



Name : MR HARIYA	Bill Number : 10027
Age/Gender : 45YEARS/MALE	Reporting Date : 18-Feb-2025 08:12 PM
Reff By : TANVI SRINU	

DEPARTMENT OF RADIOLOGY AND IMAGING SCIENCE**CT SCAN OF NECK (PLAIN & CONTRAST)****Findings:**

There is evidence of lobulated homogenously arterial enhancing isodense mass with few areas of non enhancing / necrotic areas seen approximately size 5.6x4.6x3.8 cms (AP X CC X TRA) seen in right carotid space abutting sternocleidomastoid muscle laterally causing external contour bulge.

Medially the lesion is abutting carotid arteries and and internal jugular vein.

Anteriorly the lesion is abutting submandibular gland.

Posteriorly the lesion is abutting paraspinal muscle.

No intramural fat density / calcification seen.

Nasopharynx is normal in attenuation.

Oropharynx, hypopharynx are normal in attenuation.

Posterior pharynx, post cricoid hypopharynx and cervical oesophagus are normal in attenuation.

Tongue and intrinsic muscles of tongue are normal in attenuation.

Floor of mouth is normal in attenuation.

Palatine tonsils are normal in attenuation.

Epiglottis, pharyngoepiglottic folds, valleculae are normal in attenuation.

Aryepiglottic folds and pyriform sinuses are normal in attenuation.

Vocal cords are symmetrical and normal in attenuation.

Subglottis is normal.

Parapharyngeal spaces and recesses are normal in attenuation.

Bilateral parotid glands and submandibular glands are normal in attenuation.

The thyroid gland is normal in attenuation. No distinct nodule / focal lesion.

No significant enlarged cervical lymph nodes are seen.

Neck vessels are unremarkable within plain CT resolution limits.



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Soft tissue planes, superficial and deep muscles of neck are normal in attenuation.

Evaluation of the paranasal sinuses reveals no significant sinus inflammatory disease. No air fluid levels are noted.

The central skull base is normal. The central petrous temporal bones and mastoid air cells remain clear.

The visualized base of brain appears unremarkable.

Cervical spine appears unremarkable. No prevertebral or paravertebral lesion or collection seen.

IMPRESSION :

lobulated homogenously arterial enhancing isodense mass with few areas of non enhancing / necrotic areas seen approximately size 5.6x4.6x3.8 cms (AP X CC X TRA) in right carotid space abutting sternocleidomastoid muscle laterally causing external contour bulge.

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No intralosomal fat density / calcification seen.

DDs) 1. Vagal Schwannoma
2. Paraganglioma (less likely)

ADV : MRI -NECK for further evaluation

**DR.M.Praveen Kumar. DMRD,DNB.
CONSULTANT RADIOLOGIST**