



Christenson, Alan (MRN 56462699) Encounter Date: 07/16/2019

**PET SKULL BASE MID THIGH W ATTENUATION CT INIT TX**

Order: 1069079998

Status: Final result Visible to patient: Yes (MHO) Next appt: Today at 10:40 AM in Pulmonary Medicine (Pramod B Krishnamurthy, MD) Dx: Malignant neoplasm of lower respirato...

**Details**

Reading Physician  
Murao, John D, MD

Reading Date  
7/16/2019

Result Priority

**Narrative**

**CLINICAL HISTORY:** Squamous cell lung cancer right lower and right middle lobes, 2016. With surgery and radiation therapy at Stanford Hospital. Tracheal nodular recurrence, November, 2017. Now with hemoptysis. Bronchoscopy, 06/26/2019 revealed right mainstem partial stenosis with granulation and inflammation. Persistent squamous cell carcinoma.

**COMPARISON STUDIES** : None. Previous PET CT scans unavailable for direct comparison. Correlate with most recent CT thorax studies 03/25/2019 09/20/2018 and earlier.

**TECHNIQUE:** The patient's blood glucose was 121 mg/dL at the time of FDG injection. Approximately 60 minutes following the intravenous administration of 9.5 mCi of 2-(F-18) fluoro-2-deoxy-D-glucose (FDG), PET/CT images were acquired from the mid skull to proximal thighs. Low dose, unenhanced CT images were reconstructed at 3 mm slice thickness, provided for anatomic localization and attenuation-correction of the PET data.

**REPORT:**

**Head and Neck:** There is soft tissue and/or retention cysts or polyps in the anterior margin of both maxillary antra larger on the left than right but without suspicious hypermetabolic activity. There are no abnormally enlarged lymph nodes or masses. Physiologic activity in the vocal cords tongue and tonsillar pillars. Thyroid gland is diminutive with no suspicious hypermetabolic activity.

**Chest:** Currently, no abnormal endobronchial abnormalities detected within the tracheobronchial tree. There is essentially marked narrowing and occlusion of the bronchi to the posterior

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is normal. The appendix is normal. Physiologic activity displayed throughout the gastrointestinal tract.

Musculoskeletal: Advanced degenerative changes along the entire spine. Degenerative changes of the right hip. Status post left hip replacement. Degenerative changes of the sacroiliac joints. Scoliosis of the lumbar spine concave to the right. There is a blastic focus in the right lamina of T3 without suspicious hypermetabolic activity. There is a focus of conspicuous increased metabolism affiliated with the spinous process of 5 which shows either a remote fracture fragment or relatively recent abnormality. Correlate with patient's history.

#### Impression

##### IMPRESSION:

1. Confluent postsurgical changes and soft tissue, medial right lower lobe displaying low-level metabolism. This is nonspecific and may represent postsurgical changes. Local recurrent or residual disease cannot be excluded. Of note, no appreciable change in appearance when compared to the sequence of 2 most recent CT thorax studies.
2. Interval decrease in size of reticular nodular focus in the lateral right upper lobe with maintenance of low-level metabolism.
3. Interval appearance of a reticulonodular area of hypermetabolic activity, medial left lower lobe. This has an appearance of an inflammatory/infectious process however neoplasm cannot be excluded. Interval surveillance recommended.
4. No significant change in the loculated pleural effusion, inferior medial right hemithorax.
5. No evidence for distal metastatic disease.
6. Mild cardiomegaly with coronary artery and valvular calcifications.

Total Exam Dose Length Product 677.4 mGy-cm.

Electronically Signed by: John D Murao, MD7/17/2019 5:00 PM

Specimen Collected: 07/16/19 10:51  
Last Resulted: 07/17/19 17:00

Order Details View Encounter Lab and  
Collection Details Routing Result History -  
Result Edited

#### Scans on Order 1069079998

Scan on 7/16/2019 0942 by Bernal, Robert: Docs from El Camino Hosp

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and medial subsegments of the right lower lobe featuring coarse calcifications and low-level hypermetabolic activity in the postobstructive collection of either subsegmental atelectasis collapse or fibrosis, SUV composite 3.2. There is adjacent biconvex loculated pleural fluid in the medial right lower hemithorax. There are coarse reticular opacities in the apex of the right upper lobe. The nodule in the lateral right upper lobe is decreased in conspicuity compared to March with an SUV of 2.0.

Subpleural atelectasis or scar in the lateral mid lower right hemithorax again noted without suspicious hypermetabolic activity. There is a new heterogeneous mixed reticular nodular and acinar opacity in the medial left lower lobe displaying hypermetabolic activity, SUV 5.5. The left upper lobe shows no new focal parenchymal abnormality. Limited additional groundglass opacity and atelectasis in the left lung base without suspicious hypermetabolic activity. No intervening pneumothorax.

No left pleural effusion. No new axillary or supraclavicular adenopathy. No conspicuous soft tissue at either side of the thoracic inlet. Scant fluid and superior recesses of the pericardium no abnormally enlarged mediastinal or hilar lymph nodes have developed. Indeed, no suspicious hypermetabolic activity above background. The heart is enlarged with valvular and coronary artery calcifications. No conspicuous new pericardial epiphrenic or cardiophrenic abnormality.

Abdomen/Pelvis: The liver features a punctate dystrophic calcification in the dome of the right lobe. No new focal abnormalities or suspicious hypermetabolic activity. The spleen is normal. No intrinsic hyperdensity in a mildly hydropic gallbladder. Adrenal glands are normal without suspicious hypermetabolic activity. The pancreas is mostly fatty replaced without suspicious hypermetabolic activity. Kidneys unremarkable with physiologic excretion into the collecting systems. There are some calcific atheromatous changes of the abdominal aorta. Single subcentimeter right retrocrural lymph node without suspicious hypermetabolic activity. No additional abnormally enlarged peritoneal adenopathy. Small fat filled indirect inguinal hernias. No mesenteric adenopathy. No definite omental pathology. Tiny fat filled umbilical hernia. Urinary bladder is decompressed. Seminal vesicles grossly symmetric. Prostate gland mildly prominent without suspicious hypermetabolic activity. Much of the low pelvic anatomy is obscured by streak and beam hardening artifact from a left hip replacement. The gastrointestinal tract is limited by the absence of endoluminal contrast. Hiatal hernia with paraesophageal component. Stomach antrum duodenum and proximal jejunum normal. No abnormal distended segments of small bowel. Few scattered diverticula of the proximal sigmoid colon without evidence for diverticulitis. No other eccentric mural abnormalities. The ileocecal junction

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