Supplementary

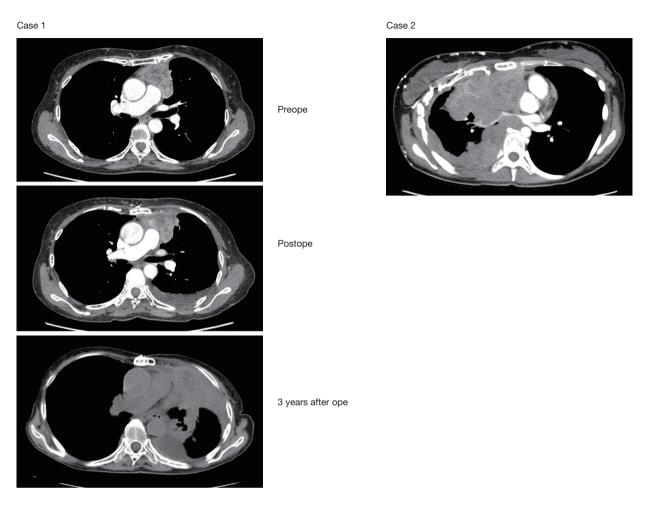
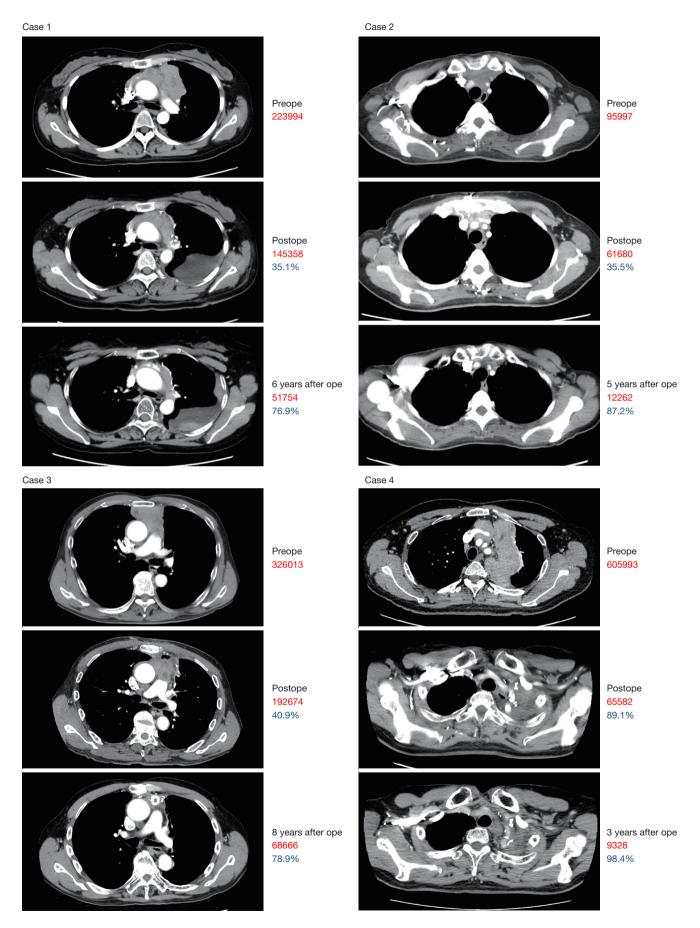


Figure S1 Representative cases that did not undergo reduction surgery. Case 1: the patient was a 66-year-old female shown to have a mediastinal tumor with pericardial effusion. Results of a tumor biopsy and pericardial fenestration performed under thoracoscopic surgery, the diagnosis was Masaoka stage IVa thymoma type B3. Although we planned to perform reduction surgery to control pericardial effusion, thoracotomy findings showed innumerable small intrapericardial and pleural dissemination, as well as the primary tumor invading the PA trunk, thus an exploratory thoracotomy was selected because tumor reduction surgery did not affect the range of PORT due to uncontrollable disseminations. This patient died of disease 4 years after surgery, even sequential chemoradiotherapy was given. Case 2: the patient was a 30-year-old female who underwent systemic chemotherapy for Masaoka stage IVa thymoma type B3. The tumor was mainly located in intracardiac space after chemotherapy, a life-threatening condition. Respiratory function was too poor for the patient to undergo surgery under a cardiopulmonary bypass, and we considered that tumor reduction outside the heart might not have a beneficial effect, thus chemotherapy and immunotherapy were performed. The patient was alive 3 years after initiation of treatment with progressive disease. Prepe, preoperative, postope, postoperative; ope, operation; PA, pulmonary artery; PORT, postoperative radiotherapy.



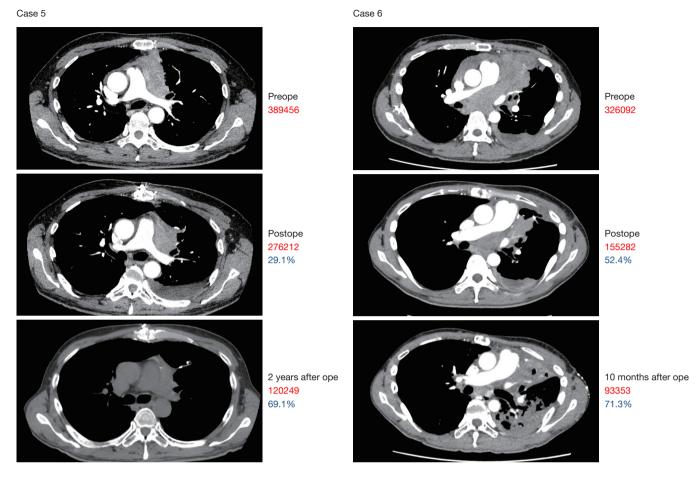


Figure S2 Chest CT imaging changes in all cases. Numbers in red indicate results of volumetric measurements obtained with a specialized software package (LISIT, Co., Ltd., Tokyo, Japan). Numbers in blue indicate tumor reduction rates which were calculated using the following formula: (preoperative tumor volume – tumor volume after surgery)/preoperative tumor volume × 100. Prepe, preoperative, postope, postoperative; ope, operation; CT, computed tomography.