We report the case of a former smoker referred to our hospital for dysphagia and weight loss. Chest radiography and computed tomography (CT) showed lower mediastinal enlargement because of a large mass in the posterior mediastinum around the distal esophagus. A diagnostic intervention revealed a surprising and rare finding.

This 76-year-old man had dysphagia for solid intake and 15% weight loss over the last 6 weeks. He had general weakness, but no particular respiratory symptoms. He had a lifelong career as an orchestra conductor and was a former heavy smoker (35 pack-years). CT scan of the chest showed a large mass in the posterior mediastinum around the distal esophagus with near-complete compression over about 10 cm, no enlarged mediastinal nodes, and a slight right-sided pleural effusion without pleural thickening (Fig. 1).

Endoscopic examination revealed a stenosis over about 15 cm without malignant mucosal lesions. Esophageal ultrasonography showed disappearance of the esophageal wall stratification through complete circular external infiltration. Fine-needle aspiration samples revealed the presence of large malignant cells that could not be further specified.

Because of inconclusive pathology results, right-sided thoracoscopy was performed to examine the pleura and lower mediastinum. Inspection showed diffuse superficial neoplastic deposits on the visceral, parietal, and diaphragmatic pleura (Fig. 2). Routine hematoxylin and eosin staining of the biopsied samples revealed an invasive proliferation of polygonal cells with large eosinophilic cytoplasm, nuclei, and presence of macronucleoli surrounded by fat tissue (Fig. 3). The tubulopapillary pattern needed differentiation from metastatic lung carcinoma, especially adenocarcinoma. Additional immunohistochemical staining was negative for thyroid transcription factor 1 (Fig. 3B). The suggestive clinic-pathological findings of epitheloid mesothelioma became straightforward with two positive epitheloid mesothelial markers, calretinin and Wilms’ tumor protein (Fig. 3C and D).

In a very detailed professional history, it became evident that the patient most probably had significant asbestos

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exposure, as he had worked for several years in auditoria in a building, which had an important asbestos hazard, and had been made asbestos-free in recent years only.

**DISCUSSION**

Malignant pleural mesothelioma is a rather rare tumor of mesodermal origin, which emanates diffusely from the pleural, pericardial, or peritoneal cavity. There is a clear causal relationship with asbestos exposure, and the latency period to development of malignant pleural mesothelioma is estimated to be 30 to 40 years. The most common presenting symptoms are chest pain and dyspnea, and chest radiography often reveals a large pleural effusion.

Dysphagia as a complication of malignant pleural mesothelioma was first described by Johnson and colleagues. It occurs in only 1.4% of all cases and is mostly caused by direct esophageal compression or invasion in very advanced stages of disease.

Dysphagia as sole presenting symptom, without respiratory complaints or pain, is very rare. In our patient, the initial clinical and CT presentation led to the wrong hypothesis of a possible submucosal esophageal tumor, such as leiomyosarcoma or myxoma, and the initial fine-needle aspiration samples failed to provide a final diagnosis. To our knowledge, only a few similar cases were reported, with mesothelial tumor tissue surrounding the esophagus in the lower posterior mediastinum, as in our patient.

**REFERENCES**