A 34-year-old man presented with a three-day history of upper abdominal pain. The day before admission he had noted fever of 101°F, increasing perspiration, and shortness of breath. He denied chest pain or dysphagia. Past history revealed a similar episode six years prior to admission. Physical examination revealed a chronically ill man with temperature 101°F (38.3°C), pulse 100/min, and blood pressure 130/80. Diffuse bilateral wheezes were noted throughout the lung fields. Abdominal examination was unremarkable.

Laboratory findings were as follows: hematocrit 40 percent, hemoglobin 13.8 gm percent, white blood cell count 16,500 with 88 percent polys, serum amylase 209 units, and a normal two-hour urinary amylase. Figures 1-3 were obtained soon after admission.
Diagnosis: Pancreatic Pseudocyst with Mediastinal Extension

PA and lateral chest roentgenograms (Fig 1 and 2) revealed a retrocardiac mass in the middle mediastinum. The left posterior oblique film of the upper GI series (Fig 3) revealed anterior displacement of the stomach by a retrogastric mass. Selective celiac and superior mesenteric arteriography revealed a large avascular mass in the body and tail of the pancreas.

The preoperative diagnosis was a pancreatic pseudocyst with mediastinal extension through the esophageal hiatus. The diagnosis was surgically confirmed.

The usual thoracic manifestations of pancreatitis and pancreatic pseudocyst include diaphragmatic elevation, plate-like subsegmental atelectasis, consolidation (pneumonic, atelectatic, or both), and pleural effusion. Pleural effusion occurs most commonly on the left, but may be bilateral. The other findings occur with equal frequency on either side and are often bilateral. Pericardial effusion, pancreatobronchopleural fistula, hemothorax, and mediastinal pseudocyst occur less commonly.

Pancreatic pseudocyst may extend into or migrate through any contiguous opening, potential space, or tissue plane that offers little resistance. It may gain access to the mediastinum through the esophageal or the aortic hiatus and is then generally found in the left retrocardiac region. Left-sided or bilateral pleural effusion is usually present (not seen in the present case). The esophagus may be compressed and deviated anteriorly. There is usually a past history of pancreatitis, and most patients present with abdominal pain. Dysphagia, dyspnea, and chest discomfort are frequent complaints.

Mediastinal pancreatic pseudocyst should be considered in patients who present with a retrocardiac mass and a history consistent with pancreatitis or of alcoholism, especially in the presence of left-sided or bilateral pleural effusion and elevated amylase level.

REFERENCE
1 Eaton AB, Ferrucci JT, Jr: Radiology of the Pancreas and Duodenum, W. B. Saunders, Philadelphia, 1973

ANNOUNCEMENT

Symposium: State of the Art — Management of Asthma, Chronic Bronchitis and Emphysema

The Symposium, State of the Art: Management of Asthma, Chronic Bronchitis and Emphysema will be held February 19 at the Lenox Hill Hospital, New York City. Sponsors of the symposium are Lenox Hill Hospital, New York University Postgraduate Medical School, the New York Trudeau Society, and the American Association of Clinical Immunology and Allergy. For registration and information, contact Dr. Gustav J. Beck, Lenox Hill Hospital, 130 East 77th Street, New York City 10021.