

Patient Loc : CCMR
Status : 0
Loc at Sched : CCMR

D0569179

LORENA,
DOB : -1958 Sex : F

ROOSEVELT DIVISION
COLOMBUS CRICLE PET

Radiology Consultation

Physician:
WANG, JOHN
426 WEST 58th St.
GROUND FL.
NEW YORK

NY 10019

3372530 21 - Jul - 2008 12 : 23 PM Requested by: John Wang
PET MISCELLANEOUS TUMOR IMAGIN / LOCM 100CC

Clinical Information : **Metastatic pancreatic carcinoma.** The patient received chemotherapy (February 2008). Prior PET/CT in **May 2008 revealed the hypermetabolic mass in the head and body of the pancreas, hypermetabolic abdominal lymph nodes and metastatic peritoneal implants.** A follow-up evaluations.

Description:

Approximately 60 minutes after the intravenous administration of 13.5 mCi of FDG, whole body PET/CT imaging was performed. The patient's blood glucose level was 91 mg/dl at the time of injection of FDG. IV Contrast was not administered prior to the CT portion of this examination. The patient received oral contrast.

Images from prior PET/CT dated 5/5/2008 are available for review.

Unless otherwise indicated, any anatomic image numbers referenced below represent axial CT images on PACS.

Unless otherwise indicated, any functional image numbers referenced below represent axial PET images on MIM PET/CT Workstation.

Head/neck:

There is **no abnormal hypermetabolism involving the parenchyma of the brain.** There is no midline shift, or mass effect on this

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nondedicated evaluation. The orbits are symmetric without abnormal preseptal or retro orbital soft tissue.

There is **no evidence of any hypermetabolic or radiographically significant lymph nodes in the neck.** Evaluation of the visualized aerodigestive tract is unremarkable. The thyroid gland again appears heterogenous in attenuation. The skull base appears grossly unremarkable. Sinuses are clear. The major salivary glands are symmetric in appearance. There is **no focal abnormal hypermetabolism in the neck.**

Chest:

There is a portacath to the superior vena cava. The superior mediastinum has **no mass of enlarged lymph nodes.** Hila and heart size are normal. The central tracheobronchial tree is patent. There is **no consolidation or focal mass.** There is **no pleural thickening or pleural effusion.** There is **no focal lateral hypermetabolism in the chest.**

Abdomen:

The **liver is normal in size.** Evaluation for focal mass is difficult in absence of intravenous contrast. There is air in the bile ducts and a common duct stent from the porta to the duodenum. The intrahepatic ducts are mildly dilated. The gallbladder is moderately distended, up to 3 cm in width over a length of a 7 cm similar to the prior examination.

The spleen is mildly enlarged, unchanged. There is redemonstration of extensive soft tissue density in the region of the pancreas, which is difficult to define due to the absence of surrounding fat. It involves most of the pancreas, most apparent anteriorly and posteriorly obscuring the fat around the celiac

axis and central mesenteric vessels. On the functional images,

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there is again heterogeneous **multifocal hypermetabolic activity**, maximal **SUV ranging 1.8 - 2.1, previously 2.9 - 3.2.** In addition to decreasing SUV values, the **metabolic activity is less extensive in the current examination.** Anatomic measurement and comparison with prior study is difficult due to the poorly defined margins but the anteroposterior diameter is between the anterior aspect of the mass and abdominal aorta is 4.4 cm compared with 4 cm, image 143.

There are enlarged periaortic nodes that appear larger; for example, a left periaortic node measures 1.2 cm compared with 0.7 cm, image 163. **This lymph node is non-hypermetabolic now, in comparison to maximal SUV values of 2.7 previously. There is an 11 mm left periaortic lymph node, image 155. which was inseparable from the descending thoracic aorta in the previous examination** but measured approximately the same size, image 156.

Oral contrast reached the colon. There appear to be nodes in the celiac axis region that indent the gastric wall near the EG junction. There is some infiltration along the proximal root of the mesentery with multiple nodes. There is minimal abdominal ascites.

The kidneys are prominent but no contour deforming lesions. A lower pole small calculus on the right is unchanged. Left kidney is malrotated, unchanged.

Pelvis:

The bladder was empty at the time of the scan. There is some ascites in the floor of the pelvis. The uterus is not enlarged. There is **no adnexal mass on anatomic images. Previously identified hypermetabolic foci suspicious for metastatic peritoneal implants are no longer seen now.** Left common iliac nodes are larger and there may be proximal left external iliac

nodes as well. However, these **lymph nodes do not demonstrate focal abnormal hypermetabolic activity.** Metabolic activity seen in the

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pelvis bilaterally is simply related to physiologic activity in the ureters.

Skeleton:

There are again degenerative changes of the thoracic and lumbar spine. There is **no discrete lytic or blastic skeleton lesion.**

There is **no focal abnormal hypermetabolism in the skeleton.** There is again slightly prominent metabolic activity in the bone marrow.

IMPRESSION:

1. There is again **heterogeneous multifocal hypermetabolic activity associated with a mass in the pancreatic head and body,** consistent with known pancreatic carcinoma. When **compared to the prior examination dated 5/5/2008, this is less extensive in less severe,** as described in detail above.
2. There are **hypermetabolic lymph nodes in the celiac axis, SMA and left paraaortic lymph node chain,** consistent with metastatic lymphadenopathy. **When compared to the prior examination, there is evidence of interval improvement,** as described above.
3. **Previously identified metastatic peritoneal implants in the abdomen and pelvis are no longer seen now.**
4. There is **no anatomic or functional imaging evidence to suggest metastatic diseases in the soft tissues of the neck or chest.**
5. There is **no definite anatomic or functional imaging evidence to suggest skeletal metastatic disease. There is again prominent metabolic activity in the bone marrow, most likely benign, such as due to anemia or a medication effect, such as due to chemotherapy or bone marrow stimulants.**

This study was jointly interpreted by Dr. Munir Ghesani, and Dr. Benjamin Bashist.