



UNIVERSITY of  
**ROCHESTER**  
MEDICAL CENTER

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**DEPARTMENT OF IMAGING SCIENCES**

**Imaging Sciences Interesting Cases**

**CASE 169**

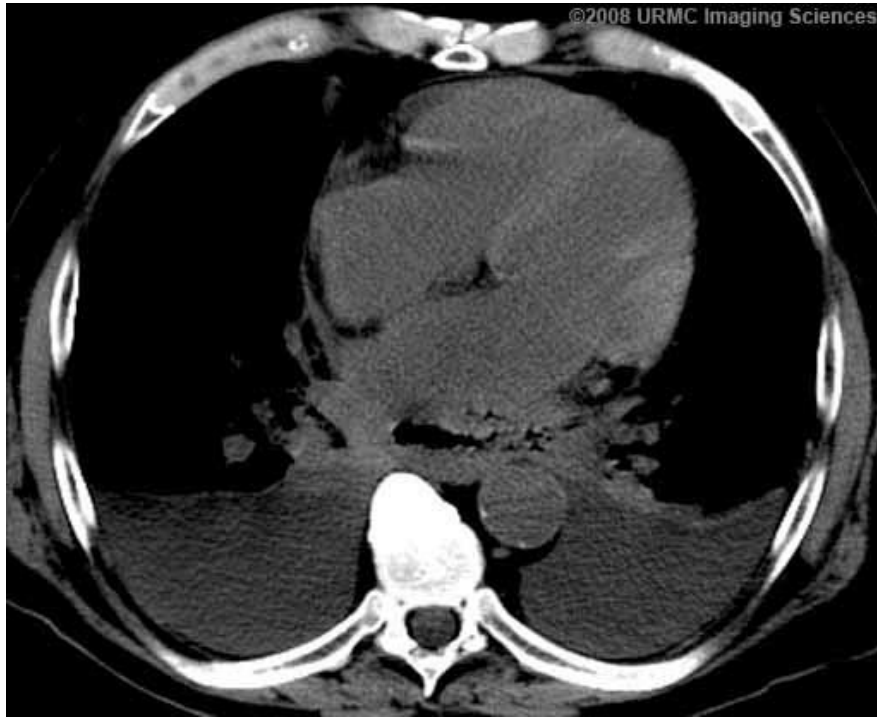
**Sam McCabe, MD**

**CLINICAL PRESENTATION:** Patient is an 77-year-old man with dysphagia.

**IMAGING FINDINGS:** A middle mediastinal mass surrounds and invades the esophagus.



**Figure 1:** AP image from a barium esophagram demonstrates a filling defect projecting into the lumen of the distal esophagus. The involved portion has an irregular mucosal surface. There is also a similar, though less well-defined area of involvement superiorly, in the middle third of the thoracic esophagus.



**Figure 2:** Non-contrast axial CT image through the chest shows a poorly defined middle mediastinal mass, indistinguishable from the esophagus.



**Figure 3:** Four chamber FIESTA cardiac MR image shows low-signal intensity thickening of the esophageal wall, with involvement of the left atrium as well. There is no clear tissue plane between the mass and the descending aorta.

## **DIAGNOSIS: Lymphoma - diffuse large B cell**

**DISCUSSION:** Although the GI tract is the most common extranodal site of primary non-Hodgkin's lymphoma (NHL), primary esophageal involvement is rare (1% of GI tract lymphomas). Patients typically have known generalized disease before esophageal spread is discovered. The esophagus is usually involved by direct spread from the stomach (the most common site of GI lymphoma) or mediastinal lymph nodes. Bulky mediastinal lymphadenopathy may result in symptomatic esophageal compression, or direct invasion, as seen here. The radiographic features of primary esophageal carcinoma, metastasis, and lymphomatous esophageal disease show considerable overlap. Esophageal metastases are most often due to direct extension from gastric, lung, thyroid, or laryngeal carcinoma. Hematogenous spread to the esophagus can be seen with breast cancer and melanoma.

The 2001 WHO classification system divides lymphoma into 4 broad categories: B Cell, T cell/Natural Killer Cell, Hodgkin's disease, and Immunodeficiency-associated lymphoproliferative disease. Diffuse large B cell lymphoma is a common, aggressive subtype, accounting for 40% of NHL in adults. Treatment typically consists of chemotherapy and steroids, with radiation for focal disease. Follicular B cell lymphoma, accounting for 30% of B cell lymphomas, typically has an indolent course.

## **REFERENCES:**

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