



REF./TO : DR. YAU TSZ KOK  
PATIENT NAME : GOHEL, BHARAT  
PATIENT HKID : XD1365172  
SEX/AGE : M/60Y  
EXAM. DATE : 09/10/2015

D.O.B. : 04/07/1955  
REF. NO. :  
CASE NO. : HK1510-00100

## RADIOLOGY REPORT

### **<sup>18</sup>F-FDG PET-CT WHOLE BODY (PLAIN)**

#### **CLINICAL HISTORY:**

Clinically carcinoma of lung with extensive intrathoracic nodal secondaries. Also right ankle numbness of unknown cause.

#### **IMAGING FACTORS:**

PET Radiopharmaceutical	11.9 mCi of <sup>18</sup> F-FDG IVI
Fasting Blood Glucose Level	5.8 mmol/dL
Uptake Time	60 minutes
Body Region Cover (CT)	Dedicated PET-CT diagnostic images from the skull base to the groin
Post-processing	PET, CT & Fusion images reconstructed in axial, coronal and sagittal
SUVmax References	Normal liver: 3.22; Mediastinal blood-pool: 2.62

#### Head and Neck

- Bilateral supraclavicular nodal metastasis seen.
- Hypermetabolic small right cervical level II node could be post inflammatory or metastasis.
- No vocal cord palsy. Symmetrical vocal cords.

Normal uptake at the scanned regions of brain and skull base.

No imaged skull vault or skull base erosions.

Pharyngeal lymphoid FDG activity within physiological limits.

No abnormal soft tissue uptake in the tonsillar region, nasopharynx, hypopharynx or larynx.

No focal FDG-avid thyroid lesion. No thyroid nodule or calcification on CT.

#### Anterior Chest Wall

No hypermetabolic axillary lymphadenopathy.

There is no FDG-avid lesion detected at the anterior wall.

No focal FDG-avid lesion along the internal mammary chain.

#### Thorax

- Hypermetabolic lung mass with lobulated borders at anterior segment of the left upper lobe suggest radiological lung carcinoma. It abuts onto the pleural with local reaction and thickening. No chest wall invasion. No FDG avid pleural mass. No effusion is seen. No cavitation of the lung mass but is due to surrounding para-septal emphysema. The presence of hypermetabolic left lower lobe nodules suggest a pT4 disease.
- Bilateral hypermetabolic lung metastasis seen. The one at right upper lobe anterior segment close to mediastinum is recommended for future comparison.



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The index lesions are summarized as below:

Page	Site	LD x PD or SA (mm)	SUVmax
1	LUL radiological CA lung	37.0 x 29.9	16.65
2	LLL metastasis	14.4 x 7.2	13.82
3	Contralateral lung metastasis RUL anterior segment next to mediastinum	8.8 x 8.4	11.11
4	R supraclavicular LN	22.2 x 13.9	13.55
5	L supraclavicular LN	16.2 x 11.1	25.69
6	L perivascular matted with APW LN	59.5 x 28.2	31.94
7	R paratracheal LN	21.9 x 61.4	25.64
8	Subcarinal LN	43.3 x 43.3	25.61
9	R hilar LN	19.9 x 15.6	7.43
10	L hilar LN	21.8 x 15.6	20.42
11	Right level II cervical lymph node	6.7 x 6.3	12.05

(SUV = Standardized Uptake Value; LD = largest diameter; PD = perpendicular diameter; SA short axis for lymph node)

### SUMMARY:

- Radiological hypermetabolic lung carcinoma, pT4 (different ipsilateral lung nodules).
- Hypermetabolic nodal disease involve at least bilateral hilar, bilateral mediastinal and bilateral supraclavicular stations, pN3. FNAC of left supraclavicular node can be considered.
- Hypermetabolic contralateral lung metastasis, pM1a.
- No other hypermetabolic metastasis shown within the scan range. The axial skeletal or lower limbs metabolic lesion to account for the lower limb numbness. Contrast MRI brain and spine can be considered.
- No SVCO. Mild pericardial effusion of ~10 mm thick. No hypermetabolic pericardial deposits.
- Hypermetabolic small right cervical level II node could be post inflammatory or metastasis.

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