Posterior Mediastinal Thymus: Case Report and Literature Review

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Abstract

Background: The incidence of aberrant thymus in the posterior mediastinum is very uncommon. It is difficult to exclude malignancy before surgical procedure.

Case Presentation: In a six-month-old male coughing for two weeks prior to admission a posterior mediastinal mass was found incidentally by chest roentgenogram. Thoracotomy was performed. Histologic study revealed normal thymic tissue.

Conclusion: When a mass located in the posterior mediastinum, ectopic thymus should be included in differential diagnosis. Imaging techniques may spare thoracotomy. Ectopic thymus has a benign clinical course, and surgical resection is not recommended.

Key Words: Ectopic Thymus; Mediastinum; Thoracotomy; Pulmonary Atelectasis

Introduction

The thymus plays a critical role in the development of immune system during early life. It is derived from the third and fourth pharyngeal pouches during sixth week of embryologic development. Generally, the thymus is located in the upper anterior portion of the mediastinum overlying the pericardium and the great vessels at the base of heart. However, during fetal development a remnant of thymus is probably detained along the thymopharyngeal duct due to abnormal migration. Most cases of reported ectopic thymus are in the neck and upper anterior mediastinum [1-3]. In rare instances, the thymus extends from its usual anterior mediastinal position into posterior mediastinum. Less than 20 cases have been reported in English literature [4-17]. Thymic tissue located in the posterior mediastinum may enlarge disproportionally and may cause airway and/or vascular compression.

Differential diagnoses of posterior mediastinal masses include neurogenic tumors, infection, hematomas, segmental lung atelectasis, or tumors arisen from bone [4,5]. Preoperative diagnosis of posterior mediastinal thymus usually is very difficult; mostly the correct diagnosis is only made during operation or histological examination. We
report an additional case of aberrant thymus in the posterior mediastinum, which was diagnosed through thoracotomy. To our knowledge, this is the first case of posterior mediastinal thymus in a Chinese patient.

**Case Presentation**

A six-month-old male presented with dry cough for two weeks, without wheezing, fever, respiratory difficulties and restlessness. An outpatient diagnosis of respiratory tract infection was considered. He received antibiotics for 10 days in the outpatient department. The cough didn’t resolve. Roentgenogram revealed a smooth mass in the right superior mediastinum (Fig. 1). It was suspected of ectopic thymus or segmental lung atelectasis. The patient was hospitalized. His past medical history was non specific. Physical examination disclosed a few wet and dry rales in the right lung. Cardiovascular and other system findings were normal. The blood cell counts, blood chemistry, C-reactive protein were no normal. Type 3 parainfluenza virus infection was diagnosed by direct fluorescent antibody staining and the patient was accordingly treated.

Further imaging techniques including computed tomography (CT) and magnetic resonance imaging (MRI) were utilized to limit the differential diagnosis. Contrast-enhanced chest CT scan (Fig 2) demonstrated a well-circumscribed, uniform mild enhancing mass (3.7×3.4cm in size) located in the right superior posterior mediastinum, adjacent to chest vertebrae, trachea, and superior vena cava (SVC). The trachea and SVC were not displaced or narrowed. The MRI confirmed the CT anatomic findings (Fig 3a and 3b).

A diagnosis of ectopic thymus was considered; nonetheless neurogenic tumors could not be excluded definitely. After he was healed of cough, right thoracotomy was performed which revealed a smooth mass located in the posterior mediastinum grossly resembling normal thymus, which had a communication with normally positioned thymus. A complete excision of the mass was carried out and the normal thymus was left alone. The resected specimen was 5×5×4cm in size. Normal thymic tissue was identified by histologic study. Postoperative chest x-ray showed that the mass in the right superior mediastinum was disappeared. The child obtained a good recovery and was discharged from hospital 10 days postoperatively. On follow-up he has been in good condition for 6 months.

**Discussion**

The occurrence of aberrant thymus in the posterior mediastinum is very uncommon. Among 3236 pediatric necropsies, ectopic thymus
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Fig. 3a: Axial T2 MRI demonstrates the mass in continuity with the normal thymus. Thymus and the mass have similar signal intensity.

Fig. 3b: Sagittal T2 MRI shows the continuity of the posterior mass and normally located thymus.

Aberrant mediastinal thymus is detected mostly incidentally by chest X-ray and is asymptomatic. However, ectopic thymus in posterior mediastinum may cause problems when it has an impact on adjacent structures such as airway, esophagus, innominate artery and SVC. Presenting symptoms include cough, respiratory distress, wheezing, fever, dysphagia and emphysema \[4-8,13,15-17]\. Postoperatively the symptoms resolved rapidly in those reported cases. Interestingly, two children with pressure symptoms gained good recovery, which received only open excisional biopsy \[8]\ and conservative therapy \[15]\, respectively.

Open thoracotomy was the most prevalent surgical procedure for the purpose of excluding malignancy or eliminating compression to neighboring structures. More than half cases of this series received complete dissection of the masses, and yet all the 20 patients had good prognosis whether complete resection was performed or not. Similarly, the two with compression to neighboring structures without resection also had good prognosis \[8,15]\. We consider that ectopic thymus in posterior mediastinum has a benign clinical course. Surgical resection is not necessary when CT-guided biopsy \[12]\ or noninvasive methods may help diagnosing. At thoracotomy, the “mass” should remain if the frozen section biopsy discovers normal thymic tissue \[4,8,14]\, avoiding a potential hazardous excision \[8]\. We thus recommend that ectopic thymus should not be resected unless there is an emergency due to compression.

The differential diagnosis of a mass in posterior mediastinum includes neurogenic tumors, ectopic thymus, lymphadenopathy, hematoma \[19]\. Franco et al \[19]\ suggested the following “four diagnostic criteria” for ectopic mediastinal thymus: (1) signal intensity similar to normally located thymus on MRI, (2) homogeneous signal intensity, (3) uniform mild enhancement of contrast, and (4) continuity with normally located thymus. Slovis et al \[11]\ claimed that the diagnosis is assured when all the imaging criteria are met, further investigation or therapy is not suggested. In our case, CT and MRI findings fulfilled these four criteria. A diagnosis of ectopic thymus in the posterior mediastinum could be made before surgery, though without histologic evidence. Nevertheless,
M, male; F, female; NA, not available; m, month; d, day; w, week; R, right; L, left; CT, computed tomography; MRI, magnetic resonance imaging

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because we had no such experience, the boy was wrongly treated with surgical dissection.

**Conclusion**

Posterior mediastinal thymus is a rare entity. When a mass located in the posterior mediastinum, a diagnosis of ectopic thymus should be considered. Imaging techniques may help differential diagnosis. Ectopic thymus has a benign clinical course, and surgical resection is not recommended.

**References**