

1-9-645, Vidyanagar, Hyderabad - 500044

PET-CT Scan Report**NAME: P YASHODA****PATIENT ID: HNP 25666****AGE/ SEX: 59 YRS /F****REFERRED BY: DR. RAVISANKAR REDDY****DATE: 12 AUGUST 2024****WHOLE BODY PET NCCT SCAN**

Following intravenous injection of 8.5mCi of ^{18}F FDG Whole body FDG PET CT without iv contrast CT scan was performed from the vertex to mid thigh with GE Discovery 600 PET/CT system without breath holding instruction. High resolution CT scan was performed using a dedicated PET scanner with 16 slice/sec MDCT. A separate sequence with breath hold was performed for lung examination. A semiquantitative analysis of FDG uptake was performed by calculating SUV value corrected for dose administered and patient body weight. The blood sugar at the time of tracer injection was 122 mg/dl.

History: Diagnosed case of ascending colon growth- biopsy s/o tubulovillous adenoma with high grade dysplasia, for evaluation.

The overall biodistribution of FDG is within normal physiological limits

Brain: The supra and infra tentorial brain parenchyma appears normal and show normal physiological FDG uptake. No focal lesion or abnormal focal uptake is noted. Atrophic changes are seen.

Sinuses: The bilateral sinuses are well pneumatized shows no abnormal FDG distribution.

Head and Neck: The nasopharynx, oropharynx including posterior tongue, tonsillar fossa, and rest of the hypopharynx shows no abnormal FDG uptake. The supra glottis including epiglottis and aryepiglottic folds, infraglottic larynx and upper trachea shows no abnormal FDG uptake.

The thyroid gland is normal in size and is sharply demarcated and shows homogenous pattern on CT scan shows no abnormal FDG uptake.

No abnormal FDG avid significant cervical lymph nodes are seen.

FDG avid left supraclavicular nodes, largest measuring 1.2 x 1.8 cm (SUVmax 12.2).

Breast: The bilateral breasts shows normal attenuation pattern and show no abnormal FDG uptake. No abnormal FDG uptake is noted in the bilateral axillary region.

Thorax: The heart and mediastinal vascular structures, trachea and both main bronchi appear normal.

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Interpretation of the scan should be done in correlation with the clinical picture and other relevant radiological and laboratory evidence

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Multiple FDG avid nodules in bilateral lung fields. Largest measuring 0.9cm (SUVmax 10.5).

FDG avid paraoesophageal and left perihilar nodes (SUVmax 14.4).

Cystic bronchiectatic changes are seen in the left lung lower lobe.

There is no evidence of pleural effusion.

Abdomen:

FDG avid asymmetrical circumferential wall thickening is seen involving the ascending colon for a length of approximately 3.9 cm with maximum thickness of 1.6 cm (SUVmax of 74.2).

FDG avid discrete and conglomerated retrocaval, aortocaval, para-aortic, bilateral common iliac, mesenteric and nodes in right iliac fossa. Largest conglomerated node in right iliac fossa adjacent to tip of appendix, measures 4.4 x 3.7cm (SUVmax 26.3).

FDG avid subcapsular hypodense lesion seen in segment VII of liver measuring 1.5 x 1.3 cm (SUVmax 44.6).

FDG avid illdefined deposits seen in pouch of Douglas (SUVmax 15.3).

The intra hepatic biliary radicals are not dilated. The portal vein is normal.

The gall bladder is normally distended with no evidence of an intraluminal radio-opaque calculus noted.

The spleen is normal in size and demonstrates physiological FDG uptake. The pancreas demonstrates normal attenuation with no evidence of abnormal FDG uptake.

Both adrenal glands and kidneys appear normal in size, shape and attenuation and FDG uptake. No evidence of hydronephrosis is noted.

The stomach, opacified small bowel and rest of the large bowel loops appear normal in caliber and fold pattern.

Urinary bladder is normal in shape, size and distention.

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The uterus appear unremarkable shows no abnormal FDG uptake.

No abnormal FDG uptake is noted in the bilateral inguinal region.

Skeleton: The bones under survey appear normal and demonstrate no abnormal FDG uptake.

IMPRESSION

HISTORY: Diagnosed case of ascending colon growth- biopsy s/o tubulovillous adenoma with high grade dysplasia, for evaluation.

- Metabolically active asymmetrical circumferential wall thickening is seen involving the ascending colon.
- Metabolically active discrete and conglomerated retrocaval, aortocaval, para-aortic, bilateral common iliac, mesenteric and nodes in right iliac fossa. Largest conglomerated node in right iliac fossa adjacent to tip of appendix.
- Metabolically active subcapsular hypodense lesion seen in segment VII of liver.
- Metabolically active illdefined deposits seen in pouch of Douglas
- Multiple metabolically active nodules in bilateral lung fields.
- Metabolically active left supraclavicular, paraoesophageal and left perihilar nodes
- Rest of the scan findings are negative for any significant hypermetabolic pathology in the regions surveyed. Imaging features suggestive of carcinoma ascending colon with metastatic disease.

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