complete tumor excision to avoid tumor fragmentation and spillage.

References


Thymoma Originating in a Giant Thymolipoma: A Rare Intrathoracic Lesion

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Thymolipoma is a rare, slow-growing, benign tumor that arises from the anterior mediastinum and corresponds to 2% to 9% of all thymic neoplasms. We present the case of a 49-year-old man who had a large heterogeneous mass with areas of soft tissue and fat tissue located on the anterior mediastinum and right hemithorax. After resection, histologic analysis confirmed the diagnosis of a giant thymolipoma containing solid components that corresponded to thymomas B1, B2, and B3. We discuss the occurrence of an atypical variant of thymolipoma containing three types of thymomas inside.

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Comment
Thymolipoma is a rare, slow-growing, benign tumor that arises from the anterior mediastinum and corresponds to 2% to 9% of all thymic neoplasms [2]. It is composed of mature fatty tissue with interspersed nonneoplastic thymic tissue and can measure up to 36 cm in diameter and 6 kg in weight. There is no sex predilection, and the tumor occurs at any age but is more common in young adults. The pathogenesis is unclear, but several theories have been proposed [3]. One of the most accepted theories proposes that diffuse thymic enlargement (true thymic hyperplasia) is replaced by fatty tissue (involuting thymic hyperplasia), the same process that occurs in the normal thymus.
Clinically, thymolipomas are usually asymptomatic and most are diagnosed incidentally during routine examinations. Patients may present with symptoms related
to extrinsic compression of the adjacent thoracic structures, including cough, dyspnea, hemoptysis, chest pain, hoarseness, or paroxysmal atrial tachycardia. Less frequently, autoimmune manifestations may be present, usually myasthenia gravis, or rarely, Grave disease, aplastic anemia, and hypogammaglobulinemia [4].

The diagnosis of thymolipoma should be considered in a patient presenting with an anterior mediastinal fatty mass [2]. The presence of soft tissue within the lesion should always be assessed carefully because it can correspond to benign or malignant components. The differential diagnosis includes lipoma, prominent epicardial fat pad, congenital diaphragmatic hernia, teratoma, thymohemangioliplomia, liposarcoma, thymoma, thymic carcinoma, and other primary thymic malignancies [4].

The literature contains few case reports of thymomas originating from a thymolipoma. Argani and colleagues [5] reported a 67-year-old woman with a thymoma within a thymolipoma that was treated with tumor resection and monitored for up to 10 years, with no evidence of recurrence. Thymic carcinoma arising within a thymolipoma has also been reported [6]. To our knowledge our report is the first case of thymoma containing three histologic subtypes (B1, B2, and B3) simultaneously seen in the same lesion arising within a thymolipoma.

Although the diagnosis of a thymic tumor may be suggested by CT findings, it is usually not possible to differentiate a benign from a malignant lesion with CT scan alone [7]. Surgical excision should be considered for patients with a gigantic intrathoracic lipomatous mass on CT, as seen in our patient.

The use of magnetic resonance imaging for the evaluation of anterior mediastinal lesions has several advantages, including excellent spatial resolution, lack of ionizing radiation, and lack of iodinated contrast [8]. The advent of functional methods, such as diffusion-weighted images, can be used to assess tumor activity and recognize areas suggestive of malignancy. Fat-suppression techniques may be useful in differentiating surrounding fat from solid areas that would represent a thymoma or thymic carcinoma. Heterogeneous signal intensity is present in tumors with necrosis, hemorrhage, or cystic change.

In conclusion, we documented and discussed the occurrence of an atypical variant of thymolipoma containing three histologic subtypes of thymomas inside. To our knowledge this is the first case reported with these characteristics.

References


Carinal Resection Requiring Cardiopulmonary Bypass in a Pregnant Patient

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A 35-year-old woman at 13 weeks gestation presented with adenoid cystic carcinoma of the distal left mainstem bronchus with chronic collapse of the left lung requiring carinal pneumonectomy. The extent of the tumor and need for significant retraction during dissection and pneumonectomy resulted in the need for cardiopulmonary bypass. The patient underwent successful left carinal

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