Infantile chest hamartoma—case outcome aged 11

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Abstract
Chest wall hamartoma of infancy is a rare lesion, usually presenting in the first year of life. Recent literature has recommended conservative management of asymptomatic children, yet most continue to undergo surgical resection irrespective of their symptom status. We report a case of spontaneous regression of a chest wall hamartoma of infancy, supporting recommendations for conservative management in asymptomatic children.

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Hamartoma of the chest wall in infancy is a rare lesion, usually presenting in the neonate or infant with a mass or respiratory symptoms. Most reported cases have been managed by surgical resection.1–6 We report expectant management and long term follow up of a case showing uncomplicated spontaneous resolution and rib remodelling.

Case report
A previously healthy 7 month old male was admitted to hospital with respiratory syncytial virus positive bronchiolitis. Coincidentally a protuberance of the right lower rib cage was noted for the first time. Chest x ray at this stage showed a peripheral soft tissue lesion in the right lower zone with a well defined inner margin (fig 1). There was associated deformity of the adjacent 7th rib with splaying of the 7th and 8th ribs, indicating a mass component. Ultrasound scan confirmed the presence of a solid lesion. Skeletal survey showed no other abnormalities and blood parameters were normal.

Computed tomography (CT) scan of the chest (fig 2) confirmed a 5 cm × 3 cm extrapleural mass containing calcification.

Discussion
Chest wall hamartoma in infancy is a rare lesion, which may be present at birth, or present in early infancy, either as an asymptomatic mass or with some respiratory compromise. Histologically, the lesion is composed of cartilage, smooth muscle, and respiratory...
epithelium forming a disorderly mass. A review of the English language literature has revealed 59 reported cases, with only scanty information available in standard paediatric or pathology textbooks.

Of those cases reported up to 1991, wide en bloc surgical excision was the recommended course of management.1 This treatment is complicated by inevitable chest wall defect postoperatively, often requiring synthetic grafts for closure, and is associated with a risk of developing scoliosis in later life.2 There are two early reports3–4 describing three infants who did not have radical surgery. However, one of these children received chemotherapy as an alternative to resection;5 one had only short term follow up of one year, remaining well without further growth of the tumour,1 and the oldest child remained well 16 years later but with evidence of residual tumour. Subsequently Gwyther and Hall,6 in 1991, were the first to recommend a conservative approach to the management of such lesions in otherwise asymptomatic children. However since then, of the 18 cases reported, only one has been managed conservatively and that patient has no recorded long term follow up.7

To our knowledge our patient is the first in whom conservative management in association with documented complete spontaneous regression of the lesion in the long term has been described. Our experience provides support for the recommendation of a conservative approach to management in an asymptomatic patient, thus avoiding the significant risks and complications of major surgery.

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