A 53-year-old man with recently diagnosed, very severe chronic obstructive pulmonary disease (forced expiratory volume in 1 s [FEV₁] 1.02 L, 28% of predicted, forced vital capacity [FVC] 3.24 L, 72% of predicted, FEV₁/FVC ratio 0.32) had an incidental endobronchial lesion discovered on computed tomography (CT) of the chest (Figure 1). There were no enlarged hilar or mediastinal lymph nodes on CT. Bronchoscopy identified a smooth, vascularized, pedunculated tumour at the right upper lobe carina (Figure 2A). Dynamic obliteration of the bronchus intermedius was present on expiration. Initial biopsy specimens were consistent with a typical bronchial carcinoid tumour. The patient declined referral to a thoracic surgeon and underwent flexible bronchoscopy with moderate sedation. Endobronchial resection of the tumour was successfully achieved using snare electroresection, followed by cryotherapy to the base of the tumour (Figures 2B and 2C). Pathology review confirmed a typical bronchial carcinoid tumour with involvement of the tumour base. At the six-month follow-up, there was no evidence of recurrence on surveillance bronchoscopy (Figure 2D).

**REFERENCES**


The ‘Images in Respiratory Medicine’ section of the Canadian Respiratory Journal aims to highlight the importance of visual interpretation, whether physiological, radiological, bronchoscopic, surgical/thorascopic or histological, in the diagnosis of chest diseases. Submissions should exemplify a classic, particularly dramatic or intriguing presentation of a disease while offering an important educational message to the reader (insightful diagnostic pearls or differential diagnosis, etc). This section is not intended to be a vehicle for publication of case reports (see the Clinical-Pathologic-Conferences for case-based leaning series).