Thoracic spinal tumor

- Thoracic SMARCA4-deficient undifferentiated tumor: A case report in a 40-year-old male without a smoking history
- Outcomes after total en bloc spondylectomy at a mean follow-up of 11 years
- Generalizable model to predict new or progressing compression fractures in tumor-infiltrated thoracolumbar vertebrae in an all-comer population
- Vertebral Telangiectatic Osteosarcoma in a Dog: MRI and Computed Tomography Findings and Outcome
- Digital study and correlation analysis of sagittal balance parameters in adolescents with idiopathic scoliosis: A comparative study with healthy adolescents
- Oncology Biomarkers, Clinical Characteristics, and Survival Outcomes in Colorectal Cancer Patients with Spinal Metastases Undergoing Spinal Surgery: Insights from a Retrospective Cohort Study
- Risk Factor Analysis for Proximal Junctional Kyphosis in Neuromuscular Scoliosis: A Single-Center Study
- Aortic cross-clamping, resection, and end-to-end anastomosis in a dog presenting with rib osteosarcoma

---

A thoracic spinal tumor is a type of tumor that grows in the spinal column in the middle section of the back known as the thoracic region. These tumors can be either benign or malignant and can originate in the spinal cord or the surrounding structures, such as the bones, muscles, or nerves.

Epidemiology

see Spinal tumor epidemiology.

Classification

Thoracic Spinal Metastases.

Thoracic Spinal Meningioma.

Thoracic Spinal Cord Ependymoma.

Dumbbell-shaped thoracic tumors

see Thoracic spinal schwannoma.

Clinical features

Symptoms of a thoracic spinal tumor can include pain or discomfort in the back or chest, numbness or weakness in the arms or legs, difficulty walking, loss of bladder or bowel control, and other neurological symptoms.

Treatment

Treatment options for thoracic spinal tumors depend on the type, location, and size of the tumor, as well as the patient's overall health and age. Surgery, radiation therapy, and chemotherapy may be used to treat thoracic spinal tumors, often in combination. A multidisciplinary team of healthcare professionals, including neurosurgeons, oncologists, and radiation oncologists, may be involved in the treatment plan.

HGUA

A 67-year-old male referred to chest pain with a past medical history of hypercholesterolemia and high blood pressure

Reports tick bite one month ago. No fever or secondary complications.

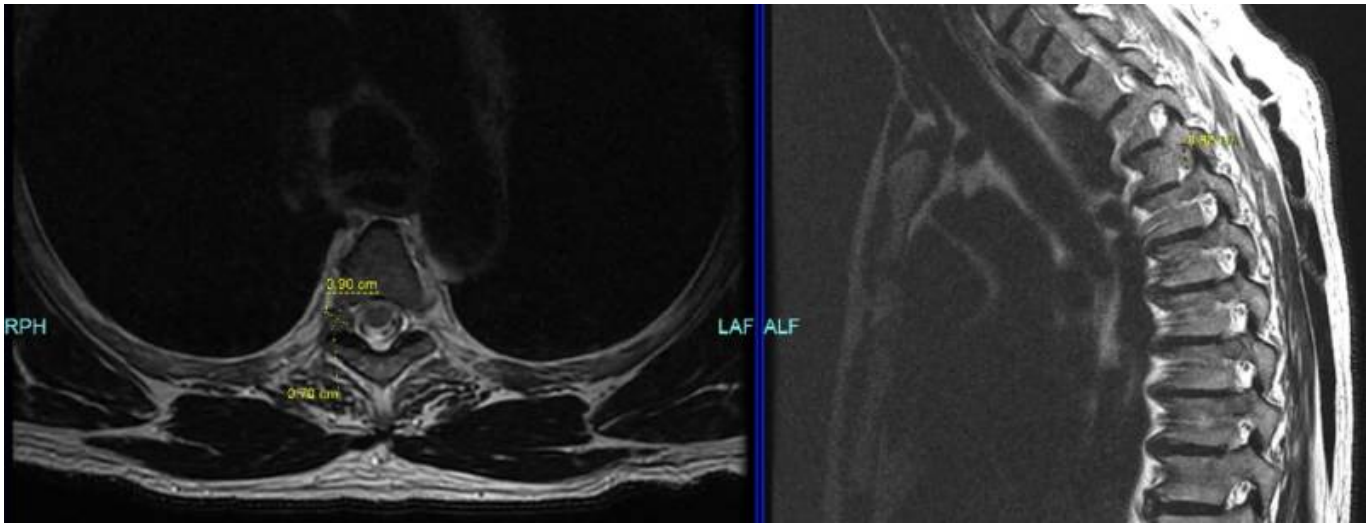
Ex-smoker for 15 years, with a cumulative consumption of approximately 30 pack-years. Diagnosed with clear cell renal carcinoma and treated with left laparoscopic nephrectomy 4 years before. Bilateral lung nodules are under investigation to rule out renal cancer metastasis.

Abdominal and pelvic CT scan: Millimeter-sized lung nodules suggestive of metastasis. No signs of local or nodal recurrence were identified. Callus fracture in the right rib.

Brain CT scan and MRI: No abnormalities.

PET-CT Multiple bilateral non-metabolic micronodules in the lungs, are not assessable by PET due to their size, although they do not rule out metastatic involvement. Recommend size monitoring with CT.

The chest pain was not justified by the current lung pathology. Continue investigation for musculoskeletal chest pain, consider an MRI of the spinal column.



Focal right foraminal lesion at T5-T6, with a rounded morphology, measuring approximately 9 x 7 x 10 mm (TR x AP x CC). It appears hypointense on T1 and hyperintense on STIR sequences, with homogeneous enhancement following contrast administration. Based on the previous imaging and PET-CT findings, a tumor of the peripheral nerve sheath (neurofibroma/thoracic spinal schwannoma) is the most likely possibility.

Under general anesthesia); Endotracheal intubation and mechanical ventilation; Cefazolin 2g IV. Prone position on Wilson's frame. Longitudinal skin incision from T2 to T4. Skeletonization of Th3-Th5 on the right side; Th4 right-sided laminectomy; Excision of LOE (lesion of uncertain etiology) compatible with Th4 root-dependent schwannoma with the assistance of a microscope and Floseal. Coagulation of root origin and remaining dura without evidence of cerebrospinal fluid leak. Hemostasis. Epidural and pleural Spongostan with Valsalva maneuver without a leak. Fascia and subcutaneous layers closed with Vicryl. Skin closure with staples.