The patient is a 38-year-old white man who had multiple admissions to our institution because of recurrent left pleural effusion, shortness of breath, cough with hemoptysis, and occasional epigastric pain. The patient denied history of fever or significant weight loss. There was history of alcohol abuse. The patient had repeated thoracenteses. During the recent admission there was spontaneous reduction in the amount of pleural effusion suggesting intra-abdominal communication. The posteroanterior and left lateral chest roentgenogram demonstrated the presence of a retrocardiac soft tissue mass in the posterior mediastinum which silhouettes the posterior lower cardiac outline, lower portion of the descending aorta and the medial one third of the left hemidiaphragm. There is thickening of the left oblique fissure due to pleural fluid (Fig 1 and 2).

**FIGURE 1.** PA chest film showing retrocardiac mass density.

**FIGURE 2.** Lateral chest film showing obliteration of clear retrocardiac space by the mass.
Diagnosis: Pancreatic pseudocyst extending into mediastinum

The pleural fluid was bloody exudate with a high amylase content of 6,150 Somogyi units. Results of bronchoscopic examination and washings were negative for malignancy and tuberculosis. The CAT scan demonstrated an encapsulated cystic mass in the posterior mediastinum with thickening of the left crura of the diaphragm. The gall bladder was normal and the pancreas was not enlarged (Fig 3). The patient had ERCP which delineated the mass in the posterior mediastinum and its continuity to the head of the pancreas by fistula tract (Fig 4). The pseudocyst was drained at surgery and cystgastrostomy was done.

Pancreatic pseudocysts are loculated collections of pancreatic enzymes, blood, fat, necrotic debris that develop over a period of one to four weeks after the onset of acute pancreatitis. Disruption of the pancreatic ductal system is common. These lesions are usually confined to the lesser peritoneal sac. As pseudocysts enlarge, they may extend along the path of least resistance and involve more distant regions, such as mediastinum, neck or scrotum. Mediastinal extension is a rare clinical entity. The mass is nonspecific in appearance and can be located in any of the mediastinal compartments. The posterior location is explained by the portal of entry through the esophageal or aortic hiatus, or both. However, unique cases of penetration through the foramen of Morgagni and direct erosion through the diaphragm have been reported.

This case illustrates mediastinal extension of pseudocyst with symptoms and signs mainly confined to the chest. This rare phenomenon should be considered in the differential diagnosis of mediastinal mass lesions. The CAT scan and ERCP are invaluable in confirming the clinical impression.

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REFERENCES