Patient:	**Melissa Gardiner**	**Patient ID:**	**8133179**
DOB:	**28/02/1967**	**Referring Dr:**	**Dr Ryan De Freitas fax:**
Patient Address:	**2 WEBB STREET BUNYIP VIC 3815**		
Examination:	**PET Head and Neck - Staging**	**Accession No.:**	**50005984673**
Date Performed:	**04/02/2020**	**Site Performed:**	**Moorabbin Hospital**

Dear Dr Ryan De Freitas. Thank you for referring Ms Melissa Gardiner to Monash Imaging.

CLINICAL INDICATION:
Left floor of mouth SCC T1 NO and right tongue SCC T1N1. Synchronous tumours treated with surgery only right neck dissection. Now recurrence in left level 2. SCC on core. No primary seen on examination.

TECHNIQUE:
FDG PET scan was performed from the skull vertex to upper thighs on our combined PET/CT scanner, following intravenous administration of 223 MBq of F-18 FDG. Contemporaneous low dose, non-contrast, CT scan was performed for purposes of attenuation correction and anatomical localisation.
Uptake Time =92 minutes. BSL = 5.1 mmol/L.
COMPARISON: Correlation is made with previous FDG PET/CT from July 2017.

FINDINGS:

Orophaynx:
Intense FDG-uptake is present within a left tongue base mass (SUV max 17.2) which partially effaces the left vallecula, consistent with a new primary malignancy. The mass measures approx 15mm trans x 13mm AP x 12mm SI.

Nasopharynx:
Markedly increased midline nasopharynx FDG-uptake (SUV max 9.7). Soft tissue fullness is appreciated at this site.

Nodal Disease:
Conglomerate intensely avid left level 2 and 3 nodal metastases (SUV max 26.9) measuring 50mm in maximal diameter (superior-inferior oblique). Suspected extracapsular extension, which would be better assessed with contrast-enhanced CT.
Moderately avid (SUV max 4.7) left submandibular node measuring 15mm x 7mm.
Mildly avid non-enlarged nodes between the left common carotid and left internal jugular vein (marked with arrow on savescreen).
Mildly avid non-enlarged supraclavicular nodes.
Previous right neck dissection. No concerning uptake in the right side of the neck.
Mildly avid subcarinal and bihilar nodes may be reactive.
Impression of a mildly enlarged, mild avid portocaval node, similar in appearance and avidity to the study from 2017.

Distant Metastatic Disease:
No FDG-avid distant metastatic disease.

Further Findings:
No suspicious lung nodule or mass.
There is physiological uptake within the abdominal and pelvic viscera. No bowel mass.
No concerning marrow uptake.

Lab. Reference: KNX1271106-CT Chest
Requested By: DR TATYANA RODINOV
Requested: Tuesday, 5 March 2024
Performed: Wednesday, 6 March 2024
Test name: CT CHEST ABDOMEN PELVIS +/- NECK WITH CONTRAST
Provider name:

Apollo RIS Patient Id : RVC776076
Patient Name : FRASER TONY **DOB :** 11/11/1955 **Service Date :** 06/03/2024

CT NECK, CHEST, ABDOMEN AND PELVIS

CLINICAL NOTES:
Suspicious lymph node enlargement in the neck? Lymphoma? Other.

TECHNIQUE:
Low-dose contrast-enhanced multiplanar imaging through the neck chest abdomen and pelvis extends from skull base to symphysis pubis.

FINDINGS:
The pulmonary parenchyma is unremarkable. There is no pulmonary nodule or mass, or area of consolidation. The pleural recesses are clear. Mediastinal structures are normal. There is no central pulmonary embolus. There are no enlarged lymph nodes in the chest or axilla.

Liver size and density is normal. There is no focal hepatic lesion. Gallbladder and bile ducts, pancreas, spleen, adrenals, and kidneys are normal.

Pelvic viscera, large, and small bowel appear normal. There is no intra-abdominal mass or free fluid. There are no enlarged abdominal, pelvic, or inguinal lymph nodes.

In the neck, there is a large necrotic posterior triangle lymph node seen superiorly on the right the level of C2/C3. It measures 41 x 33 mm trans axially. Other smaller abut abnormal necrotic lymph nodes are seen in both the deep cervical chain and posterior triangle further caudally on the right extending to the thoracic extending to the lower neck.

There is the impression of a mass centred in the right vallecula, just crossing the midline anteriorly and extending down the right aryepiglottic folds. No lateral extension. Pharyngeal mucosa, salivary glands, oral cavity structures, and thyroid are normal.

The visualised intracranial contents are normal. No malignant osseous lesion is identified.

CONCLUSION:
Findings most in keeping with primary hypopharyngeal SCC with necrotic metastatic lymph nodes in the right deep cervical chain and posterior triangle. No other evidence of disease. The lymph nodes are amenable to