Anterior mediastinal mass in a young man

John M Travaline, Gerard J Criner, Pen-Ming L Ming, Friedrich Kueppers

Abstract

The case is presented of a patient in whom the diagnosis of Klinefelter's syndrome was made only after a mediastinal teratoma was discovered. Chest physicians should be aware of this association since they are often the first to evaluate patients with mediastinal masses.

(Thorax 1994;49:283-284)

Case report

A 26 year old man was referred for evaluation of a non-productive cough, sinus congestion, and right anterior chest pain. The patient's medical history was unremarkable except for a smoking history of 30 pack years and asthma since childhood. He denied constitutional symptoms. A chest radiograph (fig 1) indicated the presence of a large anterior mediastinal mass.

Physical examination revealed a tall, thin Caucasian man with normal vital signs. On examination of the head and neck there were no masses or lymphadenopathy. His chest was clear to auscultation, and bilateral gynaecomastia was noted. Abdominal examination showed no hepatosplenomegaly or masses. His testes were smaller than normal.

Computed tomography of the chest, head, and pelvis showed a large anterior mediastinal mass containing calcium and bilateral gynaecomastia, maxillary sinusitis, and atrophic testes, respectively.

Laboratory tests revealed a normal level of β-human chorionic gonadotropin and an elevated α-fetoprotein level of 1737 ng/ml (normal <9 ng/ml). All other laboratory values were normal.

The patient underwent an exploratory median sternotomy and a well encapsulated mass was found adherent to the innominate vein, pericardium, pleura, and right phrenic nerve. The mass was successfully removed in its entirety.

The tumour was grossly heterogeneous in texture and measured 9 × 8 × 4.5 cm. Examination of the cross section revealed several cysts filled with mucoid material and multiple strands of hair. Histological examination of the tumour (fig 2) showed elements of both mature ectodermal and mesodermal germ cell lines consistent with the histological diagnosis of mature benign cystic teratoma. Neuron specific enolase staining of sections of the tumour was positive, thus confirming the presence of focal collections of primitive neural type cells. Immunohistochemical stains for α-fetoprotein, human chorionic gonadotropin, and chromogranin were negative.

The presence of the patient's chronic sino-pulmonary complaints, gynaecomastia, small testes, and tall stature suggested the diagnosis of Klinefelter's syndrome which was then confirmed by chromosomal analysis revealing the classic XXY karyotype.

Postoperatively the patient did well. The α-fetoprotein level returned to within the normal range immediately after surgery (7.2 ng/ml) and remains within the normal range at one year follow up. The patient remains asymptomatic and has no evidence of recurrent disease.

Discussion

The differential diagnosis of an anterior mediastinal mass includes thymic lesions, lymphoma, endocrine tumours, germ cell tumours and, rarely, various other benign tumours such as fibroma or lipoma. In our patient, however, the absence of clinical and radiological features consistent with thymoma or lymphoma, and the elevation of the α-fetoprotein level, strongly suggested the diagnosis of a germ cell tumour. Such tumours account for approximately 15% of all anterior mediastinal masses in adults.1

Serum markers are sometimes useful in evaluating a patient with a suspected germ cell tumour. In particular, an elevated α-fetoprotein level strongly suggests the diagnosis of a non-seminomatous germ cell tumour. In our patient, however, while the elevated α-fetoprotein level suggested a malignant germ cell tumour, careful scrutiny of multiple sections through the mass revealed no evidence of malignant transformation.

Treatment for mediastinal germ cell tumours includes chemotherapy for malignant cell types followed, in some cases, by surgical

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Figure 1 Posteroanterior radiographic view of the patient's chest showing the mediastinal mass.
Imaging of bronchial carcinoid tumours with indium-111 pentetreotide

K J O'Byrne, N J O'Hare, P J Freyne, D A Luke, J S Prichard, D N Carney

Abstract
Neuroendocrine tumours are characterised by the expression of high affinity binding sites for somatostatin. The detection of bronchial carcinoid tumours through scintigraphic imaging is described in two patients using the novel radiolabelled somatostatin analogue indium-111 pentetreotide.


Large numbers of high affinity somatostatin binding sites have been found on most tumours characterised by the expression of neuroendocrine markers.1 The development of radiolabelled somatostatin analogues for radiodiagnostic purposes has led to the detection of such tumours in vivo through scintigraphic imaging.2 4 In a recent study Lamberts et al detected the primary tumours or metastases in 12 of 13 patients with gastrointestinal carcinoid tumours.2 Bronchial carcinoid tumours are well differentiated neuroendocrine malignancies which account for approximately 5% of all lung tumours. We have investigated the efficacy of the radiolabelled somatostatin analogue indium-111 pentetreotide4 in detecting disease in two patients with biopsy proven bronchial carcinoid tumours before surgery.

Methods
Indium-111 diethylenetriaminopentaacetic acid linked SMS 201 995 (octreotide), indium-111 pentetreotide, was supplied by Mallink-
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