Benign Mediastinal Teratoma Producing Recurrent Hemoptysis

A 32 year old non-smoker, farmer had history of recurrent hemoptysis for 3 years. A chest X-ray done early in the course revealed mediastinal widening. Subsequently a bout of hemoptysis for 3 days, necessitating admission. Examination revealed crepitations in left infraclavicular and mammary region, trachea shifted to the right, and dullness on mediastinal percussion.

Investigation showed anaemia (Hb 7.8 gm%), and chest X-ray a rounded heterogeneous opacity (approx. 7 cm in diameter) with central calcified area continuous with the mediastinum and extending into the left upper lung zone (Fig. 1). CT scan of thorax showed a large (94 x 71 cm) heterogeneous rounded hypodense cystic mass containing areas of fat and calcification in left side of upper mediastinum with partial reduction in left upper lobe anterior segment volume (Fig. 2). Guided aspiration yielded inflammatory cells and necrotic material. While awaiting excision, patient coughed out hair and cheesy material mixed with blood. On exploration, a (10 x 8) cm cystic mass communicating with left upper lobe main bronchus was excised. Cut section revealed tufts of hair, a well formed bony prominence and ulcerated mucosa (Fig. 3). The tumour was diagnosed as mature cystic teratoma with elements of ecto- (skin, hairs), meso- (bronchial wall, bone, bone marrow), and endodermal (ulcerated intestinal mucosa) differentiation.

**COMMENT**

Approximately 8% of mediastinal tumours are benign teratomas. 82% of these arise in the anterior mediastinum, 4% in the middle-posterior mediastinum, and 14% in multiple compartments. The mean age at presentation is 28 years with equal sex distribution. The most common symptoms are pain, dyspnoea, and cough, but up to 36% may be asymptomatic. When communication occurs with the airways, the contents of the cyst may be expectorated. If this material contains hair, the diagnosis of mature teratoma can be made clinically. Hemothorax is a rare but potentially life-threatening presentation. It may be due to rupture into a bronchus, erosion of vessels by the growing mass, ulceration of tumor’s gastric mucosa, or systemic pulmonary shunting caused by extensive pleural adhesions. Following excision, cure is the rule.

**REFERENCES**


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