CONVERGENCE AND A CASE OF PULMONARY ANGIOSARCOMA

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INTRODUCTION

Case reports are a time-honored way for physicians to share knowledge in cases that are especially rare, interesting, or instructive. A case report typically involves only the care of one patient and therefore often appears to represent an isolated endeavor. Most cases, however, are not isolated events but rather a convergence of multiple forces. To illustrate this, I have received permission from a patient to identify him in this case discussion.

"Convergence" is defined in *The American Heritage Dictionary of the English Language* as "the act, condition or quality of converging or approaching the same point from different directions; tend towards a meeting or intersection." This case report is a story of extraordinary convergence, of people and places, of hope and happiness.

THE INITIAL DIAGNOSIS

In October 2005, I received a call from a former resident now on staff at M.D. Anderson Cancer Center, Dr. David Rice. He had received information and studies on a patient in New Zealand dying from a pulmonary artery sarcoma that had been deemed unreseccable in both New Zealand and Australia. David asked a simple question: "What can we do?"

The patient, B$_{ry}$an Hodder, was at the time a 74-year-old retired farmer in New Zealand. Having spent a lifetime working hard so chat ochers could eat, Bryan and his wife Lois were looking forward co travel and family. In June 2004, he noticed his first symptoms of wheezing when he lay on his left side in bed. He had also developed a slight buc persistent cough. B$_{ry}$an and Lois were to leave soon on a long-awaited eight-week overseas vacation. Before leaving, B$_{ry}$an visited his family physician, who diagnosed asthma and gave him an inhaler co rake with him on his trip. He noticed increasing fatigue leading up co his trip buc attributed this to doing coo much in preparation for leaving. By the second week of their vacation tour, despite having been a very vigorous man all his life, Bryan was having trouble keeping up. By week four in Copenhagen, his cough was much more incense and his wheeze clearly audible. A call to the hotel doctor resulted in a phone diagnosis of asthma and a prescription for inhalers and cough medicine. A week lacer in Dover, he was seen by a physician who wrote more prescriptions and asked co see him the following day. Because the tour was leaving, however, this was not possible, and B$_{ry}$an soldiered thru the end of che cour with increasing fatigue. *The* day afcer his recurn, his physician ordered a chest X-ray, and the result was unseccling: although he had never smoked, and despite several bronchoscopies, no one could explain the shadow in his lung. In fact, he became known at the Christchurch Hospital as "che mystery man."

Consultation was arranged with Mr. Singh, che local cardiothoracic surgeon, who finally provided him with a diagnosis - a sarcoma of his left pulmonary artery. Mr. Singh cold him chis sarcoma was unresecrable, and follow-up opinions from experts in Auckland and Australia concurred. Radiation therapy was scarred as palliation for the tumor, which had occluded the blood supply co his left lung and threatened the blood supply of his right lung. Told chat his tumor was incurable, his family braced itself for what appeared co be the inevitable end.

Eventually, the Hodders received a fax from a niece who had searched the Internet and found some information on cardiac tumor work being done at the M.D. Anderson Cancer Center and The Methodist DeBakey Heare & Vascular Center, both in Houscon's Texas Medical Center. B$_{ry}$an initially chose not to pursue this as he feared another disappointment and had already prepared himself fur the worst. Then his family physician, Dr. John Cook, told him, "You have nothing to lose; there's nothing else here in New Zealand or Australia. Let's give ic a cry." B$_{ry}$an agreed, and the call was made to Houston.

A CASE OF EXTRAORDINARY CONVERGENCE

Dr. David Rice emigrated from Ireland to pursue a career as a thoracic surgeon specializing in thoracic oncology. He planned to do a surgery residency at The M$_{ay}$o Clinic. At the time, I served as program director of the Baylor College of Medicine Cardiochoracic Surgery residency and had worked with Dr. Jack Roch, chief of thoracic surgery at M.D. Anderson Cancer Center, to create a "general thoracic" spot within the Baylor cardiochoracic residency - an approach chat was subsequently embraced by the thoracic surgery residency review committee and led to formalized "thoracic" and "cardiac" tracts within cardiothoracic residencies. Offering Dr. Rice a spot at Baylor with additional rime at M.D. Anderson, Jack