Endoscopic ultrasound-guided fine needle aspiration of a pericardial mass

The prevalence of primary pericardial neoplasms ranges from about 0.001%–0.007%. Primary malignant pericardial mesothelioma is extremely rare, with a reported prevalence of 0.0022% in autopsy series [1]. Although malignant mesothelioma is the most common primary malignancy of the pericardium, only approximately 350 cases of pericardial mesothelioma have been reported in the literature.

Diagnosing pericardial disease can be challenging, with an antemortem diagnosis of pericardial mesothelioma obtained in only 10%–20% of cases. Cross-sectional imaging is useful for diagnosis, but cytological and/or histological examinations are required to obtain a definitive diagnosis. Cytological analysis of the pericardial fluid often yields negative results; therefore, the diagnosis usually requires histological evaluation of tissue obtained during surgery or at autopsy. In patients with metastasis, half have regional lymph node involvement; hence, as already reported, endoscopic ultrasound (EUS)/endobronchial ultrasound can be used to diagnose pericardial mesothelioma [2]. Because of the proximity of the heart to the esophagus, transesophageal EUS-guided access to the heart has been performed safely in animal models and humans [3]. There are a few case reports of EUS-guided fine needle aspiration (FNA) of atrial and pericardial tumors [4, 5].

A 55-year-old man presented with progressive dyspnea on exertion over the preceding 4 months. Computed tomography (CT) of the thorax revealed a well-defined heterogeneously enhancing lesion, 2.1×1.8×1.8 cm in size, attached to the posterior pericardium and a pericardial effusion.

Endoscopic ultrasound-guided fine needle aspiration was performed, with malignancy and tuberculosis being negative. Given the necessity of obtaining a tissue diagnosis, an EUS-guided transesophageal FNA of the mass was considered, and was performed in the endoscopy room after the cardiologist and cardiovascular surgical teams had been alerted. Linear EUS re-
revealed a mixed echogenic pericardial mass with a pericardial effusion (Fig. 2a, Fig. 2b). The lesion was punctured with a 22-gauge needle (Expect; Boston Scientific, Natick, Massachusetts, USA) with five passes made (Fig. 2c; Video 1). No arrhythmias or other adverse events occurred during the following 24 hours. May–Grünwald–Giemsa (MGG) staining and immunocytochemical expression confirmed the diagnosis of pericardial mesothelioma (Fig. 3). The patient subsequently died 2 weeks after diagnosis.

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