A 57-year-old man presented with a 4-week history of dysphagia and cough. Physical examination revealed mucocutaneous pallor, and laboratory tests showed a slight anemia (hemoglobin level 12.5 g/dL). An upper gastrointestinal endoscopy revealed an obstructive neoplasm in the midesophagus (Fig. 1); biopsy specimens showed fibrinonecrotic and granulation tissue. Chest computed tomography showed a large peribronchial mass with bronchoesophageal fistula (BEF) (Fig. 2), and bronchoscopy revealed bronchial infiltration and marked caliber reduction of the left main bronchus. The results of examinations of samples from repeat biopsies of esophageal and bronchial lesions were negative for dysplasia or neoplasia. The results of polymerase chain reaction testing for Mycobacterium tuberculosis were positive, so we began administration of tuberculostatics and systemic corticosteroids, assuming lymph node tuberculosis with mediastinal involvement. However, there was a worsening of dyspnea and weight loss, and the results of the Xpert MTB/RIF Assay (Cepheid, Sunnyvale, CA) and Löwenstein–Jensen culture were both negative, leading to the assumption of a false-positive result of the first test. Endoscopic reassessment showed increase esophageal lesion and extensive tracheobronchial destruction, forming a large necrotic cavity in the mediastinum (Fig. 3). Histopathological analysis revealed large lymphocytes with a diffuse growth pattern with negative immunostaining for cytokeratin AE1, cytokeratin AE3, and for cluster of...
differentiation 3, positive immunostaining for CD20, and positive staining for Ki67 in 80% of cells (Fig. 4), leading to the diagnosis of diffuse large B-cell lymphoma. The patient continued to receive corticosteroid therapy, which was considered the beginning of chemotherapy. However, there was sudden and massive hemoptysis leading to the patient’s death.

Mediastinal large B-cell lymphoma is a clinically aggressive rare type of diffuse large B-cell lymphoma that is thought to arise from thymic B cells. One of the most difficult problems in the diagnosis of mediastinal large B-cell lymphoma can be obtaining an adequate biopsy specimen owing to the location of the tumor, so the diagnosis requires a high level of suspicion. Malignant BEFs in adults are usually secondary to esophageal neoplasms, with squamous cell carcinoma as the most frequent origin. The development of a BEF in the setting of malignancy generally indicates a poor prognosis. A BEF with esophageal mass in the setting of mediastinal lymphoma is extremely rare, and most cases reported

Figure 3. Upper endoscopy: esophageal lesion and extensive tracheobronchial destruction forming a large necrotic cavity in the mediastinum.

Figure 4. Diffuse large B-cell lymphoma: (A) large lymphocytes with a diffuse growth pattern (hematoxylin and eosin; original magnification, ×10), (B) large lymphocytes with a diffuse growth pattern (hematoxylin and eosin; original magnification, ×40), (C) negative immunostaining for cytokeratin AE1, cytokeratin AE3 (original magnification, ×40), (D) negative immunostaining for cluster of differentiation 3 (x20), (E) positive immunostaining for CD20 (×40), and (F) Ki67 positive in 80% of cells (×20).
have been associated with radiation therapy or chemotherapy.\(^2\)\(^-\)\(^5\)

**Acknowledgments**

All authors contributed to conception and design of the manuscript, acquisition and interpretation of images, and drafting and revising the content of the manuscript.

**References**


