Picture Story

A mediastinal tumour that disappeared and reappeared

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(Key words: mediastinal tumour)

An 11 year old boy developed breathlessness over 12 days and was admitted to the local hospital with facial oedema and engorged neck veins. He had been "less active" and "feeling unwell" for one month. His father had been diagnosed and treated for pulmonary tuberculosis in the past year. Chest x ray showed a superior mediastinal mass (Figure 1). To relieve increasing respiratory difficulty he had been administered intravenous hydrocortisone 100 mg six hourly for 2 days followed by oral dexamethasone 4 mg six hourly for 6 days eight days prior to transfer to Colombo.

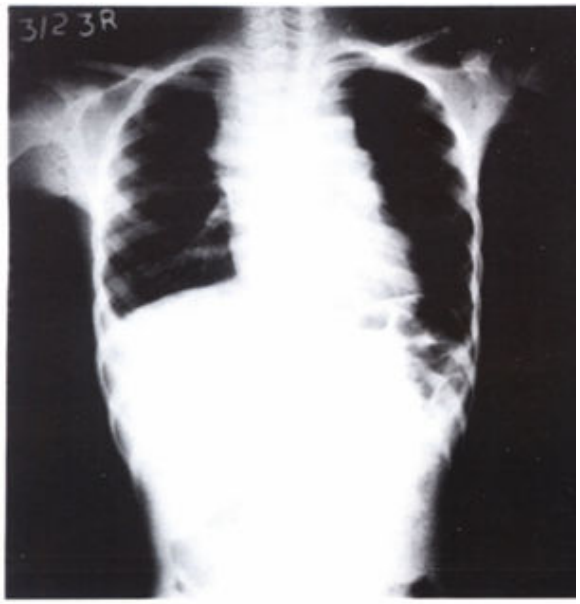

Figure 1. *Prior to transfer – widened superior mediastinum*

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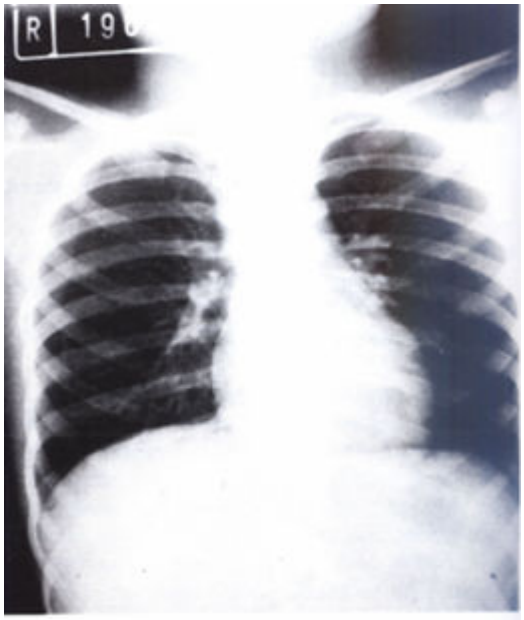

Figure 2. *On admission – normal chest x-ray*

On arrival at the Lady Ridgeway Children's Hospital he appeared well with no evidence of superior vena caval obstruction clinically or radiologically (Figure 2). The erythrocyte sedimentation rate was 22 mm 1st hour. The Mantoux test was positive (20 mm). White cell count and platelets were present in normal numbers in the peripheral blood. The haemoglobin was 10g/dl. Bone marrow showed hypo-plastic granulopoesis with all stages of maturation, normal erythropoesis and thrombopoesis and no infiltration by lymphoma or tumour cells. Macrophages were increased in number and activity, indicating chronic infection or inflammation.

Steroid induced remission was the most probable reason for the disappearance of the superior mediastinal mass lesion. The possibility of tuberculous disease resolving so quickly was considered unlikely despite the strongly positive Mantoux test. Lymphoma was a possible diagnosis. He remained in apparent good health with weekly chest x rays showing no abnormality over two weeks and no therapy

was given. The mass recurred during the third week (Figure 3). A CAT scan showed a mass lesion in the superior mediastinum.

The child deteriorated rapidly with progressive x-ray changes of mediastinal enlargement and massive right sided pleural effusion (Figure 4) which was haemorrhagic on aspiration. He developed cervical lymphadenopathy, elevated blood pressure and bilateral loin masses in addition to respiratory symptoms.

A provisional diagnosis of Non Hodgkins Lymphoma with secondary infiltration of kidneys was made at the Cancer Institute Maharagama and he is awaiting the results of tissue biopsy.

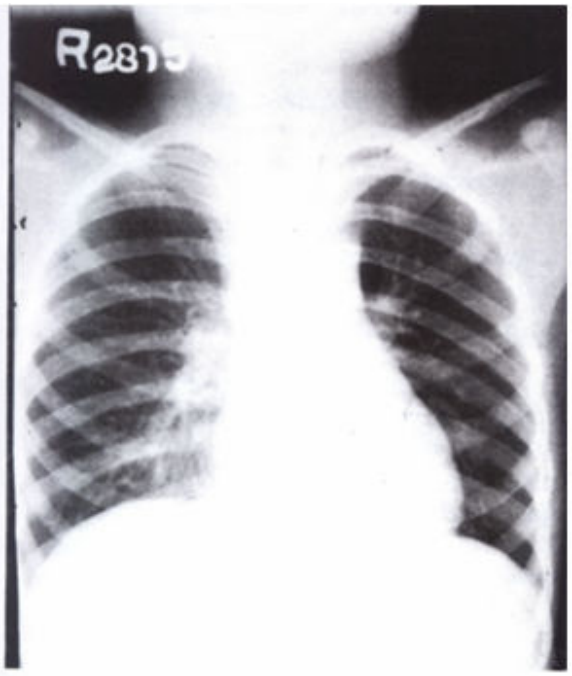

Figure 3. *3rd week – minimal widening of superior mediastinum*

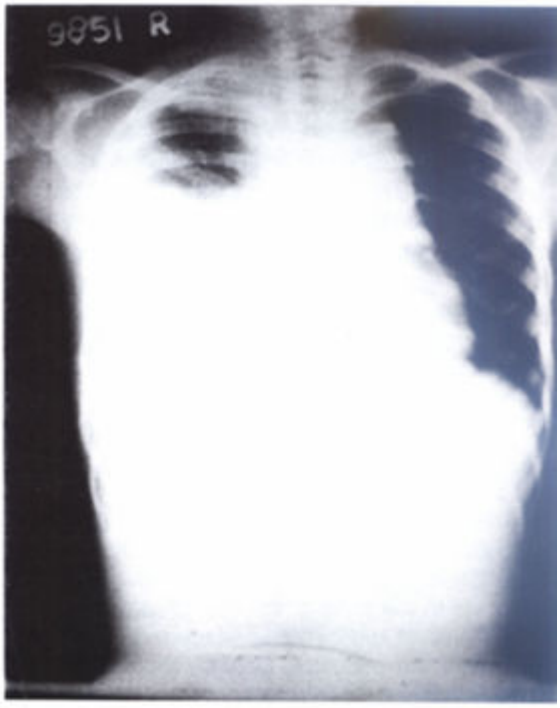

Figure 4. *4th week – Right pleural effusion and widened mediastinum*