Pseudotumor of the Mediastinum

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The case of a mass in the mediastinum which occurred following surgery and irradiation at the site of previously excised thymoma is presented. This mass proved to be a pseudotumor consisting of fibrous tissue without evidence of tumor recurrence.

Pseudotumors of the lung parenchyma are not uncommon. On the other hand, they are rare when found in the mediastinum. The term, "vanishing tumor," of which encysted effusion is the prime example, is synonymously used with phantom tumor although strictly speaking it is not a tumor but a collection of fluid.1,2 For the present, we are not concerned with the latter.

We recently encountered a pseudotumor of the right anterior mediastinum which proved to be late radiation changes of the mediastinum characterized by fibrosis that simulated recurrent tumor.

CASE REPORT

A 23-year-old white man was admitted to the NY Veterans Administration Hospital on January 20, 1970 with symptoms of chest pain, fever and generalized aches of three days' duration. There was no history of smoking or previous x-ray therapy. Physical examination and laboratory work-up were within normal limits. Chest x-ray film demonstrated a large right anterior mediastinal mass (Fig 1). Thoracic aortogram was normal.

On January 9, 1970 thoracotomy was performed and a large right anterior mediastinal mass which was adherent to the upper portion of the pericardium and to the superior vena cava was removed. Metallic clips were inserted in the regions where the surgeon felt he might have left tumor. Microscopic finding was that of a thymoma. Postoperative x-ray picture of the chest was normal (Fig 2). Postoperative radiation therapy to the mediastinum, with the use of the surgical clips as a guide, was instituted. A dose of 6,000 rads in six weeks was delivered from January 26, 1970 to March 12, 1970, using a 120° rotation technique with CO60. The field size was 10 × 12 cm and the source tumor distance was 35 cm.

Chest x-ray film taken on May 20, 1970 was normal. Ten months later on a routine follow-up examination (Fig 3) a right anterior mediastinal mass suspected to be recurrence of tumor was noted, although the patient was asymptomatic. Superior venacavagram was normal. On April 14, 1971 an anterior median sternotomy was performed and a mass of fibrous tissue with no gross tumor was found. Most of this was removed together with wedge resection of the right upper lobe. Microscopy showed fibrous tissue from the mediastinum and effects of irradiation in the resected portions of the lung. There was no evidence of recurrent tumor (Fig 4).

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Figure 1. PA chest film which shows anterior mediastinal mass.

Figure 2. Roentgen appearance of chest after excision of mass. Note metallic clips.

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SURGICAL COMPLETE HEART BLOCK

3. PA chest film which demonstrate anterior mediastinal "mass" simulating recurrent thymoma.

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REFERENCES


**Surgical Complete Heart Block**

**Alternating with Sinus Rhythm and Right Bundle Branch Block with Left Anterior Hemiblock**

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A patient is presented who developed transient complete heart block immediately following surgical repair of tetralogy of Fallot. Forty-three days postoperation sinus rhythm with a pattern of right bundle branch block—left anterior hemiblock replaced the complete heart block. Five and one-half years later the block recurred and eight and one-quarter years later it was replaced by sinus rhythm with the right bundle branch block—left anterior hemiblock pattern. This patient demonstrates the lability of the right bundle branch block—left anterior hemiblock pattern in a surgical situation. Even though complete heart block is replaced by sinus rhythm, attention must be given to the probability of recurrence of the block and the need for artificial pacing.

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