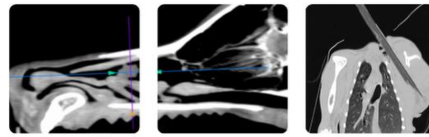


PATIENT

Stella Bugiani

SPECIES

Canine

BREED

Italian Greyhound

SEX

FS

AGE

14Y

WEIGHT

7.7kg

INTERPRETED BY

Tilde Rodrigues Froes, DMV, MSc., Dr. Med Vet., Dipl. CBraRVet

IMAGING PERFORMED BY

Christina

HOSPITAL NAME

Pet Emergency & Referral Center - NVA

REFERRING VET

Darby Toth

INVOICE

74280

DATE

3-19-26

PRESENTING CLINICAL SIGNS

- Patient presents for worsening cough of a few weeks duration. Presented to rDVM approximately one week ago. Thoracic radiographs were submitted and revealed "a large cranial dorsal mediastinal mass compressing the trachea. Possible origins include the paraspinal
- musculature, the regional vasculature, and less likely lymphadenopathy or esophageal origin. This lesion is suspected to be superimposed intracranial lung lobes on the ventrodorsal view. It is most concerning for a neoplastic process, such as a soft tissue sarcoma arising from the paraspinal musculature or neuroendocrine neoplasia (e.g. aortic body tumor). Nonneoplastic conditions such as a hematoma, granuloma or abscess are considered less likely." CT was recommended to further evaluate the mass and hopefully determine its origin.

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX

A pre- and post-contrast CT study of thorax are provided for review totaling 2 series. One pre-contrast series of the thorax, bone algorithm. One post-contrast series of the thorax, bone algorithm.

COMPUTED TOMOGRAPHIC FINDINGS

THORAX

A large, multilobulated to rounded soft tissue mass is present within the cranial thoracic cavity, predominantly located in the right dorsal cranial thorax, extending into the mediastinum.
The mass measures approximately 5.6 × 5.4 × 3.7 cm.

There is causing a marked mass effect with displacement and severe compression of adjacent structures, particularly the thoracic trachea. The tracheal lumen is reduced by approximately 80% over a length corresponding to approximately 2nd to 5th intercostal spaces. No definitive intraluminal invasion is identified; however, adhesion or mural infiltration cannot be excluded.

The mass also maintains broad-based contact with the dorsal right thoracic wall, 2nd to 5th intercostal spaces level. There is no evidence of adjacent osseous involvement (vertebrae or ribs). The angulation of the mass with the adjacent pulmonary parenchyma and the is loss of normal definition of the distal right cranial lobar bronchus, raising concern for pulmonary origin.

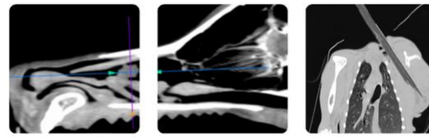
The tracheobronchial lymph nodes are markedly enlarged (right: 1.3 × 1.4 cm; left: 2.6 × 1.5 cm). The sternal and cranial mediastinal lymph nodes are mildly enlarged.

Within the remaining pulmonary parenchyma, at least three small ground-glass nodules (2.0–4.9 mm) are identified in the right caudal and accessory lung lobes. A small incidental pulmonary bulla is also noted. Mild dependent pulmonary atelectasis is present in the caudal lung lobes.

The esophagus is moderately distended with gas and is likely externally compressed by the mass.

The cardiac silhouette is mildly displaced secondary to mass effect. No intravascular filling defects are identified (noting suboptimal contrast enhancement).

The pleural space is partially obscured adjacent to the mass; otherwise, no pleural effusion or pneumothorax is observed. The diaphragm is unremarkable.



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An elongated, well-defined fat-attenuating mass consistent with a lipomatous lesion is present in the left thoracic wall.

Collimated abdomen:

The liver is diffusely enlarged. The hepatic lymph node is mildly enlarged.

A small hypoattenuating cortical lesion (approximately 5.3 mm), consistent with a renal cyst, is present in the right kidney.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Large cranial intrathoracic mass with severe tracheal compression and mediastinal involvement/displacement, predominantly located in the right dorsal cranial thorax. Primary differential diagnoses include pulmonary neoplasia (primary lung tumor) versus mediastinal neoplasia (e.g., neuroendocrine tumor, lymphoma, or less likely soft tissue sarcoma).
- Marked tracheobronchial lymphadenomegaly, consistent with metastatic lymphadenopathy.
- Mild enlargement of the sternal and cranial mediastinal lymph nodes, reactive versus metastatic.
- At least three small pulmonary ground-glass nodules. Primary differential diagnoses include early metastatic disease.
- Severe extraluminal tracheal compression (~80%) secondary to mass effect.
- Possible esophageal compression with associated gas distension, which may be partially related to anesthesia.
- Large incidental lipomatous mass within the left thoracic wall.
- Mild hepatomegaly with mild hepatic lymphadenomegaly (nonspecific; reactive, metabolic, or infiltrative).
- Small right renal cortical cyst (incidental).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

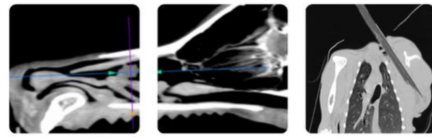
The study demonstrates a large cranial thoracic mass, predominantly located on the right side, causing significant compression of the trachea. The location associated bronchial changes, and loss of normal bronchial (right cranial lobar bronchus) definition raise concern for a primary pulmonary neoplasm; however, a mediastinal origin (including a neuroendocrine tumor, lymphoma, or other types) cannot be excluded.

The unusual dorsal position and large size of the mass make precise determination of its origin challenging even in the tomography. Due to its location, ultrasound-guided fine-needle aspiration (FNA) may be feasible and could assist in determining the tissue origin and biological behavior.

The presence of regional lymphadenopathy and small pulmonary nodules raises concern for metastatic disease.

TECHNICAL COMMENTS

Mild respiratory motion artifacts and moderate contrast enhancement limit detailed vascular assessment.



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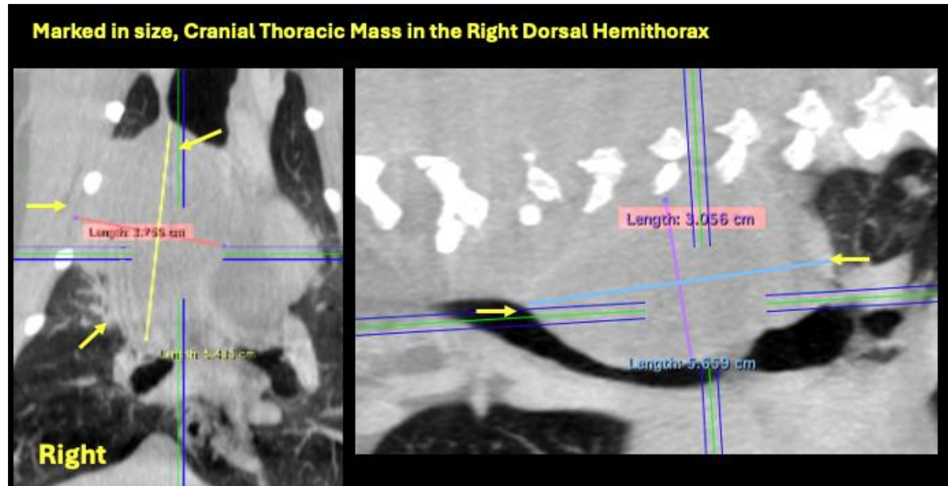

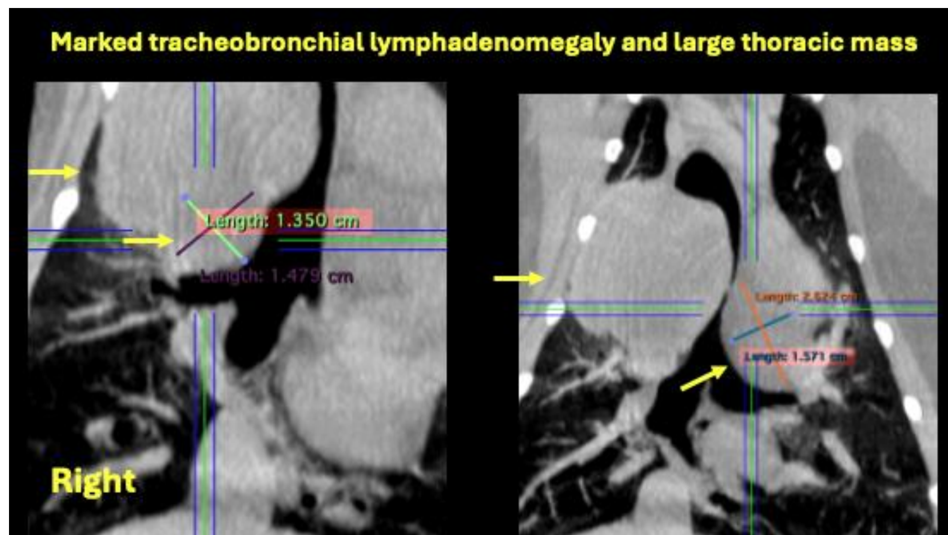

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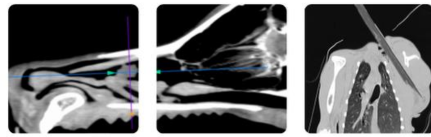

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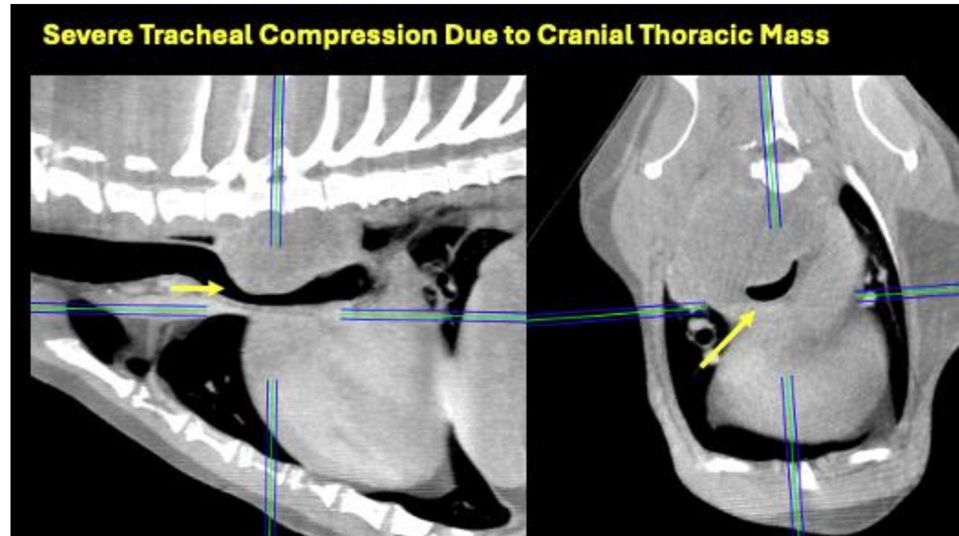

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

Tilde Rodrigues Froes, DMV, MSc., Dr. Med.Vet., Dipl.CBraRVet
info@sonopath.com