Letter to the Editor

Myasthenia gravis developed 30 months after resection of recurrent thymoma

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We have read the article by Kondo and Monden [1] with great interest. In our institution, post-thymectomy myasthenia gravis (MG) occurred in 2 of 91 patients (2%) with thymic epithelial tumors, previously diagnosed without MG (from June 1988 to June 2004). The incidence is similar to the findings of Namba et al. [2] and Ito et al. [3]. Previously, we reported a patient with thymic carcinoid who developed MG 31 days after thymomectomy [4]. Now, this patient who has been followed for 40 months has been in a state of complete remission from MG for 12 months. In this letter, we would like to share a rare experience about a patient who developed MG 30 months after resection of recurrent thymoma.

A 43-year-old man with an incidental finding of a mediastinal tumor on his chest X-ray underwent complete thymomectomy because of stage IIb (Masaoka stage) thymoma (WHO type B1) on November 25, 1980. Although postoperative mediastinal radiation treatment (4500 cGy) was given, the tumor recurred in the right pleural cavity, necessitating a pleurectomy, partial diaphragmatic resection and right lower lobe lobectomy 35 months later. After the second operation, he received adjuvant chemoradiation therapy, including six applications of cisplatin-based chemotherapy and radiotherapy of the right chest cavity (total dose of 5040 cGy). Thirty months after the second operation, he developed a general type of MG and was placed under pyridostigmine and steroid therapy. Although no recurrence of thymoma in this patient was found, he eventually died from pulmonary tuberculosis in February 1990. At that time he still required a full dose of pyridostigmine and steroids to control the MG.

The interval between thymomectomy and the onset of postoperative MG varies. Ito et al. [3] divided post-thymectomy MG into early- and late-onset types. Namba et al. [2] reported that patients with a shorter onset of postoperative MG had a better prognosis, but both Kondo’s and Ito’s studies did not find this tendency. Our results, although limited, support Namba’s findings. Ito et al. [3] ever reported five patients who had a delayed type of postoperative MG confirmed on thymoma recurrence. As mentioned in this letter, our patient showed that, after resection of recurrent thymoma, there is still a chance of developing late-onset type of postoperative MG.

References


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Reply to the Letter to the Editor

Reply to Tseng et al.

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It is a very rare and interesting case. There were a few case reports of patients with recurrent thymoma and myasthenia gravis (MG) after thymectomy like the Tseng’s case. Shinkai et al. [1] and Shimizu et al. [2] reported recurrences of thymoma with myasthenia gravis 11 and 18 years, respectively, after surgery. Ito et al. [3] also proposed that delay type of postoperative MG is related to recurrence of thymoma. MG symptoms in both patients were controllable by MG and thymoma therapy.

It is unclear whether the interval between thymomectomy and the onset of postoperative MG influences prognosis of the patients with postoperative MG because of the rarity of postoperative MG cases. Namba et al. [4] reported that patients with a shorter onset of postoperative MG had a better prognosis, but both Ito’s and our studies did not find this tendency. We speculate that this discrepancy may be due to the difference in the therapy for MG. The mortality of MG in Namba’s report was worse than that in Ito’s and our reports (10/33, 30% vs 1/15, 0/8, 7—0%) [3—5]. In the present study, the mortality of MG is almost zero by the improvement in the respiratory support and long-term medical care of MG patients.

Namba et al. reported that in patients with onset of MG after partial resection of thymoma, the interval between thymomectomy and the onset of postoperative MG varies (immediate—7 years) and that MG of these patients was severe and it responded poorly to management [4]. In general, the effect of thymectomy in patients with both thymoma and MG is less than that in MG patients without thymoma. The existence of thymoma influences the response of MG to therapy. In Tseng’s case, not only a long interval but
also recurrent thymoma may have influenced the worse clinical course of MG. We suspect that thymoma releases a number of mature T-cells into the peripheral blood and that the T-cells persist in the periphery, potentially stimulating autoantibody production and subsequent autoimmune disease. However, the trigger of MG in the MG patients with thymoma is a mystery.

References


