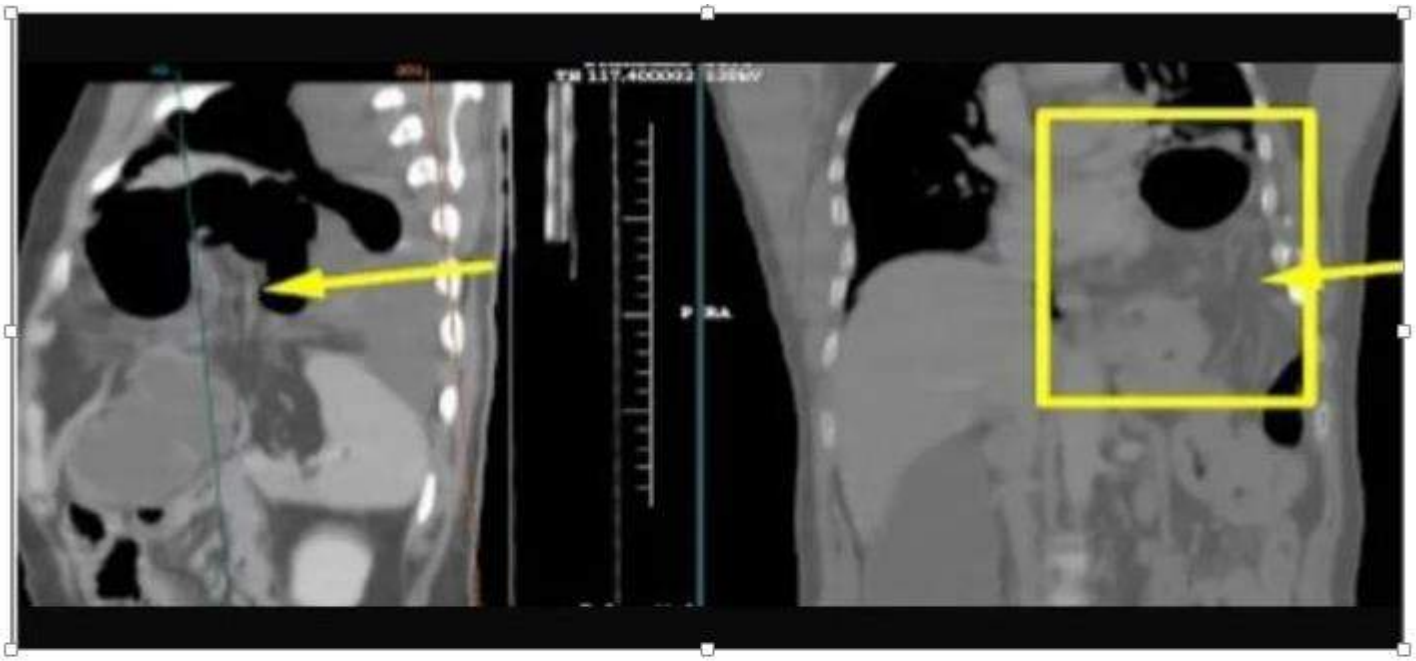


I displaced left mid, lower rib fractures at lateral and posterolateral aspect.

'*Left hemidiaphragmatic rupture' with herniation of splenic flexure of colon* .

Resultant short segment stricture of the splenic flexure of colon at the point of herniation causing high grade proximal large bowel obstruction associated with distal small bowel dilatation as described .

No evidence of free fluid or pneumoperitoneum in this study.



HRCT CHEST

Numerous tiny well defined centrilobular nodular airspace opacities involving bilateral upper, lower lobes and right middle lobe sparing thin subpleural zones ,fissural zones as described above – *likely suggestive of subacute hypersensitivity pneumonitis versus pneumoconiosis (silicosis*).

Other differential of milliary tuberculosis cannot be entirely ruled out

No evidence of mediastinal lymphadenopathy. No abnormal parenchymal or mediastinalcalcifications.

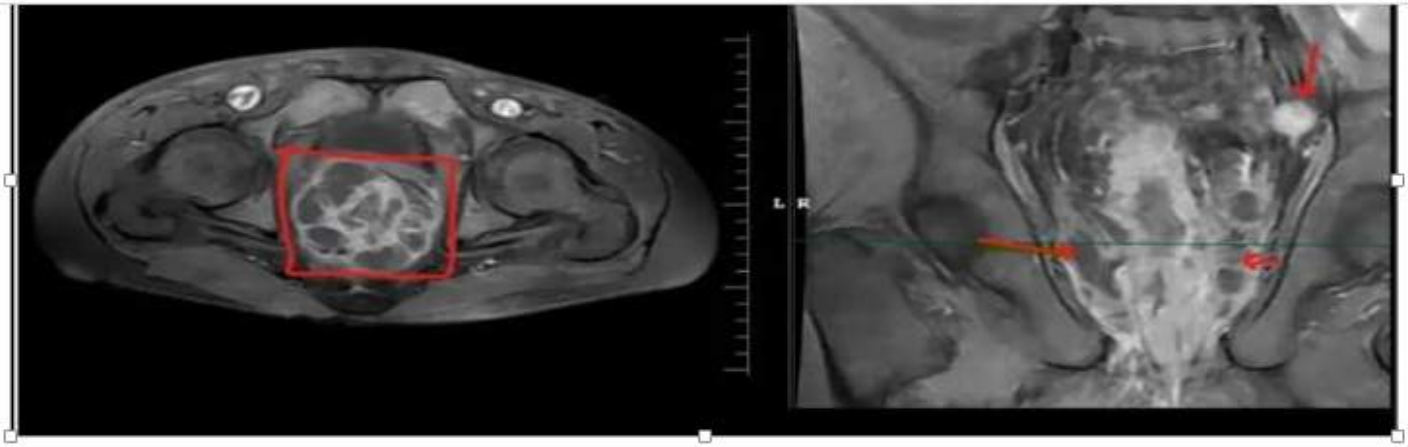


CT RIGHT UPPER LIMB ANGIOGRAPHY

Right cervical rib with markedly narrow right costo clavicular space. Which is causing focal extrinsic compression of the right subclavian artery with up to 90% luminal narrowing at this level – *suggestive of 'right thoracic outlet syndrome'*

The subclavian artery proximal and distal to the right costoclavicular space demonstrate normal calibre.

Segmental filling defect involving mid, distal brachial artery over an approximate length of 18 cm causing up to 100% luminal diameter reduction with segmental distention of the artery – *suggestive of acute thrombo-occlusion*



MRI PELVIS (WITH CONTRAST)

A large and extensive circumferential almost 'entirely T2 hyperintense mass lesion' involving the rectum, anal canal over an approximate length of 11 cm, crossing the anorectal junction demonstrating peripheral heterogeneous enhancement as described – *of concern for obstructive 'Mucinous carcinoma of rectum*'.

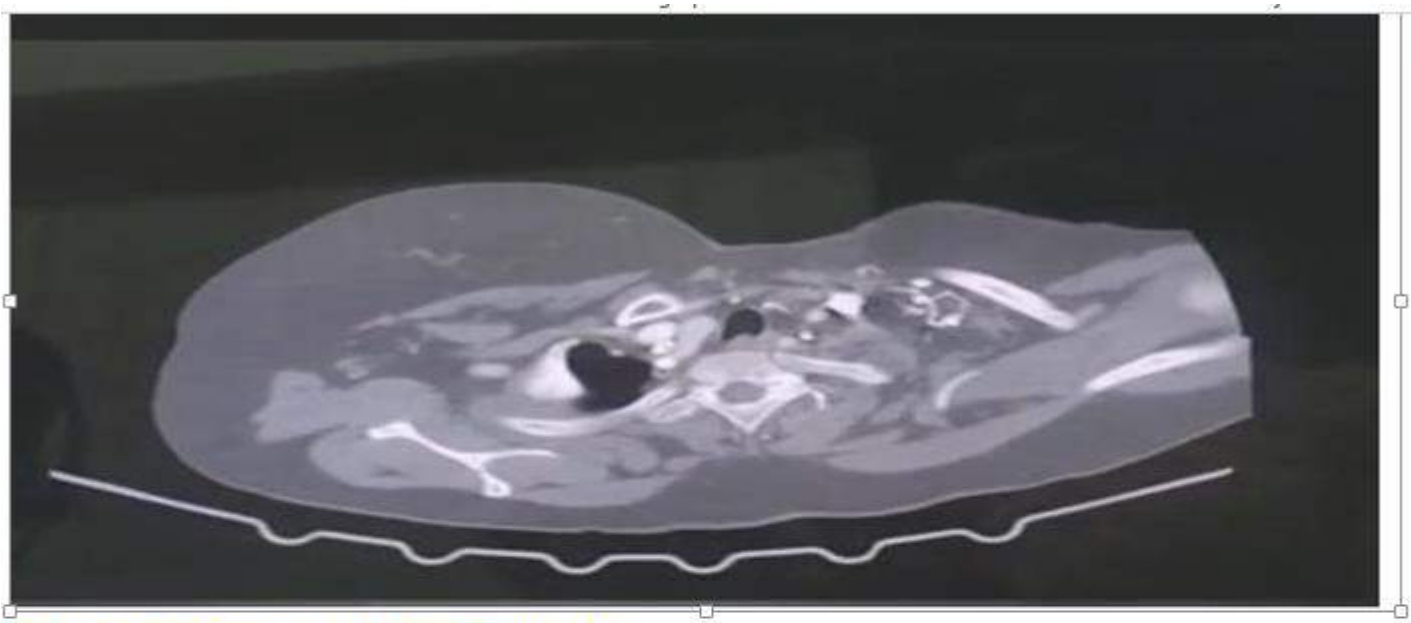
Marked luminal narrowing of the rectum with high grade *large bowel obstruction*.

The mass is sparing the rectosigmoid junction and terminal 1.8 cm of the anal canal. (distal edge of the mass is 1.8 cm proximal to anal verge). Infiltration of levator ani, proximal anal sphincters.

Transmural circumferential infiltration involving the entire mesorectal space with evidence of crossing of mesorectal fascia at focal areas.
Evidence of bilateral fluid distended *perianal fistulous tracts and loss of haustral pattern of the colon - suspicious for underlying inflammatory bowel disease such as Crohn's disease.

Multiple enlarged lymph nodes in the perirectal region, sigmoid mesocolon, bilateral internal iliac regions, largest measuring 3.2 x 2.2 cm in the left internal iliac region demonstrating mucin content.

The anterior margin of the mass lesion is close to the posterior wall of rectum and seminal vesicles, however, no evidence of invasion in this study .



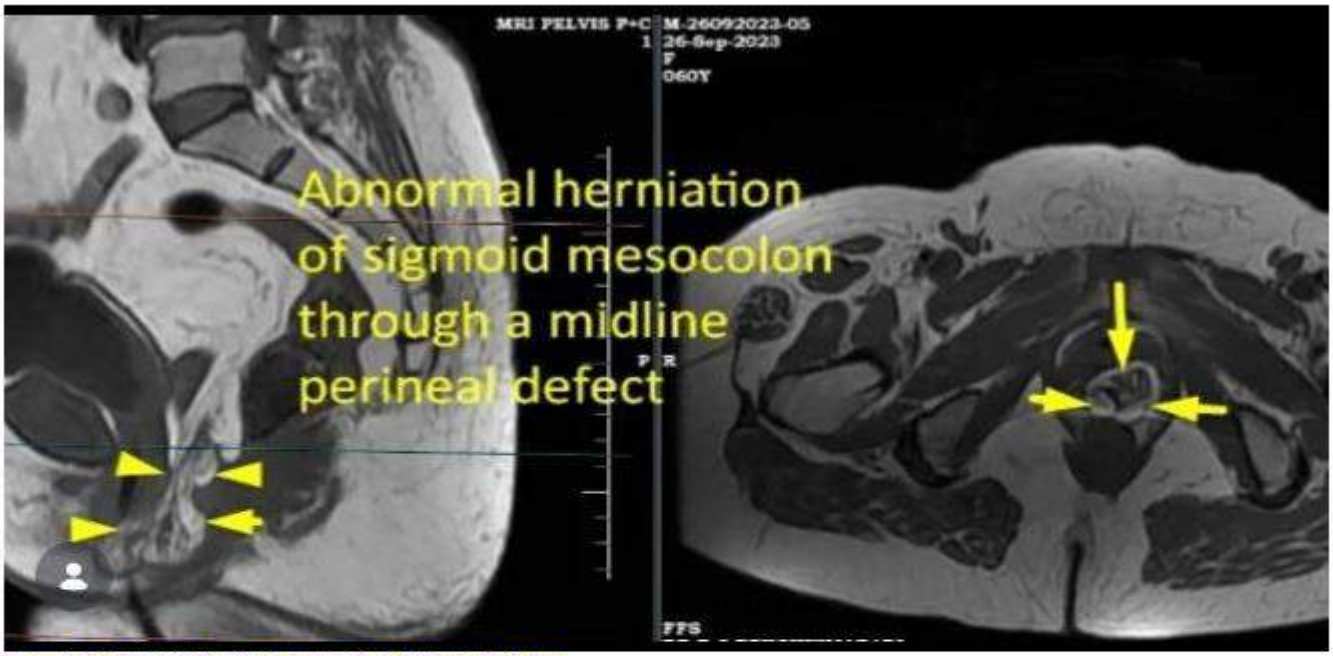
CT RIGHT UPPER LIMB ANGIOGRAPHY

54Y/F

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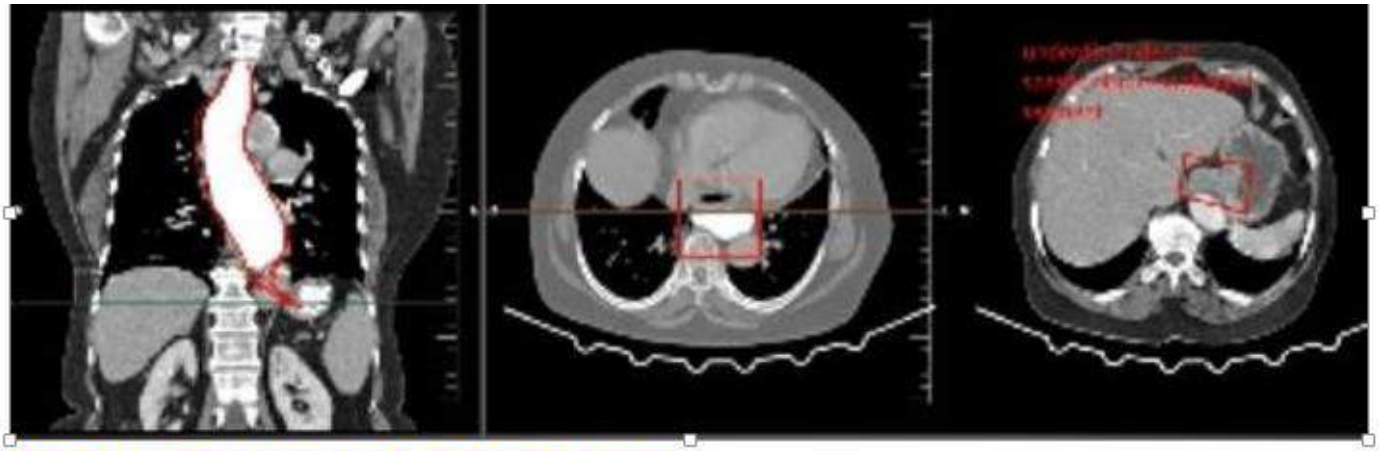
MRI PELVIS (WITH CONTRAST)

Status post hysterectomy.

Low lying pelvic floor with mild cystocele

Urinary bladder is distended with bladder wall thickening at the base

***'Abnormal herniation of sigmoid mesocolon through a midline perineal defect'*, anterior to the anal canal, posterior to the vaginal vault.**
Recommend clinical correlation



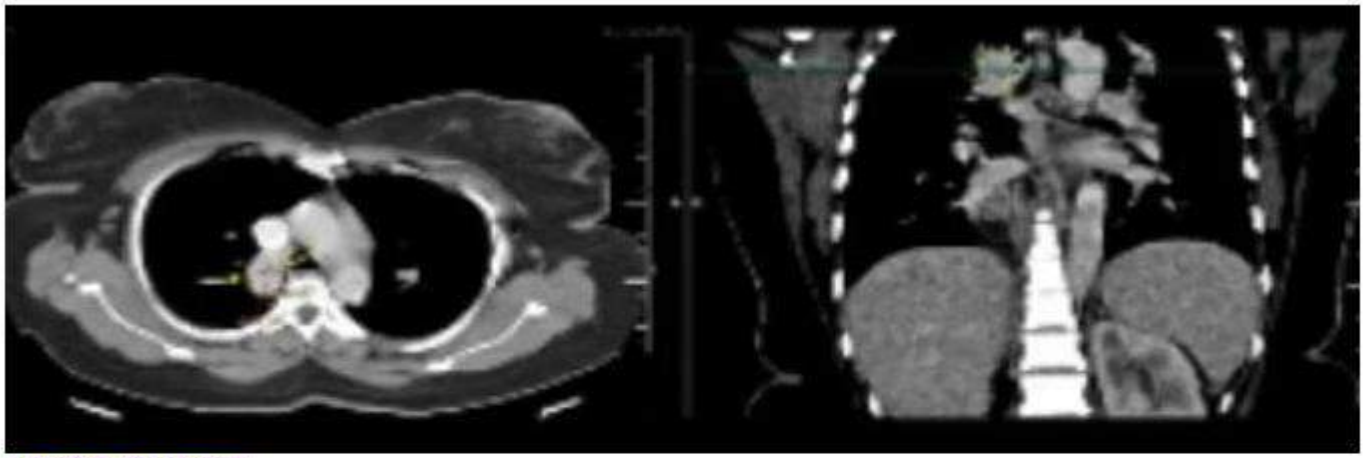
CT CHEST (W & W/O CONTRAST)

Marked dilatation of the entire course of thoracic esophagus demonstrating intraluminal fluid status with air fluid levels and smooth distal tapering at the terminal esophagus and gastroesophageal junction level (Rat tail sign) - *likely related to Aganglionic GE junction / Achalasia Cardia*.

***Segmental underdistention of the terminal esophagus and gastroesophageal junction with mild apparent thickening of the esophageal wall, which is likely related to underdistention or spastic distal esophageal contraction- however endoscopic evaluation is recommended to rule out early neoplastic etiology*.**

No evidence of aspiration pneumonia. No significant mediastinal lymphadenopathy.

Recommend upper GI endoscopy for evaluation and biopsy of the terminal spastic segment, follow up



HRCT CHEST

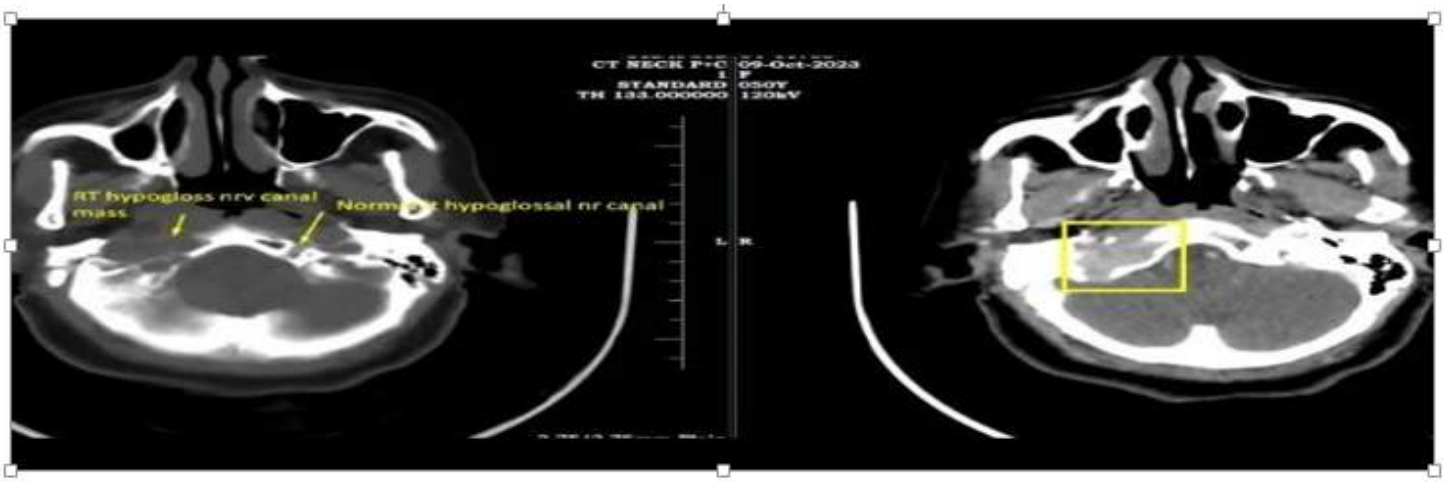
An approximately 3 x 3 x 2.2 cm ovoid intensely enhancing structure in the right paratracheal compartment of superior mediastinum communicating with the azygus arch (abutting the posterior wall of SVC) – **suggestive of aneurysm of the azygus arch**

No evidence of surrounding fat stranding or extravasation

in this study. Trace bilateral pleural effusions with bibasilar

dependent atelectasis Recommend follow up to confirm

stability



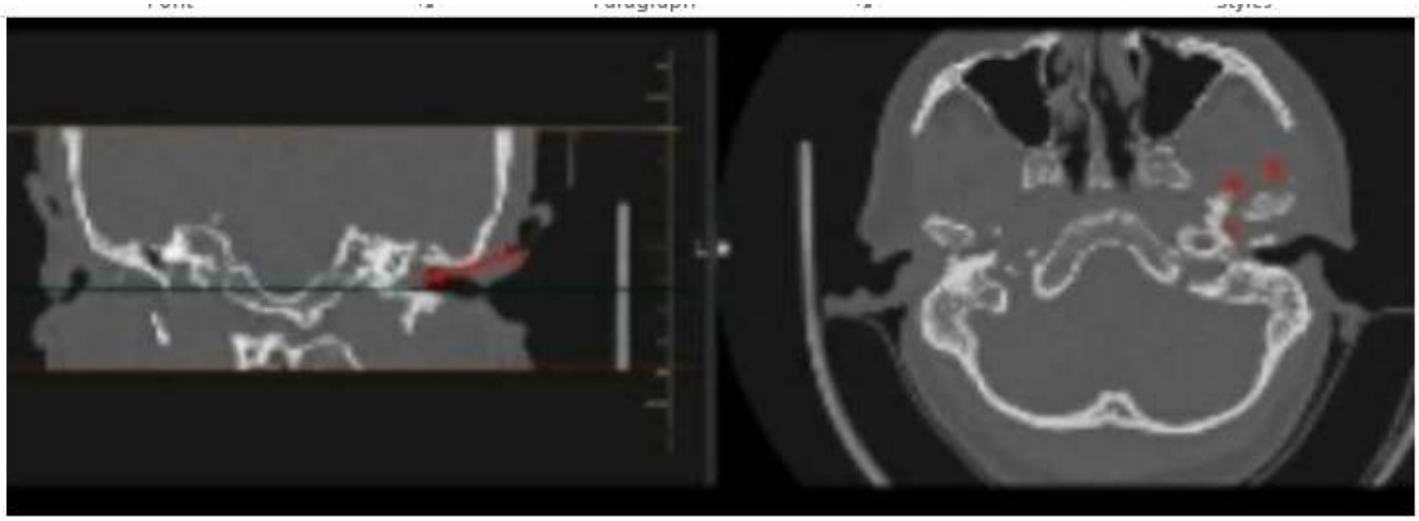
CT SCAN NECK AND ORAL CAVITY (PLAIN+CONTRAST)

An approximately 2.6 x 2 cm Lytic/destructive heterogeneously enhancing mass lesion is noted epicentered around the right hypoglossal nerve canal causing erosion of the adjoining the lateral margin of the clivus, medial wall of right inferior jugular foramen, infiltrating the lateral margins of adjoining part of right longus capitis muscle –*represents neoplasm, likely of concern for Metastasis*

Slight effacement of the right fossa of Rosenmuller due to slightly edematous right torus tubaris. Right mastoid collection, likely related to obstruction at the right Eustachian tube.

No evidence of discrete nasopharyngeal mass lesion
Focal soft tissue thickening at the anterior wall of right lateral part of vallecula indenting the anterior surface of epiglottis – needs further evaluation with MRI neck

Mild focal soft tissue thickening involving the right Palatine tonsillar fossa.
Slight anterior positioning of the right arytenoid cartilage with medial buckling of the right true vocal cord suggestive of right vocal cord palsy.



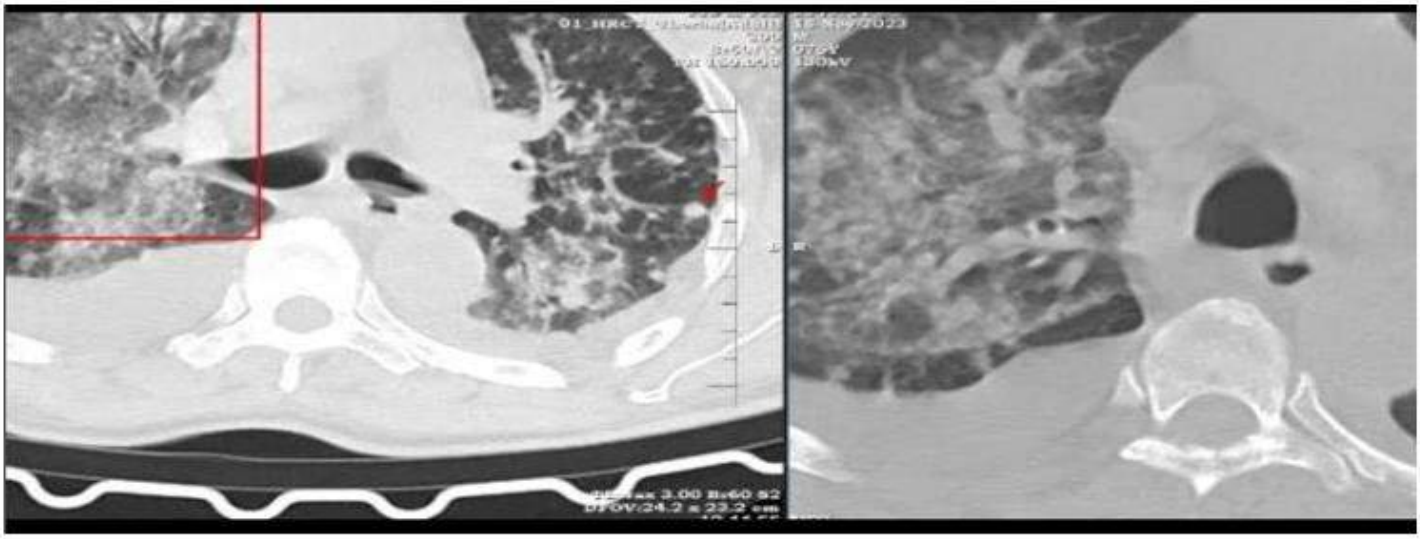
HRCT TEMPORAL BONE

Findings suggestive of bilateral chronic mastoiditis with acute on chronic changes on the right.

Abnormal soft tissue involving the left middle ear encasing the ossicles without any ossicular erosion - *likely suggestive of left middle ear –external auditory canal cholesteatoma*.

Abnormal soft tissue thickening involving the left temporomandibular joint with small erosions of the left TM joint articular margins and small focal erosion at the anterior wall of left external auditory canal with abnormal communication between the left external auditory canal and left TM joint space – *suggestive of erosive left TM joint arthritis as a sequelae to left external auditory canal – middle ear cholesteatoma*.

Recommend clinical correlation, further evaluation, HPE correlation, follow up.



An approximately 4 x 1.6 cm elongated spiculated pulmonary nodule in the left upper lobe demonstrating mild enhancement – *_likely neoplastic_*

Extensive patchy ground-glass and reticular airspace opacities involving bilateral upper, lower lobes at central peribronchovascular regions associated with multiple tiny nodules in vicinity – *_of concern for neoplastic etiology such as invasive mucinous adenocarcinoma versus lymphangitis carcinomatosa_*

Other possibility of pulmonary edema or acute viral pneumonia is less

likely Mild to moderate amount of bilateral pleural effusions (right more

than left).

Recommend clinical correlation, pleural fluid analysis, further evaluation with BAL , follow up.



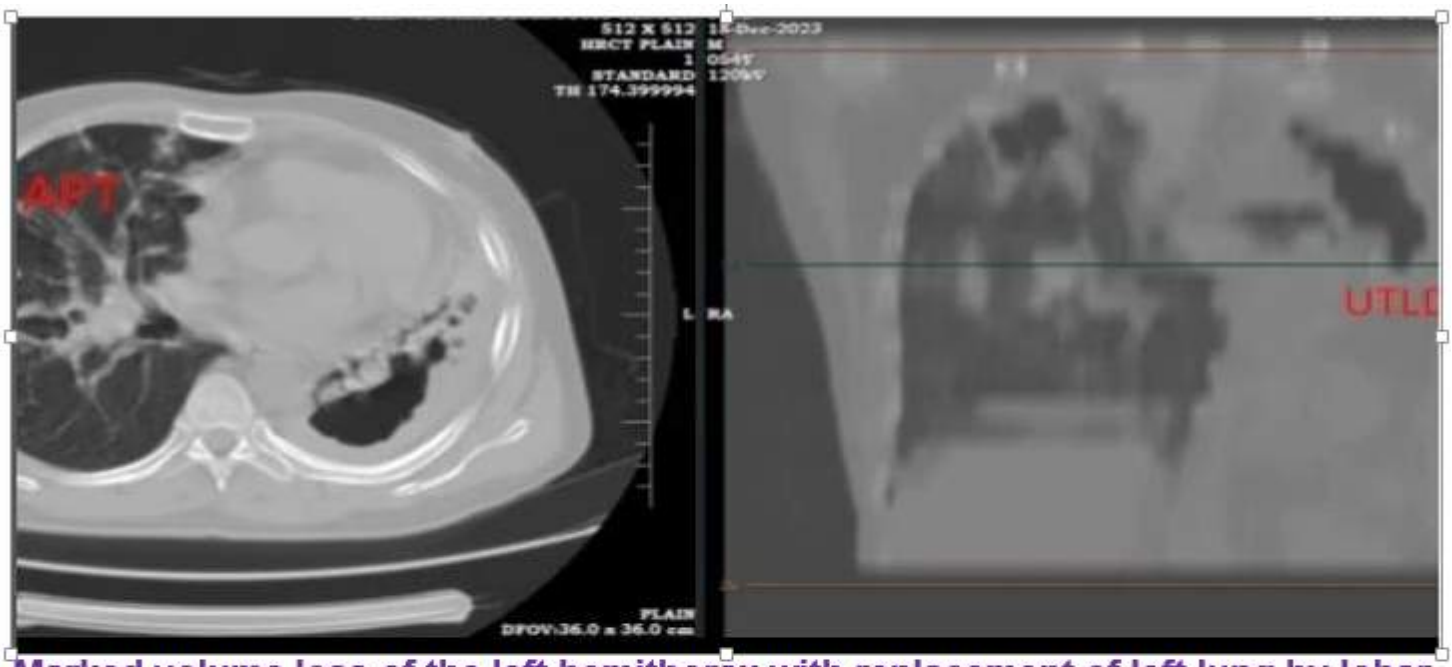
HRCT CHEST

Mild elevation of right dome of diaphragm with evidence of approximately 6 x 7.5 x 2.7 cm right subphrenic low attenuation collection (evaluation is limited due to lack of IV contrast study) – *likely suggestive of subphrenic abscess*

Trace right pleural effusion with subpleural atelectasis in posterior basal segment of right lower lobe.

Recommend IV Contrast study for complete evaluation, follow up

.

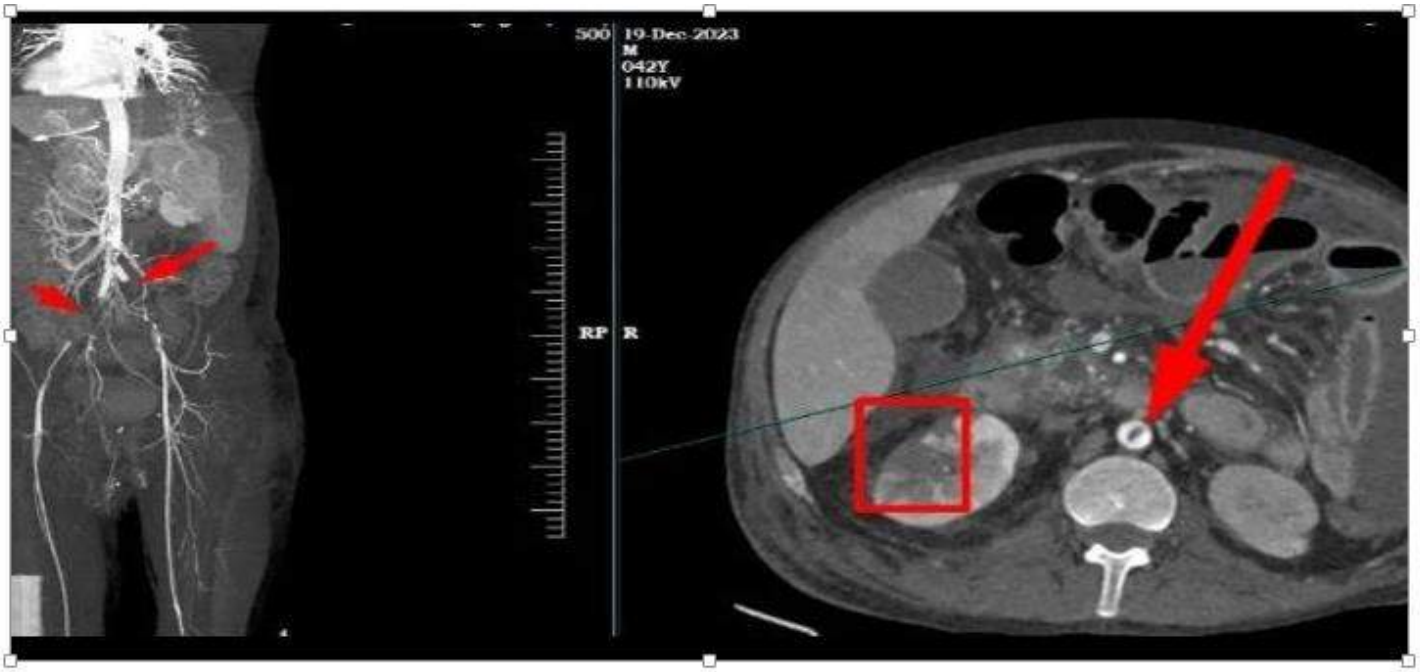


Marked volume loss of the left hemithorax with replacement of left lung by lobar atelectasis, pleural based scarring associated with traction bronchiectasis and large cavitations replacing the entire lung– *_suggestive of unilateral tuberculous lung destruction (UTLD*)._

Marked mediastinal shift to the left with elevation of left dome of diaphragm

Compensatory hyperinflation of the right lung with small thick walled pulmonary cavitations in upper, lower lobe associated with multiple tiny nodular air space opacities clustered in right lung – _suggestive of active pulmonary tuberculosis._

Recommend follow up.



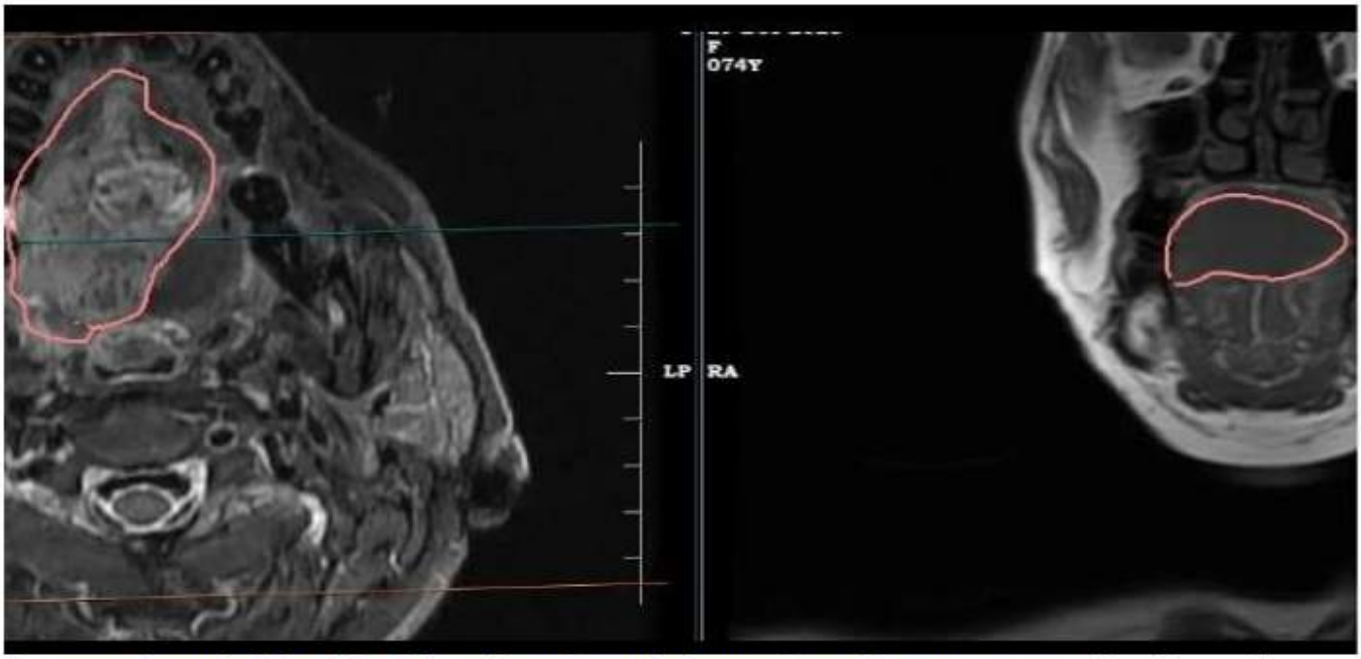
Multiple small filling defects within the lumen of infrarenal aorta with surrounding contrast opacification sparing the bifurcation – **suggestive of aortic free floating thrombus**

Abrupt luminal occlusion of bilateral common iliac arteries due to extensive low attenuation thrombosis extending to external, internal iliac arteries – **suggestive of acute thrombo-occlusion*.*

Mild narrowing of bilateral distal external iliac arteries, common femoral

arteries Acute bilateral renal infarcts

Recommend clinical correlation, coagulation profile, follow up.

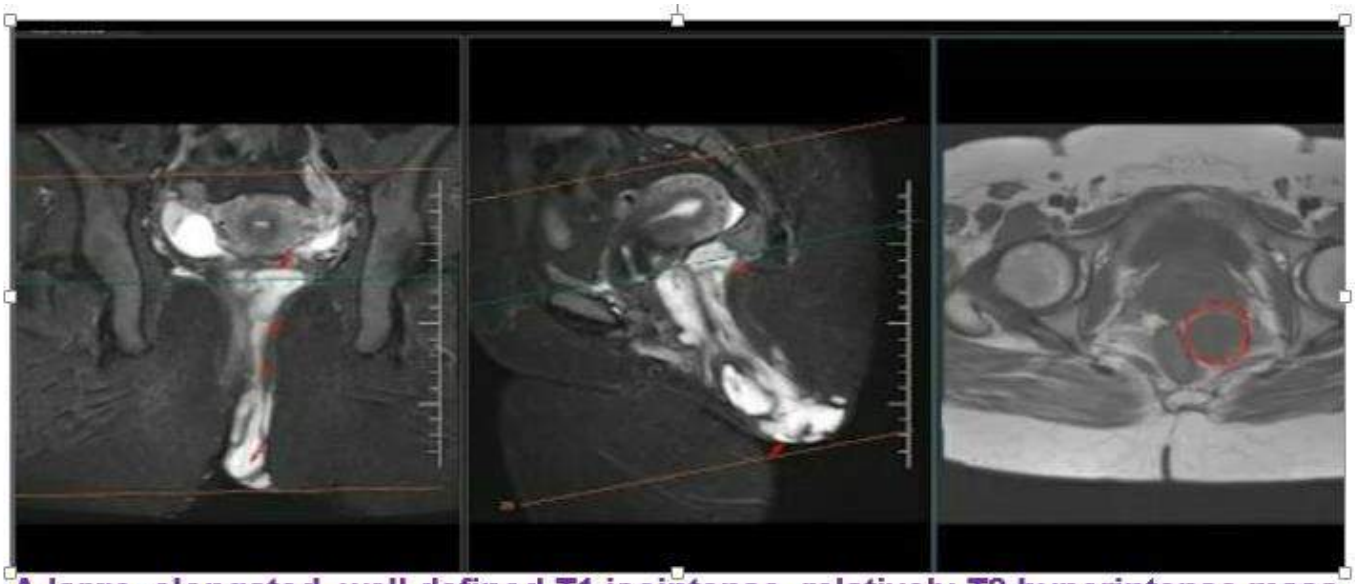


An approximately 2.5 x 4.8 x 3.3 cm large irregularly marginated heterogeneous signal intensity mass lesion epicentered along the entire right half of anterior 2/3rd of the oral tongue,, crossing the midline to involve the major portion of left half of the tongue, sparing the left lateral tongue margins (evaluation is limited due to lack of IV contrast study) – *represents neoplasm, of concern for tongue carcinoma*

Suspicious infiltration of the right tonsillar fossa with mild fullness of the right palatine tonsillar fossa.

A few enlarged lymphnodes are noted in right level II cervical compartments , largest measuring 0.9 x 0.7 cm of ? clinical significance (*evaluation is limited due to lack of IV contrast study).*

Recommend IV Contrast study for complete evaluation, axial sections of level IV cervical compartment, HPE, follow up.



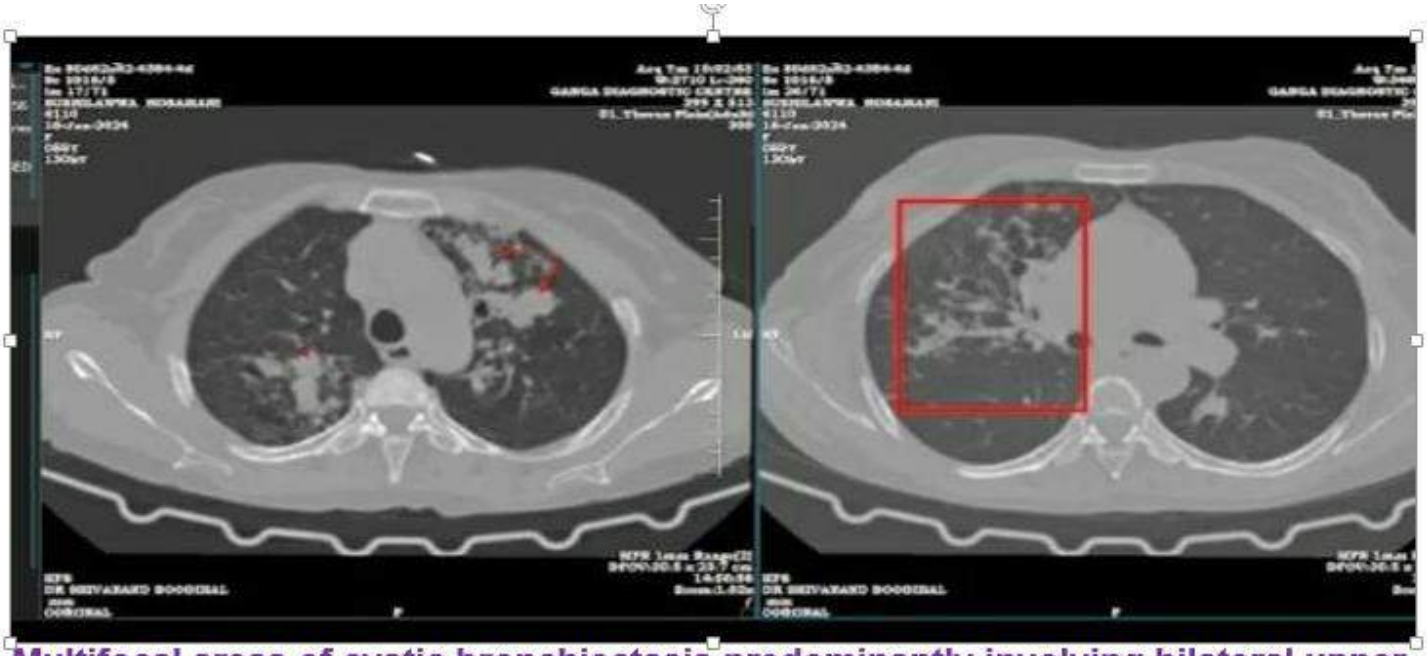
A large, elongated, well defined T1 isointense, relatively T2 hyperintense mass lesion epicentered in the left paramedian aspect of perineum extending superiorly involving the left lateral wall of anal canal, protruding into the left lateral intersphincteric space with further 'supralavator extension' involving the left lateral part of mesorectal space demonstrating moderate enhancement , swirling pattern (13 x 3.8 x 5.4 cm) as described above – **represents neoplasm, likely Aggressive Angiomyxoma*.*

Differential considerations also include:- *A myxoma versus benign mesenchymal neoplasm versus solitary fibrous tumour.*

Inferiorly the mass is protruding into the left perianal subcutaneous

space. Small free fluid in cul-de-sac.

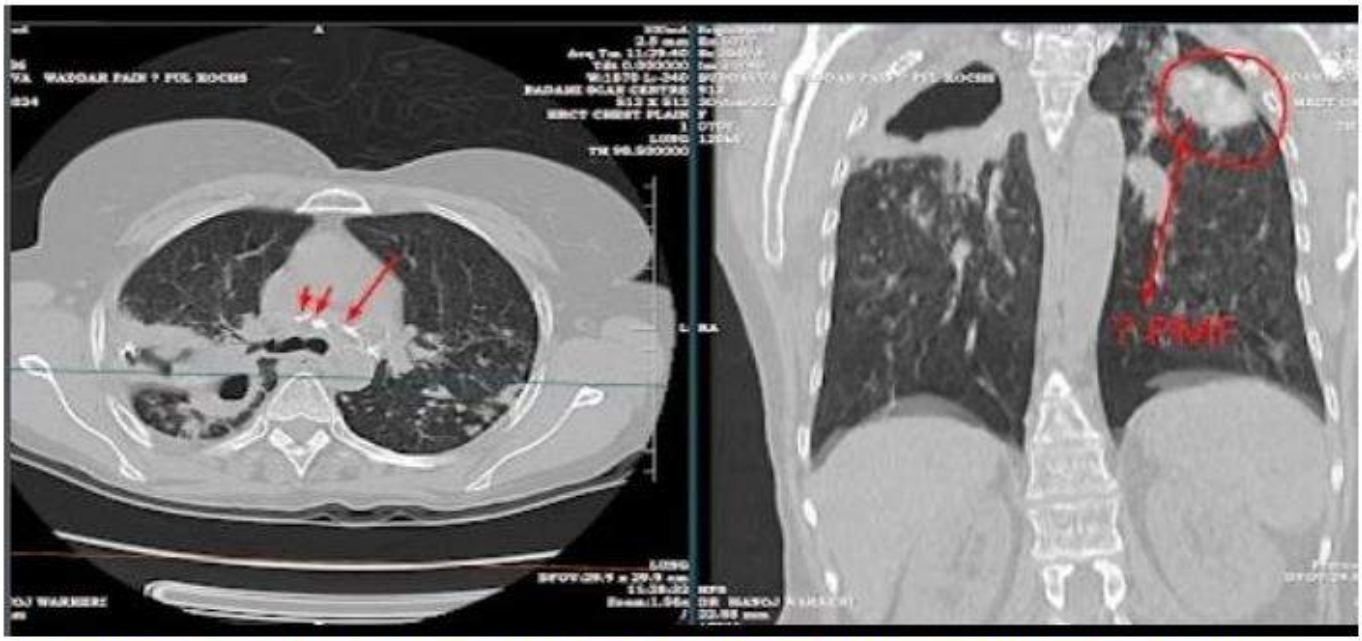
Recommend HPE correlation, follow up.



Multifocal areas of cystic bronchiectasis predominantly involving bilateral upper lobes, right middle lobe, the lingula at the central peribronchovascular regions associated with multiple pneumonic infiltrates clustered around the bronchiectatic regions, associated with multiple high density mucus plugs in vicinity – **suggestive of allergic bronchopulmonary aspergillosis (ABPA)**

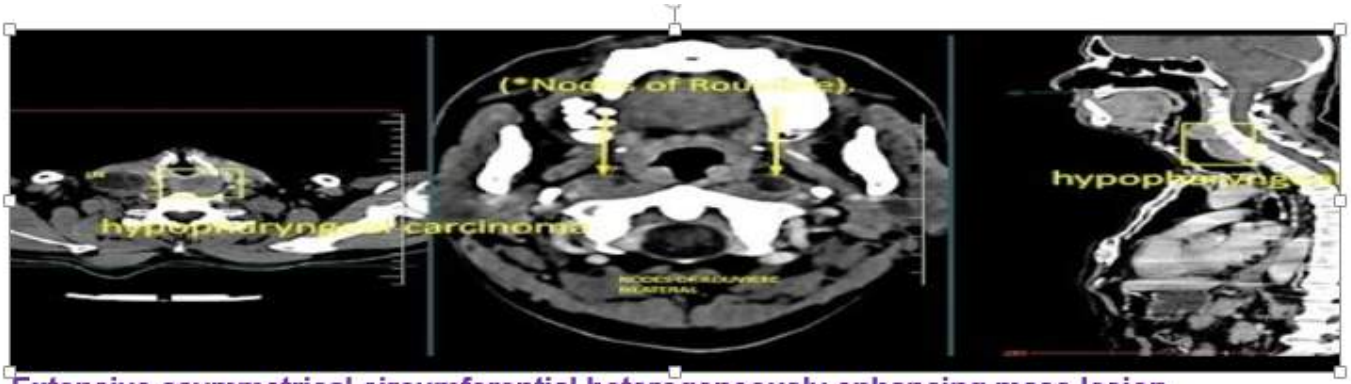
The possibility of atypical tuberculosis cannot be entirely ruled out.

Recommend further evaluation with eosinophil counts, Anti IgG, ESR, follow up



An approximately 4.5 x 4 cm thick walled irregularly marginated pulmonary cavitation involving apical segment of right upper lobe associated with multiple tiny nodular airspace opacities involving bilateral upper lobes, right middle lobe, apical basal segments of bilateral lower lobes – **suggestive of active pulmonary tuberculosis*.*

A large calcified subpleural soft tissue mass lesion involving the left upper lobe, measuring 5.8 x 2.7 cm associated with multiple calcified mediastinal lymph nodes in pretracheal, paratracheal, para-aortic, subcarinal, right hilar compartments – co-existing
****Silicosis (pneumoconiosis) with Progressive massive fibrosis (PMF) – needs consideration*.***
Recommend correlation with occupational history, follow up.



Extensive asymmetrical circumferential heterogeneously enhancing mass lesion predominantly epicentered at the posterior wall of hypopharynx involving bilateral pyriform fossa, aryepiglottic folds, extending caudally to involve the postcricoid region and proximal cervical esophagus measuring 7.5 cm in superior inferior extent with maximum thickness of 1.7 cm – *represents carcinoma of the hypopharynx – post cricoid region with proximal esophageal involvement*

Segmental narrowing of the hypopharyngeal, proximal esophageal lumen.

Early transmural infiltration of the mass lesion into bilateral tracheoesophageal groove and the prevertebral space at left paramedian aspect. No evidence of vertebral erosion.

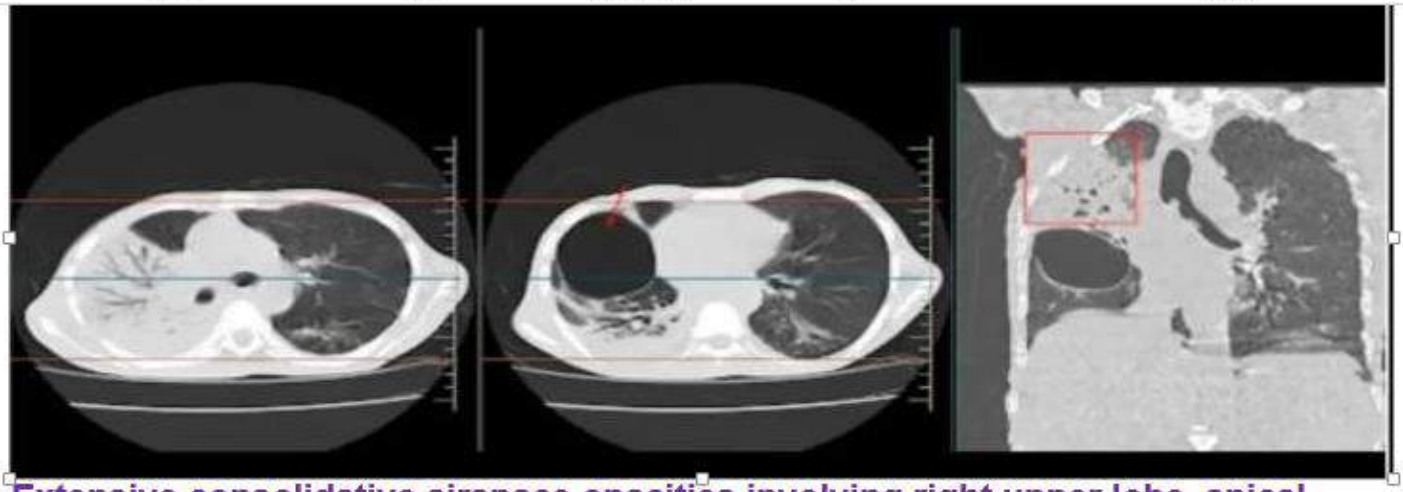
The mass is indenting posterior margins of bilateral thyroid lobes with slightly obscured fat planes.

Extensive necrotic metastatic lymphadenopathy in bilateral level I, level II, level III and level IV cervical compartments, largest lymph node measuring 4.2 x 2.6 x 2.5 cm in right level IV

Enlarged necrotic lymph nodes in right level VI compartment and bilateral lateral retropharyngeal spaces in the upper cervical region (*Nodes of Rouvière).

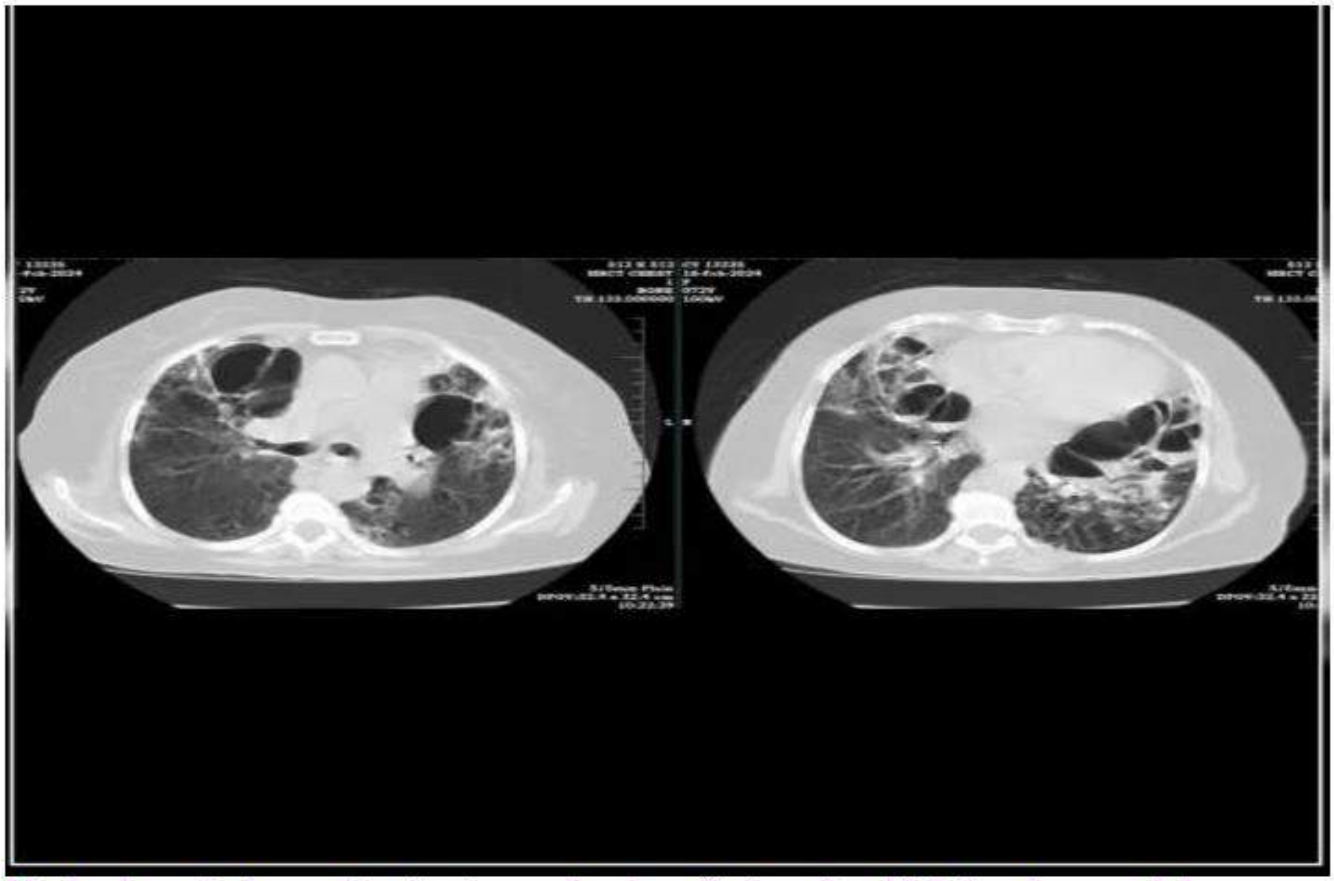
Emphysematous changes in the lungs bilaterally

Recommend HPE correlation, follow up



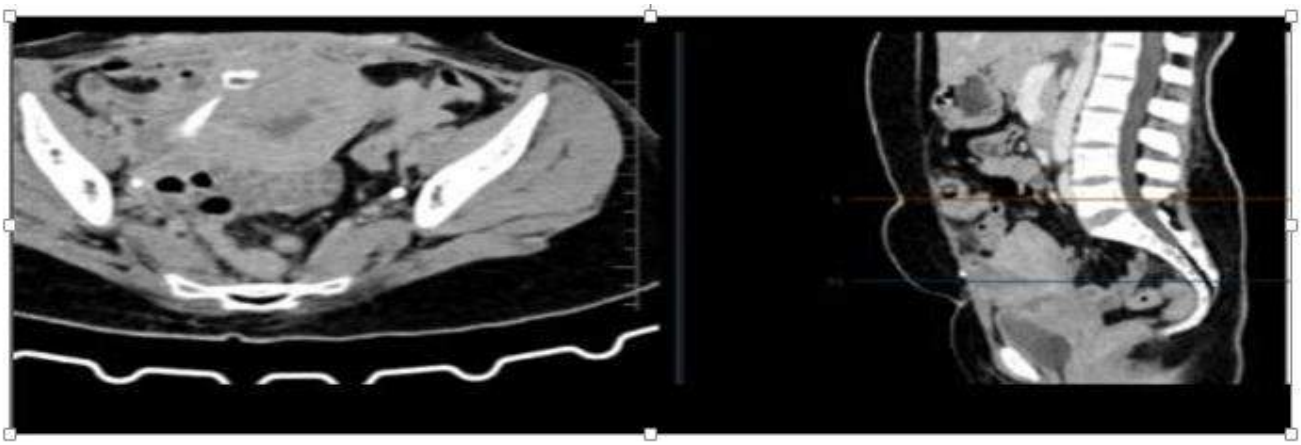
Extensive consolidative airspace opacities involving right upper lobe, apical basal segment of right lower associated with a large thin walled air containing pulmonary cystic lesion measuring 6 x 4.6 cm (pneumatocele) – *represents lobar pneumonia with post infectious pneumatocele.*

Multiple tiny pneumonic infiltrates involving bilateral apical basal segments of the lower lobes.



Marked cystic bronchiectasis predominantly localized bilateral upper lobes anterior segments, right middle lobe, lingula, anterior and apical basal segments of left lower lobe demonstrating intrabronchial air fluid levels along with mucus plugs and multiple tiny pneumonic infiltrates in bilateral upper, lower lobes – *likely suggestive of allergic bronchopulmonary aspergillosis (ABPA) versus ? infective etiology*

Recommend eosinophil count, anti aspergillus iGg, ESR, follow up

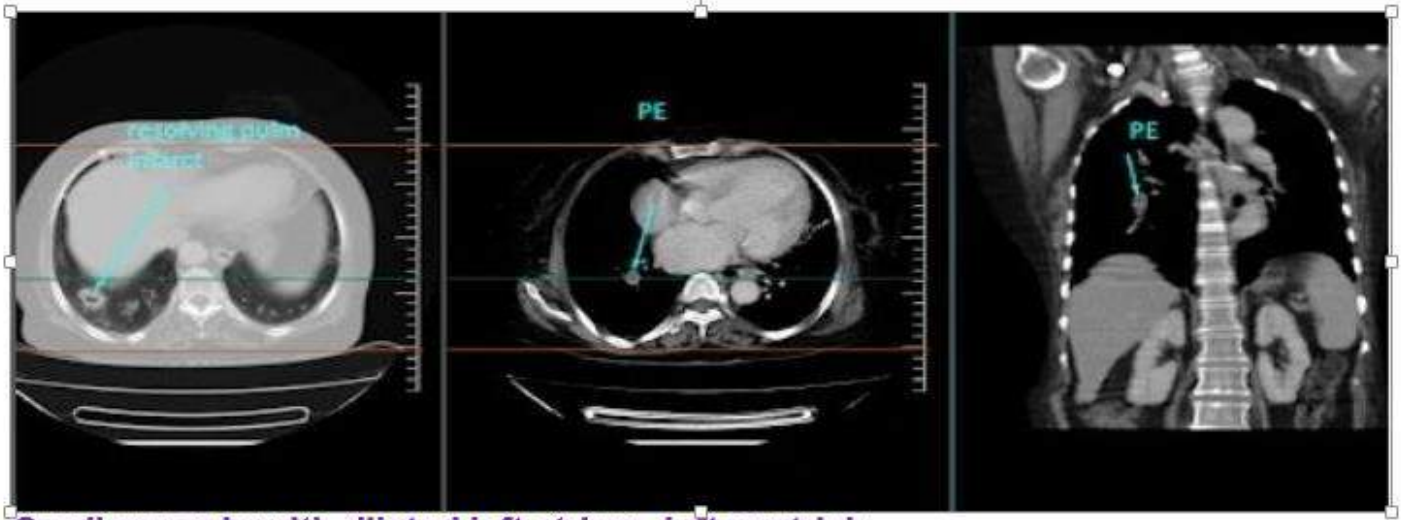


An involuting enlarged uterus is again noted with status post LSCS with percutaneous draining catheter in place.

There is interval resolution of intravesical hematoma since prior study

Thickened deformed postero-superior bladder wall is again noted with scarring

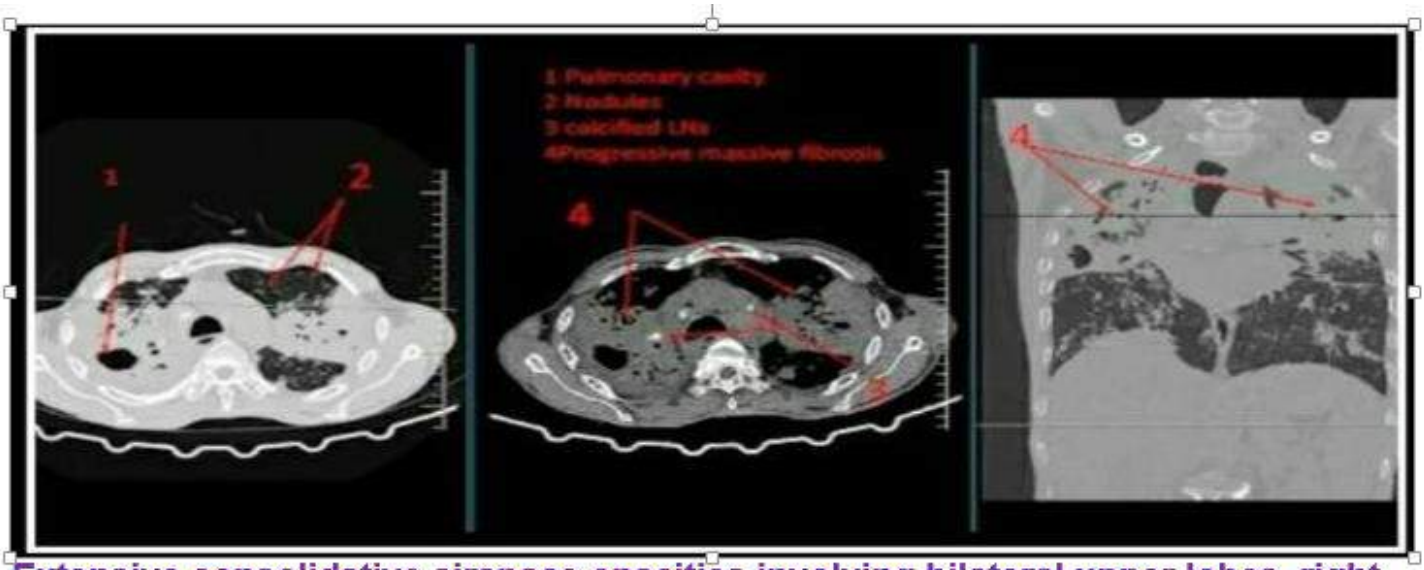
Small focal parametrial fluid collection anterior to uterine fundus demonstrating opacification with bladder contrast on delayed scan – *suggesting utero-vesical fistula .*
**No evidence of intraperitoneal extra vasation of IV contrast in this study. No evidence of free fluid in this study*



Cardiomegaly with dilated left atrium, left ventricle.

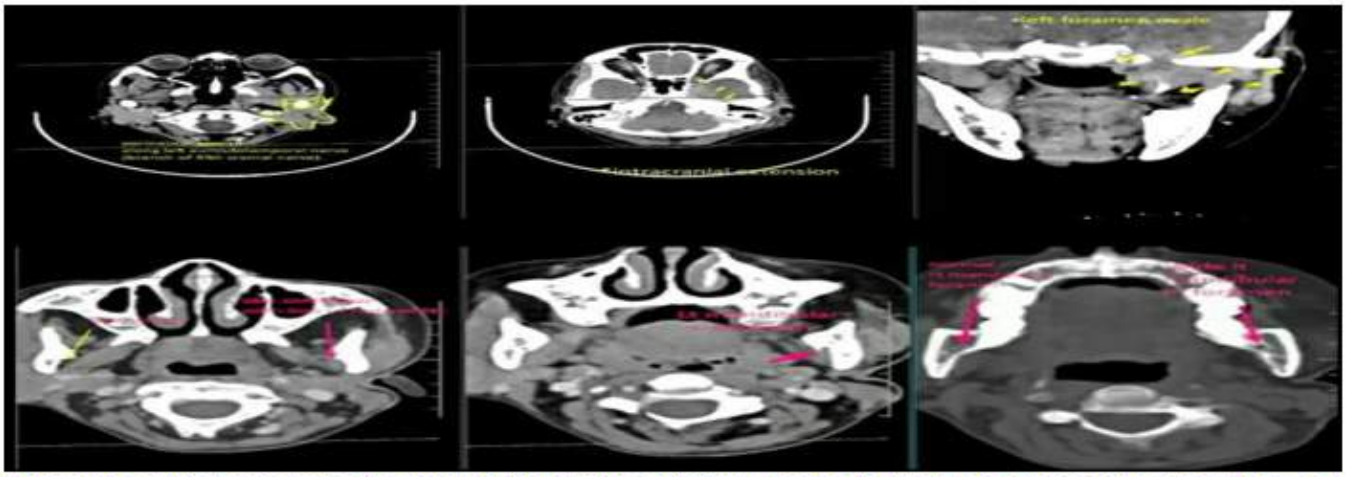
A small filling defect involving the right lower lobar branch of pulmonary artery – *suggestive of pulmonary embolism , likely chronic.*

An approximately 2.5 x 1.5 cm right lower lobe subpleural pulmonary nodule demonstrating tiny central cavitation associated with mild bronchial dilatation in the right lower lobe – *related to pulmonary infarct of indeterminate age.*



Extensive consolidative airspace opacities involving bilateral upper lobes, right middle lobe, apical basal segments of bilateral lower lobes demonstrating multiple thick walled internal pulmonary cavitations associated with multifocal soft tissue attenuation conglomerating lesions in the upper lobes with minimal traction bronchiectasis, along with multiple tiny nodular airspace opacities scattered randomly in the lungs bilaterally with upper lobe predominance - **likely suggestive of silicosis with superimposed tuberculous infection*.*

Multiple calcified mediastinal lymph nodes (egg shell calcification) stop as described above



Adenoid cystic carcinoma of parotid gland with perineural spread along left auriculo temporal nerve, V CN in to foramen ovale and left mandibular nerve.

Status post left superficial parotidectomy.

An extensive irregularly marginated infiltrative heterogeneously enhancing mass lesion involving the deep lobe of left parotid gland, extending medially

, partially encasing the left IJV with anterior extension into the left masticator space as described – ***consistent with Known case of adenoid cystic carcinoma of left parotid gland.***

Anterior aspect of the mass lesion is encasing the posterior cortex of left

condylar process, ramus of mandible with a thick curvilinear soft tissue along the posterior cortex of left condylar process of mandible, suggesting perineural spread along left auriculotemporal nerve (*branch of fifth cranial nerve).*

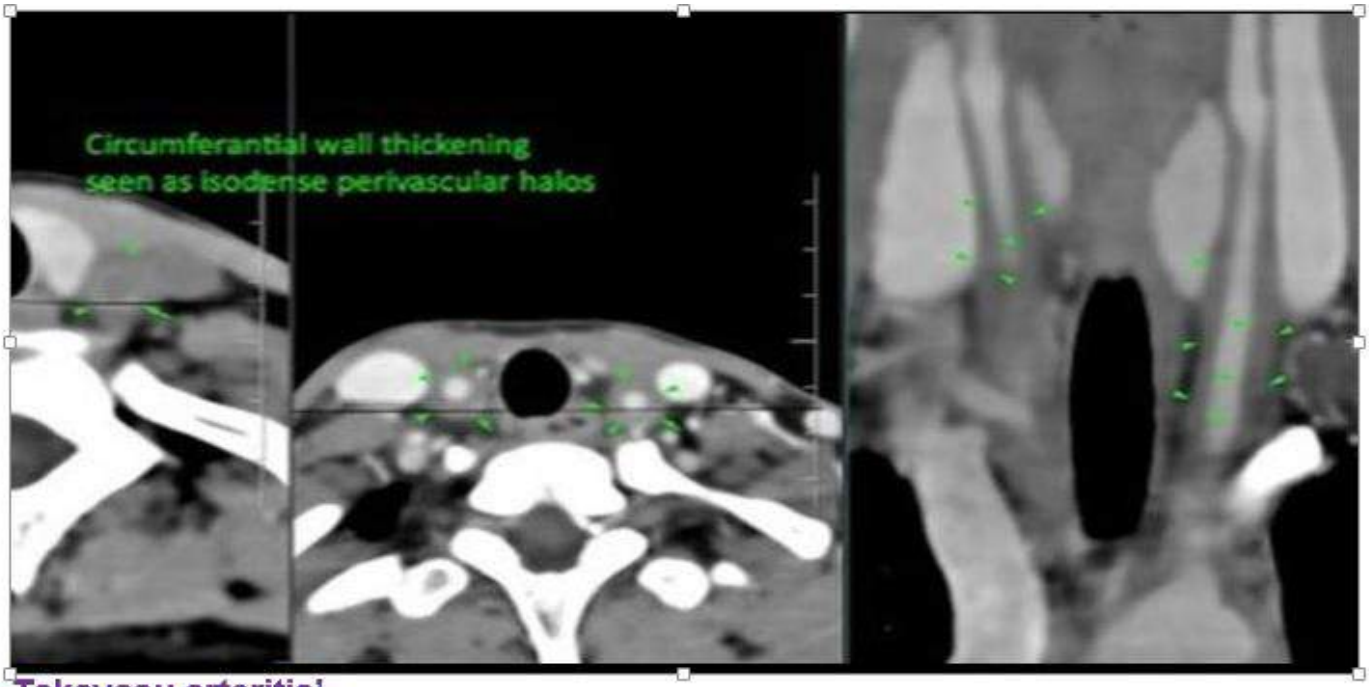
Superior extension along the course of left auricular temporal nerve, 5th cranial nerve extending into the left foramen ovale causing mild widening of the foramen.

Further *intracranial extension of the mass is noted involving the left medial inferior temporal epidural space causing encasement of the left cavernous ICA with mild vasogenic edema involving the left temporal lobe.

Left mandibular foramen is slightly enlarged, suggesting early inferior perineural spread along left mandibular nerve .

The left submandibular gland is surgically absent.

Recommend clinical correlation, PET scan, follow up.



Takayasu arteritis'.

Marked long segment circumferential wall thickening of bilateral common carotid arteries, the right brachial cephalic trunk *(seen as circumferential isodense Halos around the vessel walls) causing* segmental arterial luminal narrowing approximately by 20%-30% - *likely suggestive of large vessel vasculitides such as 'Takayasu arteritis' versus ? carotidynia.*

Bilateral carotid bifurcations, ICA appear grossly unremarkable to the extent visualized. Bilateral IJV are within normal limits.



Mucinous adenocarcinoma of the rectum with Psammomatous calcifications

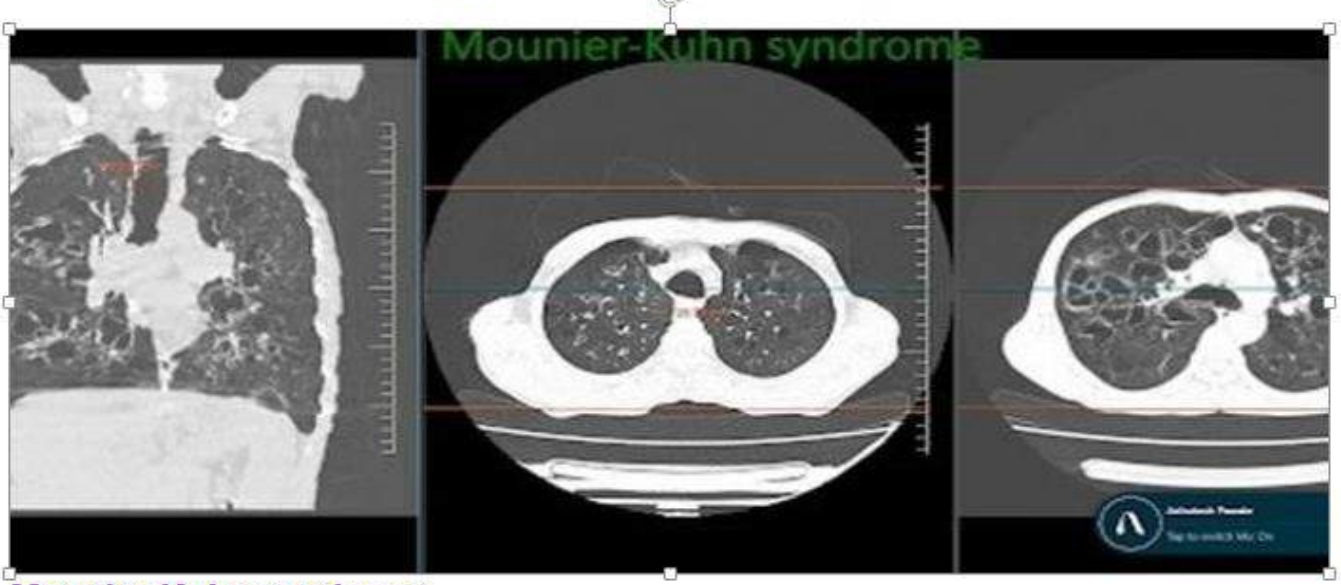
Marked asymmetric circumferential mural thickening of the rectum extending caudally to involve the proximal anal canal across the anorectal junction, over an approximate length of 12 cm and maximum thickness of 3.4 cm at the anterior wall, demonstrating predominant low attenuation areas in the submucosal space associated with numerous tiny psamomatous calcifications - *of concern for rectal carcinoma, likely mucinous adenocarcinoma of the rectum with psamomatous calcifications*

Evidence of early transmural infiltration of the muscularis propria involving the mesorectal space predominantly on the left.

Rest of mesorectal space is clear. The mesorectal fascia (CRM) appears

normal. No evidence of significant perirectal or pelvic lymphadenopathy.

No CT evidence of large bowel obstruction in this study. No evidence of fistula formation. No evidence of free fluid.



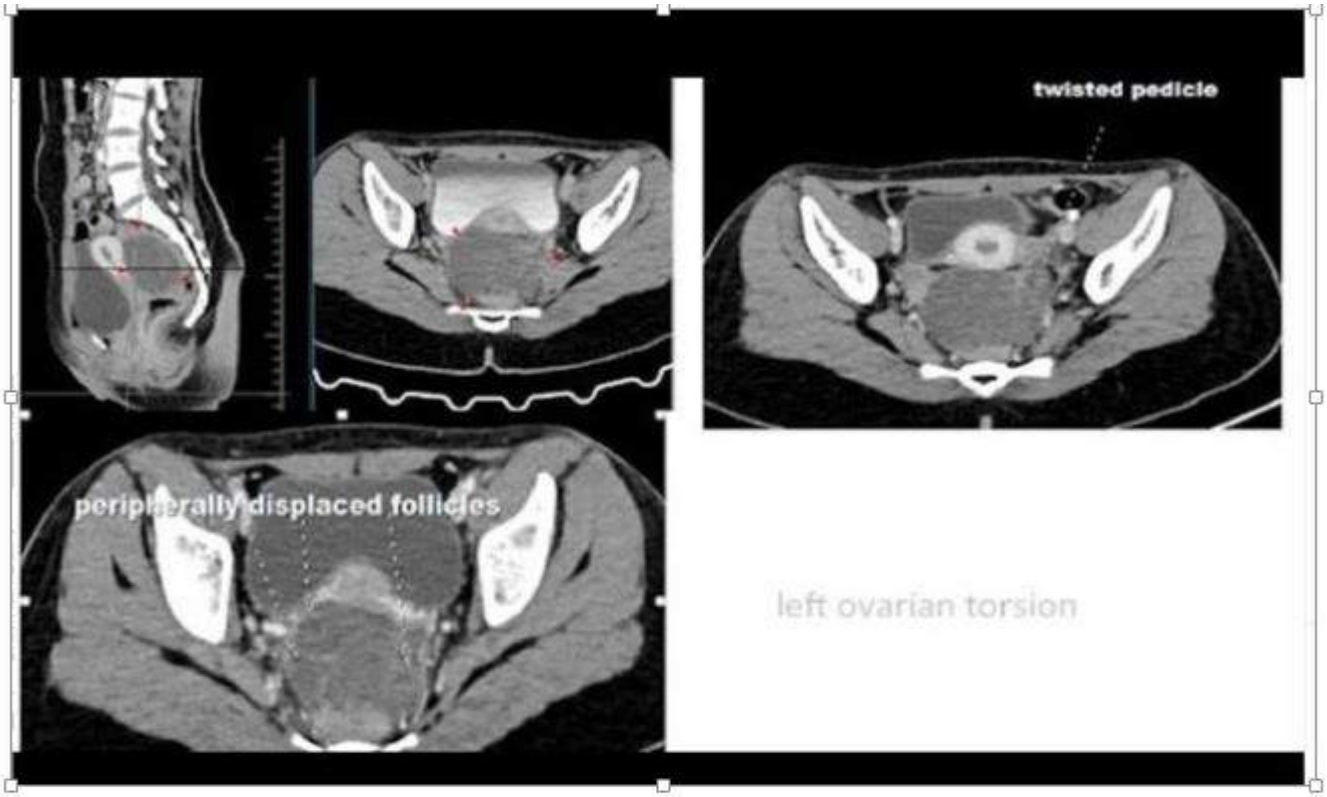
Mounier-Kuhn syndrome

Extensive cystic bronchiectasis in bilateral upper, lower lobes, right middle lobe with predominant central distribution associated with markedly dilated trachea and major air ways as described above – *likely suggestive of Mounier-Kuhn syndrome*.

No evidence of obvious intrabronchial mucus plugs in this study.

A few tiny nodular airspace opacities in bilateral upper, lower lobes likely suggestive of pneumonic infiltrates.

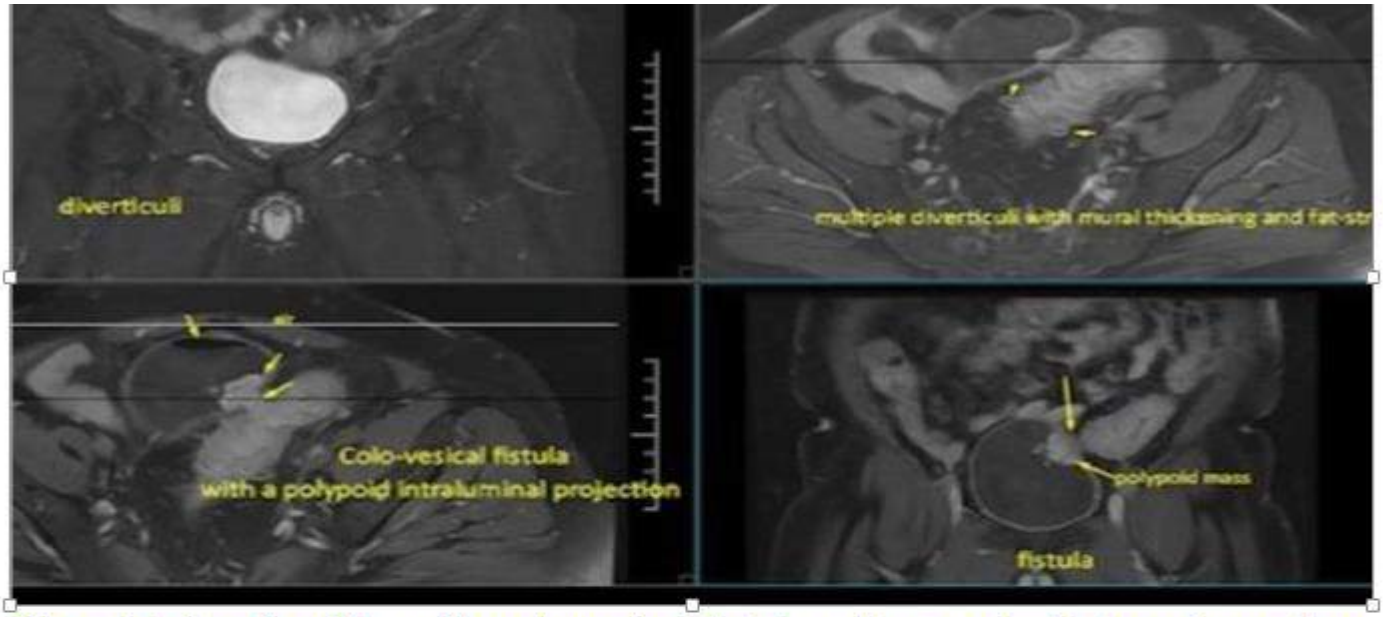
Recommend clinical correlation, further evaluation, follow up



Ovarian torsion

Enlarged , edematous left ovary in the pouch of Douglas, demonstrating peripherally displaced follicles, small hemorrhagic foci, displacing the uterus anteriorly associated with a thick twisted pedicle arising from the left lateral wall and extending toward the left lateral wall of uterus – *represents left ovarian torsion*.

Trace free fluid in the cul-de-sac. No evidence of associated mass lesion



Sigmoid diverticulitis. with colovesical fistula with neoplastic transformation

Multiple sigmoid colon diverticuli with marked circumferential long segment mural thickening of distal descending colon, sigmoid , rectosigmoid colon demonstrating paracolic mesenteric fat stranding – *represents sigmoid diverticulitis.*

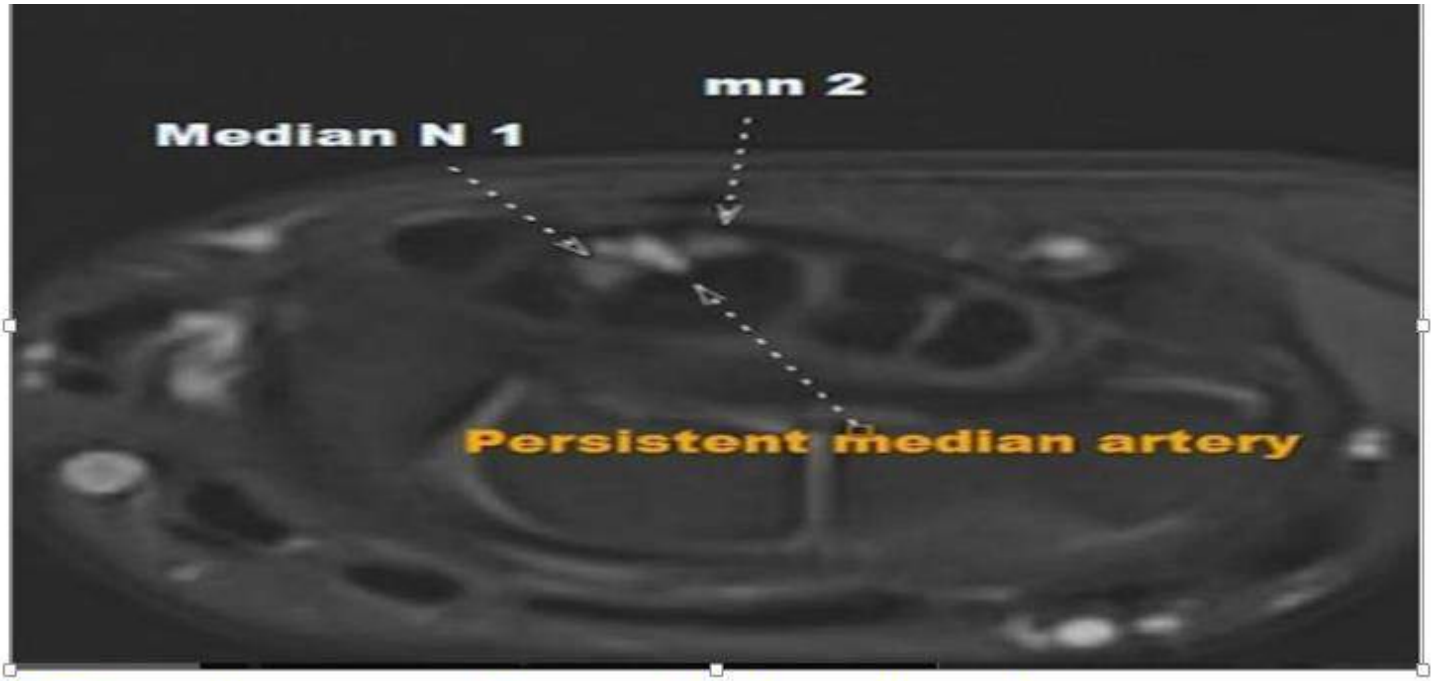
Abnormal communication between the left lateral wall of urinary bladder and medial wall of sigmoid colon– *suggestive of colovesical fistula*

3.0×2.5 cm heterogeneously enhancing polypoid mass lesion is noted protruding into the bladder lumen from the left lateral wall at the point of vesical opening of fistula – *of concern for neoplastic etiology*

Small intravesical fecal debris with tiny air loculi

atanterior aspect. No evidence of significant

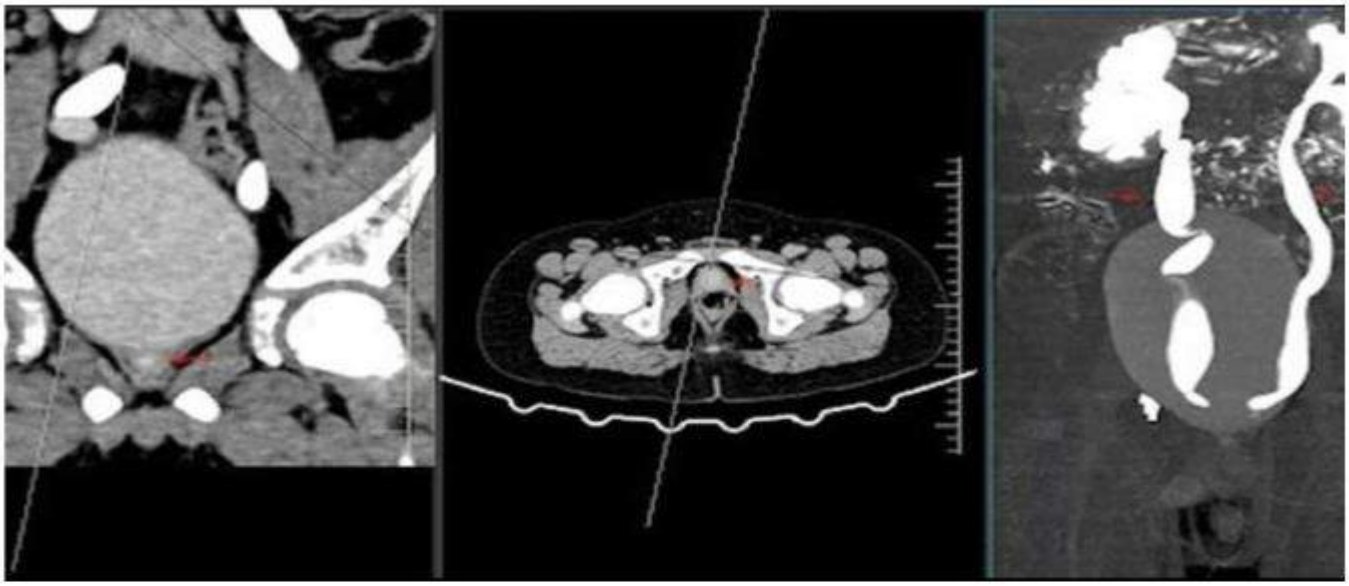
lymphadenopathy.



Bifid median nerve with persistent median artery

Suspicious bifid median nerve is noted with evidence of persistent median artery between the two bundles (evaluation is limited due to lack of T1, T2 axial sequences) with slight volar bowing of the flexor retinaculum at this level – ***Recommend axial T1, T2 thin sequences***

Recommend clinical correlation in view of carpal tunnel syndrome , contra lateral wrist MRI



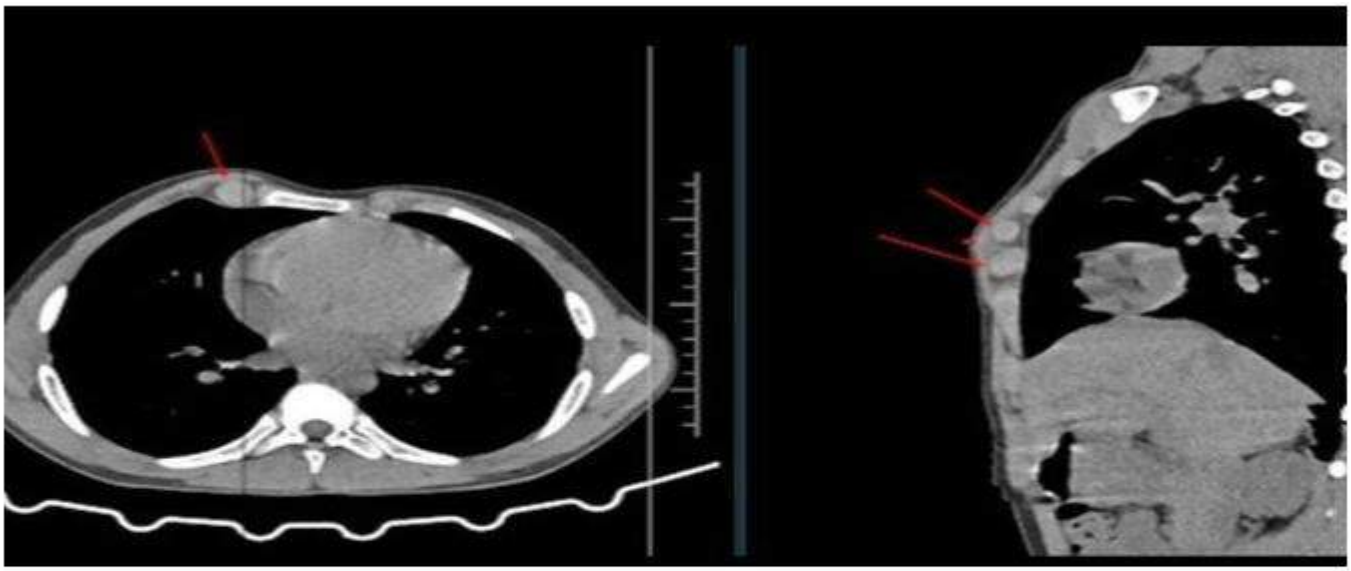
Late Presenting Posterior Urethral Valves / Urethral Stricture with bilateral vesicoureteral reflux.

Moderate right and mild to moderate left hydroureteronephrosis with markedly dilated and tortuous bilateral ureters up to the level of UV junctions associated with markedly distended urinary bladder demonstrating dilated proximal urethra *likely suggestive of late presenting posterior urethral valves / urethral stricture with bilateral vesicoureteral reflux.*

Minimal parenchymal loss of the right kidney. No perinephric collection or fat stranding.

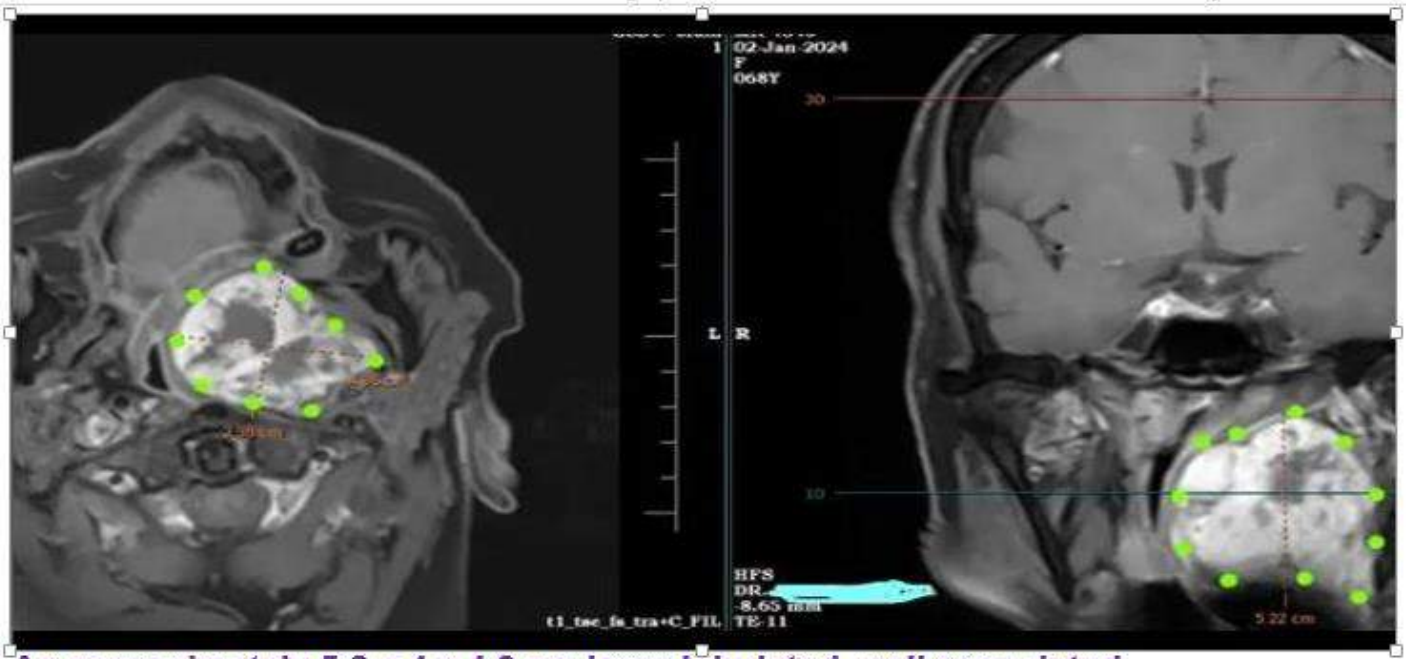
Prompt CT nephrograms and renal IV contrast excretion bilaterally.

Recommend clinical correlation, urethrography as indicated clinically



TEITZE SYNDROME

Focal cartilage thickening at the level of right fourth, fifth sternocostal joints with overlying subcutaneous soft tissue thickening – *likely suggestive of inflammatory costal cartilage hypertrophy (Tietze syndrome).*



An approximately 5.2 x 4 x 4.8 cm large lobulated, well capsulated heterogeneously enhancing mass lesion involving the 'left parapharyngeal space' and demonstrating multiple irregularly marginated internal cystic spaces protruding medially causing oropharyngeal luminal narrowing – *represents neoplasm, likely a trigeminal Schwannoma versus ? pleomorphic adenoma*.

The mass is preserving surrounding fat planes without invasion of surrounding neck spaces.

Superiorly the mass is extending up up to the level of left nasopharyngeal space. The high infratemporal fossa is spared.
Recommend HPE correlation, follow up



CT LEFT UPPER LIMB ANGIOGRAPHY

Short segment filling defect involving the left subclavian artery just distal to its origin , extending to origin left vertebral artery – possibility of resultant subclavial steal phenomenon cannot be ruled out.

Abrupt termination of the proximal left brachial artery, 4.5 cm distal to the level of left gleno-humeral joint with 100% luminal diameter reduction – suggestive of steno-occlusion

Complete lack of flow signal intensity along the entire course of left brachial

artery. Recommend clinical correlation, follow up.