Abstract: Thymoma is a common primary neoplasm of the anterior mediastinum. However, Ectopic Thymoma can arise in other locations, including the neck, the posterior mediastinum, the lung, base of the skull and the pleural cavity. There are less than ten previous case reports of a Thymoma located in the middle mediastinum. We report a case of a perihilar thymoma that was seen in an 30 year old patient who was also congenitally deaf and mute.

Keyword: Ectopic thymoma, Middle Mediastinum, Thymic Hamartoma, Perihilar Thymoma.

INTRODUCTION: Thymoma is a common primary neoplasm of the anterior mediastinum. However, Ectopic Thymoma can arise in other locations, including the neck, the posterior mediastinum, the lung, base of the skull and the pleural cavity.

There are less than Ten previous case reports of a Thymoma located in the middle mediastinum. We report a case of a peri-hilar thymoma that was seen in an 30 year old patient who was also congenitally deaf and mute.

CASE REPORT:
1. A 30 year old deaf and mute male patient was referred to our hospital with a complaint of dyspnoea on exertion for past 2 weeks and a CTand MRI chest finding of a left perihilar mass adherent to left upper lobe bronchus and lobar pulmonary arteries, which was suggestive of a bronchogenic cyst.
2. The physical examination and laboratory studies were unremarkable. FNAC was inconclusive.
3. Peroperatively the mass was found to arise from the left perihilar area deep in the oblique fissure and densely adherent to the
lung and left pulmonary lobar arteries. There was no nodes or gross infiltration. The mass was excised in toto. The cutsection revealed solid and cystic areas and was sent for Histopathological examination and immunohistochemistry.
The HPE report was “Thymoma with malignant potential”. IHC was CD 20, CD 45, CK positive. His postoperative period was uneventful; the patient is presently on adjuvant combination chemotherapy with cisplatin and adriamycin and is doing well.

**REVIEW OF LITERATURE:** Kalish et al noticed that there are two well defined groups of aberrant thymomas in relation with their location within the lung. The first group is formed by those thymic tumors which are located peripherally in the right lung.

The second group is formed by those thymic tumors which are located in close relation to the left pulmonary hilus. It seems that there are only five cases of this type recorded previously by Patterson and Hellermt in 1943.

Fontaine and colleagues in 1953 published a case of what they called “teratoid cyst with thymic tissue.” Novi in 1955 reported a case of “thymic hamartoma.” Both tumors were in close relation to the left pulmonary hilus.

The theories given from the embryologic point of view is that the thymic primordium in man is in contact with the parietal pericardium during the middle of the eighth week. This fact as stated by Yeoh et al could explain the presence of thymic tissue close to this structure. Castleman believes that the origin of the aberrant thymoma situated in or in close relation to the left hilus is due to migration of thymic tissue into the lung.

**CONCLUSION:**
In the differential diagnosis of middle mediastinal masses, thymoma is not frequently considered. However, because of its malignant potential and a 96% 10-year survival after complete macroscopic resection, thymoma should always be considered in the differential diagnosis of middle mediastinal tumors, and complete resection should be attempted at the time of the operation.

To our knowledge, a case of an ectopic thymoma arising from the perihilar regions of the lung is extremely rare. The treatment is usually multimodality with surgery, chemotherapy and adjuvant radiotherapy.
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