Figure 1 Sessile polypoidal friable carinal tumour with tumourous occlusion of both the main bronchi. Note collapsed left lung and hyperinflated right lung. Inset: smooth right bronchial mucosa after scooping out the tumour fragment.

was sudden respiratory distress and the child died.

Autopsy revealed a 2×1.8×1.7 cm, sessile, polypoidal, soft, whitish-yellow exceedingly friable tumour in the carina and left main bronchus (fig 1). The left lung was collapsed, firm with a dark brown cut surface. An unattached friable piece of tumour (0.9×0.4 cm) was present in the lumen of the right main bronchus. Removal of the right bronchial luminal fragment revealed smooth and glistening underlying mucosa (fig 1, inset). The right lung was voluminous, oedematous and haemorrhagic. On histology, a benign spindle cell tumour, arranged in intersecting fascicles, was seen to originate from the carinal smooth muscles (fig 2). The cells were stained red by Masson trichrome stain, with a strong immunoreactivity for smooth muscle actin, and were non-reactive to EBV antigen (EBNA) and CD117. No tumour was seen elsewhere.

Predisposing factors for bronchopulmonary leiomyomata in adults have not been well documented. In sharp contrast, in children, immunodeficient states have served as fertile grounds for benign and malignant smooth muscle proliferations.[2] Chadwick *et al*[3] first described pulmonary leiomyoma in three HIV-positive children; prior to their report, only eight children with such tumours had been reported.[3] Since then, 18 cases have been described with HIV infection and other immunodeficient states.[2 4] Ours will be the 19th patient. The role of EBV in smooth muscle tumourigenesis in immunocompromised conditions has been proved beyond doubt.[2 4] In the reported case, the HIV status was not available. There were no features suggesting primary or acquired immunodeficiency. Immunohistochemistry was negative for EBV antigens. In an attempt to delineate the histogenesis, we used an immunostain for CD117, as the tracheo-bronchial tree is a foregut derivative. However, this was non-reactive. Benign endobronchial or parenchymal leiomyomata have always been described as ''firm'' or ''hard''. Surprisingly, this tumour was extremely friable. A fragment had broken off from the main mass to occlude the right bronchus, which precipitated the fatal respiratory distress. Such a phenomenon, though not previously reported, should be borne in mind when diagnostic bronchoscopy is attempted. The tumours are amenable to surgical or endoscopic intervention. It is important to assess the HIV and EBV status when tumours are multifocal or involve extra-pulmonary sites.

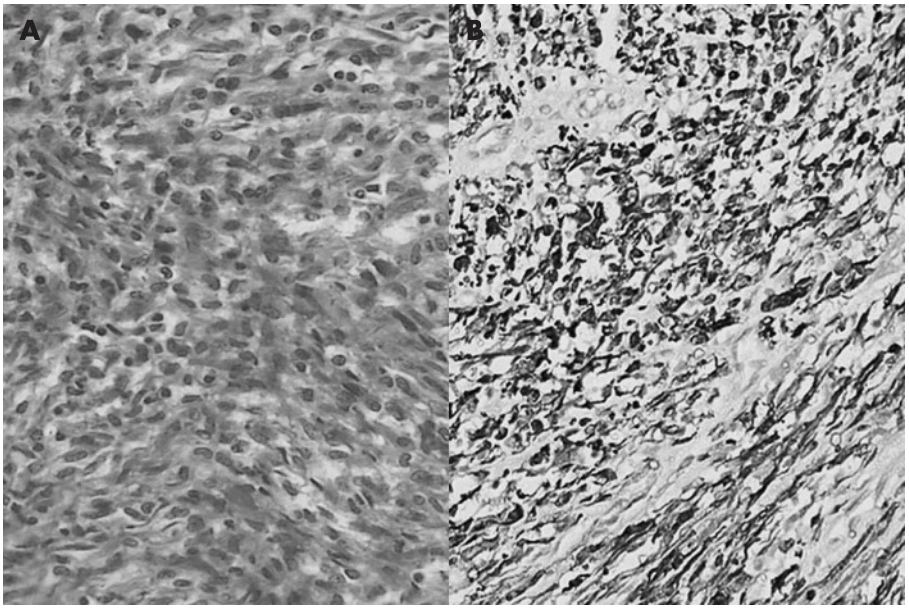

Figure 2 (A) Interlacing bundles of spindle-shaped cells without pleomorphism or mitoses (H&E, ×400). (B) Strong positivity with smooth muscle actin (×400).

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CORRECTIONS

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There was an error in an author name in the July issue of the journal (Smellie WSA, Hampton KK, Bowlees R, *et al*. Best practice in primary care pathology: review 8. *J Clin Pathol* 2007;**60**:740–8.) The correct name of the third author is R Bowley.

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There was an omission in an article published in the August issue of the journal (Lee DH, Lee GK, Kong S-Y, *et al*. Epidermal growth factor receptor status in anaplastic thyroid carcinoma. *J Clin Pathol* 2007;**60**:881–4.) The following statement should have been included: DHL and GKL contributed equally to this work.