THYMOLIPOMA of the mediastinum is an extremely rare disease. We report a giant thymolipoma weighing 4120 g that was removed from a 42-year-old male. Clinical and radiological findings and surgical management are presented.

**Case Report**

A 42-year-old male, nonsmoker, and previously healthy presented to the emergency room with a two-day history of productive cough and fever. The patient had no previous history of chest pain or shortness of breath. Generally, he was underweight (45 kg) and his vital signs were normal. On auscultation, heart sounds were not audible and there were bilateral basal crepitations. The rest of the examination was unremarkable, and investigations showed normal blood count, electrolytes, kidney, and liver functions.

However, the chest x-ray showed cardiomegaly (Figure 1). Echocardiography was performed to rule out pericardial effusion. Although there was no pericardial effusion, the investigation showed a normal heart size and a large mediastinal tumor encasing the heart and ascending aorta that extended to both pleural cavities. Computed tomography (Figure 2) revealed a large fatty tumor in the anterior mediastinum. The tumor extended to both pleural cavities that pushed both diaphragms down and collapsed the lower lobes of both lungs. A preliminary diagnosis of thymolipoma was made on the basis of the characteristic radiographic appearance. Beta-human chorionic gonadotropins and alphafetoprotein were within normal limits.

Intraoperatively, via median sternotomy, a huge thymolipoma was peeled off the pericardium, diaphragms, and both sides of the pleurae (Figure 3). There was no sign of invasion (Figure 4).

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Figure 1. Pre- and postoperative chest x-rays.

Figure 2. Cr appearance of the tumor.
The tumor was composed of fatty tissues with two large lobes on each side and an isthmus in the anterior mediastinum, draining via two large veins into the innominate vein. Pathological examination confirmed the diagnosis with the presence of Hassall's corpuscles and lymphatic tissue in the tumor.

Discussion

Thymolipoma account for 2% to 9% of all thymic neoplasms. One-half of these patients are asymptomatic and the other half present with symptoms related to compression of the lower respiratory tree.

Occasionally, a thymolipoma is associated with myasthenia gravis, aplastic anemia, or Graves' disease. Radiologically, a thymolipoma may simulate cardiomegaly as in our case or cardiomyopathy. Computed tomography is the most accurate diagnostic technique because adipose tissue has a characteristic coefficient of attenuation.

Pathologically, the tumor is encapsulated, bilobed, soft, and composed of large lobules of adipose tissue about 75% to 90% of the tumor mass. Islands of lymphoid tissue and the characteristic Hassall's corpuscles are interspersed within the fatty tissue. Although surgical excision is curative, median sternotomy is the incision of choice for almost all patients. The prognosis after surgical excision is excellent.

Acknowledgment

The authors would like to thank our medical secretary, Ms. Jennifer Towns, for typing this manuscript.

References