatment of the tracheal tumour.

INVESTIGATIONS
CT scan showed the tumour obstructing the trachea (figure 2). We initially considered the tumour as a metastasis of laryngeal cancer previously treated, but the location was near the second tracheal cartilage and different from location of the first malignancy. A week later, the truncated part of tracheal tumour had obstructed the tracheal tube, compromising his breathing. We exchanged the tube and submitted the tissue truncated in the tube to a pathologist. We considered the part of tumour was accidentally resected by tracheal tube sliding. Histopathological findings (H&E staining) of the tumour showed both an epithelial and a spindle cell component (mesenchymal component) in the same specimen (figure 3).

In immunohistochemical staining, the epithelial component stained epithelial markers such as E-cadherin, and the mesenchymal component stained mesenchymal markers such as Zeb-1 and Twist. In the part of the epithelial component in contact with the mesenchymal component, the transitional component was observed. In the mesenchymal component (spindle cell component), E-cadherin was negative, and Zeb-1, Twist and Snail/Slug were positive, so EMT was suspected (figure 4). Expression of Ki-67, a marker of cell proliferation, was similar in both component. All the results of immunohistochemical staining are shown in table 1.

DIFFERENTIAL DIAGNOSIS
At this point, we had considered the tumour to be tracheal recurrence of laryngeal cancer, but the pathological type and location was different. Pathological findings showing the epithelial and spindle cell components were decisive in diagnosis. The spindle cell component was greater than 10%, and from this result we diagnosed the
tumour as pleomorphic carcinoma, a subtype of sarcomatoid carcinoma.

**TREATMENT**

We continued antibiotic treatment for VAP and performed a tracheostomy 10 days after re-intubation. The tumour was located near the second tracheal cartilage and we made a tracheotomy at the third tracheal cartilage to avoid the tumour. We considered bronchoscopic resection for remaining tracheal tumour, but decided not to do it because the tumour was prone to bleeding and the stem was too large and we understand that bronchoscopic resection of tracheal tumour is at high risk and is generally performed only in the operating room under general anaesthesia for patients in good general condition. Although we considered the option of complete resection of the tumour, we chose RT through the tumour board meeting because surgery after CRT for laryngeal cancer would have entailed an increased risk of complications including necrosis and rupture of previously irradiated structures. RT (IMRT, 60 Gy/30Fr) was performed and avoided damage of normal tissues around the tumour as much as possible.

**OUTCOME AND FOLLOW-UP**

Two months have passed since he received RT and the patient is alive. However, we cannot yet evaluate the outcome of treatment because there was no evaluable lesion. In the future, we will evaluate the outcome based on recurrence and metastasis of the tumour, and survival.

**DISCUSSION**

Tracheal tumours cause varying degrees of dyspnoea depending on tumour size, and are often misdiagnosed as bronchial asthma or chronic obstructive pulmonary disease. In this case, because the patient received CRT for laryngeal cancer 2 years before...
17 patients reported in Japan. Pleomorphic carcinoma is a subtype of sarcomatoid carcinoma, and is defined as an epithelial component and tumour invasion ability. In this case, 22.4% of Ki-67 expression in epithelial component and 24.0% in spindle cell component were low compared with median 62% (range, 20% to 87%) expression in pulmonary pleomorphic carcinoma of epithelial component and 24.0% in spindle cell component.

This case was compatible with the characteristics of pleomorphic carcinoma. Several reports identify complete resection as the first choice for treatment of primary tracheal tumours.13 However, as the patient had undergone CRT for laryngeal cancer, we considered surgical resection to have a higher risk of complications including necrosis of the trachea and ruptured suture. We thus selected RT for this patient. However, the effect of RT can be considered to be limited. The Netherlands Cancer Registry reports median survival of 91 months in cases of resection without RT, 82 months in cases of resection with RT, 11 months for patients who underwent only RT and 3 months for patients who did not receive either therapy.17 We should note that this result included cases of palliative RT, but it is clear that RT is inferior to resection. We should consider other treatment and rehabilitation.

### Learning points

- We should consider tracheal tumour as a differential diagnosis in patients with symptoms such as shortness of breath and wheezing similar to bronchial asthma or chronic obstructive pulmonary disease.
- We should treat cases of such difficult malignant tumour with specialists through tumour board meeting.
- There have been few reports of primary tracheal tumours related to epithelial–mesenchymal transition, and we need to investigate further.
- We need to develop effective treatments for tracheal tumours that are difficult to resect.

### Immunohistochemical staining findings

<table>
<thead>
<tr>
<th>Antibody</th>
<th>Clone</th>
<th>Source</th>
<th>Dilution</th>
<th>Pretreatment</th>
<th>Result of Epithelial component</th>
<th>Result of Spindle cell component</th>
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<tr>
<td>CK AE1/AE3</td>
<td>AE1/AE3</td>
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<td>E-cadherin</td>
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<tr>
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<td>BC28</td>
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<td>4A4</td>
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<td>Twist</td>
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<td>Abcam</td>
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### Patient’s perspective

I only remember the moment before I was connected to the ventilator. I will do what I can to ensure the success of my treatment and rehabilitation.
options for unresectable tracheal tumours, and we need to follow-up this case carefully.

Contributors HS treated the patient and wrote this case report. NJU and TS made a pathological diagnosis of the patient. Makoto Maemodo provided guidance for this case report.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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