Male, 41-year-old, ventilation-dependent patient coming from Goiânia, GO, complaining of pain in the right hemithorax for 40 days. Additionally, the patient reported dyspnea at moderate stress and occasional dry cough. At clinical examination, decreased chest expansion and abolished vesicular murmur at the right lung base were observed. The patient was referred to the Unit of Radiology and Imaging Diagnosis to undergo chest radiography and computed tomography (CT).
orders, endocrinological disorders and even connective tissue disorders. Distant metastasis rarely occurs in cases of thymoma, but most commonly extends to the pleura, bones, liver, kidneys and nervous system.  

Differential diagnoses for thymoma include anterior mediastinal lesions, including thymic lesions, lymphomas, germ cell tumor (GCT) and thyroid goiter. It is important to remind that lymphomas may present either as a primary anterior mediastinal lesion or with thymic infiltration. In men, the most common CGT presentation is the seminoma, affecting patients in the third decade of life, usually extending towards the left side of the midline and with mediastinal lymphadenomegaly.  

In the present case, the patient’s age range, the fact that the pleural implants were only at the right side, and the absence of mediastinal lymphadenomegaly and thyroid alterations corroborated the diagnosis of thymoma.  

The most frequent radiographic finding of thymoma is a mass with soft tissues density, measuring 5–10 cm, and generally with lobulated margins. The most frequent site is close to large vessels and to the pericardium, less frequently close to the cardiophrenic angle and cardiac border, and rarely in the neck or in other mediastinal compartment (Figures 1 and 3). On lateral views, opacity can be observed in the retrosternal space. Areas of calcification can be observed on plain radiographs.  

CT is the method of choice for the diagnosis of thymoma because of its sensitivity and capacity of demonstrating tumor infiltration of fat planes, vascular structures, adjacent lung and pleural dissemination. In most cases, the images demonstrate a homogeneously contrast-enhanced solid lesion, however areas of lower density may be observed within the lesion, possibly corresponding to cysts, necrosis or hemorrhage. Generally, such lesions extend towards one of the sides of the anterior mediastinum – in the present case the lesion extended towards the right side (Figure 4). In this patient, a predominantly pleural involvement was observed, this presentation being rarely described in the literature. In cases where the disease is present, unilateral involvement is observed, manifesting either as nodular or diffuse pleural masses, pleural effusion and even with circumferential thickening. The presence of pleurodiaphragmatic implants (drop metastases) is compatible with the invasive thymoma presentation (Figure 2), typically occurring in the ipsilateral pleural space, with possibility of coalescence and development of a tumor crust.  

Magnetic resonance imaging does not add significant information as compared with computed tomography of the thymus, but the multiplanar evaluation may be important in cases of dubious CT, besides being an excellent method for defining vascular invasion by the lesion, without requiring the utilization of intravenous contrast media.  

Although surgical management is the most widely known treatment for thymomas, chemotherapy was chosen in the present case, because of the finding of multiple implants. The patient was referred to the oncology ambulatory, where stage IVa was determined according to the system proposed by Masaoka et al. At the time the present report was completed, the patients had already completed the second chemotherapy cycle (cisplatin, doxorubicin and prednison) with satisfactory clinical progression.