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Clinical Image

Partial Regression of Thymoma With the Treatment of Myasthenia Gravis

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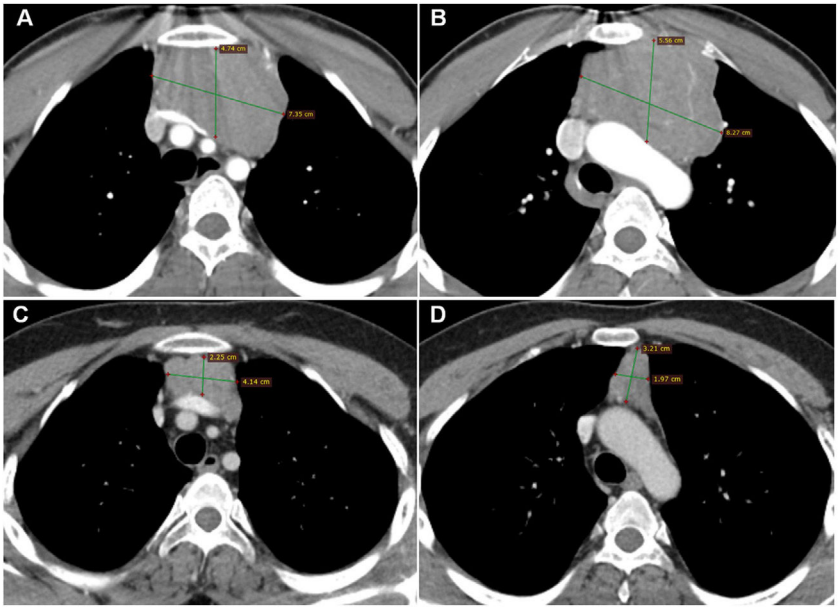

Fig. 1. Axial sections CT of the thorax, with mediastinal window show thymoma with the anterior mediastinal location (A, B). After one month of myasthenia gravis treatment, serious regression is seen in thymoma (C, D).

A 27-year-old male patient presented with complaints of ptosis, hoarseness, and muscle weakness (The modified Osserman score: 3). His anti-acetylcholine-receptor (anti-AchR) antibody level was 13.3 nmol/L (normal range, <0.4 nmol/L). In the neurological evaluation, the patient was diagnosed with myasthenia gravis and thymoma was detected simultaneously. The patient was given pyridostigmine bromide 4 × 60 mg per oral (PO), IV immunoglobulin (IVIg) 0.4 g/kg to five days, and methylprednisolone 1 mg/kg PO treatment for myasthenia gravis before surgery. Significant regression in thymoma was detected in the follow-up imaging one month after the medical treatment (Fig. 1). The patient did not accept surgical treatment, and pyridostigmine bromide and methylprednisolone (the dose was gradually reduced) treatments were continued during the six-month follow-up period. No progression in the size of the lesion was detected during this period.

Thymoma is the most common tumor of the anterior mediastinum and can occur at any age. Myasthenia gravis (MG) is the most common autoimmune disease associated with thymoma and accounts for 20–30% of all thymomas.[1] Thymoma may rarely remission with or without treatment for myasthenia gravis.[1,2] In cases of thymoma and myasthenia gravis diagnosed simultaneously, initiation of myasthenia gravis treatment before surgery may regress the thymoma and make surgical resection easier. In any case, clinical control of myasthenia gravis is necessary before a surgical approach to thymoma.

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Conflict of interest

The authors declare that they have no conflict of interest to the publication of this article.

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