CASE REPORT

Dilemma in Diagnosing Malignant Pleural Mesothelioma with Atypical Clinical Presentation and Imaging Findings : Recurrent Chylothorax, Mediastinal Lymphadenopathies and Pulmonary Embolism

Koa Ai Jiun[1], Teh Yong Sim[2]

[1] Radiology Department, Faculty of Medicine and Health Sciences, Universiti Malaysia Sarawak (UNIMAS) 94300 Kota Semarahan, Sarawak, Malaysia
[2] Pusat Jantung Sarawak, Kuching –Semarahan Expressway 94300 Kota Semarahan, Sarawak, Malaysia

ABSTRACT

Malignant pleural mesothelioma (MPM) is a rare malignant tumor affecting the mesothelium. It commonly manifests as pleural thickening on contrast enhanced CT (CECT) thorax. We reported a case of a young lady who presented with respiratory symptoms and was initially treated as pneumonia. However, she had recurrent episodes of chylothorax with progressive internal jugular vein (IJV), brachiocephalic vein and superior vena cava (SVC) thrombosis leading to pulmonary embolism, associated with extensive mediastinal and supracalvicular lymphadenopathies. There are no evidence of pleural thickening in the initial investigations. Our case highlighted that MPM must remain in the differential diagnosis for these presentations, albeit rare.

Keywords: Malignant pleural mesothelioma (MPM), Recurrent chylothorax, Pulmonary embolism, Mediatsinal lymphadenopathies

Corresponding Author:
Koa Ai Jiun, MRAD
Email: koaaijiun@yahoo.com
Tel: +60138259062

INTRODUCTION

Malignant pleural mesothelioma (MPM) is an aggressive malignant tumor of mesothelium. It is present mostly in the elderly age group with strong relation to asbestos exposure. Imaging plays an essential role in detection and diagnosis of MPM, in which Computed Tomography (CT) is the primary imaging modality used for the diagnosis and staging of the disease. Key CT findings that suggest MPM include unilateral pleural effusion and nodular pleural thickening which will lead to tumoral encasement of the lung. Although rarely reported, there are reported cases of MPM which presented with chylothorax, pulmonary embolism as well as mediastinal lymphadenopathies.

CASE REPORT

A 39 years old lady, passive smoker, and worked as a cahsier in a mini-market; presented with cough, shortness of breath, fever and night sweat for 1 week duration. She was treated as right lobar pneumonia with parapneumonic effusion. CECT Thorax showed right pleural effusion with no evidence of pleural thickening or enhancement (Fig. 1). The pleural fluid was drained and macroscopically it was milky and turbid in appearance, with pleural fluid Triglycerides of 4.175 mmol/L (normal < 1.1 mmol/L), ratio of pleural fluid to

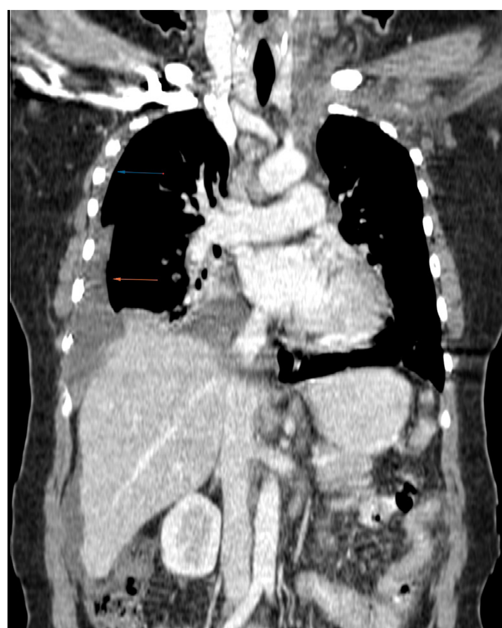

Figure 1: CECT Thorax coronal view: Minimal right pleural effusion (orange arrow) with no evidence of pleural thickening (blue arrow)