Pneumothorax and malignant mesothelioma in patients over the age of 40

J D H Sheard, W Taylor, A Soorae, M G Pearson

Abstract
Five patients over the age of 40 with malignant mesothelioma of the pleura presented with a spontaneous pneumothorax in the course of five years. The diagnosis of malignant mesothelioma was not suspected at surgery but was made by histological examination of the pleurectomy specimens. During this time 91 pleurectomies for recurrent pneumothorax were performed, 45 in patients over the age of 40; malignant mesothelioma therefore accounted for 11% of spontaneous pneumothorax requiring pleurectomy in this age group. The association of spontaneous pneumothorax and malignant mesothelioma is not emphasised in current publications. These five cases highlight the need for all pleurectomy specimens in cases of spontaneous pneumothorax to be sent for histological examination and for a full occupational history to be taken, especially in older patients.

Two categories of spontaneous pneumothorax are described. Benign pneumothorax occurs chiefly in young men aged 20–40 years, and is often associated with a small apical bulla. In the other category the pneumothorax is due to pulmonary disease. Spontaneous pneumothorax occurs in association with pulmonary neoplasia. Of the 1143 patients presenting with spontaneous pneumothorax reported by Dines et al,1 10 had tumours, including metastatic sarcoma, lymphosarcoma, and bronchogenic carcinoma.

The five cases reported here confirm the association of malignant mesothelioma and spontaneous pneumothorax in patients over the age of 40.

Methods
Ninety one specimens from pleurectomies carried out for recurrent or persistent spontaneous pneumothorax were received over five years. Forty five were from patients over the age of 40. Sections from all patients were stained by haematoxylin and eosin. The diagnosis of malignant mesothelioma was made from the morphological appearances, including invasion of adipose and connective tissue. Staining to confirm the absence of epithelial mucin and carcinoembryonic antigen was performed in all cases. In four of the five cases the diagnosis was confirmed at postmortem examination; in the fifth patient (still alive) the clinical and radiological findings support the diagnosis of mesothelioma.

Patients and findings
Tables 1 and 2 summarise the relevant clinical and pathological findings in the five cases.

Case 3 was unusual in that the diagnosis of malignant mesothelioma was not made at the time of pleurectomy. At histological examination the pleurectomy specimen was reported as showing florid hyperplasia of mesothelial cells. Necropsy a year later, however, revealed

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Table 1  Details of patients and pneumothoraces

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Sex</th>
<th>Age (y)</th>
<th>Site</th>
<th>Number</th>
<th>Months before pleurectomy</th>
<th>Other treatment</th>
<th>Interval to death</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>87</td>
<td>Left</td>
<td>2</td>
<td>3</td>
<td>Chest drain, tetracycline pleurodesis</td>
<td>3 weeks</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>60</td>
<td>Left</td>
<td>1</td>
<td>1</td>
<td>Chest drain</td>
<td>2 years</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>63</td>
<td>Right</td>
<td>1</td>
<td>9</td>
<td>Chest drain</td>
<td>1 year</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>56</td>
<td>Right</td>
<td>3</td>
<td>6</td>
<td>Chest drain</td>
<td>1 ½ years</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>43</td>
<td>Left</td>
<td>1</td>
<td>2</td>
<td>Chest drain</td>
<td>[Alive]</td>
</tr>
</tbody>
</table>

Table 2  Smoking, occupation, asbestos exposure and fibre count, and histological type of mesothelioma

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Smoking history</th>
<th>Occupation</th>
<th>Asbestos exposure</th>
<th>Asbestos fibre count (fibre/g dried lung)</th>
<th>Histological type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td>Lagger</td>
<td>Yes</td>
<td>1.24 × 10⁴</td>
<td>Mixed</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td>Docker</td>
<td>Yes</td>
<td>2.4 × 10⁴</td>
<td>Mixed</td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
<td>Shipyard worker</td>
<td>Not known</td>
<td>4.7 × 10⁴</td>
<td>Epithelial</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
<td>Lagger</td>
<td>Yes</td>
<td>8.0 × 10⁴</td>
<td>Mixed</td>
</tr>
<tr>
<td>5</td>
<td>Yes</td>
<td>Teacher</td>
<td>No</td>
<td>[Not done: patient alive]</td>
<td>Epithelial</td>
</tr>
</tbody>
</table>

*Electron microscope.
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Table 3  Details of previously described cases of pneumothorax and malignant mesothelioma

<table>
<thead>
<tr>
<th>First author, reference</th>
<th>Sex</th>
<th>Age (y)</th>
<th>Histological type</th>
<th>Asbestos exposure</th>
<th>Interval to death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ehrenhaft6</td>
<td>F</td>
<td>25</td>
<td>Mixed</td>
<td>Not known</td>
<td>3 months</td>
</tr>
<tr>
<td>Ratzer1</td>
<td>M</td>
<td>63</td>
<td>Epithelial</td>
<td>Not known</td>
<td>Not known</td>
</tr>
<tr>
<td>Ratzer1</td>
<td>F</td>
<td>31</td>
<td>Sarcomatous</td>
<td>Not known</td>
<td>Not known</td>
</tr>
<tr>
<td>Handa5</td>
<td>M</td>
<td>85</td>
<td>Undifferentiated</td>
<td>Not known</td>
<td>15 weeks</td>
</tr>
<tr>
<td>Ohkado1</td>
<td>M</td>
<td>49</td>
<td>Not known</td>
<td>Not known</td>
<td>7 weeks</td>
</tr>
<tr>
<td>Mannes4</td>
<td>M</td>
<td>60</td>
<td>Epithelial</td>
<td>Not known</td>
<td>Not known</td>
</tr>
</tbody>
</table>

Discussion

Spontaneous pneumothorax is a very rare presenting feature of malignant mesothelioma. Hillerdal1 in 1982 reviewed 4710 published cases of malignant mesothelioma and found only one case (from 1960) that presented with a pneumothorax.4 A search of published reports yielded five other cases, reported from 1967 to 1991.5–4 (see table 3). The usual presenting feature of malignant mesothelioma in these reports is an insidious onset of chest pain or breathlessness.5–11 A review of 327 cases of malignant mesothelioma did not mention previous treatment for recurrent pneumothorax12 and several recent medical and pathological textbooks fail to mention an association.13–17

Our five cases presented at the same hospital in the course of five years, during which time 91 pleurectomies for pneumothorax were performed by one of two thoracic surgeons working in the hospital (it was not the practice of the other thoracic surgeon to send his pleurectomy specimens for histological examination at that time). Forty five of these 91 patients were over 40. Thus the five cases account for 11% of all pleurectomy specimens received from patients over 40 during this period. In all five cases the chest radiograph showed no preoperative abnormality other than the pneumothorax. In only one case (No 3) was malignancy suspected before operation, as the patient also had chest pain and weight loss. Mesothelioma was not suspected in any of the cases during thoracotomy. The treatment received by the five patients before surgery consisted of intercostal chest drains and, in one case, tetracycline instillation, none of which is likely to be relevant to the development of mesothelioma.18 All three main histological types of malignant mesothelioma—epithelial, sarcomatous and mixed—were seen in our five cases and the five already published.

Many surgeons discard pleurectomy specimens, but it is apparent from these cases that all pleurectomy specimens should be sent for histological examination, especially with patients over 40. It is also important to elicit a thorough occupational history from patients with spontaneous pneumothorax. In three of the five cases there was a definite history of exposure to asbestos, though this was obtained retrospectively and was not communicated to the pathologist at the time of pleurectomy.

When faced with a differential diagnosis of florid mesothelial hyperplasia or early malignant mesothelioma, histopathologists may be reluctant to make a diagnosis of malignancy in a patient with a spontaneous pneumothorax but no clinical suspicion of neoplasia. Awareness that malignant mesothelioma may present with spontaneous pneumothorax and of the occupational history should prompt a detailed examination of the pleurectomy specimen.

We would like to thank Dr A R Gibbs for his opinion on the sections from case 3 and for performing the electron microscope asbestos fibre count and Mr Alan Lloyd and Miss Janet Walters for technical help.

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