Coexistence of MALT lymphoma with carcinomas was seen primarily in gastric lesions associated with H. Pylori infections. To our knowledge only one case was reported with synchronous pulmonary adenocarcinoma and MALT type extranodal marginal zone lymphoma.

**Case Report:** A 49 years old male presented with back pain, weight loss and fatigue. Chest x-ray revealed an increased density suggesting a mass localized to superior zone of left lung. Systemic radiologic examination of the patient did not reveal any other mass lesion. Endoscopic examination of upper gastrointestinal system revealed gastric ulcer. The biopsy taken from the stomach and duodenum showed MALT lymphoma in both locations. He underwent an exploratory chest operation, during which a mass lesion completely invading thoracic outlet and a second mass lesion located in apical segment of left upper lobe, separated from the first mass by a thickened pleura were noted. A frozen section diagnoses of malignant neoplasm was given for the mass lesion invading thoracic outlet. Therefore, this mass was exsized along with wedge resection of the second apical lung lesion. The exsized first mass measured 5x4x0.7 cm, it was hard and gray to brown colored. The wedge resection covered with visceral pleura measured 8x5,5x 2cm and contained an infiltrative grayish white mass of 2 cm diameter without pleural involvement. These two tumors, one of which was primarily localized in pleura with limited extension into the lung parenchyma and the other mainly localized in the lung parenchyma had different morphologic and immune phenotypic features. Light microscopy of the tumor involving mainly pleura showed a malignant epithelial tumor with mainly diffuse pattern with focal papillary areas. The differential diagnoses of this tumor included primary or metastatic adenocarcinoma and epithelial mesothelioma. Mucicarmine stain was negative while PAS and D-PAS stains were positive in some tumor cells. Tumor cells were pankeratin and vimentin positive, TTF-1, CK7, CK 5/6, CK20, CEA, calretinin, NSE, synaptophysin and chromogranin negative. There was focal CD15 positivity. Although CK7 and TTF-1 were negative, these morphologic, histochemical and immunohistochemical features suggested that this tumor might represent an undifferentiated large cell or poorly differentiated pulmonary adenocarcinoma. The second tumor localized in lung parenchyma was well differentiated adenocarcinoma with mucicarmine positive intracytoplasmic mucine secretion. It had CK7, TTF-1 positive and vimentin, CK 5/6 and CK20 negative immunophenotype. This tumor was intimately associated with diffuse neoplastic lymphocytic infiltration. Neoplastic lymphocytic cells had a monocytoid appearance with formation of occasional lymphoepithelial lesions. Lymphocytic tumor cells CD20 positive, CD5, CD10, CD23, CD3 and cyclinD1 negative immunophenotype. Because of these features, a diagnoses of MALT lymphoma was given. To the best of our knowledge our case is the first one that presented with two different lung carcinomas which had different morphologic and immunophenotypic features, one of which was associated with multisystemic (lung, stomach, duodenum) extranodal marginal zone lymphoma of MALT type.