Case Report

Single Thymic Gland Metastasis From Resected Non-small-cell Lung Cancer

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ARTICLE INFO

Article history:
Received 29 November 2011
Accepted 1 December 2011
Available online 25 September 2012

Keywords:
Lung cancer
Metastasis
Thymus
Surgery

ABSTRACT

Primary thymic tumors are rare, but secondary ones are exceptionally uncommon. We report the case of a single metastasis within the thymic gland from a lung adenocarcinoma that had been completely resected 3 years before. There was high diagnostic doubt because the thymic lesion was not associated with the recurrence of the paraneoplastic syndrome or the increased CEA levels described at the moment of the treatment of the primary tumor. The lesion was diagnosed and treated at the same time by transcervical thymectomy. At the 1-year follow-up, the patient is alive and disease-free.

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Metástasis exclusivas en el timo de un cáncer de pulmón no microcítico resecado

RESUMEN

Los tumores primarios del timo son excepcionales, pero se han descrito unos pocos casos de tumores secundarios. Describimos el caso de una paciente con metástasis exclusivas en el timo a partir de un adenocarcinoma de pulmón resecado por completo 3 años antes. La duda diagnóstica aumentó porque la lesión timica no se asociaba a la recidiva del síndrome paraneoplásico y a un aumento de los valores de antígeno carcinoembrionario (ACE) documentados en el momento del tratamiento del tumor primario. La lesión se diagnosticó y trató al mismo tiempo mediante timectomía transcervical. Al año de seguimiento, la paciente sigue viva y libre de la enfermedad.

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Introduction

Primary tumors of the thymus are very rare, but secondary tumors have occasionally been described.1–3 In the clinical notes of the case that we present, we document an extremely rare case of exclusive metastasis in the thymus of a lung cancer that had been diagnosed and treated 3 years before.

Case Report

In May 2007, a 54-year-old woman with an important smoking history was referred to us due to an adenocarcinoma of the right lower lobe associated with a paraneoplastic syndrome (Pierre Marie Bamberg syndrome). At that time, she was found to have increased serum levels of carcinoembryonic antigen (CEA) (34 ng/dL). Right lower lobectomy was carried out along with resection of the hilar and mediastinal lymph nodes by means of thoracotomy, which preserved the muscles of the right hemithorax. Three months after the surgery, we documented the complete regression of the paraneoplastic syndrome with the normalization of CEA serum levels (4 ng/dL). The anatomic pathology evaluation of the samples confirmed a lung adenocarcinoma in stage pT2aN0. In the post-operative period, total body computed tomography (CT) was done every 6 months. In June 2009, a small
A 35-year-old woman presented with a retrosternal mass, which was confirmed by computed tomography (CT) to be a thymic tumor. The tumor was suspected and confirmed, and the patient underwent thymectomy with en bloc resection of the tumor. Postoperative follow-up at a 1-year interval showed no clinical signs of recurrence. Petet et al. published a case report in 1966 where they described a retrosternal mass as a manifestation of thymoma. The patient was diagnosed with thymoma based on immunohistochemistry and presented with a retrosternal mass. The tumor was suspected and confirmed, and the patient underwent thymectomy with en bloc resection of the tumor. The patient was followed up for 1 year, and no signs of recurrence were observed. This case report highlights the importance of thorough clinical evaluation and histopathological examination in the diagnosis and management of thymic lesions, especially those presenting with retrosternal masses.