

## **Research Article**

# Pulmonary Artery Intimal Sarcoma: A Review of the Literature Manjit K Bhandal<sup>1</sup>, David L Stockman<sup>1</sup>

<sup>1</sup> Department of Medicine, M.D. Candidate, B.A. Integrative Biology, Central Michigan University College of Medicine, University of California, Berkeley, USA.

**Copyright:** © 2018 Manjit K Bhandal, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

## Introduction

Pulmonary artery intimal sarcoma (PAIS) is a rare and aggressive tumor that is an unlikely cause of chronic pulmonary arterial obstruction [1] and is thus often misdiagnosed as thromboembolic disease. It has gone by several names, including intimal sarcoma, primary pulmonary artery sarcoma, and pulmonary sarcoma. Due to the paucity of data on the symptomology, diagnosis and prognosis of PAIS, this paper aims to help facilitate clinical recognition of PAIS through a comprehensive literature review and data analysis of the key clinical features of this tumor type.

Sarcomas of the pulmonary artery and cardiac vessels have been mistakenly classified as intimal sarcoma. In this paper, we focus on high grade spindle cell pulmonary artery sarcomas, including malignant fibrous histiocytoma (MFH), which is also known as undifferentiated pleiomorphic sarcoma (UPS) (Figure 1). Due to the similar clinical presentation of PAIS to chronic thromboembolic pulmonary hypertension (CTEPH), in combination with the paucity of this tumor, diagnosis is difficult and the prognosis is poor. Given the similarity to CTEPH, echocardiography studies are the first to be employed in patients with PAIS and often reveal pulmonary masses similar to thromboembolic disease. For patients who are stable enough to undergo further testing and evaluation, computed tomography or FDG-positron emission tomography scan is commonly implemented and are the imaging modalities of choice in diagnosing PAIS.

PAIS is a highly malignant tumor that most often affects the pulmonary trunk and thus commonly presents with pulmonary hypertension-like symptoms including dyspnea and chest pain. Many patients also exhibit hemoptysis due to a pulmonary emboluslike blockage, exertional syncopal episodes as well as symptoms mimicking myocardial infarction including chest pain with radiation to the shoulder and left arm and acute shortness of breath [2]. Less



Figure 1: PAS is subdivided into intimal and intramural sarcomas. Intimal sarcomas are further classified as fibroblastic/myofibroblastic differentiation, with several different subtypes. The four most common are listed here. In this paper, we focus on Malignant Fibrous Histiocytomas, also referred to as high grade spindle cell sarcoma, or undifferentiated pleiomorphic sarcoma (UPS).

common symptoms at presentation include back and lower leg weakness [3,4] lower extremity edema [5-7], syncope [7-11], chronic diarrhea [12], and pyrexia [13-15].

Due to its invasive nature, PAIS is often diagnosed at autopsy [16]. However, due to the initial presentation of cardiovascularlike disease, echocardiography is often used in preliminary workup. Several case reports specify finding right ventricle enlargement with hypokinesis and a severely enlarged right atrium, indicating findings similar to McConnell's sign seen in acute pulmonary embolus (PE) [7,17-20].

Further workup with computed tomography or FDG-positron emission tomography scan often reveals filling defects in the pulmonary arteries and elevated systolic pulmonary arterial pressure [7], as well as a mass most commonly involving the main pulmonary artery. Unfortunately, this disease often presents late in its course and imaging frequently reveals tumors metastases, contributing to the high mortality rate of this tumor type. The most common metastatic sites were noted to be the in the lung, while rarer sites included the spleen, adrenals, femoral artery, and brain.

Due to the common misdiagnosis of pulmonary embolus in PAIS, patients are often prescribed anti-coagulants with little or no improvement in symptoms. At present, the most commonly implemented therapy is considered surgical resection of the tumor. Adjuvant chemotherapy with agents such as ifosfamide and doxorubicin [21] is often added to the regimen, with radiation therapy being the least common treatment method for PAIS. Despite these interventions, the aggressive nature of this tumor continues to result in high mortality rates.

## Methods

Clinical data was obtained on tumor site (pulmonary artery, pulmonary vein, aorta, vena cava), tumor extension (endocardium, myocardium, pericardium), patient symptomology, disease recurrence, distant metastasis, and patient survival. The duration of follow-up ranged from 3 to 84 months with a median follow-up of 12 months. Progression-free survival (defined as time to local recurrence or metastasis), distant-metastasis free survival, and disease-specific survival curves and estimates were calculated using the Kaplan-Meier

Received: April 26, 2018; Accepted: May 14, 2018; Published: May 18, 2018

<sup>\*</sup>Corresponding author: Manjit K Bhandal, Department of Medicine, M.D. Candidate, B.A. Integrative Biology, Central Michigan University College of Medicine, University of California, Berkeley, USA, Tel: (989) 774-3076; Fax: (989) 774-7267; E-mail: bhand1mk@cmich.edu

method. Comparison between survival outcomes for different strata was evaluated with the log-rank test. Univariate and multivariate analyses of the prognostic variables were calculated using the Cox proportional hazards model. Statistical significance was set at P </= 0.05. Statistical analyses were performed using SPSS for Windows version 20 (SPSS, Inc, Chicago, IL) software. (Table 1)

		Table1																						
			Sites Symptomology														Tre	atme	ent	Outcome				
Iterature	Xe	ge (yrs)	himary Tumor Location	Pulmonary artery	Pulmonary vein	Aorta	VC	Dyspnea	Chest Pain	Chest pressure	Fever	Nocturnal Diaphoresis	Weight loss	Cough	Hemophysis	Syncope	Back pain	Fatigue	ower extremity edema	Diarrhea	Surgical Resection	Chemotherapy	Radiation	AND/DOD/NED
2016. Wang et al	F	37	Pulmonary Artery	х				×											-	_	х			NED
2016. Kitajima et. al.	F	42	Pulmonary Artery	X					х			_	¥								×	-	-	NED
2016. Kriz et. al. 2016. Sakata et. al.	F	72	Pulmonary Artery Pulmonary Artery	x	×			×					X	x							×.	×.	×	NED
2016. Chen et al	F	36	Pulmonary Artery	x				x		х						х					х	-		DOD
2015. Siorda et al	M	59	Pulmonary Artery	x				~		~	x	х	х	x	×						X	X	×	NED
2015. Mori et al	M	54	Pulmonary Artery	x				-	_	^				x							x	x	x	AWD
2015. Xu et. al.	F	40	Pulmonary Artery	х																х	x	-		DOD
2015. Afzal et. al. 2015. Kaira et. al.	M	52	Right Pulmonary Artery	x			X	×	×					×			_	×	x		â	â	×	NED
2015. Caraway et. al.	M	78	Right Pulmonary Artery	x													Х				х	х	-	DOD
2014. Shomaf et al	F	60	Pulmonary Artery	×				×	×					x						_	×		-	DOD
2014. Ahmed et al	M	77	Pulmonary Artery	x				x												_	x	х	x	NED
2014. Umezawa et. al.	F	84	Pulmonary Artery	x				×													-	*	-	DOD
2014. Inoue et. al. 2014. Evison et. al.	F	30	Pulmonary Artery Pulmonary Artery	x				×			×	-	x					×		_	x	x	-	NED
2014. Tanaka et. al.	M	61	Metastatic	x																	х	х	-	DOD
2014. Min et. al. 2013. Shirupoj et al.	M	18	Pulmonary Artery	X					×					×	×						x	x	-	DOD
2013. Fukai et al	F	57	Right Pulmonary Artery	x				х	×	5	х			^							х		-	NED
2013. Choi et. al.	F	62	Pulmonary Artery	x				X													x	x	×	NED
2013. Chen et al. 2013. Hu et. al.	F	43	Pulmonary Artery Pulmonary Artery	×				×	×												×.	×.	-	DOD
2013. Lee et. al.	м	58	Pulmonary Artery	×				×													x	-		DOD
2012. Bohn et. al. 2012. Vamamoto et. al.	F	36	Pulmonary Artery	×				×				_	x	×					×		X	X	×	DOD
2012. Vasuri et. al.	F	44	Pulmonary Artery	x				x						~					^		x	+	-	DOD
2012. Hoiczyk et. al	F	76	Right Pulmonary Artery	x				X												_	X	-	×	NED
2011. Chaachoui et al 2011. Xu et. al.	F	55	Superior Vena Cava	X			×	×													x	x	-	AWD
2011. Zurick et. al.	M	33	Pulmonary Artery					x													х		-	NED
2011. Fukuda et. al.	M	61	Pulmonary Artery	×				×	~					~	x		_			_	x	×	×	DOD
2011. Shah et. al.	M	65	Pulmonary Artery	x	×			x	~		×	×	x	^						_	x	x	x	AWD
2011. Ebaugh et. al.	M	87	Superficial Femoral Artery																x		х	-	×	DOD
2011. Ramjee et al 2010. Halank et al.	M	64	Pulmonary Artery Pulmonary Artery	×		×		×	×			-	x								x	<u>.</u>		DOD
2010. Scheidl et. al.	M	40	Pulmonary Artery	x				x					~			x					х	-		DOD
2009. Shehatha et al	M	61	Pulmonary Artery	×				×							_	3					X	x	-	DOD
2009. Timmers et. al.	F	58	Pulmonary Artery	x	×			x	10.7%												x	-	-	-
2009. Koch et. al.	м	64	Pulmonary Artery	х	×				×												x	X	-	-
2009. Schuler et. al. 2009. Hou et. al.	F	38	Pulmonary Artery	x				×	x												x	*	-	NED
2009. Domas et. al.	M	45	Pulmonary Trunk	x				x			х		х							_	x	х	-	
2009. Hirose et. al.	F	45	Pulmonary Artery	x				X												_	x	х	х	DOD
2008. Terra et al 2008. Huwer et al	M	63	Pulmonary Trunk	×				×	×						*	x				_	â	-	-	NED
2008. Fernandez-Golfin	F	43	Right Pulmonary Artery	×				×						×							x	х		AWD
	F	41	Pulmonary Artery Pulmonary Trunk	×				×							-	×				_	x	x	-	NED
	M	56	Pulmonary Trunk	x				x	×				х			~		×			-	x		AWD
2008. Jin et al.	M	73	Pulmonary Artery	x				х													×	X	-	DOD
2008. Viana-Tejedor et. al. 2008. Soltvs et. al.	M	48	Pulmonary Artery Pulmonary Artery	x	×			×								x					x	x	x	DOD
2008. Rashid et. al.	F	38	Pulmonary Trunk	x				~									х				х	х	-	AWD
2008. Long et. al. 2008. Scheffel et. al.	F	54	Right Pulmonary Artery	×				×	~							_				_	×	×	×	NED
2008. Chappell et. al.	M	0.2	Pulmonary Trunk	x	×				~												x	x	-	NED
2008. Austin et. al.	M	44	Pulmonary Artery	×		×	х	x		x				x							x	×	×	DOD
2007, Ishiguro et al	F	53	Pulmonary Trunk Pulmonary Artery	x				x	_	~					x					-	x	-	-	NED
2007. Chong et al	M	29	Right Pulmonary Artery	х											х						х	-		NED
2007. Hsing et. al. 2007. Coli et. al.	M	51	Pulmonary Trunk	x				×	×		~	~			~					_	x	x	-	NED
2007. Nakajima et. al.	F	44	Left Pulmonary Artery	x				-		- 2	x	-			x					-	x	х		NED
2007. Ozbek et. al.	M	42	Pulmonary Artery	x	×			X	×											_	x	х		NED
2006. Levy et al 2006. Dimitrakakis et al	F	63	Bight Pulmonary Artery	x				×	×				x				-	×			x	x	×	NED
2006. Alsoufi et. al.	M	76	Pulmonary Trunk	x				x										х			x	•	-	NED
2006. Strobel et. al. 2005. Kunimura et. al.	M	40	Right Palmonary Artery	×		×		×				×	X	×	×					_	x	-	×	DOD
2005. Kerr et. al.	F	40	Pulmonary Artery	x				x	×												х	+	-	AWD
2005. Miura et. al.	F	68	Pulmonary Artery	X				x	~				-	x							X	X	×	DOD
2003. Uchida et. al. 2004. Choi et. al.	F	64	Right Pulmonary Artery	x	_			×	×		_				_		_	_			x	-	-	· ·
2002. Dennie et. al.	F	34	Pulmonary Artery	х				x						х	х	х					X	-	-	DOD
2000. Kaplinski et al	F	42	Pulmonary Artery Pulmonary Artery	x				x							x						X	-	-	DOD
1999. Weijmer et al.	F	89	Left Pulmonary Artery	x				x							~									DOD
1993. Gosalbez et al	M	35	Pulmonary Artery	X				X	×					-	x						X	X		DOD
1991. Waller et al	M	48	Pulmonary Anery Pulmonary trunk	X				x	x							x				_	-	-		DOD
1990. Pandit et al	F	25	Pulmonary Artery	x					×													•	-	DOD
1990. Fitzmaurice et al 1976. Murthy et al	E	67	Aorta Pulmonary Trunk	X		×		×	×	_	x	×	X	×	_		X				-	-	-	DOD
1973. Altman et al	F	64	Pulmonary Artery	x				~	~		_	~	x	x				x			х		-	DOD

AWD: alive with disease, DOD: dead of disease, NED: no evidence of disease

### Results

Kaplan-Meier survival plots did not indicate statistically significant correlations between mean survival and tumor location; however, metastasis and tumor recurrence showed statistical significance in correlation with mean survival time (P=0.21, P=0.31 respectively; figure 2). Chi-squared values indicated tumor location in the pulmonary valve and aorta were significant factors in mean survival time (P=0.004, P=0.23 respectively, figure 2), as well as metastasis and tumor recurrence (P=0.003, P=0.001 respectively). (Figures 2-4)





Figure 3: Kaplan-Meier survival curve in patients with/without tumor recurrence. FU = follow up (months).

### Discussion

Pulmonary artery intimal sarcoma, also commonly referred to as pulmonary artery sarcoma and intimal sarcoma, was first described by Mandelstamm in 1923 [22], It is a highly malignant tumor type that is often diagnosed at autopsy16 and most commonly arises in the main pulmonary arteries or pulmonary valve. Patients typically present with symptoms of PE or CTEPH, most frequently dyspnea with additional chest pain, cough and hemoptysis [7]. Although the mean age of presentation for this tumor type is 52 years old [7], there has been one pediatric case reported of a 2-month old infant with poor feeding, tachypnea, and a heart murmur [22]. Statistical analysis of over sixty case reports indicated that patients with metastasis, tumor recurrence, or chest pain on initial presentation show a statistically significant correlation with survival time.

The principal method of diagnosis is through imaging, including



Figure 4: Kaplan-Meier survival curve in patients with/without metastatic PAIS. FU = follow up (months).

chest CT and echocardiography. Chest CT findings often indicate filling defects of the main PA, left PA, and right PA with or without a visible mass. Echocardiographic findings are similar to those of pulmonary embolus with RA/RV dilation and blockage of the right ventricular outflow tract [7,17-20,23]. PA pressures up to 157 mmHg have also been reported on echocardiography indicating pulmonary hypertension in these patients [5,7-9,19,23-28]. PET scans have been valuable for identifying metastases as well differentiating PE from PAIS as PAIS is more metabolically active and shows increased FDG activity than thrombi. Metastases have been reported largely to be in the lungs but have also been present in the adrenal glands [12,13,29,30], liver [29,31,32], brain, intestines [13,33], and an isolated case of metastasis to the chin [34]. Although employed less commonly due to misdiagnosis of PE, cardiac MRI has been implemented in some cases for confirmation of diagnosis [1,3,6,10,11,19,22,28,35-38]. T1 weighted images characteristically show a low-density mass, while T2 weighted images present a high-density mass, as representative of most tumor types [7], which is beneficial for distinguishing between thrombi and PAIS. In one particular case, cardiac MRI confirmed tumor recurrence 24 months after initial diagnosis and surgical resection [11], however, the patient expired 1-month post-recurrence.

As mentioned previously, PAIS is a highly malignant and invasive tumor, with nonspecific radiological characteristics making it difficult to diagnose [7]. Furthermore, diagnosis is made once patients are symptomatic which often indicates poor prognosis and high risk of mortality [7]. Due to the nonspecific manifestations of this tumor type with striking similarities to PE, anti-coagulant therapy is often implemented when patients first present with symptoms refractory to therapy, leading to further work up and diagnosis of PAS [7]. Therapeutic strategies consist of radiotherapy, chemotherapy, surgical intervention, or combination of these three (Table 1). The most commonly implemented therapeutic strategy is surgical resection of the tumor (Table 1), followed by chemotherapy. Chemotherapeutic agents most frequently employed include doxorubicin, dacarabazine, ifosfamide, and interferon (Table 1). One patient, a 52-year-old female with an undifferentiated intimal sarcoma of the IVC, was treated with surgical resection of the tumor and chemotherapy; she developed encephalopathy on dual doxorubicin/dacarbazine therapy, which was then changed to dual gemcitabine/docetaxel therapy with complete remission of the tumor and no evidence of disease at 19 months follow up6. Radiation therapy is the least implemented and is often combined with adjuvant chemotherapy and/or surgical intervention [5,16,20,27,30,35,38-43]. In one particular case, radiation therapy was implemented with local tumor recurrence, although treatment was unsuccessful and the patient expired 11 months after initial diagnosis [29]. Thus, surgical resection and chemotherapy remain the most common therapeutic strategies in treating PAIS, with radiation therapy being the least common. Extensive surgical resection of the tumor has been proposed to prolong survival [44].

The pathological origin of PAIS is assumed to be of mesenchymal origin form the pluripotent intimal cells of large vessels, including the aorta and pulmonary arteries [7]. Although exceedingly rare, pulmonary artery intimal sarcoma is twice as common as intimal sarcomas arising from the aorta and can manifest in other large blood vessels such as the IVC [44]. Conversely, pulmonary artery leiomyosarcomas arise from the vascular media and are so named mural sarcomas (Figure 1). Amplification of MDM2 are rare in cases of intimal sarcoma (<3% of cases). No unifying histopathologic or clinical correlations emerged from this or other studies of intimal sarcomas with MDM2 amplifications. MDM2 amplifications in intimal sarcoma are associated with increased protein expression by immunohistochemistry. The functional correlate of protein expression is unknown. Future studies are necessary to determine the possible functional, diagnostic or therapeutic significance of MDM2 amplification in intimal sarcoma.

Thus, while PAIS is a rather rare tumor type with an insidious onset and is often misdiagnosed as PE, clinicians treating patients for suspected PE that is refractory to anti-coagulant or thrombolysis therapy should have a high level of clinical suspicion for PAIS. Echocardiography followed by PET scans are the most useful tools for diagnosis, along with Cardiac MRI. Surgical resection and chemotherapy to prevent metastasis or recurrence of the tumor are the most commonly employed tactics to treat PAIS. Factors that correlate with reduced survival time are chest pressure, metastasis and recurrence of the tumor and thus aggressive treatment should be employed.

### References

- Kitajima T, Marumo S, Shoji T, Huang CL, Yuba Y, et al. (2016) Large Vessel Vasculitis with an Isolated Lesion of a Single-lobe Pulmonary Artery. *Intern Med* 55: 1801-1805.
- Uchida A, Tabata M, Kiura K, et al. (2005) Successful treatment of pulmonary artery sarcoma by a two-drug combination chemotherapy consisting of ifosfamide and epirubicin. *Jpn J Clin Oncol* 35: 417-419.
- Rashid A, Molloy S, Lehovsky J, Tirabosco R, Hughes R, et al. (2008) Metastatic pulmonary intimal sarcoma presenting as cauda equina syndrome: first report of a case. *Spine (Phila Pa 1976)* 33: E516-520.
- Caraway NP, Salina D, Deavers MT, Morice R, Landon G, et al. (2015) Pulmonary artery intimal sarcoma diagnosed using endobronchial ultrasoundguided transbronchial needle aspiration. *Cytojournal* 12: 3.
- 5. Yamamoto K, Nozue T, Tsuchida M, et al. (2012) Pulmonary embolism caused by intimal sarcoma of the pulmonary artery. *Intern Med* 51: 3031-3034.
- 6. Afzal AM, Alsahhar J, Podduturi V, Schussler JM (2015) Undifferentiated Intimal Sarcoma of the Inferior Vena Cava with Extension to the Right Atrium and Renal Vasculature. *Case Rep Cardiol* 2015: 812374. [crossref]
- Chen D, Zhu G, Wang D, Zhang Z, Fang W, et al. (2016) Clinicopathological and immunohistochemical features of pulmonary artery sarcoma: A report of three cases and review of the literature. *Oncol Lett* 11: 2820-2826.
- Madu EC, Taylor DC, Durzinsky DS, Fraker TD, Jr. (1993) Primary intimal sarcoma of the pulmonary trunk simulating pulmonary embolism. *Am Heart* J 125: 1790-1792.
- Dennie CJ, Veinot JP, McCormack DG, Rubens FD (2002) Intimal sarcoma of the pulmonary arteries seen as a mosaic pattern of lung attenuation on highresolution CT. *AJR Am J Roentgenol* 178: 1208-1210.

- Viana-Tejedor A, Marino-Enriquez A, Sanchez-Recalde A, Lopez-Sendon JL (2008) Intimal sarcoma of the pulmonary artery: diagnostic value of different imaging techniques. Rev Esp Cardiol. Vol 61. Spain.
- 11. Scheidl S, Taghavi S, Reiter U, Tröster N, Kovacs G, et al. (2010) Intimal sarcoma of the pulmonary valve. *Ann Thorac Surg* 89: e25-27. [crossref]
- Xu X, Zhang R, Hu H, et al. (2015) Diarrhea as initial manifestation of pulmonary artery intimal sarcoma: a case report and literature review. *Onco Targets Ther* 8: 2651-2656.
- 13. Fitzmaurice RJ, McClure J (1990) Aortic intimal sarcoma: an unusual case with pulmonary vasculature involvement. *Histopathology* 17: 457-462.
- Nakajima J, Morota T, Matsumoto J, et al. (2007) Pulmonary intimal sarcoma treated by a left pneumonectomy with pulmonary arterioplasty under cardiopulmonary bypass: report of a case. Surg Today 37: 496-499.
- Coli A, Parente P, Bigotti G (2007) Pulmonary artery sarcoma: an insidious tumor still diagnosed too late. Analysis of the literature and report of a case. J Exp Clin Cancer Res 26: 151-156.
- Austin BA, Griffin BP (2008) Pulmonary artery intimal sarcoma: a brief case series. J Am Soc Echocardiogr 21: 978. [crossref]
- Kerr KM (2005) Pulmonary artery sarcoma masquerading as chronic thromboembolic pulmonary hypertension. *Nat Clin Pract Cardiovasc Med* 2: 108-112.
- Fukuda W, Morohashi S, Fukuda I (2011) Intimal sarcoma of the pulmonary artery--diagnostic challenge. Acta Cardiol 66: 539-541. [crossref]
- Lee DH, Jung TE, Lee JH, Shin DG, Park WJ, et al. (2013) Pulmonary artery intimal sarcoma: poor 18F-fluorodeoxyglucose uptake in positron emission computed tomography. *J Cardiothorac Surg* 8: 40.
- Kriz JP, Munfakh NA, King GS, Carden JO (2016) Pulmonary Artery Intimal Sarcoma: A Case Report. Case Rep Oncol 9: 267-272. [crossref]
- Min D, Lee JH, Jeong HC, et al. (2014) A case of pulmonary artery sarcoma presented as cavitary pulmonary lesions. *Tuberc Respir Dis (Seoul)* 76: 136-140.
- Chappell T, Creech CB, Parra D, Strauss A, Scholl F, et al. (2008) Presentation of pulmonary artery intimal sarcoma in an infant with a history of neonatal valvular pulmonic stenosis. *Ann Thorac Surg* 85:1092-1094.
- Yamasaki M, Sumi Y, Sakakibara Y, et al. (2011) Pulmonary Artery Leiomyosarcoma Diagnosed without Delay. Case Rep Oncol 4: 287-298.
- Dornas AP, Campos FT, Rezende CJ, Ribeiro CA, Amaral NF, et al. (2009) Intimal sarcoma of the pulmonary artery: a differential diagnosis of chronic pulmonary thromboembolism. *J Bras Pneumol* 35: 814-818.
- Timmers L, Bové T, De Pauw M (2009) Intimal sarcoma of the pulmonary artery: a report of two cases. *Acta Cardiol* 64: 677-679. [crossref]
- Ramjee V, Lewis MM, Clements SD (2011) High-grade, nonmyogenic pulmonary artery sarcoma: rare findings on coronary angiography. *Tex Heart Inst J* 38: 71-73.
- 27. Shah DK, Joyce LD, Grogan M, et al. (2011) Recurrent pulmonary intimal sarcoma involving the right ventricular outflow tract. *Ann Thorac Surg* 91: e41-42.
- Zurick AO, Lenge De Rosen V, Tan CD, Rodriguez ER, Flamm SD, et al. (2011) Pulmonary artery intimal sarcoma masquerading as pulmonary embolism. *Circulation* 124: 1180-1181.
- Long HQ, Qin Q, Xie CH (2008) Response of pulmonary artery intimal sarcoma to surgery, radiotherapy and chemotherapy: a case report. *J Med Case Rep* 2: 217.
- Choi YM, Jang EK, Ahn SH, et al. (2013) Long-term survival of a patient with pulmonary artery intimal sarcoma after sequential metastasectomies of the thyroid and adrenal glands. *Endocrinol Metab (Seoul)* 28: 46-49.
- Bohn OL, de Leon EA, Lezama O, Rios-Luna NP, Sanchez-Sosa S, et al. (2012) Pulmonary artery sarcoma with angiosarcoma phenotype mimicking pleomorphic malignant fibrous histiocytoma: a case report. *Diagn Pathol* 7: 154.
- Vasuri F, Resta L, Fittipaldi S, Malvi D, Pasquinelli G, et al. (2012) RUNX-1 and CD44 as markers of resident stem cell derivation in undifferentiated intimal sarcoma of pulmonary artery. *Histopathology* 61: 737-743.

- 33. Murthy MS, Meckstroth CV, Merkle BH, Huston JT, Cattaneo SM, et al. (1976) Primary intimal sarcoma of pulmonary valve and trunk with osteogenic sarcomatous elements. Report of a case considered to be pulmonary embolus. *Arch Pathol Lab Med* 100: 649-651.
- Gosalbez F, Gudin C, Miralles M, Naya J, Valle JM, et al. (1993) Intimal sarcoma of the left pulmonary artery: diagnosis, treatment and survival. *Cardiovasc Surg* 1: 447-448.
- Miura S, Meirmanov S, Nakashima M, Hayashi T, Abe K, et al. (2005) Intimal sarcoma of the pulmonary artery: report of an autopsy case. *Pathol Res Pract* 201: 469-474. [crossref]
- Hsing JM, Thakkar SG, Borden EC, Budd GT (2007) Intimal pulmonary artery sarcoma presenting as dyspnea: case report. *Int Semin Surg Oncol* 4: 14.
- Schuler PK1, Weber A, Bode PK, Neuhaus M, Prêtre R, et al. (2009) MRI of intimal sarcoma of the pulmonary arteries. *Circ Cardiovasc Imaging* 2: e37-39. [crossref]
- Ebaugh JL, Yuan M, Hu J, Chen A, Raffetto JD (2011) Intimal sarcoma of the superficial femoral artery with osteosarcomatous differentiation. *J Vasc Surg* 53: 1394-1397.

- Soltys SG, Kalani MY, Cheshier SH, Szabo KA, Lo A, Chang SD (2008) Stereotactic radiosurgery for a cardiac sarcoma: a case report. *Technol Cancer Res Treat* 7: 363-368.
- Hirose T, Ishikawa N, Hamada K, et al. (2009) A case of intimal sarcoma of the pulmonary artery treated with chemoradiotherapy. Intern Med 48: 245-249.
- Ote EL, Oriuchi N, Miyashita G, et al. (2011) Pulmonary artery intimal sarcoma: the role of (1)(8)F-fluorodeoxyglucose positron emission tomography in monitoring response to treatment. *Jpn J Radiol* 29: 279-282.
- Inoue Y, Izumi Y, Sakaki K, Abe K, Oka T, et al. (2014) A case of pulmonary sarcoma with significant extension into the right lung. *Case Rep Med* 2014: 279374. [crossref]
- Kaira K, Imai H, Yamada M (2015) Recurrent intimal sarcoma mimicking pulmonary embolism. Jpn J Clin Oncol 45: 695-696.
- 44. Ozbek C, Emrecan B, Calli AO, Gurbuz A (2007) Intimal sarcoma of the pulmonary artery with retrograde extension into the pulmonic valve and right ventricle. *Tex Heart Inst J* 34: 119-121.