**Shilan Health Services**

**Summary of Imaging Exam Interpretation**

**Professor Idit Merom**

**Date: 17 March 2020**

**Patient’s name**: Masasa Ayela

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**Purpose of consultation:**

Interpretation of Chest CT of March 17, 2020 with a question of response to treatment.

**Background:** Celiac disease and asthma. In April 2019, was diagnosed as suffering from adenocarcinoma in the RLL with lymphangitic dissemination to the lungs, and dissemination to the liver and brain.

**The interpretation was given for the Chest CT exam of Marc 17, 2020**

**Comparison to exams:**

Chest CT April 15, 2019

Chest abdomen and pelvis CT April 22nd, 2019

Chest abdomen and pelvis CT June 25th, 2019

FDG PET-CT, September 1st, 2019

Chest abdomen and pelvis CT November 13th, 2019

FDG PET-CT, February 9th, 2019

**Imaging method:** Chest CT without injection of contrast agent.

**Technical remark**: the present exam, which is a dedicated chest CT, was performed according to accepted practice, during the inspiratory phase in slices of 1 mm whereas the exam to which it is compared, the PET-CT of Feb. 09, 2020 in the lung window, was performed in thin slices of 1.2 mm during the expiratory phase according to accepted practice, and in addition, there are respiratory movements.

**Findings**:

Thyroid: appears normal.

Lungs**:** bilateral pulmonary nodules, too numerous to count, with lymphangitic dissemination in the interlobular septa and along the fissures. Due to the differences in imaging (see technical remarks above), we are unable to exactly measure the fine differences. Despite this, there is exacerbation. The exacerbation is expressed primarily by numerous minute nodules which grew, for example, along the minor and major fissures in the rt. lung, slice 3-128 or in slice 3-140, or in nodular nodules which appear to have progressed in the interlobular septa such as in the upper lt. lung, slice 3-90, peripheral nodules adjacent to the isthmus, 8 mm in circumference in slice 3-65 which measured 5 mm in the previous exam, or in the increase of minute nodules in the periphery of the lower lobes together with septal thickening which is increasing in the lower lungs. However, the new nodules, when making a comparison to Nov. 13, 2019, there is no recurrence of the initial infiltrative mass which was observed in the exam of Apr. 22, 2019 and involved the rt. middle and lower lobe.

Lymph glands: no lymphadenopathy in the isthmus, pulmonary hila, or axillae.

Breasts: appear normal.

Pleura: no pleural effusion and no pericardial effusion.

Cardiovascular: there is minimal coronary calcification in the LAD origin without calcifications in the remainder of the coronaries. The heart is normal in size. Diameter of the ascending aorta 3.5 cm without change. Diameter of the main pulmonary artery normal.

Upper abdomen: assessment of metastases in the upper abdomen is limited because contrast agent was not injected. However, even with this limitation, no metastases are seen in the liver or spleen. The lt. adrenal appears normal. Nodule in the rt. adrenal 1.6\*1.1 cm in diameter, without changes. 22HU was measured. Partial imaging of lymph glands smaller than 1 cm posterior to the lt. renal vein, stable.

Bones: since contrast agent was not injected, the assessment of dissemination to the thecal sac at level D1-D2 observed in the previous FDG-PET-CT exam where contrast agent was injected, is limited in today’s exam.

In summary:

1. . Within the technical limitations of comparison of today’s exam with that of the previous exam, performed using a different technique, there is progression of the pulmonary lymphangitic disease, but which cannot be measured according to RECIST criteria. However, it appears that the rate of exacerbation was slowed when comparing the rate of progression of Nov. 13, 2019 to that of Feb. 09, 2020.
2. In regard to the known metastasis demonstrated at level D1-D2 on Feb. 09, 2020, indeed, the protocol of today’s exam cannot assess it and there is need for a directed exam with contrast agent for this purpose.

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