Anatomage Table 9.0 Case Library Descriptions

Case Nun	Case Title	Age	Sex	Notes
1	Brain	unknown	unknown	
2	Shoulder	unknown	unknown	
3	Lupus Rule Out Stroke	55	Female	55 year old female with Lupus, end-stage renal disease, and mitral valve endocarditis, presents for stroke evaluation. CT head without contrast: Very small calcification noted in the region of the left caudate head, and right anterior lentiform nucleus, perhaps vascular in nature, related to prior injury. There is a region of hypoattenuation in the medial aspect of the right cerebellar hemisphere (image 13-18 of series 2). This is in the right PICA distribution. There is no evidence of associated mass effect. There is some very mild asymmetric enlargement of the 4th ventricle toward this side. This suggests some element of volume loss. The remainder of the brain parenchyma is appropriate in size, signal, and configuration. No mass, midline shift, hemorrhage, or hydrocephalus. CT angiogram: There is a common origin of the brachiocephalic and left common carotid arteries. The origins of the common carotid arteries are widely patent bilaterally. There is some mild atherosclerotic vascular calcification at the carotid bifurcations bilaterally, slightly more prominent on the right compared to the left. No evidence of flow-limiting stenosis. The origins of the bilateral vertebral arteries appear patent. Both vertebral arteries markedly diminutive. No evidence of flow-limiting stenosis in the small vessels throughout their cervical course. Note is made of a prominent, partially anomalous right vertebral artery, originating from the low right CT perfusion: Suggestion of a focal area of delayed perfusion in the left middle cerebral peduncle on T-max imaging is artifactual, related to streak artifact in the posterior fossa and patient motion. Cerebral perfusion imaging is normal. 1. Small area of hypoattenuation in the right posteroinferior cerebellar artery distribution is age-indeterminate. While the imaging features suggest this is a remote insult, acute injury is not excluded and perfusion imaging is difficult to assess in this region. 2. Mild irregularity of the anterior communicating artery. 3. No flow-limiting stenosis in the head or neck vasculature. 4. Symmetric brain perfusion is demonstrated. 5. Multiple additional findings, including bilateral large pleural effusions, presumed atelectasis in both lungs, and a markedly dilated esophagus, with air-fluid level. Report:H:-mitral valve endocarditis, ESRD, Lupus. concern for stroke F: HEAD: - no intracranial hemorrhage - R-cerebellar hypodensity, which could reflect old ischemia - L-max sinus mucous/debris ANGIO: - no thromoboemboli, dissection, or aneurysm - small amt of gas in R-transverse foramen surrounding R-vert artery, m/b gas within veins from injection - collateral R-vertebral artery, which merges at C2 level PERFUSION: - no CT perfusion abnormality OTHER: - dilated esophagus w/ fluid level, NG tube - B/L pleural effusions w/ loculation on R Technique: Non-contrast CT of the head was performed, followed by contrast-enhanced CT angiography of the head and neck, following the uneventful administration of a timed bolus of intravenous contrast. Coronal, sagittal, curved planar, and volumetric reformations were performed on an independent work station. Maximum intensity projection images were performed on an independent work station. Bolus perfusion imaging was also performed.
4	Thrombosis of Fem-Fem Bypass	85	Male	85 year old male with history of occluded femoral-femoral bypass. Vasculature: The left hepatic artery arises from the aorta just superior to the celiac axis. The left hepatic artery arises from the celiac axis. The SMA arises from the celiac axis. There is a 50% stenosis of the celiac trunk. A proper IMA is not seen. The splenic artery is normal. There is redemonstration of an infrarenal abdominal aortic aneurysm. An aorto-bi-iliac graft is seen, with chronic occlusion of the left common iliac limb. The right chronic iliac limb is contrast opacified. At the level of the iliac ala there is a 6-mm contain stent graft leak into the aneurysm sac which appears new compared to prior. Please see series 3 image 139. There is an adjacent ch OTHER: There is dystrophic calcification of the papillary muscle of the left ventricle, suggestive of possible prior infarct. The visualized portion of the lungs are emphysematous but grossly clear. There is a large hiatal hernia. A focal calcification is seen within the right kidney. Small, nonenhancing simple cysts are seen within the right kidney. There is a large duodenal diverticulum, unchanged from prior. There is diffuse atrophy of the leg muscles, predmoninantly within the lower legs. The patient is status post right hallux surgery. 1. Interval development of small, contained stent-graft leak into the aneurysm sac from the right common iliac limb of the aorto-bi-iliac graft. 2. Interval increase in size of fluid collection within the left abdomen, which appears to be contiguous with the aneurysm sac. 3. Interval thrombosis of the femoral-femoral bypass graft. 4. Diffuse atherosclerotic calcifications of the arteries of the bilateral lower extremities, with single-vessel blood flow to the feet via the anterior tibialis arteries. bilateral posterior tibial and peroneal arteries are occluded more proximally. Report: Diameters in mm: Major, Minor Aorta at maximum diameter - Aorta @L3: 53.30, 49.10 Diameter at -femfem bypass graft: 27.80, 24.30 Renal artery aneurysm - LT RENAL ARTERY: 8.80, 7.30
5	Cerebral Palsy	13	Male	
6	Hip Fracture	unknown	Male	
7	Perthes	unknown	Female	
8	Slipped Capital Femoral Epiphysis	unknown	Male	
9	Knee	unknown	unknown	
10	Stab Wounds	21	Male	21 year old male status post left lower quadrant stab wound and multiple stab wounds to the chest. No pleural effusion or pneumothorax is identified. No mediastinal hematoma or pneumomediastinum is seen. The lungs are clear. The heart size is normal. The great vessels are intact. No mediastinal, hilar, or axillary adenopathy is present. Non-enlarged, calcified lymph nodes are noted. There are two locules of subcutaneous gas within the left lateral chest wall (3/95, 3/103). An additional area of subcutaneous gas is seen in the left posterior chest (2/254). There is linear stranding with a defect in the overlying skin within the left lateral chest wall (3/146) likely representing one of the stab wounds. Abdomen and pelvis: A large stab wound with hematoma formation is seen in anterior left abdominal wall (3/390). The area of soft tissue injury measures roughly 4.4 x 2.6 cm in diameter and appears to extend to the level of the transversalis muscle. Internal density within the stab in likely represents iodine containing packing material. There is contained air compatible with open wound. There is no definite intraperitoneal extension or underlying bowel injury. No intraperitoneal fluid or air is identified. The principal vascular structures of the abdomen and pelvis are intact. No definite evidence of solid organ or viscus injury is present. The liver, spleen, gallbladder, pancreas, adrenal glands, kidneys, and GI tract appear normal. The urinary bladder and pelvic organs are unremarkable. No abdominopelvic adenopathy is identified. No acute fracture or suspicious osseous lesion is identified. A bilateral L5 pars defect is noted. Mild gynecomastia is present right greater than left. 1. No definite evidence of abdominopelvic visceral injury. A large left stab wound extends through the transversalis musculature and in close proximity to the peritoneal surface on the left. Although not suggested by imaging, underlying injury is not entirely excluded. 2. No evidence of internal injury within the chest. superficial stab wound and subcutaneous air is noted. 3. Bilateral L5 pars defect, chronic. 4. Calcified mediastinal lymph nodes, correlate for her underlying granulomatous disease. Report: 3D reformations consisting of curved and multiplanar reformations, maximum intensity projections, and volume rendered images were performed on an independent workstation and corroborate the findings. Chest: At least 2 small superficial left lateral chest wall and left posterior back skin defect with minimal subQ gas. No vascular injury. No ptx, no contusion, no effusion. LLQ stab wound with small superficial active extav and small abdominal wall hematoma (S 3 I 388) with ectopic gas seen "apparently" just lateral of peritoneum. There is adjacent small bowel in this region with no obvious interloop fluid. No mesentery hematoma. No intraperitoneal. Due to very close proximity and the setting of setting of penetrating trauma, very subtle injury to SB just adjacent to this puncture site cannot be definitively excluded based on this imaging.
11	H/O R Common Iliac Dissection	70	Male	70 year old man with history of CABG, and perioperative IABP resulting in right common iliac artery dissection, treated with stent that subsequently occluded. Had recent fem-fem bypass. Now has chronic right leg non-healing wound. Abdominal vasculature: The origin of the celiac axis is patent. The origin of the SMA is 75-90% stenotic. The origin of the right renal artery is 50-75% stenotic. The origin of the IMA is 50-75% stenotic, with a 50% stenosis 1 cm distal to the origin. The superior mesenteric vein and portal veins are patent. There is mild calcified atherosclerotic plaque within the abdominal aorta. Otherwise, the abdominal aorta is normal in caliber and morphology. The IVC is patent. Bilateral lower extremities: Right lower extremity arterial vasculature: Right common iliac artery: 50-75% stenosis at origin. Right external iliac artery: 100% occluded stent graft. Right internal iliac artery: Markedly atretic and atherosclerotic. Left to Right Fem-fem bypass: widely patent. Right common femoral artery: Normal caliber and contour. Right superficial femoral artery: Occluded, reconstitutes at adductor hiatus, stenotic to the popliteal. Right deep femoral artery: Normal caliber and contour. Right popliteal artery: Normal caliber and contour. Right anterior tibial artery: Markedly atretic, no significant contribution to foot run-off. Right tibial-peroneal trunk: Normal caliber Left lower extremity arterial vasculature: Left common iliac artery: 50% proximal intra-stent narrowing. Left external iliac artery: Atretic but patent. Left internal iliac artery: Atretic but patent. Left common femoral artery: Normal caliber and contour. Left superficial femoral artery: Occluded, reconstitutes past adductor hiatus. Left deep femoral artery: Normal caliber and contour. Left popliteal artery: Normal caliber and contour. Left anterior tibial artery: Markedly atretic, no significant contribution to foot run-off. Left tibialperoneal trunk: Normal caliber and contour. Left posterior tibial artery: Markedly atretic, no significant contribution to foot run-off. Chest: The lung bases demonstrate interlobular septal thickening and right greater than left pleural effusions. Abdomen and pelvis: The liver parenchyma is normal without evidence of intra-/extrahepatic biliary duct dilatation nor focal hepatic lesions. The hepatic and portal veins are patent. There is conventional hepatic arterial anatomy. The gallbladder is unremarkable without evidence of radiopaque gallstones. The pancreas is normal without evidence of ductal dilatation nor focal pancreatic lesions. There is no splenomegaly. The adrenal glands are symmetric bilaterally without evidence of nodularity nor hyperplasia. The kidneys demonstrate normal enhancement and excretion of contrast. There is no hydroureteronephrosis nor focal renal lesions appreciated. There is no contrast extravasation on the delayed images to suggest injury to the urinary collecting system. The urinary bladder is unremarkable. The small and large loops of bowel are normal in caliber without evidence of obstruction nor ileus. The appendix is normal. There is no pneumoperitoneum nor free fluid. There are no pathologically enlarged retroperitoneal nor mesenteric lymph nodes by CT criteria. Bilateral knee degenerative joint disease. No suspicious lytic/blastic osseous lesions are identified. There is no soft tissue abnormality involving the thoracic/abdominal wall. 1. Widely patent fem-fem bypass. 2. Run-off to the right foot is supplied by the peroneal artery. The SFA is occluded, and reconstitutes past the adductor hiatus. Neither the anterior or posterior tibial arteries meaningfully contribute to the run-off to the foot. 3. The right external iliac artery stent is completely occluded. 4. The left common iliac artery stent is patent, but there appears to be a 50% stenosis in its proximal portion. The left external iliac artery is patent but atretic. 5. The left SFA is occluded, with reconstitution past the adductor hiatus. The left popliteal is patent, and run-off to the foot is predominantly via the peroneal artery.
12	Heart	50	Male	
13	Pelvic Fx	unknown	Male	There is a complex, displaced fracture involving the left acetabulum, including a large centrally displaced fragment involving the medial acetabular wall and roof. The fracture extends into the iliac wing and the anterior lateral aspect of the ilium and acetabular roof is rotated laterally with a fracture, comminuted, through the superior pubic ramus. The symphysis demonstrates offset of the left side superiorly and laterally, with a transverse fracture component through the symphysis, and a buckled fracture of the inferior left ischial pubic ramus. The femoral head is not grossly dislocated within the fractured acetabulum. The SI joints show mild anterior widening on the left and anatomic alignment on the right. No discrete fracture of the sacrum is identified. No fractures involving the right hemipelvis or femoral necks are present. Incidentally demonstrates are pars interarticularis defects at the L5-S1 level, presumably chronic. Soft tissue windows demonstrate an extensive amount of hemorrhage adjacent to the left medial acetabular fracture. Embolization coils are evident consistent with angiographic procedure. There is a complex, displaced fracture involving the left acetabulum, including a large centrally displaced fragment involving the medial acetabular wall and roof. The fracture extends into the iliac wing and the anterior lateral aspect of the ilium and acetabular roof is rotated laterally with a fracture, comminuted, through the superior pubic ramus. The symphysis demonstrates offset of the left side superiorly and laterally, with a transverse fracture component through the
15	Arm Angio	13	Female	13 year old female patient with history of right upper extremity pain/numbness with a monophasic right radial artery and absent ulnar pulse on physical examination. Evaluate for embolic disease. Vasculature: The right brachiocephalic, subclavian, axillary, brachial, interosseous, and radial/ulnar arteries are patent. These vessels are normal in caliber and morphology without evidence of aneurysmal dilatation nor focal dissection. There are no intraluminal filling defects to suggest embolic disease. The right deep palmer and superficial palmar arches are patent. The1st/2nd - 2nd/3rd intermetacarpal and dorsal 5th digital arteries, arising from the superficial palmar arch, are moderately attenuated. The aortic arch is unremarkable without evidence of aneurysmal dilatation nor dissection. The great vessels are normal. The left vertebral artery arises from the aortic arch. Chest: The lung apices are unremarkable without evidence of focal consolidations nor pleural effusions. There is no pneumothorax. There is increased soft tissue attenuation within the anterior mediastinum, likely representing residual thymic tissue. There are no pathologically enlarged right axillary, supraclavicular, nor superior mediastinal lymph nodes by CT criteria. The supraclavicular spaces are clear. The visualized osseous structures and soft tissues are normal. No suspicious lytic/blastic osseous lesions are identified. 1. Anatomy: The right deep palmar arch off the radial artery is intact with dominant blood supply to the deep metacarpals supplying digits i, ii, and radial aspect of dig. iii. The superficial palmar arch off the ulnar artery is hypoplastic/incomplete, and supplies the deep metacarpals to digi. v (ulnar) and iv, iii, with a diminutive vessel connecting to the radial artery territory. 2. The metacarpals to 1st/2nd - 2nd/3rd intermetacarpal as well as the 5th metacarpal artery, arising from the superficial palmar arch, are moderately attenuated. findings may represent normal arterial anatomy with vasospasm not entirely excluded. 3. There is no radiographic evidence to suggest embolic disease involving the right upper extremity arterial circulation. 4. There is no radiographic evidence of focal dissection nor aneurysmal dilatation involving the right upper extremity arterial circulation.
16	Concha Bullosa	26	Male	
17	Deviated Septum	61	Female	
18	Ear	1	Male	
19	Ethmoid Sinus	67	Male	
20	Frontal Sinus	63	Male	
21	Maxilla	35	Male	
22	Maxillary Sinus	44	Male	
23	Maxillary Sinus 2	27	Male	
24	Normal Sinus	37	Female	
25	Polyp	31	Male	
26	Post Surgical	61	Female	
40	Impaction Fx of R Knee	17	Female	17 year old female status post MVA, lipohemarthrosis on plain film, concern for knee fracture, tibial plateau fracture. Head on collision at 35 mph, knee pain. There is a depressed impaction fracture of the medial trochlea of the right knee involving a region measuring approximately 2.3 x 1.4 cm (cc/lat). The trochlear surface is depressed by approximately 3 mm. A large lipohemarthrosis is present, which widens the patellofemoral joint space. The patella is intact. An 8-millimeter linear calcification is seen in the medial compartment of the knee joint space, and represents a small loose fracture fragment (series 3/134). The tibial plateau demonstrates mild sclerosis along the lateral and medial compartments, however there is no fracture line, surface displacement, or cortical irregularity to indicate a fracture. Remaining bones are within normal limits. Remaining visualized soft tissues are within normal limits; ligamentous structures of the knee are poorly visualized due to the lipohemarthrosis. 1. Depressed impaction fracture of the medial trochlea with large lipohemarthrosis. 2. 8mm loose body fracture fragment in the medial compartment of the knee. 3. No acute fracture seen in the tibial plateau. Report: Lipohemarthrosis. Approximately 1 x 2 cm slightly depressed comminuted fracture along the medial aspect of the patellar femoral groove 2 tiny calcifications within the medial compartment (series 303 image 72, series 303 image 77) may represent tiny fragments of bone from the above fracture. No evidence of medial tibial plateau fracture as suggested on x-ray.
53	Aneurysm with Endoleak	73	Male	Interval placement of an aorto-bi-iliac metallic stent graft into an infrarenal abdominal aortic aneurysm. The stent graft originates just below the right renal artery and a stent is seen extending laterally into the left renal artery. The celiac, SMA, and bilateral renal arteries are patent. A large endoleak is noted at the junction of the aortic and iliac portions of the stent graft. We cannot ascertain the continuity between these two components namely the aortic and iliac components. The graft ends in the bilateral common iliac arteries. The approximate maximal diameter measured on Series 3, Image 174 of the aortic aneurysm measured at Series 3, Image 174 is 4.8 x 3.6 cm (please note that 3-D orthogonal measurements will be provided) and these are grossly within range of the previous measurements provided. A soft tissue density measuring 2.8 x 1.8 cm seen on Series 3, Image 369 over the right groin soft tissues likely represents a soft tissue hematoma perhaps from the puncture site. Within the thorax there is interval development of small bilateral pleural effusions. The visualized portions of the lung bases are otherwise unremarkable, respiratory motion does degrade the images. The liver is unremarkable. There is vicarious secretion of contrast into the gallbladder. The pancreas appears atrophic. There are multiple punctate calcifications noted within the spleen consistent with splenic granulomata. The visualized portions of the small and large bowel appear grossly unremarkable. The bilateral kidneys enhance symmetrically. 1. Interval placement of aortobi-iliac stent graft for infrarenal abdominal aortic aneurysm with a large endoleak noted at the junction of the aortic and iliac components of the stent graft. We cannot ascertain continuity between these aortic and iliac components. The graft ends at the bilateral common iliac arteries. 2. There are small bilateral new pleural effusions. 3. Small 1.8 x 2.8 cm right groin soft tissue hematoma possibly from puncture site noted. 4. Left proximal renal artery stent with bilateral single renal arteries patent. Report: Volume rendered, curved planar reformations, minimum intensity projections were acquired. The orthogonal dimension of the aorta at the maximum diameter at the level of L3 measures 43 x 38 mm. Total aneurysm volume is 87 cc. These are likely unchanged from the prior exam. Attention on follow-up.
73	Tibial Fx	52	Female	52 year old female with postsurgical changes related to high tibial osteotomy with a medial titanium screw plate, as well a interference screw from previous anterior cruciate ligament reconstruction demonstrated. Severe narrowing of both the medial and lateral tibial femoral compartments is also present. At the osteotomy site, there is a considerable amount of osseous density forming, with relatively mature-appearing bone growth identified in an estimated 75% of the osteotomy site. Laterally, there remains a lucency. Along the anterior and posterior cortex, there is some callus formed, but no bridging callus. There are no findings to suggest a nonunion. The hardware appears intact. 1. CT of the left proximal tibia demonstrating that approximately 75% of the osteotomy site has relatively mature-appearing bone formation. No bridging callus at the cortex, as yet and slight lucency persists laterally. There are no imaging findings to suggest nonunion. 2. Severe degenerative change in the bilateral tibial femoral compartments as well as osteophytosis of the patella. Status post anterior cruciate ligament reconstruction.
74	Arthritic Knee	78	Female	With respect to the lateral meniscus, the meniscal contour and overall size is within normal limits. No discrete meniscal tear is demonstrated. The sensitivity of this test is likely lower than that of state of the art MR imaging. The osseous structures demonstrate moderate cystic change involving the tibiofibular joint, consistent with moderate degeneration and intra-osseous ganglion formation. There is no evidence of fracture. There is moderate osteophytosis involving the medial tibial femoral compartment and moderate diffuse loss of articular cartilage along the medial compartment. The medial meniscus appears grossly intact. The patellofemoral compartment demonstrates moderate loss of articular cartilage, best seen on axial sections. The contrast filling the joint space is irregular in its margins, consistent with moderate synovitis. The lateral tibial femoral compartment cartilage is relatively preserved. Cruciate and collateral ligaments are grossly intact. 1. CT arthrotomography of the left knee demonstrating moderate degenerative joint disease involving the medial compartment and patellofemoral joint, but no evidence of tear of the meidal or lateral meniscus. 2. Moderate degenerative change involving the proximal tibiofibular joint could be one source of posterolateral joint pain. Teaching Points: Arthritic Knee, limited Field of view, poor muscles.
76	Right Clavicular Fracture	36	Male	A 36 year old male, with history of right clavicular fracture. The patient has had hardware removal. A fracture of the distal clavicle is noted, with approximately one shaft width of inferior displacement of the distal fragment. There are several bony fragments seen in the region of the fracture site anterolaterally and inferiorly, some of which appear relatively smooth in contour and may be more chronic in nature. There is also discontinuous ossification in the coracoclavicular region suggesting ossification in the coracoclavicular ligament. The fracture lies in the region of a previous surgical screw. A residual screw tract is seen in the region of the fracture in the distal clavicle as well as in the scapula in the region of the coracoid process. Some bony sclerosis is seen anteriorly along the fracture site along the proximal fragment. There appears to have been more solid bony union posteriorly, with less sclerosis. There also appears to be mild offset at the acromioclavicular joint. The acromion lies approximately 4 mm inferior to the level of the distal clavicle. 3-D reconstructions collaborate the findings of the 2-D source images. 1. A fracture through the distal clavicle is seen in the region of the screw tract from prior hardware removal. There is inferior displacement of the distal fracture component. 2. Mild offset is seen at the acromioclavicular joint as mentioned previously. 3. Several small bony fragments are also seen in the region of the fracture site anterolaterally and inferiorly, at least some of which appear to chronic in nature. There is also discontinuous ossification in the region of the coracoclavicular ligament.
79	Tibial Plateau Fx	42	Male	There is a comminuted fracture of the lateral tibial plateau, with extension into the central portion of the tibia in the region of the intercondylar eminences. There is an approximately 5-6 mm of depression of the central fracture fragment. A large lipohemarthrosis is present. The medial compartment appears unremarkable. There is no evidence of fibular or femoral fracture. Teaching Points: Great resolution of a knee, limited field of view, good resolution of the fractured tibia laterally.
80	Comminuted Femoral Fx	unknown	Male	Ankle: Note is again made of an osteochondroma of the distal fibula. A tiny accessory navicular bone is noted. There is no evidence of fracture of the ankle. Hip: The acetabulum appears intact. Three screws are seen through the femoral neck with slight angulation of femoral neck fracture with apex slightly oriented posteriorly. One of the screw tips is very near to the bony surface of the femoral head. Gas and fluid are seen in the soft tissues consistent with recent surgery. External fixator is noted with screws in the femur and tibia. There is a highly comminuted fracture of the distal left femur, supra and intracondylar, impacted, with moderate displacement of the fragments. Some of the fragments are adjacent to the popliteal vessels, best seen on image 212 of series 2. There is medial soft tissue injury with gas within the soft tissues suggestive of an open fracture. The tibia and fibula are intact without any evidence of fracture. 1. Screw fixation of left femoral neck fracture with slight angulation, apex posteriorly of the fracture. One of the screw tips is very close to the bony surface of the femoral head. 2. Highly comminuted fracture of the distal femur as described above. 3. No evidence of fracture of the ankle. Teaching Points:Great for external fixation of comminuted femur fracture, muscles not highly visible.

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82	Shoulder Scapula	unknown		Female	1. Unusual prominent hook configuration of the superior and medial margin of the scapula adjacent to the area of bone marrow edema and possibly causing early impingement or a friction type syndrome on the adjacent serratus musculature. 2. No definite osteochondroma identified.
83	Knee-Likely Sarcoma		12	Female	12 year old female with history of right knee pain. Evaluation for tumor. Within the region of the distal right femur, there is a large heterogeneous enhancing soft tissue mass that is located between the semimembranous muscle medially and the biceps femoris muscle laterally and extends over approximately 15 cm length. This mass extends from the distal one-third shaft of the femur to the distal epiphysis of the femur. There is additional component of fat surrounding the proximal portion of the mass, suggestive of a prior resection. The characteristics of this mass are concerning for a sarcoma. There is additional edema seen located along the medial and ar Within the calf, there is diffuse edema and stranding of the posterior calf muscles. There may be a component of necrosis. Recommend correlation with labs or prior surgical history. There is additional significant amount of soft tissue subcutaneous lymphedema that extends from the proximal tibia to the ankle. Evaluation of the bones demonstrate expansion of the intramedullary cavity of the distal tibia with extensive marrow replacement. There is additional extensive marrow replacement involving the distal femur. No obvious bony destruction is noted. Multiple surgical clips are seen within the proximal tibia, fibula, and ankle as seen on prior plain film. 1. Large heterogeneous soft tissue mass adjacent to the distal femur, with associated soft tissue edema, stranding and inflammation.likely a sarcoma. 2. Multiple areas of low-density within this mass, likely necrosis. 3. Diffuse edema, stranding and possible necrosis of the posterior calf muscles. Possible necrosis, fatty replacement or secondary to disuse. 4. Extensive amount of lymphedema seen extending from the proximal tibia to the ankle. 5. Possible atypical fibrous dysplasia versus a marrow replacement disorder or possible radiation changes. Teaching Points: Interesting Pathology and shape of Tibia and bones in the knee.
92	Scapholunate Tear		64	Male	1. Successful right wrist arthrogram by radial carpal joint injection. 2. Contrast communicating with the distal radial ulnar joint consistent with a TFCC perforation or tear. 3. Contrast communicating with the mid carpal joint which is consistent with a scapholunate and/or a lunotriquetral perforation or tear.
104	Aneurysm Clips	unknown		unknown	Brain: The brain parenchyma is unremarkable without hemorrhage, mass, or mass-effect. Aneurysm clips are seen in keeping with prior MCA aneurysm obliteration. The ventricles and extra-axial fluid spaces are normal in size and configuration. The visualized paranasal sinuses and mastoid air cells are clear. Expected post surgical changes are seen in the calvarium. No enhancing lesions are seen in the brain parenchyma following the administration of iodinated contrast. Intracranial CTA: Aneurysm clips have been applied to the M1 segments of both middle cerebral arteries. No residual aneurysm sac is identified on either artery. There is a stable laterally projecting 3-mm aneurysm of the proximal horizontal segment of the left internal carotid artery. No other aneurysms are identified. No vascular malformations are seen. There is no significant intracranial atherosclerosis. Neck CTA: There is a left-sided aortic arch. There is normal arch anatomy. There is calcific atherosclerosis of the great vessel origins without hemodynamically significant narrowing. There is increased calcific atherosclerosis of the proximal left internal cor artery in comparison with the prior exam. However, there is less than 30% narrowing. There is stable calcific atherosclerosis of the proximal right internal carotid artery with less than 30% narrowing. There is no abnormality of the soft tissues of the neck. Several small thyroid nodules are seen. There is no lymphadenopathy. Mild degenerative changes are seen in the cervical spine worst at C6-C7. 1. No acute intracranial findings. 2. There is no evidence of residual or recurrent middle cerebral artery aneurysm. There is a stable 3mm aneurysm of the proximal horizontal segment of the cavernous internal carotid artery on the left side. 3. Calcific atherosclerosis of the proximal internal carotid arteries as described above with less than 30% narrowing.
106	Shoulder Dislocation		82	Male	82 year old male post fall, history of myasthenia gravis. There is an anteroinferior dislocation of the left shoulder with an engaging Hill-Sachs impaction fracture of the greater tuberosity and luxatio erecta positioning of the left arm. There is irregularity of the anteroinferior glenoid and lipohemarthrosis but no definite fracture of the glenoid. The scapula is intact. There is non-specific sclerosis in the left seventh rib posterolaterally. Multi-level degenerative changes are seen in the cervical spine with multiple anterior osteophytes which likely reflect DISH. Limited evaluation of the lung fields demonstrates numerous lung nodules at the left lung base, ranging from 2-4 mm, with the largest approximately 5-6 mm and located in the left lower lobe. 1. Anteroinferior dislocation with an engaging hill-sachs impaction fracture of the greater tuberosity and luxation erecta positioning of the arm. 2. Numerous left lower lobe nodules.
110	Scaphoid Fracture	unknown		unknown	CT upper extremity right hand tenderness and pain status post screw fixation of right scaphoid fracture. A Cancellous screw is present within the scaphoid. The proximal portion of the screw appears to project extracortically from the proximal pole of the scaphoid and may abut the distal radius. No demonstrable fracture line remains. No evidence of avascular necrosis. No new fractures. There may be a small bony defect in the distal radius, best seen on Series 4, Image 55 and Series 3, Image 40. A bone island is incidentally noted in the proximal aspect of the first phalanx. A bony fragment adjacent to the ulnar styloid is redemonstrated. Cancellous screw p
113	Fracture of Talus		31	Male	31 year old male status post trauma with left ankle pain, referred for CT evaluation to characterize talar fracture. There is a comminuted fracture of the lateral process of the talus with approximately 4 mm distraction gap between the body of the talus and the largest fragment (axial image 40, series 203). The fracture extends into the posterior subtalar joint. There is a 2-mm osseous fragment (sagittal image 32, series 202) and a 1 mm osseous fragment (sagittal image 35, series 202) in the posterior subtalar joint capsule recess, compatible with intra-articular bodies. There is soft tissue swelling over the lateral malleolus. Elsewhere, the soft tissues are within normal limits. The tibia, fibula, calcaneus, and tarsal bones are within normal limits. Comminuted fracture of the lateral process of the talus with associated intra-articular joint bodies and lateral malleolar soft tissue swelling. Teaching Points: Ok example of a talar fracture, decent tendons.
118	Fracture of C1 Vertebra		88	Male	88 year old male with history of neck pain, evaluate for fall. Head: The ventricles and sulci are markedly prominent consistent with diffuse volume loss. There is no midline shift, mass effect or focal extra cerebral collection. Vasculature calcification is also noted. Cervical spine: There is significant prevertebral soft tissue swelling. Additionally, there is significant fracture of the anterior and posterior ramus at C1 as well as a fracture of the base of the dens extending into the body with significant approximately 7 mm posterior displacement of the dens relative to the body of C2. Multilevel degenerative disc disease with end plate changes and osteophyte formation is also present particularly at the levels of C4/C5, C5/C6, C6/C7. 1. Volume loss with no evidence of acute intracranial injury. 2. Anterior and posterior fractures of the C1 right (jefferson fracture) as well as Type three odontoid fracture.
120	Calcaneal Fracture	unknown		unknown	There is a severely comminuted fracture of the calcaneus, with loss of calcaneal height, and fracture lines extending in multiple throughout the entire calcaneus. Fracture lines extend into the calcaneocuboid joint and posterior sub-talar joint. A hairline fracture extends into the sustentaculumtali. A small lateral corner fracture of the anterolateral talus is also seen. There is also a minimally displaced fracture along the inferior cuboid. Tarsometatarsal aligment is intact, without Lisfranc injury. Small bone islands are seen within the talus. Visualized tendons and ligaments are within normal limits without evidence for entrapment or attachment to free-floating osseous fragments. Extensive soft tissue swelling is seen surrounding the ankle and foot. 1. Severely comminuted calcaneal fracture with loss of calcaneal height, and fracture extension into the calcaneocuboid joint, posterior sub-talar joint, and sustentaculum tali. 2. Small lateral corner fracture of the anterolateral talus. 3. Minimally displaced fracture along the inferior cuboid. Teaching Points: Great example of a calcaneal fracture, tendons are not very visible, no vasculature.
125	Possible Small Bowel Obstruction	unknown		Male	No filling defects identified within the pulmonary arterial branches or the venous system from the level of the inferior vena cava to the level of the popliteal veins. No pleural or pericardial effusion is present. The heart and great vessels are unremarkable. A left upper lobe calcified granuloma is seen. Focal area of scarring is seen in the right middle lobe. Mild dependent atelectasis seen bilaterally. A 5 mm left lower lobe pleural based nodule is seen on Image 123 of Series 2. The visualized portion of the upper abdomen demonstrates a small hiatal hernia. A subcentimeter low attenuation lesion is seen in the right kidney, likely a simple cyst. Diverticula are seen. Thee are mildly dilated small bowel loops in the right part of the abdomen without an obvious point of transition identified. There is no mass, adenopathy or ascites. Visualized osseous structures are remarkable for degenerative changes. A subcentimeter low attenuation lesion seen in the lateral segment of the left lobe of the liver is too small to characterize but likely represents a simple cyst. 1. No evidence of pulmonary embolism. No evidence of deep venous thrombosis. 2. 5 mm left lower lobe pleural based nodule. calcified left upper lobe granuloma is seen. 3. Mildly dilated distal small bowel loops with stool seen within the distal small bowel and no obvious point of transition. This may represent a partial small bowel obstruction. If clinically indicated, a small bowel follow through may be performed. 4. Hiatal hernia.
131	Bronchial Stent		35	Female	35 year old female with history of subglottic and left main stem bronchus narrowing status post- stent placement. Mediastinum: Few small lymph nodes, none pathologic by size criteria. Normal heart size. No pericardial effusion. Chest wall: No axillary lymphadenopathy. No pleural effusion. Ribs and bony structures are unremarkable. Lungs: Interval stent placement in the left main stem bronchus with improved caliber of the prior high-grade stenosis. 17 mm of the proximal left main stem bronchus not covered by this stent has approximately 50% stenosis. Left upper lobe with slightly worse bronchial wall thickening and airway narrowing. Superior and inferior lingular bronchi again with mucous impaction. New small parenchymal opacity in the inferior lingular segment probably represents inflammatory process. Right lung with bronchial wall thickening similar to the left bronchi, with the right upper lobe bronchus slightly worse in wall thickening. Question polypoid lesion in the right main stem bronchus producing mild stenosis. Visualized abdomen: Noncontrast examination unremarkable. 1. Interval left main stem bronchus stent placement with improved caliber at the stent site. Proximal left main stem bronchus not covered by stenct has approximately 50% stenosis. 2. New small parenchymal opacity visualized in the inferior segment of the lingula probably represents inflammatory change. 3. Right upper lobe bronchus with question of polypoid wall thickening producing mild stenosis. 4. Bronchial thickening seen throughout the bilateral bronchi with the right upper lobe component slightly worse.
132	Tracheal Stent		85	Female	85 year old woman with history of ectatic ascending aorta and tracheal stenosis with annual evaluation. Tracheal stent is seen within the subglottic trachea with mild intimal hyperplasia. The tracheal lumen is patent with maximal caliber measuring 7.2 mm x 9 mm. There is no focal filling defect within the central airways. Redemonstration of a non-calcified 7 mm pulmonary nodule is stable (Series 3, Image 192). Additional 2 mm left lower lobe pulmonary nodule (Series 3, Image 204), 3 mm non-calcified nodule in the left lower lobe (Series 3, Image 229) are stable since 2003. Additional 2 mm nodule within the left lower lobe (Series 3, Image 160) is also stable. There is redemonstration of several non- calcified nodules within the right upper lobe (Series 3, Image 144 and Series 3, Image 100). There is a additional branching opacity within the right upper lobe, which may represent mucous plugging and the right upper lobe is also stable (Series 3, Image 142). No new pul No evidence of mediastinal or hilar adenopathy. The heart size is within normal limits. There is extensive coronary arterial calcification. There is redemonstration of prominent ascending aortic aneurysm measuring 4.1 x 4.2 cm, stable since prior study, which measured 4 x 4.1 cm in 2003. Incidental finding of a hypodense thyroid nodule measuring 1.2 cm. No additional thyroid nodules are seen. The gallbladder is surgically absent. The remainder of the upper abdominal organs are grossly unremarkable. Multiple degenerative changes of the thoracic spine are seen. Three-dimensional reconstruction images confirm the above findings. 1. Redemonstration of tracheal stent with mild intimal hyperplasia, otherwise, stable in position. 2. Stable ascending aortic aneurysm, as above. 3. Redemonstration of multiple tiny pulmonary nodules without interval change since 2003 and without evidence of new pulmonary nodules. 4. Stable volume loss and traction bronchiectasis of the left lower lobe. 5. Status post cholecystectomy.
133	Tracheostomy-Tracheal Stenosis		27	Male	27 year old man with history of achondroplasia status post prior tracheostomy times 2 and upper airway reconstruction surgery for obstructive sleep apnea with recent respiratory problems presenting for evaluation. There is mild narrowing of the trachea at the level of the thyroid gland, which may correspond to previous tracheostomy site. However, the airway remains open. The subglottis is also widely patent. No discrete mass is identified along the airway. Marked bony sclerosis and thickening is identified along the skull base and visualized calvarium. Note is made of prior suboccipital decompression. Resection of the posterior elements of C1 and C2 is again identified. Congenital cervical spinal canal stenosis is demonstrated. Dysmorphic appearance of the clivus and odontoid is also present. Cervical spine kyphosis is demonstrated as noted on prior MRI cervical spine 2000. Prior facial surgical changes are demonstrated. Mild tracheal stenosis at the level of the thyroid gland. However, the airway remains patent, including the subglottis, which is widely open. No discrete mass is present.
138	CT Angiography of Chest	unknown		unknown	
140	Left Thyroid Vein Dilation	unknown		unknown	Good neck veins and arteries CT Head and neck angiogram demonstrates possible left thyroid vein dilatation abnormally enhanced unilaterally with swelling on the left side. No flow-limiting stenosis or aneurysm within the Circle of Willis.
154	Prior Aortic Valve Replacement		54	Female	54 year old female status post aortic valve replacement in 2007. Patient presents with back pain. Evaluate for aortic dissection. There is no evidence of aortic dissection. There are no filling defects within the central, lobar, segmental, or subsegmental pulmonary arteries to indicate a pulmonary embolism. There is minimal linear opacity, likely scar in the lung bases. The lungs are otherwise clear. There is no pneumothorax or pleural effusion. The heart size is normal. There is slightly increased amount of pericardial fluid with an attenuation coefficient equal to 20 Hounsfield units, indicating simple fluid. This is most likely related to the patient's recent surgery. Contrast-enhanced images demonstrate a thin rim of peripheral enhancement around the pericardial fluid (Series 3, Image 207); thus, the possibility of infected pericardial fluid and pericarditis is not excluded. There are subcentimeter mediastinal lymph nodes in the aortopulmonary and right paratracheal stations. No hilar or axillary lymphadenopathy. 3-D reformats demonstrate a persistent ductus arteriosus. At the origin of the ductus not Limited evaluation of the abdomen and pelvis during this arterial phase demonstrates that the liver, spleen, gallbladder, adrenals, and kidneys are unremarkable. There is mild prominence of the common bile duct measuring 9 mm. The pancreatic duct is also mildly prominent but there is no evidence of an interrupted pancreatic duct sign. There is no increased soft tissue density or fat stranding around the head of the pancreas to indicate a mass. The stomach, small bowel, and large bowel are unremarkable. There is no evidence of obstruction. Aortic and common iliac calcifications indicate atherosclerosis. The urinary bladder and uterus are unremarkable. There is no free air or free fluid. No lymphadenopathy within the abdomen or pelvis. The visualized bones demonstrate no worrisome lytic or sclerotic bony lesions. 1. No evidence of aortic dissection. 2. No evidence of pulmonary embolism. 3. Expected postoperative changes following prosthetic aortic valve replacement. 4. There is slightly increased pericardial fluid. 5. Mildly prominent common bile duct and pancreatic duct. There is no evidence for a pancreatic head mass.
155	Complex A-V Formation	unknown		Male	There is extensive convoluted vessels in the palmer surface of the right hand over the first through third metacarpals that involves both the superficial and deep compartments. Both ulnar and radial arterial feeding vessels are identified with early tortuous venous drainage. Findings are consistent with a large arteriovenous malformation of the right hand. There is a 1 cm aneurysmal dilatation of the radial artery at the level of the distal radius. Small lymph nodes are present in the right axilla. Complex arteriovenous malformation of the right hand involving the metacarpal soft tissues from the first through third metacarpal space. Hypertrophy of the radial, ulnar, and interossea arteries as well as the superficial and deep palmar arch which supply the illdefined lesion. Prominent earlyfilling veins.
156	Complex Facial Malformation		11	Male	11 year old male with recurrent venous/lymphatic malformation, status post four prior resections, including right parotidectomy and neck dissection, left para-hyoid neck dissection and tongue resection, and two floor of mouth resections with supra-hyoid dissection. There is re-demonstration of a large, primarily left-sided inflitrating or multispacial mass, containing both macrocystic and microcystic elements, and areas of vascular enhancement, suggestive of a mixed venous/lymphatic malformation. This primarily involves the submental, submandibular, and premaxillary spaces of the left face, and to a lesser extent the right face centered about the mandib A large left buccal malformation is again noted, containing areas of suggestive of macrocystic components. There is mass-like soft tissue in the expected location of the tongue and floor of mouth. There is prominence of the marrow and cortex of the mandible with associated bony overgrowth. Multiple enhancing vascular structures are identified including areas within the location of the tongue, submental, submandibular, and premaxillary spaces, left greater than right, which may be venous and/or arterial. Specifically, there is prominence of branches of the right external carotid artery, including the facial artery and lingual artery. The thyroid gland is well defined and within normal limits. The airway is widely patent. There is prominence of the adenoid and palatine tonsils, which may be congestive or inflammatory. Select images of the brain are grossly within normal limits. No vascular occlusive disease is identified. There is evidence of prior right parotidectomy and neck dissection, and surgical changes of the left neck, which are less conspicuous on the current examination, which may be secondary to technique. 1. Large complex facial malformation, involving the left greater than the right face, with macro- and micro- cystic components and vascular enhancement which may be venous and/or arterial. 2. Evidence of extensive prior neck and floor of mouth surgery. Technique: 1 mm thin section multi-axial contrast enhanced CT angiography of the head and neck was performed with coronal, sagittal, curved planar, and volumetric reformations performed on an independent workstation.
163	Aortic Aneurysm		75	Female	75 year old female with history of ascending aortic aneurysm. Inhomogeneous thyroid gland, containing low-density nodularity. No enlarged axillary or paraclavicular lymph nodes. Stable aneurysmal dilatation of the thoracic aorta, maximal diameter of 47-mm x 47-mm within the ascending segment. The aortic root, including the annulus and sinuses of Valsalva, remains unchanged in dimension and configuration. The thoracic aorta measures 38-mm x 38-mm at the sinotubular junction, also unchanged from prior examination. Orthogonal aortic luminal measurements provided by the 3-D laboratory. Multivessel coronary arteriosclerotic calcification with evidence of percutaneous coronary intervention. Specifically, there is a stented vessel within the expected distribution of an obtuse marginal branch. The left circumflex artery appears diminutive. Mild stenosis of the right coronary artery origin. No pericardial effusion. Heart size remains within normal limits. Thoracic aortic and arch vessel calcific plaque. Conventional three-vessel arch anatomy. Unchanged small solid pulmonary nodule within the left lower lobe, seen on image 182 of series 6K. Symmetric basilar dependent ground-glass opacities most likely represent atelectatic change. No new are Technique: Multiple contiguous axial images were obtained from the thoracic inlet to the iliac bifurcation following the uneventful administration of 98 mL of Isovue 370 utilizing the standard CT angiogram protocol with gating of the chest. Additional 3-D reformatted images were performed and reviewed on an independent workstation.
164	Elbow Joint Hematoma		62	Male	62 year old male with a long- term history of left upper extremity arteriovenous dialysis graft. Recently a phlebotomist attempted a venous draw with development of a large hematoma. There is a tortuous arteriovenous dialysis graft in the forearm distal to the elbow. There are several areas of focal dilation in the graft with calcification of the walls. Please see the report for the CT angiogram of this extremity done at the same time. There is marked calcification of the native arteries. Extensive subcutaneous edema in the soft tissues proximally. There is a large moderately heterogeneous, mildly dense mass over the medial antecubital fossa region, which measures up to 16 cm in length x 7.7 cm transverse x 4.7 cm deep. There is no internal gas. This is 1. Large soft tissue mass as described above, compatible with reported hematoma. There is no internal gas to suggest development of abscess. 2. Arteriovenous dialysis graft as described above. Demonstration of a large iso- to slightly hyperattenuating collection medial to the elbow joint measuring approximately 14 x 8 x 4 cm which likely represents a hematoma. AV Graft with dystrophic calcification and dilatation of the presumed venous segment may be related to thrombosis.
165	Tetralogy of Fallot		3	Female	A three-year-old female with tetralogy of Fallot, MAPCAs, Alagille syndrome, juvenile rheumatoid arthritis, status post bilateral unifocalization revision with Blalock-Taussig shunt, status post shunt dehiscence and re-operation 2011, now with septic shock and evidence of splenic infarction on ultrasound. Evaluate for vascular abnormality, thromboembolic disease, vasculitis, abscess. Instrumentation: Sternal wires, endotracheal tube in appropriate position, right-sided power PICC with tip at SVC/atrial junction, gastrostomy tube, left femoral venous catheter ending at the left common iliac, mediastinal surgical clips, and right-sided chest tube are in place. Situs: There is a left upper quadrant spleen, diffusely infarcted, only a very small region of normally-enhancing tissue remaining approximate to the hilum. There is situs solitus by atrial appendage morphology. Cavae: There are patent and normal-caliber right-sided SVC and IVC terminating in the right atrium, unobstructed. Pulmonary veins: There are 2 right and 1 left pulmonary veins draining unobstructed into a normal-appearing left atrium. Atria: There is mild right atrial enlargement. The left atrium is normal in caliber. Based on technique, cannot exclude interatrial communication. Atrioventricular connection: AV relationship is concordant. Two separate and normally-positioned inlet valves are identified. Ventricles: There is evidence for right ventricular hypertrophy. There is a malalignment VSD. The left ventricle is otherwise unremarkable in appearance. The ventricles are D-loop, levocardia. Ventriculoarterial connection: There is an overriding aorta, consistent with tetralogy of Fallot. There is pulmonary atresia. Coronary arteries: Two sets of coronary arteries are present emanating from the facing cusps. There is mild clockwise rotation orientation of the aortic root with consequent clockwise-appearing rotation of the coronary artery origins, which nevertheless originate from the appropriate cusps. There is a normal-appearing LAD branching from the left main coronary artery. Coronary arteries are right-sided dominant. Aorta: There is a left-sided aortic arch. What appears to be surgical materials lie immediately adjacent to the left-sided contour of the ascending aorta. The appearance is consistent with recent surgical repair. There is an abrupt caliber change at the ascending aorta/proximal arch junction, the ascending aorta measuring 8 mm, the proximal-to-mid arch 13 mm, likely related to the surgical repair. There is three-vessel supra-arch cervical branching. A Blalock-Taussig shunt is present from the innominate artery to the right pulmonary artery. There is no evidence for coarctation or patent ductus arteriosus. The descending aorta to the hiatus is normal in caliber an Pulmonary arteries: A widely-patent 5-mm diameter graft is present from the innominate to the right pulmonary artery. There are surgically-created, centrally-confluent pulmonary arteries, widely patent, the narrowest point at the central confluence measuring approximately 6 mm. The right and left pulmonary arteries and branch pulmonary arteries appear to be patent. Airways: The central airways and peripheral airways appear widely patent with normal architecture. Lungs: There is a loculated pleural effusion within the major fissure measuring approximately 4 cm anterior-posterior x 5.1 cm transverse x 2.7 cm anterior-posterior, accounting for the right lower lung opacity seen on chest x-ray. There is loculated complex/thickened material layering along the right pleural margin, with multiple gas bubbles contained it, possibly tracking from the chest tube insertion site. The chest tube pigtail lies deep within the right lower lung sulcus medially, remote from either the effusion or the pneumothorax. There is a loculated pneumothorax measuring 4.9 cm anterior-posterior x 3.6 cm transverse x 2 cm craniocaudal, accountin Mediastinum: There is a 6-mm pericardial lymph node. No pericardial effusion is present. There are mildly prominent soft tissues surrounding the ascending aorta and proximal arch, with no evidence for mediastinal fluid collection to suggest abscess. Thoracic wall: There are multiple enlarged bilateral axillary lymph nodes. A right-sided chest tube is in place. There is no evidence for subcutaneous emphysema. Supraclavicular soft tissues are unremarkable. Chest wall osseous structures are unremarkable. Abdomen and pelvis vasculature: The abdominal aorta is of somewhat narrow caliber, but normal in course and patent to the iliac bifurcation. Branching vessels of the abdominal aorta are markedly narrowed, likely due to vasoconstriction, most notably the origin of the celiac trunk which is severely narrowed to approximately 1 mm, widening to approximately 1.8 mm proximal to the normal-appearing bifurcation into the splenic and common hepatic arteries. There is conventional branching of the hepatic arteries. The splenic artery is patent to the splenic hilum. The superior mesenteric artery is also narrowed, vasoconstricted, normal in distribution. The c The IMV, SMV, portal and splenic veins, and renal veins appear widely patent, best seen on delayed phase imaging. Abdomen and pelvis soft tissue: The liver, gallbladder, pancreas, kidneys, stomach, retroperitoneum, colon, urinary bladder, and pelvic floor are unremarkable. Oral contrast is present throughout the small bowel. There is minimal small bowel distension, possibly suggesting mild ileus. There is no evidence for ascites nor for any other abnormal intraabdominal or pelvic fluid collections to suggest abscess. Chest wall soft tissues are unremarkable. Note is made of gastrostomy tube with bulb inflated in the stomach body. Osseous structures are unremarkable. 1. Native anatomy consistent with tetralogy of fallot, pulmonary atresia, and aortopulmonary collaterals. 2. Status post unifocalization, and Taussig-Blalock shunt from innominate artery to right pulmonary artery. Central pulmonary arterial reconstruction. 3. Widely-patent shunt and pulmonary arterial arborization. 4. Right lung loculated effusion and loculated pneumothorax as described. 5. Minimal ground-glass patchy opacity in the right middle lobe 6. Infarction of the majority of the spleen 7. Diffuse vasoconstriction. None available

Anatomage Table 9.0 Case Library Descriptions

167	Bilateral Aneurysms	unknown		Male	Scout view of the abdomen demonstrates unremarkable bowel gas pattern. Multiple findings consistent with osteogenesisimperfecta, including the following: Healed rib fractures, severe scoliosis, protrusioacetabuli, postoperative changes of the pubic symphysis, marked deformity of the pelvis. Harrington rods and bilateral femoral rods are seen. A rectal tube was inserted and contrast was gravity-administered into the rectum. Symmetrical tapering of the rectum between the angulated sacrum and anterior pubic rami with side to side narrowing by the bilateral protrusio acetabula. Massive distention of the rectum and sigmoid colon measuring up to 10 cm. Sharp angulation of the coccyx. Contrast passed into the left colon, transverse colon, and eventually the right colon. Sigmoid dilatation did not allow more contrast to reflux into the small intestine. The descending colon and proximal sigmoid colon are of normal caliber. Marked colonic redundancy is noted. Large amount of air and feces is seen throughout the colon. Postevacuation film demonstrates persistent dilatation of the rectosigmoidcolon which is displaced out of the pelvis. The colonic mucosa appears unremarkable, however masses cannot be evaluated. 1. Large bilateral aneurysms of the popliteal arteries with narrowing of the opening to the distal popliteal arteries bilaterally. Three-vessel runoff is seen. Stranding is noted around the left sided aneurysm, raising concern for impending rupture. 2. Slight wall thickening and focal irregularity of the abdominal aorta with fusiform dilatation along with the bilateral popliteal aneurysm raise the concern for a systemic vasculopathy. 3. Small pericardial effusion.
170	Behcet's and Venous Sinus Thrombosis		17	Male	17 year old male with Bechet's disease admitted with lower extremity thrombosis, with known venous sinus thrombosis in the brain. There is a non-occlusive thrombus within the right sigmoid sinus extending into the right upper jugular vein, which appears improved compared to MRI from 2011, where thrombus involving the transverse sinus was also present. There is no new evidence for dural venous sinus thrombosis, with the superior sagittal, inferior sagittal, transverse, and left sigmoid sinus patent. There are prominent venous structures within the right middle cranial fossa as well as around the brainstem, which may reflect collateral venous drainage There is a right frontal approach ventriculostomy catheter with tip terminating within the frontal horn of the right lateral ventricle, unchanged in course and position from 2011. The size of ventricular system remains stable, with asymmetric enlargement of the left lateral ventricle relative to the right. No intracranial hemorrhage, mass effect or midline shift is present. The gray-white differentiation is preserved. Mild fluid collection is identified within the right mastoid air cells, which may be congestive or inflammatory. There is mild thinning of the right perionalcalvarium, of no clinical significance. 1. Nonocclusive thrombus involving the right sigmoid sinus, extending into the upper right jugular vein, improved compared to an earlier MRI. Prominent venous structures around the brainstem and right middle cranial fossa most likely reflect collateral venous drainage relating to chronic sinus thrombosis. 2. Stable right frontal approach ventriculostomy catheter with stable size of the ventricular system. 3. Stable ventricular configuration. Technique:A CT angiogram and venogram of the head and neck were performed following the administration of contrast. Coronal and sagittal reformations were obtained.
173	Osteogenesis Imperfecta		35	Female	35 year old female with history of osteogenesis imperfecta and chronic constipation. Scout view of the abdomen demonstrates unremarkable bowel gas pattern. Multiple findings consistent with osteogenesis imperfecta, including the following: Healed rib fractures, severe scoliosis, protrusio acetabuli, postoperative changes of the pubic symphysis, marked deformity of the pelvis. Harrington rods and bilateral femoral rods are seen. A rectal tube was inserted and contrast was gravity-administered into the rectum. Symmetrical tapering of the rectum between the angulated sacrum and anterior pubic rami with side to side narrowing by the bilateral protrusio acetabula. Massive distention of the rectum and sigmoid colon measuring up to 10 cm. Sharp angulation of the coccyx. Contrast passed into the left colon, transverse colon, and eventually the right colon. Sigmoid dilatation did not allow more contrast to reflux into the small intestine. The descending colon and proximal sigmoid colon are of normal caliber. Marked colonic redundancy is noted. Large amount of air and feces is seen throughout the colon. Postevacuation film demonstrates persistent dilatation of the rectosigmoid colon which is displaced out of the pelvis. The colonic mucosa appears unremarkable, however masses cannot be evaluated. Osteogenesis imperfecta with severe involvement of the pelvis including narrowing of the inlet. This finding leads to compression of the rectum and secondary dilatation of the rectum and sigmoid colon.
178	Abdominal Ectopic Pregnancy		30	Female	30 year old woman with a known abdominal ectopic pregnancy. Angiogram: The celiac axis and SMA are unremarkable. There are 3 right and 1 left renal arteries. No mesenteric, renal, common iliac, or external iliac branches supply the placenta or fetus. The hyperemic enlarged uterus is supplied by single right and single left uterine arteries, as well as the right gonadal artery. The placenta is supplied by a left inferior epigastric artery branch, left uterine artery branches, and the left gonadal artery. Several arteries and veins are seen crossing between the uterus and placenta. The umbilical vessels are not visualized. The uterus is drained by bilateral uterine veins and the right gonadal vein. The placenta is drained by 2 left Abdomen/ pelvis: Large abdominal ectopic pregnancy, with the fetus in the right abdomen measuring 14 cm (crown-rump length), and a 12 x 7 cm placenta attached to the serosa of the left anterior funds of the uterus. The uterus is enlarged and surrounded by large varicose, with a large collateral vein anteriorly that connects the right and left sides. No amniotic fluid is seen surrounding the fetus. Fetal soft tissues were better evaluated on the MRI, but the fetal bones are unremarkable. The maternal liver, gallbladder, pancreas, spleen, bilateral adrenal glands, bilateral kidneys, bladder, bowel, and bones are unremarkable. 1. Large abdominal ectopic pregnan 2. The uterus is supplied by bilateral uterine arteries and the right gonadal artery. The placenta is supplied by a left inferior epigastric artery branch, left uterine artery branches, and the left gonadal artery.
183	Basilar Aneurysm		56	Male	Noncontrast CT head: There is extensive bilateral white matter hypoattenuation in a periventricular and subcortical location compatible with chronic small vessel ischemic disease. This is associated with moderate symmetric brain parenchymal atrophy. A more focal region of encephalomalacia is seen in the left frontal lobe. This finding along with small punctate foci of low density in the basal ganglia presumably represent more focal regions of ischemia. No hemorrhage, mass, mass effect, or midline shift. The ventricles are appropriate for degree of atrophy. CT angiogram: There is diffuse atherosclerotic vascular calcification of the intracranial vessels. There is marked dolichoectasia of both vertebral arteries and the basilar artery. There is significant compression of the brain stem at the vertebrobasilar junction. This dolichoectasia extends to the basilar tip where a saccular aneurysm is identified measuring on the order of 1.9 cm from the base, and 2 cm in mediolateral dimension. Note is made of origin of both posterior cerebral arteries from the aneurysm sac as well as origin of the superior cerebellar arteries from the inferior aspect of the aneurysm sac. There is some low attenuation in the left anterolateral as There is some fusiform dilation of the entire length of the right M1 segment extending to, however not involving the bifurcation. Mild dilation of the left M1 is seen. There is some irregularity and atherosclerotic vascular calcification in the internal carotid arteries without evidence of flow limiting stenosis or additional aneurysm. There is some mild ectasia of the anterior cerebral arteries as well. No aneurysm in the anterior circulation is seen. Post contrast CT head: There is no abnormal parenchymal enhancement. There is appropriate opacification of both arterial and venous structures. 1. Large saccular aneurysm of the basilar tip. Both posterior cerebral arteries and the superior cerebellar arteries take origin from the aneurysm sac. 2. Diffuse dolichoectasia of the remainder of the intracranial vessels. 3. Atherosclerotic vascular calcification and vessel irregularity without areas of flow limiting stenosis.
184	Knee Replacements and Amputation	unknown		unknown	On the right, the femoral artery, popliteal, tibioperoneal trunk and trifurcation are patent, 3-vessel runoff to the ankle, posterior tibial artery into the plantar arch, anterior tibial artery into the dorsalis pedis to the toes. There is right total knee arthroplasty. Soft tissues and osseous structures exhibit no acute process. On the left, the superficial femoral artery at the proximal-most slices, adjacent to a healed femoral shaft fracture and large osteophyte spur, exhibits near circumferential atherosclerotic appearing calcification over a length of approximately 4 cm, no significant right limiting stenosis suspected at this location. More distally, the superficial femoral artery is widely patent, diminutive as compared to the right, the P2 segment of the popliteal not well evaluated, obscured by left total knee arthroplasty. The P1 and P3 segments are diminutive but widely patent as is the tibioperoneal trunk. There is 2-vessel runoff demonstrated to the amputation stump. The perone Note is made of severe diffuse muscular atrophy within the left lower leg and moderately severe muscular atrophy within the left thigh, concordant with the patient's extensive prior medical history status post remote trauma. 1. Somewhat diminutive left lower extremity arteries as compared to the right, concordant with severe muscular atrophy of the left limb and disuse. 2. Two vessel runoff demonstrated into the distal stump soft tissues, the posterior and anterior tibial arteries. 3. Atherosclerotic calcification without rate limiting stenosis of the mid superficial femoral artery immediately adjacent to midshaft healed femoral fracture and a large osteophytic spur. The appearance is concordant with comparative X-rays of the femur demonstrating moderate atherosclerotic calcification of an approximately 7 cm segment of the superficial femoral artery, likely secondary to vascular insult at the time of trauma. Teaching Points:atrophy of muscles in stump, good muscles around the knee, good vasculature, only a view of knee down.
186	Thumb Melanoma	unknown		unknown	In the left axilla, there is a large lobulated hypervascular nodal mass measuring 10.6 x 5.5 cm, with necrotic regions. Adjacent to the large mass, there are several smaller lymph nodes, the largest of which is superomedial to the mass and measures 2.6 x 1.3-CM. There are several subpectoral lymph nodes measuring up to 0.7-cm (series 8, image 82). In the left antecubital fossa, there are small lymph nodes measuring up to 4 mm (series 11, image 615). In the left thumb, there are postsurgical changes, with exposed bone over the distal phalanx. There is soft tissue swelling versus a residual mass in the thumb pad. The underlying bone appears normal. The large left axillary mass is adjacent to the axillary vein, although there does appear to be a fat plane separating the two. The axillary vein bifurcates at the distal portion of the mass. No significant venous compression or evidence for venous thrombosis. The axillary artery is not adjacent to the mass. No significant atherosclerosis or stenosis in the left upper extremity arteries. The lung apices, upper mediastinum, neck, and visualized portions of the brain are unremarkable, without any masses or lymphadenopathy. 1. Left axillary hypervascular conglomerate mass measuring 10.6 x 5.5 cm, with several surrounding smaller lymph nodes, the largest of which is superomedial to the mass and measures 2.6 x 1.3 cm. Multiple subpectoral lymph nodes, measuring up to 0.7-cm. Antecubital fossa lymph nodes, measuring up to 0.4-cm. Postsurgical changes in the left thumb. 2. The large left axillary mass is adjacent to but does not appear to involve the axillary vein macroscopically. It does not contact the axillary artery.
187	Hyperparathyroidism		29	Female	29 year old female with history of end-stage renal disease on chronic dialysis. The study demonstrates diffuse enlargement of bilateral mandibles, maxillas, hard palate, orbital walls and bony thickening of the calvarium and skull base, with superimposed bony permeative change and periosteal reaction. Findings are compatible with OsteitisFibrosaCystica, sequela of hyperparathyroidism, given patient history of end-stage renal disease on chronic dialysis. Decreasing size of bilateral maxillary sinuses is noted, secondary to bony overgrowth of the maxilla. Bilateral skull base neural foramina are preserved. Scattered nonspecific small bilateral cervical lymph nodes are seen. Bilateral orbital contents, mastoid air cells and visualized portion of the brain parenchyma are unremarkable. There is left lower lip metal ring. 1. Diffuse enlargement of bilateral mandibles, maxillas, hard palate, orbital walls and bony thickening of the calvarium and skull base, with superimposed bony permeative change and periosteal reaction are seen, compatible with sequela of hyperparathyroidism, with combination of both bony resorption and remodeling (osteitis fibrosa cystica). Technique: Axial noncontrast 3-D CT of the face was performed with 3-D, coronal and sagittal reformats.
192	Unicoronal Synostosis	19 Days		Female	Facial and head asymmetry in nineteen-day-old female. Evaluation of the calvarium demonstrates left anterior plagiocephaly and partial fusion/bony bridging of the inferior aspect of the left coronal suture. The more superior aspect of the left coronal suture is patent. The right coronal suture is widely patent. The metopic, lambdoid sutures are widely patent. There is associated bony deformity of the left orbit. Evaluation of the visualized intracranial structures is grossly within normal limits, without evidence of ventriculomegaly. No evidence of acute intracranial hemorrhage is identified. Left-sided unicoronal sutural synostosis with associated orbital defor Technique: Multiple contiguous helical CT images of the head were obtained. No contrast was administered. Coronal and sagittal reformations obtained on a separate workstation. Multiple 3D reformations also obtained.
195	Normal Elbow	unknown		unknown	The bones of the left elbow appear within normal limits without evidence for fracture or dislocation. Radial head is unremarkable in appearance. The coronoid process is unremarkable. Joint space is preserved. No loose bodies are seen in the intra-articular joint space. Visualized soft tissues are within normal limits. 1. Normal appearance of the elbow without evidence for fracture or loose bodies.
196	ACA Aneurysm		64	Female	64 year old female with history of outside MRA suggesting basilar aneurysm. Head: A bulbous deformity is seen within the anterior suprasellar cistern, which is non-specific, but which is noted to opacify with contrast on post-contrast imaging. There is mild prominence of the ventricles and sulci consistent with senescence volume loss. There is no acute intracranial hemorrhage, abnormal extra-axial fluid collection, or midline shift. The visualized portion of the orbits, paranasal sinuses, and mastoid air cells are preserved. Head and neck angiogram: Atherosclerotic calcifications are seen in the aortic arch and throughout the great vessels. Bilateral common carotid and vertebral artery origins are patent. Bilateral common carotid arteries are normal in course and caliber and are patent. Bilateral carotid bifurcations are patent and give rise to patent bilateral internal carotid arteries, which are patent and give rise to patent bilateral middle cerebral and anterior cerebral arteries. An approximately 4 mm anterior and minimally inferiorly pointing anterior communicating artery aneurysm is seen with a neck of approximately 2.7 mm. The left A2 segment origin may arise from the ane Bilateral vertebral arteries are normal in course and caliber and give rise to a patent basilar artery, which gives rise to a patent bilateral posterior cerebral arteries. No irregularity of the basilar artery is seen. There is no basilar aneurysm identified. The visualized portion of the lung apices are clear. The airway is patent. The visualized osseous structures demonstrate no definite blastic or lytic lesions. 1. 4 mm anterior and minimally inferiorly pointing anterior communicating artery aneurysm and with origin of left A2 vessel potentially being involved with aneurysm neck. 2. No basilar artery or other aneurysm identified. no dissection or arterial venous malformation. 3. Extensive atherosclerotic calcifications without veno-occlusive disease. 4. Senescence volume loss. Technique: The department CT head and neck angiogram protocol was performed using 55 mL of Isovue 370 contrast agent.
197	Moyamoya		50	Female	50 years old female with history of moyamoya. CT head without contrast: The ventricles and cortical sulci are appropriate for the the patient's age. There is no acute intracranial hemorrhage, extra-axial fluid collection, or loss of gray-white differentiation to suggest large area acute territorial infarction. Small area of left basal ganglia low attenuations, likely representing a prominent VR space. No mass effect or midline shift is present. The paranasal sinuses are well aerated. The orbits appear normal. Post surgical changes related to prior right mastoid surgery are seen. CT head with contrast: No abnormal enhancement is seen on post contrast images. CT angiography: The origins of bilateral common carotid arteries and vertebral arteries are patent. Bilateral carotid bifurcations are patent. The left internal carotid artery is patent and normal in course and caliber. The right internal carotid artery is smaller than the left internal carotid artery, and the supraclinoid internal carotid artery is occluded with numerous moyamoya type collaterals vessels seen, some of which are suggested to be supplying distal right MCA vessels. There is no evidence of cerebral aneurysm. CT perfusion:Perfusion imaging demonstrates delayed perfusion to the right MCA distribution. Scattered nonspecific lymph nodes are seen throughout the neck bilaterally, not enlarged by size or morphologic criteria. The visualized portion of the lung apices are clear. The visualized osseous structures are grossly unremarkable. 1. No acute intracranial abnormality. 2. Right internal carotid artery noted to be smaller from level of right common carotid bifurcation with complete occlusion of the supraclinoid right internal carotid artery. Demonstration of numerous moyamoya collateral vessels, with some flow seen within right MCA distribution branches. 3. Right MCA distribution perfusion defect seen. 4. No aneurysm identified within the Circle of Willis. Technique: Sequential axial images were obtained from skull base to the level of the vertex both before and after the uneventful intravenous administration of contrast. Additionally, noncontrast CT head was performed followed by contrast-enhanced CT angiography of the head and neck, after the uneventful administration of IV 150 mL of isovue370 contrast agent. Coronal, sagittal, curved planar, and volumetric reformations were performed on an independent workstation. Maximum intensity projection images were performed on an independent 3-D workstation.
198	Takayasu Arteritis	unknown		Female	Vasculature: Demonstrated is circumferential soft tissue thickening surrounding the cervical branch vessels including the right subclavian, left common carotid, and left subclavian arteries. A common origin of the right brachiocephalic and left common carotid artery is again identified. There is persistent high grade at least 95% stenosis of the right common carotid artery, left common carotid artery, left subclavian artery which is difficult to quantify but appears worse on the current exam. The right brachiocephalic artery is narrowed but appears patent. There is persistent mild soft tissue thickening of the proximal descending thoracic aorta, unchanged from
204	Hypertropic Cardiomyopathy		57	Female	57 year old female with history of congenital hypertrophic cardiomyopathy with left ventricular outflow track gradient, paroxysmal atrial fibrillation status post aortic valve repair with St. Jude valve, subaortic membrane resection, and ascending aortic arch repair with Dacron graft and PDA ligation in 2007. Patient presents with 4 days of chest pressure is low left lower quadrant pain. The thyroid gland is unremarkable. There is no significant axillary, supraclavicular, mediastinal or hilar lymphadenopathy. Median sternotomy is noted. Dense mitral annular calcification is noted extending into the adjacent myocardium. Again demonstrated is circumferential myocardial thickening of the base and mid left ventricular wall compatible with known hypertrophic cardiomyopathy. There is relative sparing of the left ventricular apex. There is no pericardial effusion. There are minimal coronary arterial calcifications without obvious stenosis within the limits of a non-gated examination . A prosthetic mechanical aortic valve is again noted (St. Jude type). There is a short segment supracoronary Dacron tubular aortic interposition graft. There is mild aneurysmal dilatation of the ascending aorta distal to the interposition graft measuring 3.6 x 3.3 cm at the level of the pulmonary artery, unchanged from 2008. No intramural hematoma, aortic dissection, or additional aneurysm is identified. Again noted is a patent ductus arteriosus with an associated ductus diverticulum. The abdominal aorta is normal in caliber. Celiac, superior mesenteric, and inferior mesenteric arteries are patent with conventional branching. There is a small accessory right upper pole renal artery. Bilateral single main renal arteries are present. There is scarring or atelectasis in the right middle lobe and lingula. Linear left lower lobe scarring and or atelectasis is also identified. There are no pleural effusions. The liver is homogeneous without focal enhancing masses. There is mild prominence of the common duct as well as the central intrahepatic duct up to 10 mm. The gallbladder is unremarkable. The spleen, pancreas, and adrenal glands are unremarkable. The kidneys are normal in size and enhance symmetrically without hydronephrosis. There is no evidence of bowel obstruction or inflammation. There is no significant retroperitoneal, mesenteric or pelvic lymphadenopathy. There is no ascites. Uterus is unremarkable. The adnexa are not clearly visualized. No pelvic mass is identified. The urinary bladder is unremarkable. There is nodular soft tissue thickening of the midline chest and upper abdomen likely related to a postsurgical scar. No suspicious osseous lesions are detected. There are mild degenerative changes of the spine. History of aortic root dilation s/p graft, mother with dissection, hypertrophic cardiomyopathy, subaortic membrane resection, thyroid gland, St. Jude prosthetic mechanical aortic valve, degenerative changes of the spine.
206	Aortic Aneurysm		66	Female	66 year old female with history of abdominal aortic aneurysm. There is occlusion of the left subclavian vein as well as stenosis of the left brachiocephalic vein resulting in multiple adjacent venous collaterals. Sternal wires and mediastinal clips are present suggestive of previous coronary artery bypass graft. The ascending aorta is somewhat prominent and measures 4.3 cm. There is diffuse atherosclerosis with areas of calcification involving the aorta. There is a descending thoracic aortic aneurysm measuring approximately 5.4 cm at the level of the left atrium with a large amount of mural thrombus. The aorta gradually returns to a somewhat normal size di The left kidney is atrophic and demonstrates marked decreased perfusion following administration of contrast. Bilateral hip prostheses are present which result in metallic artifact in the pelvis. A small, 6 mm, nonspecific pulmonary nodule is seen in the right upper lobe on image #58. Linear opacities are seen involving the lower lung zones which may represent atelectasis versus scarring. 1. Large descending thoracic aortic aneurysm with a large amount of mural thrombus. 2. Large infrarenal aortic aneurysm with a large amount of mural thrombus. 3. Common origin of the celiac axis and superior mesenteric a. 4. Occluded left renal artery as well as inf mesenteric a. 5. Patent single RT renal a. 6. Stenotic left brachiocephalic vein and occlusion of the distal LT subclavian vein resulting in multiple adjacent venous collaterals.
209	Possible Carotid Aneurysm		20	Male	20 year old male with possible aneurysm of the left carotid artery, family history of aneurysms. Head CT: No intracranial hemorrhage, large vessel territory infarction, or mass is seen. The ventricles are normal in size. There is no abnormal extra-axial fluid collection. The calvarium is intact. Paranasal sinuses and mastoid air cells are clear. CT of the head with contrast: No abnormal intracranial enhancement. CT angiogram of the head and neck: No definite intracranial aneurysm, vascular malformation, flow-limiting stenosis, or dissection is seen. 1. No acute intracranial abnormality. 2. No head and neck aneurysm, vascular malformation, flow-limiting stenosis, or occlusion. Summary: No significant abnormality Technique: With and without intravenous contrast contiguous axial images were obtained through the head. Following the intravenous administration of contrast thin-section contiguous axial images were obtained from the aortic arch through to the cranial vertex, curved and sagittal multiplanar reformatted images were obtained. Sagittal and coronal MIPs, 3D volumetric display.
210	Conjoined Twins	2, 2		Female, Female	Two-year-old girl, one of two conjoined twin. Here for evaluations of soft tissue avascular anatomy in a planning of separation. This report pertains to twin 1. Chest: Diaphragm is joint with likely communicating phrenic and subphrenic arteries and veins. The bilateral internal mammary arteries can be traced to the lateral margins of the joint diaphragms, and they may be communicating at their inferior termini. The lungs are separate. There is significant atelectasis at the dependent right lung and its internal fissures cannot be determined. There is a bilobed left lung. Patency of the trachea and branch bronchi are normal with no evidence for obstruction. The parietal pleural and the visual pleural are separate from the opposite twin. There is joining of the sterni at their inferior portion. The superior sternae and anubrea are separate. The remaining skeletal system is separate as well. There is pectus carinatum deformations of the anterior chest wall. Cardiovascular system: Situs of the abdomen is solitus, determined by normal shaped spleen in the left upper quadrant of the abdomen. There is situs solitus of the chest, determined by pulmonary artery airway relationships. A single right-sided superior vena cava and a single right-sided inferior vena cava enter the right atrium unobstructed. There are three right pulmonary veins and two left pulmonary veins that enter the left atrium unobstructed. Since this is a non-gated study, intracardiac surgery is not well visualized. Grossly, there is atrioventricular concordance and ventriculoarterial concordance. The ventricular position is D-loop with apex of a heart In the abdomen, the left lower lobe are joined. For twin 1 there are three hepatic veins draining into the inferior vena cava. The left hepatic vein may drain only the upper portion of the left lower lobe (Segment 4A and Segment 2). The lower portion of the left lower lobe appears to be drained by the middle hepatic vein of the opposite twin. The intrahepatic portion of the portal veins are normal in architecture. The left portal vein communicates with that in the opposite twin. There may be some small communications through the anterior segment, right lower lobe portal vein as well. The companion hepatic arteries are not well visualized, but they likely join The aorta gives off a celiac axis that is triforcated into a normal splenic artery, left gastric artery, and common hepatic artery. The superior mesenteric artery and inferior mesenteric artery arise from their expected location from the aorta. There are bilateral single renal arteries. The iliac arteries appear normal in the pelvis. The iliac vein drains through a right-sided inferior vena cava unobstructed. There is a normal anterior aortic veins. No evidence for deep venous thrombosis. The superior mesenteric vein joins the splenic vein to form a main portal vein. This end to deliver at the portahepatis unobstructed. Abdomen and Pelvis: There is a mild degree of intrahepatic ductal dilatation in both liver lobes, more prominent than the opposite twin. The intrapancreaticportion of the common bile duct appear normal in size. A separate gallbladder is present. The pancreas, kidneys, adrenal glands, and the stomach are separate. The oral contrast within the GI tract of twin 1 can be traced to the rectum. Since no oral contrast is found within the GI tract of the opposite tract, a GI communication has been excluded. There is however, herniations of a small amount of large and small bowel from the opposite twin into the peritoneal cavity of twin 1. Status of the omentum can 1. Thoraco-amphilophus conjoined twin 2. Joined diaphragm 3. The inferior half of the LT lower lobe of twin 1 appears to be drained by the middle hepatic vein of twin 2. 4. Connecting LT portal vein 5. Separate GI tracts 6. Separate cardiac chambers 7. Status of the omentum is not certain 8. Herniation of small amount of bowel from twin 2 into the peritoneal cavity of twin 1. 9. Joined sternum.
216	Ankle Fx-Subluxation	unknown		unknown	There is a comminuted fracture of the talar neck with significant lateral subluxation of the talus with respect to the calcaneus. Thetalar head remains in normal articulation with the navicular. There is also an avulsion fracture at the posterior aspect of the lateral malleolus. Asymmetry of the ankle mortise is seen anteriorly as well as at the talonavicular joint, and there is a lipohemarthrosis within the talonavicular joint. 1. Comminuted fracture of the talar neck with significant subluxation of the subtalar joint. 2. Avulsion fracture of the posterolateral malleolus. Teaching Points: Comminuted Talus Fracture, discuss weight bearing bones in foot and leg.
219	Ureteral Stent		42	Female	A double J ureteral stent is visible in the right kidney extending from the renal pelvis to the bladder. Ureteral thickening is noted around the stent. There is no evidence of hydronephrosis or renal stones. While not an optimal contrast phase for venous evaluation, filling defects in the right ovarian vein and right pelvic sidewall veins may represent thrombi.
235	Cystic Fibrosis Inspiration	unknown		Female	The abdominal aorta, celiac artery, superior mesenteric artery, and inferior mesenteric artery are patent. The left gastric artery again arises from the descending aorta. Conventional hepatic arterial anatomy is present. There are single bilateral renal arteries, patent. 1. Diffuse peribronchial thickening bilaterally, most prominnet in the right upper and right middle lobes. 2. Diffuse cystic and cylindrical bronchiectstasis, peripheral mucous plugging and centrilobular nodularity within the right lung, most prominent in the right upper and middle lobes with associated air trapping. These findings are all consistent with patient's history of cystic fibrosis. 3. No focal consolidation or pneumothorax.
236	Cystic Fibrosis Expiration	unknown		Female	Right lung: There has been interval moderate increase in bronchial wall thickening and mucoid impaction in the right upper lobe. The degree of bronchiectasis in the right upper lobe is grossly unchanged and appears moderate to severe. There is new inferior RUL consolidation. There has been interval significant increase in bronchial wall thickening, mucoid impaction, and airspace consolidation in the right middle lobe. The appearance is compatible with a significant acute exacerbation of disease. There is mild bronchiectasis and mucoid impaction in the superior right lower lobe. The inferior portions of the right lower lobe appear slightly improved compared to prior study and appear relatively normal. Left lung: There is very mild bronchiectasis and mucoid impaction in the left upper lobe and lingula. There is very minimal bronchial wall thickening in the left lower lobe. Overall, the degree of involvement in the left lung is markedly less than in the right lung. No pleural effusions are seen. On expiratory images, there is patchy air trapping in the lungs, most pronounced in the right middle lobe and posterior left lower lobe. The heart size is normal. Several lymph nodes are seen posterior to the superior vena cava. The right hilum appears slightly full, possibly representing lymphadenopathy, thought full evaluation is limited by lack of intravenous contrast. Limited visualized of the upper abdomen, including portions of the liver, pancreas, spleen, and stomach, is grossly unremarkable. The pancreatic gland does not appear significantly atrophied. The visualized osseous structures demonstrate no suspicious lytic or sclerotic lesions. 1. Significant acute exacerbation, with interval marked increase in disease in the right middle lobe and right upper lobe. This is characterized by increased bronchial wall thickening, bronchiectasis, mucoid impaction as well as airspace consolidation. 2. Interval slight decrease in disease in the inferior portions of the right lower lobe. 3. The degree of involvement of the left lung is markedly less compared to the right lung, as before.

Anatomage Table 9.0 Case Library Descriptions

				Post external fixation replacement and flaps retrieved. There is evidence of reoperation including new external fixation equipment positioned over the right lower extremity.
				Evidence of prior screw placement is demonstrated along the tibia. There is gas within the distal femur consistent with the reported history of cancellous bone graft donor site. There is hazy ground-glass opacification within the region of the oblique fracture of the distal tibia, which may reflect the recipient site. Overlying streak artifact from hardware placement obscures fine bony visualization. There are multiple fracture fragments of the fibula again demonstrated. The more proximal of these is in the mid to distal fibula and demonstrates oblique course and callus formation. The fracture, slightly more distally, is relatively sharp in nature and may represe
				There is diffuse soft tissue swelling of the right lower extremity and numerous tiny clips consistent with reported history of free plat repair.
				There is no evidence of fluid collection within the subcutaneous tissues.
				The leg length from femoral head to talar dome on the right measures 81.2 cm. On the left this length measures 82.4 cm. Measured on axial images, the right tibia measures 34.1 cm and the left tibia measures 35.3 cm. Comparing the angle of the anterior tibia with respect to the posterior condylar lines on the femur demonstrates 18.6 degrees of external rotation on the left and 9.2 degrees of external rotation on the right. Status post redo external fixation hardware of the right lower extremity.
237	Tibia Fibula Fx	unknown	Male	Degree of external rotation and leg length. Teaching Points: Good example of external fixation, possible use in bioengineering course.
				Teaching Points: good forearm and elbow vessels, muscles in hand & forearm
				Analysis: - Diffuse oedema of the soft tissues. - The other imaged structures appear normal within the limits of the technique.
238	Forearm Vessels	unknown	Female	Analysis provided by Università degli Studi de L'Aquila (Prof. Mucchiarelli, Prof. Bianchi and Dr.Bernardi)
				89 years old female with CT arthrogram Left shoulder for surgical planning for total shoulder arthroplasty. Patient has a history of rheumatoid arthritis and severe shoulder pain. The joint is well distended with contrast. Multiple small filling defects within the joint fluid are consistent with extensive synovitis with rice body formation in large axillary and superior subscapularis recesses. Contrast within the anterior defined is iatrogenic
				There are extensive arthritic changes within the glenohumeral joint consistent with the given history of rheumatoid arthritis with associated secondary degenerative changes. This includes severe joint space narrowing, subchondral sclerosis and subchondral cystic formation, and osteophyte formation. The joint space is nearly completely obliterated.
				Contrast is seen entering the undersurface of the supraspinatus and infraspinatus tendons. There are a few small pinhole full thickness tears of the supraspinatus and infraspinatus tendons and associated contrast material in the subacromial/subdeltoid bursa. There is only mild atrophy of these muscles. There is partial thickness tearing of the subscapularis tendon. The biceps tendon appears grossly intact. There are signs of biceps tenosynovitis.
239	Shoulder Arthritis		89 Female	1. Findings consistent with severe rheumatoid arthritis of the left shoulder with associated secondary degenerative changes. 2. Partial-thickness and pinhole full thickness tearing of the supraspinatus and infraspinatus tendons, partial tearing of the subscapularis tendon. There is no large full thickness, retracted tear.
				57 year old female with arm swelling and cellulitis, concern for abscess. There is an ill-defined approximately 7 x 4.8 cm region of hypoattenuation in the posterior axilla involving the long head of the triceps, posterior deltoid, and adjacent teres muscles, best seen on coronal image 96, series 500. Skin thickening is seen in the medial arm distally (axial image 234, series 3), which may reflect edema or cellulitis. Mild edema and superficial peri- fascial stranding is seen in the pectoralis muscle and arm, with no discrete rim enhancing fluid collection. Evaluation of the regional lung fields demonstrate multiple parenchymal lesions, the largest include an irreg
240	Axilla Tumor		57 Female	1. Ill-defined hypoattenuation in the triceps, deltoid, and teres muscels, which is non-specific and may represent metastatic, infection, or less likely, post radiation change such as necrosis; if clinically indicated, MRI may be helpful for further evaluation. 2. Non-specific skin thickenin and superficial fascial stranding in the right arm, with no discrete rim enhancing fluid collections. 3. Multiple lung lesions, compatible with history of metastasis.
				31 year old male. This section through the whole head (3D-CT) & 3D reconstruction performed to visualize the position of the bullet. Patient has most likely R Temporal lobe epilepsy. Located along the right middle cranial fossa, lateral to the right temporal horn, an ovoid metallic density is present consistent with history of gun shot injury. There is a focal defect in the contralateral calvarium at the level of the inferior left coronal suture. No osseous fragments are seen within the cranium. The overlying soft tissues are within normal limits. Beam hardening artifact limits evaluation of the soft tissues between the calvarial defect and the metal.
				There is no acute intracranial hemorrhage, abnormal extra-axial fluid collection, midline shift or loss of gray-white differentiation to suggest acute territorial infarction. The ventricles and subi are appropriate for the patient's stated age.
				Mucosal thickening is present within the right maxillary sinus. A mucous retention cyst is present within the left maxillary sinus.
				The visualized portion of the orbits and mastoid air cells are preserved. 1. Right middle cranial fossa bullet fragment, likely from a left inferior coronal suture entry point, without hemorrhage or herniation. 2. Bilateral maxillary sinus mucosal thickening likely secondary to a congestive or inflammatory process.
242	Gun Shot Wound to Head		31 Male	Technique: CT images were taken from the skull base to the level of the vertex without the administration of intravenous contrast at 0.625-mm intervals and reformatted as needed.
				1. No evidence of stenosis, aneurysms, or wall thickening involving the aorta and its proximal cervical branches including the proximal bilateral carotid and vertebral arteries as well as the bilateral subclavian arteries to the level of the axillary arteries.
				Please refer to Report for CTA neck for evaluation of vessels more superiorly.
				2. Asymmetric appearance of the humeral heads bilaterally, characterized by diffuse sclerosis of the right humeral head physis containing multiple small lytic lucencies, not seen on the left. Differential includes degenerative changes with subchondral cysts, osteonecrosis secondary to steroids, and less likely infection. Correlate clinically, and if indicated obtain a dedicated plain film of the right shoulder.
				Bilateral scarring. Lungs otherwise clear. No axillary, hilar, or mediastinal lymphadenopathy.
				Heart size within normal limits. The visualized thoracic aorta is normal in caliber and wall thickness, measuring 27 mm in the ascending aorta, 19 mm in the mid descending aorta, and 18 mm at the level of the diaphragmatic hiatus. An aberrant right subclavian artery is seen, with no evidence of airway compression. The major cervical branches of the aortic arch demonstrate no evidence of stenoses, aneurysms, or wall thickening. A dominant left vertebral artery is seen which is patent.
				No consolidations or effusions.
				Visualized abdomen demonstrates two hypodense lesions in the left hepatic lobe that are too small to characterize. A larger hypodense lesion measuring up to 17 mm is seen in the right hepatic lobe, likely a cyst.
				There is asymmetric appearance of the humeral heads bilaterally, characterized by diffuse sclerosis of the right humeral head physis with multiple small lytic lucencies which are not seen on the left.
243	Dominant Left Vertebral Artery		47 Female	Technique: Before and following the uncomplicated IV administration of 55 mL Isovue 370, CT angiogram of the chest was performed from the thoracic inlet to the level of the kidneys. 3D reformatteres consisting of curved and multiplanar reformations, maximum intensity projections, and volume rendered images were performed on an independent workstation and corroborate the findings.
				Gunshot track #1: Track originates in the right anterior shoulder, causes a comminuted fracture of the proximal right humerus and humeral head. Track continues anterior to the scapula with associated subcutaneous emphysema, before proceeding through the lateral aspect of the right upper lobe. Track continues by leading to complex fractures of the articulating aspect of the posterior right fifth rib and posterior elements of the T5 and T6 vertebral bodies. T5 right and left inferior articulating processes and spinous process/lamina are invo
				Gunshot track #2: Track begins in the right anterior chest, causing complex fractures of the anterior aspect of right rib 5, right rib 4, right rib 3, and the manubrium. There is adjacent pulmonary contusion along the right upper lobe. The right internal mammillary artery is lost at the level of rib 5, and is likely/occluded. Hematoma is present posterior to the sternum. Track continues through the proximal left clavicle generating a complex fracture. This is a mildly comminuted fracture of the the anterior/superior aspect of the humeral head. Bullet is lodged in the subcutaneous tissue along the left lateral shoulder.
				There is a small right hemothorax. Small right pneumothorax. A chest tube has been placed in the right hemithorax, distal tip abuts the mediastinum. No mediastinal shift. Left lung is clear. No left pneumothorax.
				Multiple motion artifacts are caused due to patient breathing during this gated study. No evidence of aortic injury. There is retrosternal hematoma within the anterior mediastinum, but no perisotnic hematoma. No pericardial effusion. No evidence of active arterial extravasation. The great vessels appear uninvolved, including the left subclavian artery. Left subclavian vein is poorly evaluated due to high-density contrast material within, but it and the left innominate vein demonstrate no clear evidence of injury. Limited evaluation of pulmonary arteries demonstrate no filling defects. None available Report: Brief findings 1. GSW extending from R anterior to L shoulder. This track is through the subcutaneous tissues and chest wall. It passes through the anterior mediastinal fat and just misses the heart. Multiple associated rib fx, sternal fx, and L clavicular fx. Anterior mediastinal bleeding most likely related to sternal fx. Great vessels intact. Cervical vessels intact. 2. GSW extending from R shoulder through humeral head, soft tissues of R back, R posterior lung, and ~T5 thoracic spine, with bullet lodged in left back. Pulm hemorrhage, destruction of posterior elements of ~T5 and bullet trajectory basically through spinal canal. Bone fragments, metallic fragments, and gas seen in spinal canal. Likely traumatic cord injury.
				Other (major findings): -R pneumothorax, ~R humerus fx, ~L clavicle fx -no major airway injury, -no pericardial effusion
244	Two Gunshot Tracks		58 Male	abd/pelvis: no s/s major organ injury or fracture 55 year old woman, recently died from breast cancer. Contrast media was injected into the arteries.
				Analysis: - Diffuse subcutaneous emphysema and oedema of the soft tissues - Multiple occlusions at the level of the division of the lateral branch of the palmar artery, at the 4th metacarpal bone level with the disappear of the superficial anastomotic circle between the ulnar and the radial artery. - In addition, there is a stenosis of the radial artery at the distal extremity of the radial bone. - It cannot be evaluated if these findings are due to postmortem signs or to artificial processes.
245	Cadaveric Hand with Contrast		55 Female	Analysis provided by Università degli Studi de L'Aquila (Prof. Mucchiarelli, Prof. Bianchi and Dr.Bernardi) Normal foot anatomy, high resolution CT scan Teaching Points: High Resolution of bones in foot, great bones and tendons in foot.
				Analysis: - Diffuse degenerative phenomena (arthrosis) of the foot joints, in particular at level of cuboid-metatarsal joint and of the bones and relative joints forming the medial border of forefoot (first ray). The latter include: medial cuneiform, first metatarsal and the two phalanges of hallux. - The others imaged organ appear normal within the limits of the technique.
247	Foot Anatomy	unknown	unknown	Analysis provided by Università degli Studi de L'Aquila (Prof. Mucchiarelli, Prof. Bianchi and Dr.Bernardi) Lower extremity- old/healed fracture. Severe calcification noted beginning Right distal popliteal, continued calcification noted beginning of popliteal art bilaterally down to distal trifurcation. Right peroneal tapers off half way of beginning of trifurcation with minimal collaterals, right posterior tibial art also diminishes distally.
248	Knee and Foot Runoff	unknown	unknown	Right calcaneous and talus bone demonstrate bursitic resulting from an old fracture as concluded with scrow of Right toe. Teaching Points: Knee to Foot scan, good arteries, fractured 1st metatarsal. Deep vein thrombosis. Filter in IVC to block emboli going to heart and lungs.
				Analysis: - Presence of an inferior vena cava filtrum suggestive of risk of pulmonary embolism. - Superficial femoral artery occlusion at its origin. - Calcification of abdominal aorta. - The others scanned structures appear normal within the limits of the technique.
249	Pelvis Runoff		19 Male	Analysis provided by Università degli Studi de L'Aquila (Prof. Mucchiarelli, Prof. Bianchi and Dr.Bernardi)
250	Leg Runoff		77 unknown	Venous phase runoff; Varicose veins - prominent veins Teaching points: Good bones & tendons, muscles into foot.
				Purchased by Mrs. Hearst in 1899, this mummy is owned by the Phoebe A. Hearst Museum of Anthropology in Berkeley, California. This 6 foot-long (1.8-meter-long) Crocodile mummy with babies it is from the Graeco-Roman Period (c. 332 BCE-323 CE) although Its Provenance is unknown. It is covered in a black tar-like coating and contains crocodile remains including wood, cordage, linen, balm.
252	Crocodile Mummy	unknown	unknown	The young crocodiles were placed on the adult's back to emphasize the positive nurturing aspect of this fearsome creature. Thanks to Richard Evershed and Lucy Cramp (University of Bristol, Organic Geochemistry Unit) we now know that the black coating used to embalm PAIMA crocodile mummy 5-513 consists of a mixture of coniferous resin, beeswax, and fat/oil; all common components of Egyptian mummification balms.
				The young crocodile were placed on the adult's back to emphasize the positive nurturing aspect of this fearsome creature. Crocodiles were sacred to the crocodile god Sobek, and this mummy likely was embalmed as an offering to the god and interred in a mass grave. Recent CT scanning of 2 croc mummies in partnership with Stanford.
				The measurements for the mummy are: Length (head to toe): 64 1/2 in. : 1640 mm Width (widest point at shoulders, across chest): 15 in. : 381 mm Height (at chest): 9 1/4 in. : 235 mm Height (at face): 10 in. : 254 mm Ikotherosa, a priest from Akhmim, Egypt 500BC, Mummy owned by Ancient Arts Department of The Fine Arts Museums of San Francisco.
				Images acquired by Dr. Rebecca Fahrig, Department of Radiology, Stanford University.
				Couple of observations: amazing how well preserved even tiny structures like inner ear and middle ear structures are.
				There is one "abnormality" dural thickening in the spine from about T3 to T9 - possible origin includes (most likely) previous infection or even old hemorrhage. Description: Egyptian Mummy from Akhmim, Egypt
253	Mummy Akhmim	unknown	unknown	Report: The Fine Arts Museums of San Francisco Expertise of Jonathan Elias of the Akhmim Mummy Studies Consortium (AMSC), Elizabeth Cerny and Alisa Eagleston of the Conservation Department of the Fine Arts Museums (FAMSF), and Renae Dreyfus Curator in Charge of Ancient Art and Interpretation of the FAMSF
				There has been interval placement of an aorto-bi-iliac stent graft which commences immediately below the level of the celiac axis and extends to the distal portion of the common iliac arteries bilaterally. Bilateral renal artery stented stent grafts have been placed. The renal arteries appear patent bilaterally.
				Significant calcified and noncalcified mural thrombus is noted in the distal descending thoracic aorta and supra-celiac abdominal aorta. The native abdominal aortic aneurysm sac measures 5.3 x 5.3 cm and contains a small amount of air. No obvious endoleak is identified. The origin of the SMA is adjacent to the superior metal marker of the aortic stent graft and resultant metal artifact, obscuring the SMA ostium. There is abrupt caliber change in the distal SMA noted immediately distal to the ileo-celic artery origin concerning fetlical dissection. The right colic artery is patent. There is satisfactory opacification of the celiac axis and its branches.
				Mild subcutaneous emphysema and post operative changes are noted anterior to the visualized femoral vessels, compatible with recent bilateral catheterization.
				There is a filling defect involving the proximal portion of the IMA.
				There is mild bowel wall thickening of the descending and sigmoid colon. There is no obvious pericolonic fat permeation. The superior hemorrhoidal artery and left colic artery are patent.
				There is redemonstration of the 2-cm hypoattenuating lesion in the right hepatic lobe which demonstrates sluggish discontinuous and peripheral nodular enhancement on this arterial phase study. This most likely represents a hemangioma. Note is again made of nodularity of the left adrenal gland.
				Note is made of vicarious excretion of contrast material into the gallbladder and extrahepatic biliary system, which can be traced into the duodenum. A Foley catheter is noted in the urinary bladder.
				There is no free fluid in the abdomen or pelvis.
				Limited images of the lung bases redemonstrates mild peripheral bronchiolectasis. Bilateral lower lobe dependent areas of subsegmental atelectasis are noted. Negative for pleural effusions. The visualized heart chambers are unremarkable. Negative for pericardial effusion.
254	Gallbladder with Contrast	unknown	Female	The visualized osseous structures are unremarkable. 1. Status post placement of an abdominal aortobiliac stent graft with bilateral renal artery stent-kel stent grafts. 2. Innumerable bilateral renal cortical hypodensities are suspicious for microembolic phenomenon from shedding of cholesterol emboli potentially from thetacsabdominal atherosclerotic disease. Larger areas of inhomogeneous parenchymal enhancement in the upper pole of the left kidney and interpolar regions of both kidneys likely reflect sequela of ischemia/infarction. Persistent nephrographic phase of both kidneys on the initial noncontrast images can be seen in ATN [acute tubular necrosis], which may be superimposed on the aforementioned findings. 3. Focal dissection of the distal SMA just distal to the ileo-colic artery origin. Metal artifact from the metal marker of the superior aortic stent obscures the SMA ostium. 4. Mild bowel wall thickening of the descending and sigmoid colon with proximal IMA occlusion. The radiographic findings are concerning for watershed bowel ischemia.
				4 month old male Gender: male Gender differentiation appears preserved. Ventricles appear appropriate in size and morphology. Extracerebral spaces appear intact. There is questionable slightly small frontal lobes.
				The anterior fontanelle appears slightly small. The superior metopic suture appears open. The inferior metopic sutura appears closed with mild ridging along the inferior frontal midline calvarium. The sagittal suture, coronal suture, lambdoid suture and posterior fontanelle appear open. The orbits appear symmetric and preserved. 1. The superior metopic suture appears open, while the inferior metopic suture appears closed with mild overlying ridging. Correlate clinically for primary or secondary craniosynostosis. 2. Small anterior fontanelle. 3. Questionable slightly small frontal lobes.
255	Craniosynostosis	4 Months	Male	Technique: Multiple contiguous helical CT images of the head were obtained. No contrast was administered. Coronal and sagittal reformations obtained on a separate workstation. Multiple 3D reformations also obtained.
				41 years old male with CT upper extremity with contrast, LT. Assess bidirectional measurements for treatment response. There is redemonstration of diffuse dermal thickening within the left supraclavicular region measuring approximately 5.5 cm transversely, similar to the previous examination. The exophytic component of this measures about 17 x 9 mm, similar in appearance to the previous exam.
				The nonunited fracture of the left clavicle is again seen. Small subcutaneous nodules along the posterior neck, back, anterior upper arm, and left forearm are unchanged. There are no other prominent exophytic tumors.
				Fractures within the left-sided fourth and fifth ribs are again noted. Multiple low-attenuation lesions within the left kidney are unchanged in appearance. A hyperdense lesion in the posterior interpolar region of the left kidney is also unchanged. Small left-sided inguinal lymph nodes are unchanged. Multiple Schmorl's nodes are present within the thoracic spine. A probable hemangioma in the T5 vertebral body is also unchanged. The nonunited fracture of the left clavicle is again seen. Small subcutaneous nodules along the posterior neck, back, anterior upper arm, and left forearm are unchanged. There are no other prominent exophytic tumors.
256	Clavicular Fracture		41 Male	Schmorl's nodes in thoracic spine.
258	Dog	unknown	unknown	
259	Child Mummy	unknown	unknown	This 2000 year old child mummy is from the Roxicrucian Egyptian Museum, San Jose CA. This high-resolution scan was performed by Rebecca Fahrig, PhD, Department of Radiology at Stanford University on a Siemens C-arm high contrast scanner. None available None available Description: Shetit, 41/2 year old Child Mummy
260	Cat	unknown	unknown	
261	Frog	unknown	unknown	
262	Full body		26 Male	26 year old male. Recent death from rhabdomyosarcoma. This patient was scanned several times before and after embalming as part of a study to see the radiographic changes with embalming. None available Report: High resolution CT scan of a 26 year old fresh cadaver.
263	Sliced Mouse	unknown	unknown	
264	Parrot	unknown	unknown	
				CT angiogram head and neck: There is a vein of Galen aneurysmal malformation, which appears unchanged compared to a recent MRI. in regards to size and morphology. Associated with this is diffuse enlargement of the posterior cerebral artries, left posterior communicating artery, basilar artery and bilateral intracranial as well as cervical vertebral arteries throughout. Prominent vessels are seen near the posterior cerebral arteries, with an apparent dominant midline feeder artery extending into the vein of Galen malformation. The origin of this feeder is difficult to lateralize given its midline location, though appears similar to angiogram 3 years earlier. T
				Within the brain, moderate ventriculomegaly is stable. With contrast administration, assessment for intracranial hemorrhage is limited, though none is identified. There is no edema, mass, or infarct. The left maxillary sinus is opacified with moderate mucosal thickening of the left ethmoid air cells. The remainder of the visualized paranasal sinuses and mastoid air cells are normally aerated.
				The soft tissues in the neck reveal no focal abnormality. Specifically, no lymphadenopathy by size criteria is identified. The nasopharynx, oropharynx, hypopharynx,and subglottic trachea appear appropriate in appearance. The visualized lung apices are clear. Osseous structures reveal no focal abnormality.
				1. Vein of Galen aneurysmal malformation, unchanged in size or morphology compared to a recent MRI allowing for differences in modality.
				2. Associated diffuse enlargement of the cervical vertebral arteries, intracranial vertebral arteries, basilar artery, bilateral posterior cerebral arteries as well as a left posterior communicating artery.
268	Arteriovenous Malformation	unknown	Female	3. A large midline feeder artery extends into the Vein of Galen malformation, as seen previously. The origin of this is difficult to lateralize given its midline location. Technique: A CT angiogram of the head and neck were performed following the uneventful intravenous administration of iodinated contrast. Coronal and sagittal reformations were obtained. On a separate workstation, 3D reconstructions of the Circle of Willis were created and reviewed.
				Female skin is 64 year old with a history of hepatocholecarcinoma status post bilateral lung transplant who had two recent admissions for bacteremia and persistent "GI issues". The study was ordered to evaluate for a source of infection and/or emetic lesions. The heart size is normal without a pericardial effusion. The aorta is normal in course and caliber. Adhesions and postsurgical changes from the prior bilateral lung transplant are seen without significant change from the CT 9/20/2010. Radiodensities lying along the posterior pleural margin of the inferior portions of the lower lung lobes bilaterally are not significantly changed from the prior CT.
				In the liver, there is multifocal and predominantly peripheral biliary ductal dilatation which is more extensive in the left lobe and not significantly changed since the prior studies. The previously seen 2.2 x 1.6 cm low-density lesion at the periphery of the liver in segment 5/4b is no longer present. Three simple cysts in the region of the left portal vein are unchanged since the prior MRI. The gallbladder is surgically absent. The pancreas, spleen, and adrenal glands are normal in appearance.
				A 4-mm hypodensity in the superior pole of the right kidney and a 14-mm hypodense lesion adjacent to the renal pelvis and the right kidney are both seen on the prior MRI where they appear to be simple cysts. No nephrolithiasis or hydronephrosis.
				In the stomach, a 15 x 13 x 13 mm polypoid enhancing lesion extends into the lumen from the anterior wall. Evaluation of the small and large bowel is limited by incomplete distention with oral contrast. The small and large bowel are normal in course and caliber. Again seen is diverticulosis without evidence of diverticulitis. The appendix is normal in appearance, without peri-appendiceal inflammation.
				The bladder is normal in appearance. The calcification of the anterior myometrium of the uterus likely represents a calcified fibroid and is unchanged since the prior study in 2008. No ascites or pneumoperitoneum.
				Enlarged retrocrural (9-mm) and retroperitoneal (10 mm) lymph nodes are unchanged since the prior studies.
				Atherosclerotic calcification of the aorta and coronary arteries is noted.
273	Lymphangioleiomyomatosis		54 Female	No suspicious bony lesions identified. Soft tissues are normal in appearance. 1. 15-mm polypoid enhancing lesion in the stomach projecting into the lumen from the anterior wall was not clearly present on prior studies. Endoscopic evaluation is recommended. 2. Multifocal predominantly peripheral intrahepatic biliary ductal dilatation and may be due to inspissated biliary sludge (reported on ERCP in 2008) or nonopaque biliary stones. No hepatic mass seen on this exam. Hepatic cysts seen on MRI 11/10/2010 are not significantly changed. Previously seen peripheral segment 5/4b low-attenuation lesion is no longer present, suggesting it had an infectious etiology. 3. Enlarged retrocrural and retroperitoneal lymph nodes unchanged 4. Diverticulosis without evidence of diverticulitis.

Anatomage Table 9.0 Case Library Descriptions

				87 years male with CT venogram from diaphram to the ankle. HX thrbophlebitis, ulcer of lower limb UNS, varicos veins with ulcer and inflammation. The heart size is within normal limits. The aortic valve and mitral annulus calcifications are present. The abdominal aorta is normal in caliber with marked atherosclerotic calcifications. The SMA and celiac axis are patent with mild to moderate atherosclerotic disease. An accessory right lower pole renal artery is visualized. The bilateral main renal arteries are patent with mild to moderate atherosclerotic disease. The IMA is patent. There is mild ectasia of the bilateral common iliac arteries measuring up to 1 The bilateral common iliac, external iliac, superficial femoral, and popliteal veins are patent with no evidence of venous thrombus. Within the right calf there is focal thrombus within the right anterior tibial vein (2, 845). The remaining right calf veins appear unremarkable. A focal filling defect is seen within the distal superficial femoral/proximal popliteal vein (2, 581) which may represent a small nonocclusive thrombus versus mixing artifact. Bilateral subcutaneous edema is present, most prominent along the left lower extremity laterally. There is marked atrophy of the muscles in the lower extremities. The osseous structures demonstrate bilateral total knee arthroplasties, calcaneal enthesophytes bilaterally, and marked bilateral SI joint degeneration.
				Mild atelectasis versus scarring is seen at the bases. The 11-mm intraluminal gastric lipoma is seen at the level of the antrum. An 11-mm hypodensity is seen at the peripheral liver, too small to characterize. The spleen, pancreas, and adrenal glands are unremarkable. Moderate atrophy that the kidneys are is present.
				Scattered renal hypodensities are present as follows: 16 mm left lower pole hypodensity, and 2.4-cm in pole hypodensity are visualized, exophytic right upper pole 17-mm hypodensity. The hypodensities are favored to represent renal cysts, though incompletely characterized. A large left fat containing inguinal hernia is present, and a small right inguinal hernia seen. A right lower quadrant ileal conduit is present. At the level of the pubis, there is an anterior drainage catheter with tip located in the lower pelvis. No significant fluid collection is identified. A left lower quadrant colostomy present. A small 2.1 cm well-defined cystic collection is seen at the junction where the ureters join the ileal conduit with no significant surrounding inflammation, nonspecific finding. Gallstones are seen within the gallbladder. Postsurgical changes consistent with a prostatectomy are present.
274	Venogram	87	Male	1. Focal thrombus within the right anterior tibial vein in the calf mixing artifact versus focal thrombus is seen within the left distal SFA/popliteal vein. 2. Large left fat containing inguinal hernia. 3. Post surgical changes as described above.
				58 year old male. Reason for study: "Patient with history of renal cell carcinoma. Assess for recurrence." Additional history of hepatitis C status post liver transplant. 3-mm nodule right lower lobe (3:14), stable since 2003. Calcified granuloma left lung base. Ill-defined 4-mm nodule left lung base (3:41), new since prior. No effusions.
				Multiple moderate perisplenogastric varices 1.5 cm left hepatic cyst. Stable prominence of the CBD, likely attributable to cholecystectomy. Multiple pancreatic calcifications including a 9-mm dystrophic calcification at pancreatic head. Stable dilatation of proximal pancreatic duct with gradual tapering upstream. Spleen, bilateral adrenal glands within normal limits. Postsurgical changes upper pole right kidney.
				Bowel normal in caliber. Bladder unremarkable.
				No lymphadenopathy.
				Stable bilateral inguinal hernias, left containing a small non-incarcerated portion of sigmoid colon, right containing a small portion of bladder.
				Stable degenerative changes of visualized spine. 1. Status post right partial nephrectomy with no evidence of recurrent tumor. However, note that evaluation is limited by lack of IV contrast. 2. New ill-defined 4-mm nodule left lung base, nonspecific. Attention on follow-up imaging. 3. Findings related to chronic pancreatitis, including dystrophic calcifications and dilated pancreatic duct 4. Status post liver transplant, with stable prominent paraesophageal varices.
276	Renal Cell Carcinoma	58	Male	5. Stable bilateral inguinal hernias, left containing a small non-incarcerated portion of sigmoid colon, right containing a small portion of bladder.
				Large intracranial hemorrhage, evaluate for underlying vascular malformation. 36-year-old female with history of sudden onset nausea and vomiting presenting with large right intraparenchymal hemorrhage. Scout localizer images demonstrate an endotracheal tube that terminates within the thoracic trachea above the carina. A nasopharyngeal tube terminates within the left upper quadrant overlying the gastric bubble.
				CT Angiography: A3-vessel arch is present. The origins of bilateral common carotid arteries and vertebral arteries are patent. Bilateral carotid bifurcations are patent. Bilateral internal carotid arteries are patent. No evidence of flow-limiting stenosis within the Circle of Willis. No evidence of cerebral aneurysm. Again demonstrated is a large intraparenchymal hemorrhage centered overlying the right basal ganglia with associated midline shift, subfalcine and subtentorial herniation. There is mass-effect on the surrounding vasculature. There is minimal change within the interventricular hemorrhage within the lateral ventricles as well as within the fourth ventric
				CT head with contrast: No abnormal enhancement is seen on post contrast images. There are no focal areas of increased density within the intraparenchymal hemorrhage to suggest active extravasation. Minimal change in the large right intraparenchymal hemorrhage with associated midline shift and herniation without focal areas of increased density to suggest active extravasation. There is no associated aneurysm or AVM demonstrated on the volume rendered images.
				Report: Postcontrast:
280	Intraparenchymal Hemorrhage	36	Female	-Rudemonstration of large R frontotemporal intraparenchymal hemorrhage, diffuse subarachnoid hemorrhage and intraventricular hemorrhage with mass-effect including effacement of the right lateral ventricle, approximately 1 cm right-to left midline shift, and right uncal herniation similar in appearance to recently performed noncontrast head CT
				41 year old male with epilepsy. Study is of limited diagnostic quality. There is interval placement of subdural electrodes over the posterior parietal region with postsurgical change. No midline shift. No large hematoma. 1. Study is of limited diagnostic quality. No large hematoma. No midline shift. 2. Interval placement of subdural electrodes with postsurgical change.
281	Intracranial Electrode	41	Male	Technique: Multiple contiguous axial non-contrast CT images were obtained through the head.
				Severe Pulmonary HTN patient with chest pain, r/o coronary artery compression by enlarged pulmonary artery. Cardiac and great vessels: Since the prior exam, no significant interval change is seen in the caliber and contour of the aorta or the main pulmonary artery, which is markedly dilated (35 mm). Please note, orthonormal measurements will be added by 3D-laboratory. There is minimal enlargement of the right ventricle with hypertrophy, which is essentially unchanged compared to the prior exam. Right atrial enlargement is also noted.
				The greatest is seen subcontinuer atrium septum defect is again noted. The left ventricle is within normal limits for size and morphology. No pericardial effusion is seen, trace pericardial fluid is noted.
				Coronaries: There is right dominant coronary circulation. The right and left coronary arteries arise from their respective cusps. No coronary stenotic lesion seen. During dynamic cine views of the LMCA withe respect to the main pulmonary artery, stable to slightly increased contact of the LMCA by the MPA is appreciated.
				Extracardiac findings: There is significant breathing motion artifact, which limits evaluation of the lung parenchyma. Within these limitations, no nodule or mass is seen. The previously noted centrilobular groundglass nodules are not well seen in this exam. No pneumothorax.
				No pleural effusion.
				Limited evaluation of the upper abdomen in pulmonary arterial contrast phase demonstrates no gross abnormalities.
				Evaluation of the osseous structures demonstrates no suspicious appearing lesions. 1. Essentially unchanged enlargement of the main pulmonary arteries consistent with patient's history of severe pulmonary hypertension. 2. No pulmonary embolism evident. 3. Stable to slightly increased main pulmonary artery contact with left main coronary artery (LMCA) with minimal downward deviation of the LMCA during diastole. 4. Right dominant coronary circulation without significant stenosis. 5. Essentially unchanged right ventricular hypertrophy and prominence with enlargement of the right atrium. Unchanged small ASD. Report: Preliminary measurements were made during primary interpretation. The following protocol measurements were obtained:
				Diameters in mm Ascending aorta - 70% phase (major 23.60, minor 23.10
				Percentages Left ventricle ejection fraction 74.90%
				Volumes: Left ventricle volume - Systolic 15.60cc Left ventricle volume - Diastolic 62.20cc
286	Coronary Angiogram	unknown	Female	There appears to be minimal sparing of the acromioclavicular joint, as well as irregularity on the undersurface of the right acromion and distal right clavicle. A screw tract is present in the right humeral head compatible with previous fracture and postoperative change. The right coracoid process appears slightly closer to the clavicle, but on the contralateral side in abduction position. However, there is no evidence of definite bony impingement or significant asymmetry otherwise. Regional musculature demonstrates no significant abnormalities. The upper aspects of the right and left lungs demonstrate no evidence of significant lesions. Ribs and vertebra apj
288	Accromioclavicular Joint	unknown	Female	1. No evidence of significant bony impingement in neutral or abduction position in the right or left shoulder. 2. Slight irregularity of the undersurface of the right acromion and clavicle, which appears postoperative in nature. Recommend correlation. 3. 3D images generated from original exam data corroborate these findings.
				On the left, there is a comminuted intra-articular pylon fracture with multiple intra-articular fragments. A comminuted mid to distal fibular fracture is also present. External fixation devices noted with screws in the calcaneus and mid fibula. There is a comminuted intra-articular fracture of the distal right tibia with two main oblique fracture planes. Multiple intra- articular fracture fragments are also identified. There is nondisplaced posterior talus fracture. External fixation device is also noted with screws in the mid tibia and calcaneus.
289	Ankle Fx	unknown	Male	1. Bilateral comminuted intra-articular fractures of the distal tibia described above. 2. Comminuted mid to distal right fibular fracture. 3. Nondisplaced right posterior talus fracture.
				Coronaries: There is right dominant coronary circulation. The right and left coronary arteries arise from their respective cusps. No coronary stenotic lesion seen. During dynamic cine views of the LMCA withe respect to the main pulmonary artery, stable to slightly increased contact of the LMCA by the MPA is appreciated.
				Extracardiac findings: There is significant breathing motion artifact, which limits evaluation of the lung parenchyma. Within these limitations, no nodule or mass is seen. The previously noted centrilobular groundglass nodules are not well seen in this exam. No pneumothorax. No pleural effusion. Limited evaluation of the upper abdomen in pulmonary arterial contrast phase demonstrates no gross abnormalities. Evaluation of the osseous structures demonstrates no suspicious appearing lesions. 1. Essentially unchanged enlargement of the main pulmonary arteries consistent with patient's history of severe pulmonary hypertension.
				2. No pulmonary embolism evident.
				3. Stable to slightly increased main pulmonary artery contact with left main coronary artery (LMCA) with minimal downward deviation of the LMCA during diastole.
				4. Right dominant coronary circulation without significant stenosis.
290	Pulmonary Artery	41	Female	5. Essentially unchanged right ventricular hypertrophy and prominence with enlargement of the right atrium. Unchanged small ASD.
				25 year old female with post open tibiotalar dislocation. The tibia, fibula, talus, calcaneus, and tarsal and proximal metatarsals are intact with no displaced fracture. There is soft tissue swelling around the ankle with subjacent subcutaneous emphysema along the deep fascia and extensive radiopaque material (presumably sand debris and/or surgical material) around the flexor and peroneal fascia, predominantly above the mytondinous junction, with the largest deposit seen between the flexor digitorum and flexor hallucis, measuring 8 mm (axial image 119, series 2). Additionally, radiopaque material is seen along the anterior tibiotalar capsule (axial image
292	Open Tibiotalar Dislocation	25	Female	1. Soft tissue swelling around the right ankle with extensive adjacent subcutaneous emphysema tracking to the deep fascia. 2. Radiopaque material around the flexor and peroneal fascia and, to a lesser extent, along the anterior tibiotalar capsule, as described.
				History of PE, subtherapeutic INR, cardiac arrest. Cardiac arrest with hemoptysis. Subtherapeutic anticoagulation. Previous pulmonary thromboembolism. Motion degrades the exam. No central pulmonary thromboembolism.
				Right upper lobar and left upper lobe segmental pulmonary thromboemboli are identified. No definite radiographic features to suggest elevated right heart pressures. Main pulmonary artery is within normal limits in caliber. Mild cardiomegaly/left atrial enlargement.
				Multiple bilateral groundglass opacifications and focal opacities, with confluent bilateral airspace consolidations within the lower lobes, most compatible with atelectasis and/or multifocal pneumonia.
				Superimposed aspiration within the lower lobes may be present. In addition, superimposed pulmonary edema may also be present.
				Fluid-filled esophagus, which raises patient's risk for aspiration. Enteric tube courses within the esophagus with tip at pylorus. No lymphadenopathy. Endotracheal tube tip situated about 4 cm above carina. Diffusely enlarged and heterogeneous thyroid with cystic lesion within right thyroid lobe. Apparent foci of subcutaneous gas within soft tissues overlying thyroid/anterior lower neck, incompletely characterized.
				Mild ascites. Calcified gallstones within nondistended gallbladder, which is without pericholecystic fluid or wall thickening. Atrophic bilateral kidneys, with simple cyst noted at superior pole of right kidney. The liver parenchyma is dense.
				No suspicious osseous lesions.
294	Pulmonary Thromboemboli	unknown	Female	1. Bilateral upper lobe pulmonary thromboemboli. 2. Confluent airspace consolidations within the lower lobes, compatible with pneumonia, aspiration, and/or atelectasis. Of note, there is fluid-filled esophagus, which significantly raises the patient's risk for aspiration. 3. Multiple additional scattered groundglass opacities/focal consolidations within the bilateral upper lobes and right middle lobe, compatible with atelectasis, multifocal pneumonia, and/or asymmetric pulmonary edema. 4. Mild cardiomegaly/left atrial enlargement. 5. Trace ascites. 6. Cholelithiasis, without cholecystitis.
				7. Subcutaneous air within the soft tissues overlying lower anterior neck, of unclear clinical significance but may be related to recent attempted line placement versus dissected gas from endotracheal tube placement; clinical correlation advised. 8. Dorsa liver, possibly related to aminodarone use; clinical correlation advised.
				67 year old male with metastatic neuroendocrine tumor with bone and liver metastases. Restaging examination. Chest: There is a right PICC line tip within the superior vena cava. The thyroid is normal. There is normal arch anatomy. The aorta and the pulmonary artery are normal in course and caliber. The heart is normal in size with no pericardial effusion. There is no mediastinal, axillary, or hilaradenopathy.
				The lungs are clear. There is bilateral atelectasis. There is small amount ground glass opacification in the medial segment of the right upper lobe near the apex which may be related to prior radiation if patient had radiation therapy within this region otherwise, could be secondary to atelectasis. There is no suspicious lung nodule. There are no pleural effusions.
				Abdomen: There is a hepatic abscess drainage catheter with tip within segment 8 of the liver. There is minimal residual fluid around the drainage catheter which measured 2.0 cm x 3.0 cm in size. There is resolution of the previously identified mild stable intrahepatic and biliary dilatation. There are stable low attenuation lesions in the liver, most compatible with simple cysts, unchanged from prior study. The previously identified hypervascular foci throughout the liver were not seen on this examination. The portal vein and hepatic veins enhance n
				There has been a prior Whipple's resection. Other than postsurgical change, the pancreas is unremarkable. The adrenal glands are normal. There are bilateral cortical and parapelvic cysts that are stable as compared to the previous exam. There is no hydronephrosis or hydroureter. The urinary bladder is normal in appearance. Incidental mode is made of two right-sided renal arteries and one left sided renal artery.
295	Pancreas and Liver Cancer	67	Male	There is a 18-mm short axis enhancing lymph node in the fissure for the ligamentumvenosum that has increased in size as compared to 12 mm. There is enhancing soft tissue nodules in the small bowel mesentery and in the periaortic region.
				Vascular: Extensive thrombus is identified extending from the IVC at the level of the renal veins to the bilateral common iliac veins, external and internal iliac veins, common femoral veins, superficial femoral veins, profunda veins, popliteal vein, and peroneal veins and posterior tibial veins. The entrance of the greater saphenous vein into the superficial femoral vein is clotted bilaterally, however, the remaining greater saphenous and lesser saphenous vein are patent.
				The right renal vein is patent and empties into the IVC. The left renal vein appears diminutive and is mostly drained by collaterals into the paravertebral plexus. The bilateral perisacral veins are occluded.
				Beginning at L1, paravertebral plexus collateralization is identified which empties into prominent hemiazygos and azygos veins.
				The splenic vein, SMV, and portal system are patent. The hepatic veins are unremarkable.
				The arterial vasculature appears patent and unremarkable.
				Lungs: The lung bases are clear.
				Abdomen and pelvis: Evaluation of the abdominal solid organs is limited due to the venous phase of imaging. The liver and gallbladder, pancreas, spleen, adrenal glands, and kidneys are normal in appearance. No nephrolithiasis or hydronephrosis. The bowel is normal in course and caliber. No ascites or pneumoperitoneum.
				Prominent bilateral ovaries with multiple follicles are seen.
296	Venogram-ABD, PEL, LL	24	Female	Bones and soft tissue: No acute osseous abnormality. The soft tissues demonstrate swelling in the bilateral lower extremities. Complete occlusion of the deep venous system of the bilateral lower extremities, extending proximally to the infrarenal IVC. There is enhancement of the venous walls. Enlarged hemiazygos and azygos veins are noted. Only mild soft tissue edema is noted throughout the bilateral lower extremities. Technique:CT venogram of the abdomen and pelvis with run- offs to knee was performed with IV contrast. Multiplanar reformatted, maximal intensity projection, and 3-D volume-rendered reconstructions were reviewed on an independ
				26 year old male with pelvic fracture. There is a comminuted burst fracture of the right acetabulum, with the fracture extending from the iliac wing just adjacent to the sacroiliac joint into the roof of the acetabulum, involving the posterior wall and extending into the anterior column. There is an associated segmental fracture of the inferior pubic ramus on the right. There is resultant traumatic acetabular protrusion.
				There is significant soft tissue swelling and edema around the acetabular fracture. There is increased soft tissue in the presacral region, which is not clearly simple fluid in attenuation and could represent hematoma.
				A Foley catheter is in place with gas in the bladder.
297	Pelvic Fracture	26	Male	High attenuation linear material is noted along the bowel in the right lower quadrant likely related to old surgery. 1. Comminuted right acetabular burst fracture involving the iliac wing, anterior column, and posterior wall, with resultant acetabular protrusion. 2. Significant surrounding soft tissue swelling with possible blood in a presacral location in the pelvis.
				17 month old ex-preemie boy with history of macrocephaly, brachycephaly. There are mildly prominent bifrontal extracerebral spaces, likely representing benign extracerebral collections of infancy. No acute intracranial hemorrhage nor large vascular territory infarction is identified. The ventricles are symmetric in size and configuration without ventriculomegaly. Visualized orbital contents, paranasal sinuses, and mastoid cavities are clear. Note is made of tiny bilateral Haller cells. Linear lucency in the right frontal calvarium likely represents a vascular groove. All sutures appear within normal limits.
				1. Mildly prominent bifrontal extracerebral spaces likely representing benign extracerebral collections. No additional findings to suggest chronic subdural hematomas/hygromas. 2. No acute intracranial hemorrhage nor large vascular territory infarction. 3. Craniosynostosis.
299	Macrocephaly	17 Months	Male	Technique: High resolution CT images of the brain were obtained with 3D reconstruction performed on a separate workstation.
				Two-year-old male status of craniofacial microsomia status post mandibular distraction. Evaluate bony formation of the osteotomy site. There has been interval metallic fixation of the bilateral mandibles with hypertrophic pariosteal formation at the surgical site, left greater than right. Mandibular hypoplasia with hypoplastic right mandibular condyle is again noted. There is stable appearance of right external auditory canal atresia and middle ear hypoplasia/dysplasia. Maxillary hypoplasia is also seen. There is mild hypotelorism. Visualized intracranial contents demonstrate no abnormality. Paranasal sinuses and left mastoid air cells are clear.
300	Hemifacial Microsomia	2	Male	1. Postsurgical changes related to bilateral mandibular fixation with reactive bony changes as above described. 2. Stable findings of maxillary and mandibular hypoplasia, right external auditory canal atresia, and right middle ear hypoplasia/dysplasia.
				Technique: High resolution CT of the face without contrast was performed with 3D reconstruction performed on an independent workstation.
				Possible bronchopulmonary malformation. Congenital laryngotracheal esophageal cleft. A long segment of communication is present between the larynx, trachea, and esophagus to the level of the carina. The enteric tube passes into the stomach. The central airways are patent. There is high origin of the left mainstem bronchus with an unremarkable branching pattern. The right bronchial branching pattern appears normal. A cystic and solid lesion in the right upper lobe measures approximately 2.4 x 1.2 x 1.3 cm. The lesion is surrounding by ground glass opacity. There is additional consolidation or atelectasis of the right upper lobe and consolidation or atel
				1. Right upper lobe bronchopulmonary malformation without definite feeding vessel although somewhat limited study. Findings may represent CPAM or hybrid lesion. 2. Consolidation or atelectasis of the right lower lobe with possible underlying lesion. No definite identification of feeding vessel. 3. Bilateral ground glass opacity may represent poor inspiration versus mild respiratory distress syndrome. 4. Long segment communication between the larynx, trachea and esophagus to the level of the carina. 5. Multiple ventralsed body clarbs.
302	Laryngotracheal Esophageal Cleft	unknown	Male	6. Ultrasound may be helpful for visualization of possible feeding vessel to the bronchopulmonary malformation.
				38 week old infant with Pierre-Robin sequence, micrognathia, cleft palate, and history of respiratory distress. Evaluate airway. The ventricles and sulci demonstrate no abnormality in size and configuration for the patient's stated age of eleven days. No midline shift, acute intracranial hemorrhage, or abnormal extra-cerebral fluid collection is present.
				Micrognathia, glossoptosis and a palatal cleft defect are noted. The sutures are all open throughout the calvarium. The airway is patent. Nasogastric tube is identified. A left parietal subpericranial collection is present, probably representing a cephalohematoma. Left periorbital soft tissue swelling is also present.
				1. Micrognathia, glossoptosis, palatal cleft defect.
				2. Airway is patent and cranial sutures appear to be open.
				3. Probable left parietal cephalohematoma and left-sided periorbital soft tissue swelling.
303	Pierre Robin Syndrome	38 Weeks	Female	Technique: Sequential axial thin section CT images were obtained from the vertex down to the level of the clavicles without the administration of intravenous contrast. Additional coronal and sagittal reformatted images were also created. 3D reconstructions were then produced on a separate work station.
				18 year old male status post trauma. Lacerate ball v face from point blank. Small focal high density within the subcutaneous soft tissues in the left supraorbital area which could represent small foreign body. Clinical correlation is recommended.
				There is displaced fracture of the left mandibular condyle with widening of the left temporomandibular joint and lateral displacement/angulation of the distal fragment. In addition, there is a minimally displaced fracture of the left mandibular body extending to the left parasymphyseal area. The right temporomandibular joint is intact.
				No other facial bone fractures identified. Bilateral orbital contents are within normal limits. There is mucous retention cyst in the left maxillary sinus. Bilateral mastoid air cells are clear. Visualized portion of the brain parenchyma is unremarkable. 1. Displaced fracture of the left mandibular condyle with associated widening of the left temporomandibular joint and lateral displacement/angulation of the distal fragment. 2. Minimally displaced fracture of the left mandibular body with extension to the left parasymphyseal region. 3. Small punctate focal high density seen in the subcutaneous soft tissues of the left supraorbital area, which could represent small foreign body. Clinical correlation is recommended.
				Technique: Nonocontrast CT of the face with coronal and sagittal reformats was performed.
				Report: - L subcondylar mandible fx with mild distraction. L mandibular condyle remains well seated in glenoid fossa. - Fx L mandibular body extending to L parasymphyseal region.
305	Fractured Condyle	18	Male	- L>R mas xmas mucosal thickening.
306	Golden Eagle Pre Contrast	unknown	unknown	
307	Golden Eagle Post Contrast	unknown	unknown	Perfused with BriteVu™, www.Scarletimaging.com
308	Green Iguana	unknown	unknown	Perfused with BriteVu™, www.Scarletimaging.com
309	Rat Heart	unknown	unknown	Perfused with BriteVu™, www.Scarletimaging.com
310	Rat Kidney	unknown	unknown	Perfused with BriteVu™, www.Scarletimaging.com
311	Mojave Rattlesnake	unknown	unknown	Perfused with BriteVu™, www.Scarletimaging.com
312	Crested New Caledonian Gecko	unknown	unknown	Perfused with BriteVu™, www.Scarletimaging.com

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313 Ball Python	unknown		unknown	Perfused with BriteVu™, www.ScarletImaging.com
				Previous abnormalities found in the liver. Limited evaluation of the lung bases demonstrates a 3-mm nodule in the right lower lobe that was not present on previous examination.
				The remainder of the lungs bases appear clear. Evaluation is slightly limited secondary to respiratory motion. A cardiophrenic lymph node measures 7 mm in short axis and is increased in size compared previous examination. Two small lymph nodes are noted in adjacent to the IVC. The largest of these measures 8 mm in short axis. These appear stable compared to prior exam.
				Innumerable lesions are noted throughout the liver. These demonstrate pronounced peripheral enhancement on arterial phase imaging with a central region of low attenuation. The low-attenuation center measures less than 1 cm in all lesions. Delayed phase images of the liver show no evidence of significant washout with persistence of multiple low attenuation lesions. The liver is significantly increased in size compared to previous examination where it measured 19 cm. It currently measures 25 cm. Several calcifications are noted in the superior aspect of the liver and are unchanged from prior study. The hepatic and portal veins appear patent. The biliary t
				gallbladder, spleen, pancreas, adrenal glands, and visualized GI tract appear normal.
				The common hepatic artery arises from the SMA. The aorta and its main branches appear normal.
				The kidneys appear normal. A sub-1 cm hypoattenuating lesion is noted in the anterior aspect of the right kidney. This is stable from previous examination and likely represents a small cyst. No evidence of hydronephrosis.
				No free fluid or abdominal adenopathy identified. The principal vascular structures of the abdomen appear patent.
				No suspicious osseous lesion identified.
				1. Interval increase in multiple hepatic lesions compared to previous examination as detailed above. The liver also has significantly increased in size. This finding is concerning for (but not limited to) multiple small microabscesses versus hypervascular metastatic disease. Biopsy is recommended.
314 Vertebral Fractures	unknown		Male	2. Interval development of a 3-mm nodule in the right lower lobe. A cardiophrenic lymph node has increased in size.
315 Nile Monitor	unknown		unknown	Perfused with BriteVu™, www.ScarletImaging.com
316 Sulcata Tortoise	unknown		unknown	Perfused with BriteVu™, www.ScarletImaging.com
				Previous abnormalities found in the liver. Limited evaluation of the lung bases demonstrates a 3-mm nodule in the right lower lobe that was not present on previous examination.
				The remainder of the lungs bases appear clear. Evaluation is slightly limited secondary to respiratory motion. A cardiophrenic lymph node measures 7 mm in short axis and is increased in size compared previous examination. Two small lymph nodes are noted in adjacent to the IVC. The largest of these measures 8 mm in short axis. These appear stable compared to prior exam.
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				gallbladder, spleen, pancreas, adrenal glands, and visualized GI tract appear normal.
				The common hepatic artery arises from the SMA. The aorta and its main branches appear normal.
				The kidneys appear normal. A sub-1 cm hypoattenuating lesion is noted in the anterior aspect of the right kidney. This is stable from previous examination and likely represents a small cyst. No evidence of hydronephrosis.
				No free fluid or abdominal adenopathy identified. The principal vascular structures of the abdomen appear patent.
				No suspicious osseous lesion identified. 1. Interval increase in multiple hepatic lesions compared to previous examination as detailed above. The liver also has significantly increased in size. This finding is concerning for (but not limited to) multiple small microabscesses versus hypervascular metastatic disease. Biopsy is recommended.
317 Liver A&V	unknown		Female	2. Interval development of a 3-mm nodule in the right lower lobe. A cardiophrenic lymph node has increased in size.
				58 year old female. Follow-up of mesenteric lymphangioma. Lower chest: The heart is normal in size and configuration, without pericardial effusion. The lung bases and pleural spaces are clear.
				Liver: The liver is normal in size, contour, and attenuation. A 7-mm too small to characterize hypodensity in hepatic segment IV (series 3 image #79) is unchanged from 2009 and likely reflects a cyst. There is no intrahepatic biliary ductal dilation.
				Gallbladder: Unremarkable.
				Spleen: Normal in size and attenuation. A 4.7 x 4.1 cm cyst is again noted in the spleen.
				Pancreas: Unremarkable.
				Adrenal glands: Unremarkable.
				Kidneys: There is symmetric renal cortical enhancement and contrast excretion.
				Bowel: The small bowel and colon are normal in course and caliber. The appendix is normal.
				Peritoneum: As seen on the 2009 examination, there is a poorly marginated lobular water density lesion centered around the root of the mesentery , located anterior to the aorta and posterior to branches of the superior mesenteric artery. The lesion measures up to 10-cm in transverse diameter, unchanged from the 1/28/2009 examination. There is a 2.5 x 1.5 cm round and higher density nodule within the right anterolateral aspect of the lesion (series 3 image #189) that is new when compared to prior studies. There is no intra-peritoneal free air or abdominal ascites.
				Vasculature: The abdominal aorta is normal in course and caliber.
				Adenopathy: None.
				Pelvic viscera: The bladder, uterus, and adnexa are unremarkable. There are prominent parametrial veins in the pelvis, which are nonspecific but can be seen with pelvic congestion.
				Skeletal structures: No destructive osseous lesions are seen. Mild degenerative changes are noted in the lumbar spine.
				1. An irregular water attenuation lesion is again noted centered around the mesenteric root, similar in size dating back to 2008 and likely reflecting a lymphangioma. There is a new well-circumscribed 2.5 x 1.5 cm higher density nodule within the lesion that was not seen on prior studies. Although this may reflect a reactive process such as fat necrosis, malignancy cannot be excluded and a gadolinium enhanced MRI is recommended for further evaluation.
318 Mesenteric Lymphangioma		58	Female	2. A 4.7 cm splenic cyst is unchanged.
				Spina bifida, Chiari 2, and deformity noted at bottom of construct
				There is marked deformity of the entire spine with severe levoscoliosis of the thoracolumbar spine. There is extensive thoracolumbosacral fusion, with the fusion hardware articulating with the left iliac wing. No evidence of hardware failure. The posterior elements of the sacrum are not fused, compatible with spina bifida.
				The right hip is dislocated posteriorly with a hypoplastic acetabulum and femoral head. The left hip is subluxed posteriorly, with a hypoplastic acetabulum and femoral head.
				There is diffuse muscular atrophy.
				The left lung is hyperinflated. There is an 8mm non-obstructing gallstone. A VP shunt is in place with a small amount of free fluid in the pelvis. Remainder of the abdominal and pelvic organs appear unremarkable.
				1. Marked scoliosis with thoracolumbosacral fusion hardware that articulates with the left iliac wing. No evidence of hardware failure.
				2. Chronic right hip dislocation and left hip subluxation.
319 Spina Bifida	unknown		Male	3. Cholelithiasis without cholecystitis.
				67 year old man with left mandibular squamous cell carcinoma status post resection of a dentigerous cyst and teeth 17 and 18, presenting for preoperative CT examination. A lucent lesion in the left mandibular body and angle with areas of associated bony erosion is unchanged since the prior MR study. There has been interval removal of a small tubular structure present on the preceding CT study. Overlying asymmetric soft tissue thickening and fat infiltration is also stable with thickening of the left masseter muscle. There are several areas of thinning and frank dehiscence along the outer mandibular cortex in this region. The left inferior alveolar canal is s
				There are a few mucus retention cysts or polyps in the left maxillary sinus. Mild mucosal thickening in the right frontal and ethmoid sinuses may be congestive or inflammatory in nature. There are bilateral concha bullosa and a small right Haller cell. Bilateral ostiomeatal units are patent.
				The orbits and their contents are normal. The calvarium is unremarkable. The visualized intracranial contents are notable for mild ventricular prominence consistent with generalized volume loss.
				There is no intracranial hemorrhage.
				There is calcific atherosclerotic plaque along the cavernous segments of the carotid arteries. Several left greater than right prominent lymph nodes are noted in the upper neck.
				1. Stable lucent lesion in the left mandible with stable adjacent masseteric thickening and inflammatory changes.
320 Squamous Cell Carcinoma		67	Male	2. Prominent left greater than right cervical lymph nodes. Technique: Thin section axial CT of the facial bones was performed without contrast, followed by coronal reconstructions.
				Right hand injury There is a minimally displaced fracture of the base of the 2nd metacarpal. There are comminuted fractures of the 3rd and 4th metacarpal heads with apex dorsal angulation that extend to the margin of the articulation without disruption. There is a comminuted fracture of the base and proximal shaft of the 5th metacarpal with
				dorsal displacement and intra-articular extension to the
				carpal-metacarpal joint. There is a comminuted fracture of the hamate that is mildly displaced and extends to the joint space.
				There is extensive soft tissue swelling and subcutaneous emphysema. The distal radial ulnar joint is normal.
				There is a focal lucency within the lunate that may represent a geode.
				1. Multiple fractures
				- mildly displaced frx of base of 2nd metacarpal
				- comminuted frx of 3rd and 4th metacarpal metaphysis with apex dorsal angulation. The MCP joints are not involved.
				- comminuted frx of base and proximal shaft of 5th metacarpal
				- comminuted mildly displaced hamate frx
321 Fractures of Hamate and Metacarpals	unknown		Male	- marked sts and dorsal subcutaneous emphysema
				Four-year-old male with reported history Williams' syndrome who has immigrated from China. Prior history of supravalvular aortic stenosis as well as branch pulmonary artery stenosis. Prior surgical history includes patch augmentation of the aortic arch and aortic isthmus as well as autologous pericardial patch across the right and left pulmonary arteries distal to the main pulmonary artery. Procedures were performed at Shanghai Children's Heart Center. CT angiogram requested for evaluation of aortic arch hypoplasia. Situs: Solitus of the chest and abdomen by normal bronchial arterial relationships and a normal shaped spleen in the left upper quadrant.
				Cavae: A single right-sided superior vena cava and single right-sided inferior vena cava drain unobstructed into the right atrium.
				Pulmonary veins: Three right-sided and two left-sided pulmonary veins drain unobstructed into the left atrium.
				Atria: Atria are morphologically unremarkable bilaterally. No evidence for interatrial communication.
				Atrioventricular connection: There is atrioventricular concordance with two inlet valves and an endocardial cushion present.
				Ventricles: Ventricles are morphologically unremarkable although ventricular function is not evaluated. No evidence for interventricular communication.
				Ventriculoarterial connection: Concordant. The right and left ventricular outflow tracts are patent without stenosis. The aortic and pulmonary valves are trileaflet without evidence for valvular stenosis.
				Coronaries: There is codominance with the right coronary supplying the PDA and the left circumflex supplying the PLV arteries. The RCA arises from the far leftward aspect of the right coronary cusp with a short segment of proximal narrowing of approximately 50-60%. The left main coronary arises from a superior position upon the left coronary cusp without stenosis.
				Aorta: Left-sided aortic arch with normal cervical branching, no evidence of patent ductus arteriosus or aortopulmonary collateral. No evidence of coarctation distal to the transverse arch. There is irregular narrowing of the ascending aorta with a minimum cross-sectional diameter of 7.5 x 7.5 mm. This may reflect prior surgical intervention or underlying supravalvular stenosis of Williams' syndrome. The aorta proximal to the brachiocephalic artery measures 9-10 mm in diameter with this diameter maintained through the transverse arch tapering to 8 mm at the level of the isthmus. The descending thoracic aorta proximal to the hiatus measures approximat
				Pulmonary arteries: The main pulmonary artery measures 16.5 mm in diameter without evidence of stenosis. There is mild dilation of the proximal left pulmonary artery which measures 12 mm in diameter tapering to 9 mm proximal to the origin of the left upper lobe artery. The right pulmonary artery measures 10 mm in diameter.
				Airways: The trachea and central bronchi are patent without stenosis or endoluminal filling defect.
				Lungs: Patchy areas of mosaic attenuation are seen in the superior segment of the right lower lobe suggesting mild degree of air trapping. Minor atelectatic changes are present in the upper lobes bilaterally. The lungs are otherwise unremarkable.
				Extracardiac thoracic sutures: Overlying chest wall musculoskeletal structures are nonconcerning in appearance.
				1. There is a long segment of irregular narrowing of the ascending aorta in keeping with mild supravalvular stenosis. Minimal luminal diameter of approximately 7.5 mm. Patch augmented region of the transverse and proximal descending thoracic aorta shows no evidence for recurrent stenosis with a mean diameter of approximately 9 mm.
				2. Central pulmonary arteries of normal caliber without stenosis. Minor focal dilation of the proximal left pulmonary artery in keeping with prior patchy augmentation.
324 Gated Heart		4	Male	3. Right coronary artery arises from the far left aspect of the right coronary cusp with mild proximal narrowing of approximately 50-60% as it passes between the aortic sinus and the pulmonary artery.
				Head: No intraparenchymal blood. However, slight subtle GW indiff diffusely, early swelling, though no evidence of herniation or mass effect on the visterns. Slight density in the anterior extraaxial space, crossing vessels, suggesting fluid in subdural space, versus early or prior hemorrhage. Fluid in the right external ear canal, blood. No obvious skull base fx. No air within the cranial cavity. Scalp hematoma.
				Face: comminuted fx of the mandible (left body and right process), without obvious dislocation of the TMJ's. Comminuted fx of the maxilla involving bilateral sinuses' walls. Fx of the pterygoid processes bilaterally. Fx of the nasal bones. Comminuted fx of the right zygomatic arch and dislocation of the orbit-zygoma suture, with likely small avulsion fx.
				C Spine: small ossicle inferior to C1 with sclerotic border, likely due to prior injury. Inferior C spine eval suboptimal.
				T- and L-spine:
				L5 posterior element fx with slight anterior shift of L5 on S1. Sharp border of the elements, likely acute fx. No definite evidence of canal compromise.
				1. No definite acute intracranial abnormality.
				2. Extensive facial fractures as described above.
				3. Laryngeal fracture as well.
				4. No definite acute fracture or subluxations involving the cervical, thoracic and lumbar spine. Bilateral L5 pars defect with mild 3 mm anterolisthesis, likely chronic.
				Report:
				CT head: The brain parenchyma appears normal. No evidence of acute infarct. No definite intracranial hemorrhage. No midline shift or mass effect.
				Multiple facial bone fractures as described in facial bone section.
				Diffuse subcutaneous and subgaleal soft tissue swelling is noted in the scalp with left scalp hematoma.
				CT of the face: Extensive facial fractures are noted. More specifically, comminuted nasal fracture, likely right medial orbital wall blow out fracture, right orbital floor fracture with right proptosis. Bilateral comminuted maxillary fractures involving the lateral and medial walls and extension of the fracture into the right hard palate. Comminuted
				fracture of the right mandible, ramus/condylar process and left mandibular body. Without condyle dislocation. Bilateral pterygoid plate fractures. There is near complete opacification of bilateral maxillary, ethmoid and sphenoid sinuses. Fluid in bilateral frontal sinuses.
				Cervical spine CT: Examination of the cervical spine demonstrates no gross acute fracture or subluxations. Bony alignment is grossly normal.
				Laryngeal fracture is noted. With tracheostomy in place.
				Nasogastric tube is visualized. Evaluation of somewhat limited due to body habitus and some motion.
				Thoracic spine and lumbar spine: There is L5 pars defect with 2 mm anterolisthesis, however, this likely represents a chronic change. No definite acute fractures or subluxations are visualized. Otherwise, the thoracic and lumbar spine alignment is normal. Incidentally visualized right-sided small
				pleural fluid. Inferior vena cava filter also visualized. No evidence of spinal canal stenosis.
325 Multiple Facial Fractures		42	Male	Technique: Non contrast CT of the head was performed from the vertex to the skull base. CT of the facial bone is also performed and sagittal and coronal reformats were made. CT of the cervical spine, thoracic spine and lumbar spine were performed with coronal and sagittal reformats made.
				51 year old male with history of recent right upper quadrant pain and upturning LFTs. The patient has a common bile duct stricture on ERCP concerning for cholangiocarcinoma or pancreatic carcinoma. The heart is within normal size limits. No pericardial effusion. The distal descending thoracic aorta is normal in course and caliber.
				The distal esophagus and gastroesophageal junction are grossly unremarkable.
				No pleural effusions. Evaluation of the lung parenchyma demonstrates dependent, reticular and ground glass opacities compatible atelectasis.
				The liver is normal in size, contour and attenuation. No focal hepatic mass. There is geographic low attenuation without associated mass effect or vascular deviation adjacent to the falciform ligament compatible focal fat deposition. There are two nonspecific, subcentimeter, hypoattenuating liver lesions which are too small to characterize [series 5, image 37 and 63]. The hepatic and portal veins are patent. There is fluid infiltrating the portahepatis.
				There is no significant residual intrahepatic biliary ductal
				dilatation. There is enhancement and thickening of the biliary ductal epithelium. Pneumobilia is present. A biliary stent is in place which originates in the common bile duct and terminates in the second portion of the duodenum. Evaluation of the distal common duct for wall thickening or associated subtle mass is limited secondary to presence of stent.
				The gallbladder and cystic duct contain gas related to the patient's biliary stent. There is mild gallbladder wall thickening. The gallbladder is otherwise is unremarkable without evidence of radiopaque gallstones or pericholecystic fluid.
				The adrenal glands are within normal limits.
				The spleen is normal in size, contour and attenuation.
				Evaluation of the pancreas demonstrates mild pancreatic ductal dilatation measuring up to approximately 4 to 5 mm with an abrupt transition to a no longer visualized pancreatic duct in the head.
				There is heterogeneity of the pancreatic head with a focal contour abnormality involving the anterior pancreatic head. There is infiltration of the peripancreatic fat in the anterior perirenalspace and retroperitoneum. Infiltration of the retroperitoneal fat is noted along the course of the superior mesenteric artery which could be related to post ERCP pancreatitis or perineural vascular spread of malignancy. No encasement or distortion of the superior mesenteric vein. No narrowing of the superior mesenteric artery. The uncinate process remains sharp.
				The kidneys are symmetric in size, contour, contrast enhancement and excretion. There is a 1.3-cm well-circumscribed, hyperattenuating lesion which appears to demonstrate both subtle enhancement and washout arising from the posterior cortex of the left kidney concerning for a small renal cell carcinoma [series 6, image 160]. No hydronephrosis or nephrolithiasis. Punctate hypo-densities within the renal parenchyma are too small to characterize, however statistically, likely represent renal cysts.
				The stomach is grossly unremarkable. The visualized small bowel is within normal limits without evidence of bowel wall thickening, hyperemia, pneumatosis or obstruction. The imaged colon is normal in course and caliber. Scattered diverticula are present without evidence of diverticulitis. The appendix is within normal limits.
				No free fluid within the abdomen or pelvis.
				The abdominal aorta is normal in course and caliber.
				No pathologically enlarged lymph nodes within the abdomen or pelvis.
				There are more numerous than expected lymph nodes in the upper abdomen including a 10 mm portocaval node [series 6, image 117], an 11 mm portahepatis lymph node [series 6, image 107] and a 9 mm perihepatic lymph node [series 6, image 96].
				Evaluation of the visualized osseous structures demonstrates 0326multilevel degenerative changes.
				1. Mild pancreatic ductal dilatation with an abrupt termination of the pancreatic duct in the head of the pancreas. Given the coexisting previous biliary ductal dilatation, heterogeneity of the pancreatic head, numerous upper abdominal lymph nodes and infiltration of the fat along the superior mesenteric artery, findings are concerning for an iso-attenuating pancreatic adenocarcinoma. However, interpretation is somewhat complicated by likely coexisting acute pancreatitis. Further evaluation with an MRI of the abdomen is recommended following resolution of the patient's acute symptoms. Alternatively, endoscopic ultrasound may be obtained.
				2. Fluid within the anterior pararenal space and retroperitoneum concerning for pancreatitis which may be secondary to gallstones or recent ERCP.
				3. Enhancing biliary epithelium and mild gallbladder wall thickening which may be secondary to cholangitis. No radiopaque gallstones are identified in the gallbladder and there is gas within both the cystic duct and gallbladder lumen arguing against obstruction, however consider right upper quadrant ultrasound to exclude acute cholecystitis.
				4. Status post placement of a biliary stent with significant interval decrease in intra-and extrahepatic biliary ductal dilatation. Evaluation of the common duct for a stricture or subtle cholangiocarcinoma is limited secondary to existence of the stent.
326 Pancreas-Gallbladder		51	Male	5. 1.3-cm exophytic likely enhancing left renal mass. Recommend attention on follow-up ultrasound to exclude a solid lesion [renal cell carcinoma].
331 Dog	unknown		unknown	

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				62 year old woman with history of endometrial stromal sarcoma, preoperative planning Redemonstration of the large mass, with its center located in the right pelvis and retroperitoneum, measuring approximately 12 x 7 cm on transverse images and it least 15 cm in craniocaudal direction. In the pelvis, the mass extends from the posterior aspect of the bladder near the vesicoureteral junction which appears infiltrated by the tumor, along the lateral wall of the pelvis superior to superiorly to the level of the iliac artery bifurcation. The mass completely encases the interna iliac artery as well as all its branches, and encases and completely occludes the internal, external and common iliac veins. Posteriorly, a small portion of the tumor extends into the second sacral foramen. From the level of the right iliac artery bifurcation superiorly, it continues within the expected location of the common iliac vein and the inferior vena cava, which is substantially dilated and filled with enhancing tumor mass to the level of the the lower pole of the right kidney. The tumor appears to abutt the fragments of the disintegrated IVC filter. Redemonstration of right-sided hydronephrosis. The there is a stent in the right ureter, which shows that the ureter is pushed anteriorly by the mass, the most distal portion of the ureter appears to be circumferentially encased by tumor tissue. The infiramnal aorta the abuts the tumor. The colon is not treated at abuts the tumor over its entire length. The proximal portion of the external rupture seems to be partially encased by tumor, and is displaced anteriorly for its remaining D. first remaining portion. The left side its pelvic venous system is patent, and the left common iliac vein drains into prominent retroperitoneal and lumbar collateral veins. Several trans-pubic and abdominal wall collaterals are also noted. Several enlarged inguinal lymph nodes as seen on the right. No focal liver lesions are noted. Incidental note is made of a gallstone. Pancreas spleen and adrenal glands are within normal limits. The visualized portions of the lung bases are unremarkable. 1. Large right-sided pelvic and retroperitoneal mass as described, extending from the vesicoureteral junction to the right pelvic wall, and to the right iliac artery bifurcation. Superior extent of the mass with large tumor thrombus into the IVC to the level of the fragment II IVC filter. 2. Complete encasement and occlusion of the external, common and internal iliac veins and large tumor thrombus in the IVC. 3. The aorta, the common iliac and external iliac arteries about the tumor. The iliac bifurcation and the internal iliac artery with all its branches are completely encased by tumor. 4. Right-sided hydronephrosis with a ureter stent in place, which is encased by tumor near the bladder. Report: Upon further review of the images together with several prior CT outside studies, there are small linear high-attenuation opacities in the right ventricular apex, which cannot be explained by motion artifact in the same location across several studies, and are therefor suspicious for thin metal fragments (thin wires, rather than struts) of the patient's disintegrated IVC filter. A second metal fragment is visualized in Morison's pouch; likely impinging on the liver. This could be an intraperitoneal strut fragment rather than a surgical clip.
336	Endometrial Sarcoma		62	Female	If it will change clinical management, a gated CT angiogram of the chest may be of benefit to further delineate the fragment in the right ventricle, which appears stable since previous scan. Analysis: - Mediastinal herniation of the transverse colon through the diaphragm muscle in antero-lateral right direction. - A calcification of ascending aorta is present. - The others imaged organ appear normal within the limits of the technique.
338	Diaphragmatic Hernia	unknown		Male	Analysis provided by Università degli Studi de L'Aquila (Prof. Maccharielli, Prof. Bianchi and DrBernardi)
341	Chondromyxoid Fibroma and Mandible Graft		10	Male	10 year old male with a giant cell tumor of the mandible. History of a mandible tumor with resection. History of a chondromyxoid fibroma. There is an expansile, mixed, solid and cystic heterogeneous right mandibular mass associated with marked cortical thinning and tarefaction. There is frank cortical disruption along the posteromedial aspect. The overlying right masseter muscle is somewhat thickened. The lesion itself demonstrates probable fluid levels with locations internally. There are several small foci of probable gas along the medial aspect of this lesion. There are subtle hyperdense septations versu calcification, which may reflect residual normal bone. The lesion has maximal transverse dimensions o 1. Expansile, heterogeneous right mandibular mass with fluid levels and thickening of the overlying masseter muscle. Differential considerations would include primary bone tumors including osteoblastoma, aneurysmal bone cyst.
342	Chondromyxoid Fibroma and Mandible Graft 2		10	Male	10 year old male with a giant cell tumor of the mandible. History of a mandible tumor with resection. History of a chondromyxoid fibroma. Again noted is an expansile, mixed lytic and sclerotic right mandibular lesion involving the mandibular head and ramus. This extends towards the mandibular body. This is likely incnased since prior examination, both in terms of the degree of overall expansion and specifically, the size of the lytic portions. There are speckled high-density regions (series 3, image 69), which are similar in appearance to prior examination and could represent chondroid matrix, but are not specific. Also again seen is an extremely low-density region within the central aspects of the mass (series 1. Increase in size of expansile right mandibular mass, with slight increase of associated soft tissue component. Please see above. Technique: CT of the facial bones with contrast with 3D reformations. 10 year old male with a Giant cell tumor of the mandible. History of a mandible tumor with resection. History of a chondromyxoid fibroma. This study demonstrates interval right segmental mandibulectomy and surgical resection of the expansile lytic lesion involving the right mandible with associated postsurgical changes. There is right mandibular reconstruction with a rib segment. There is non-ossified component of the graft within the right glenoid fossa, which could represent cartilaginous segment of the rib. Reconstruction metallic screws are seen in the graft adjacent to the resected mandibular body. There are multiple surgical clips within the right masticator space. There is marked soft tissue thickening/swelling in the right perimandibular area, which could represent postoperative edema/hematoma. Correlation for clinical improvement of the swelling or hematoma is recommended. Bilateral orbital contents and visualized portion of the brain parenchyma are within normal limits. There is minimal mucosal thickening of the paranasal sinuses, congestive or inflammatory. 1. Interval resection of the right mandibular expansile lytic lesion with mandibular reconstruction, as described above. There is marked soft tissue swelling and thickening in the right perimandibular area, which could represent postoperative edema or hematoma. Correlation for clinical improvement of the soft tissue swelling or hematoma is recommended.
343	Chondromyxoid Fibroma and Mandible Graft 3		10	Male	Technique: CT of the facial bones with contrast with 3D reformations. 10 year old male with a giant cell tumor of the mandible. History of a mandible tumor with resection. History of a chondromyxoid fibroma. Postsurgical changes are redemonstrated following prior right mandibulectomy and reconstruction. In the interval, a mandibular fixation plate has been removed. There is continued further healing at the mandibular reconstruction site with rib grafting, with osseous bridging noted. A nonossified component of the graft within the right glenoid fossa remains stable in appearance. Multiple surgical clips are seen within the right masticator space. There is an area of calcification/ossification seen within the right submandibular space, series 2, image 66; which appears increased i 1. Right segmental mandibulectomy and reconstructive postsurgical changes, with increased osseous healing and bony bridging at the mandibular reconstruction site, with the rib graft. 2. Calcification/ossifications in the soft tissues; in the region of the right submandibular space, which appears increased from prior study, which may reflect increasing areas of dystrophic calcifications. Attention on follow up studies.
344	Chondromyxoid Fibroma and Mandible Graft 4		10	Male	3. Paranasal sinus mucosal thickening, may be congestive or inflammatory. Technique: CT of the facial bones with contrast with 3D reformations.
					69 year old man with chest pain, and possible ascending aortic dissection seen on non-gated outside hospital CTA. Cardiac-gated CTA requested for evaluation of aortic dissection. There is a limited intimal tear in the left lateral aspect of the ascending aorta, originating from the mid-ascending portion and extending to the undersurface of the proximal arch. There is no intramural thrombus or hematoma. Intimal flaps are evident, although there is no true or false lumen. The tear does not extend to the arch vessels, or retrograde to the coronary arteries. The aortic root (sinotubular junction and sinuses of Valsalva) is not involved. There is minimal aneurysmal There is variant aortic arch anatomy, with an aberrant right subclavian artery arising from the medial distal aortic arch. The first branch of the aortic arch is the right common carotid, followed by the left common carotid, followed by the left subclavian artery, followed by the right subclavian artery. The descending thoracic aorta has normal course and caliber, without significant atherosclerotic disease, and no luminal irregularity. There is no intimal injury or dissection of the descending thoracic aorta. The aorta valve has leaflets that are mildly nodular, with 3 commissures and cusps identified. The right coronary artery originates from the right coronary cusp, and the left main coronary artery originates from the left coronary cusp. The heart right coronary artery dominant; the left circumflex artery ends in an obtuse marginal branch. There is mild calcified atherosclerosis of the left main, left anterior descending, and circumflex arteries. The heart size is normal without pericardial effusion. The main pulmonary artery is normal in course and caliber. While not a dedicated pulmonary embolism study, no filling defects are seen in the main or lobar pulmonary arteries to suggest pulmonary embolism. There is a minimal degree of dependent atelectasis; the lungs are otherwise clear. No pleural effusions. No pneumothorax. The airways are patent and of normal course and caliber. No mediastinal, hilar or axillary lymphadenopathy. Limited evaluation of the upper abdomen is unremarkable. The mesenteric artery origins are not imaged. No suspicious bony lesions identified. 1. Limited intimal tear (intimal flap) of the ascending aorta, originating in the left aspect of the mid-ascending aorta, extending into the undersurface of the proximal arch. trace periaortic fluid. 2. The tear does not involve the arch vessels (of which there are three, with aberrant right subclavian artery anatomy, as the distal-most branch). 3. No retrograde extension of the tear to the aortic root; normal origins of the right and left coronary arteries. 4. Minimal aneurysmal dilatation of the ascending aorta, measuring up to 41 mm, maximally. 5. Normal size and appearance of the descending thoracic aorta.
347	Potential Ascending Aortic Dissection		69	Male	Summary: critical result, clinician notified
348	Mouse Full Body	unknown		unknown	Foot drop – CT of hips and Pelvis to eval for any tumor. 54-year-old female presenting with right foot drop which started after her right total hip arthroplasty. According to the patient, after her right total hip arthroplasty she woke up with numbness and tingling feeling in her right lower extremity which progressed to pain in the right lower extremity just proximal to the ankle the following evening. She says the pain has improved but she has had progressive weakness in her lower extremity over the last 6 months. She now complains of a "full locked foot drop" in her right lower extremity. Notes make reference to an MRI examination of the RIGHT knee that demonstrate denervation atrophy of the extensor musculature of the right calf. Clinical concern is for a soft tissue mass compressing the sciatic nerve. This CT scan is ordered as a prosp evaluation to look for tumor. Right: There is no abnormal lucency surrounding the acetabular cups or the femoral components to suggest loosening. However, a fixation screw from the right acetabular component extend posteriorly through the cortex of the bone for approximately 17 mm into the expected location of the right sciatic nerve. Left: There is no abnormal lucency surrounding the acetabular cups or the femoral components to suggest loosening. However, a fixation screw from the left acetabular component extends posteriorly through the cortex of the bone for approximately 9 mm into the fat and soft tissues of the pelvis. Pelvis/Visualized Abdomen: The visualized liver is normal. There is no evidence of enteric obstruction or ileus. There is mild atherosclerotic calcification of the iliac arteries. In the midline pelvis is a structure thought to represent the uterus there is a heterogeneously enhancing mass which is thought to represent a fibroid, ultrasound examination would be helpful for confirmation. There are no other pelvic masses. 1. In a structure thought to represent the uterus there is a heterogeneously enhancing mass which is thought to represent a fibroid, ultrasound examination would be helpful for confirmation. There are no other pelvic masses. 2. A fixation screw from the right acetabular component of the total right hip arthroplasty extends posteriorly through the cortex of the bone for approximately 17 mm into the expected location of the right sciatic nerve and is a likely source of nerve impingement. 3. A fixation screw from the left acetabular component of the total left hip arthroplasty extends posteriorly through the cortex of the bone for approximately 9 mm into the fat and soft tissues of the pelvis, without nerve impingement.
357	Hip Arthroplasty		54	Female	Teaching points: Good entire lower limb. Arteries and muscles are good. Analysis: - Marked calcified atherosclerosis of the iliac vessels. - Arterial stent of the right superficial femoral artery. - Atherosclerosis of the popliteal arteries. - Poor opacification of the left anterior tibial artery. - The others scanned structures appear normal within the limits of the technique.
362	Lower Limb Runoff	unknown		Male	Analysis provided by Università degli Studi de L'Aquila (Prof. Maccharielli, Prof. Bianchi and DrBernardi)
363	Tortoise	unknown		unknown	
364	Owl	unknown		unknown	
365	Calf with Two Heads	unknown		unknown	About 40 miles east of Dallas, in the small eastern town of Grand Saline, this three eyed, dual-mouthed calf was born. Her owners, James and Virginia Hale gave the light red female calf the name "Unique" for her peculiar face. This face possessed a second mouth on the lower left side and a third eye, which was capable of blinking. Her extra mouth was functional, allowing her to feed from her mother and lap up water using both tongues. At birth the young animal weighed 57-pounds and appeared to be in good health except for a runny nose, which was treated with antibiotics by a veterinarian. Eleven days after birth, Unique suffered from fluid in her lu
367	Occluded Iliac Arteries		63	Male	63 year old male with Aortic occlusion; recent CTA not able to identify reconstituted common or deep femoral arteries bilaterally. CT taken to evaluate for potential bypass targets for aortofemoral bypass grafting. Vascular findings: The visualized abdominal aorta (to the level of the bifurcation), celiac artery, superior mesenteric artery, and inferior mesenteric artery are normal in course and caliber. Conventional hepatic arterial anatomy is present. The bilateral renal arteries (one right and two left) are normal in course and caliber. The bilateral common iliac arteries are occluded, starting just past the bifurcation. Occlusion extends from the proximal common iliac arteries to the external iliac, common femoral, superficial femoral and popliteal arteries bilaterally. Both proximal internal iliac arteries are occluded. The left internal iliac artery is filled via retrograde collateral flow. Collateral flow is provided to the pelvis and lower extremities, via prominent lumbar arteries supplying internal iliac artery branches, as well as collaterals from the lower intercostal arteries, inferior epigastric arteries, and inferior mesenteric artery. In the right lower extremity, flow is reconstituted via collaterals to the peroneal and posterior tibial arteries which are patent down to the ankle. The anterior tibial artery is occluded after the proximal third. The plantar artery is patent. In the left lower extremity, flow is reconstituted via collaterals in the proximal calf and there is thine vessel run off down to the ankles. Of note, the posterior tibila artery is only reconstituted in the mid-calf. The dorsalis pedis and plantar arteries are patent. Non-vascular findings: Lung bases are clear. Limited evaluation of the abdominal organs in the noncontrast and arterial phases demonstrates no abnormality the liver, spleen, gallbladder, general glands, pancreas, or bowel. The kidneys demonstrate small wedge-shaped cortical defects, likely related to subacute and chronic infarctions. No hydronephrosis or renal stone. The decompressed bladder is unremarkable. Prostate gland is normal. No aggressive osseous lesions. 1. Chronic arterial occlusion from the proximal common iliac arteries to the popliteal arteries bilaterally. The abdominal aorta is patent to the level of the bifurcation. No significant change compared to outside study. 2. Collateral flow to the pelvis and lower extremities from lumbar arteries, inferior mesenteric artery, inferior epigastric arteries, intercostal arteries, and numerous unnamed collaterals in the thighs. 3. Small multifocal subacute and chronic infarcts in both kidneys.
368	Basilar Aneurysm		32	Female	32 year old Female with vertebrobasilar junction aneurysm. CT head without contrast: The ventricles and cortical sulci are appropriate for the the patient's age. There is no acute intracranial hemorrhage, extra-axial fluid collection, or loss of gray-white differentiation to suggest acute territorial infarction. No mass effect or midline shift is present. The paranasal sinuses are well aerated. The mastoid air cells are clear. The orbits appear normal. No fracture defects are seen on the bone windows. The osseous structures demonstrate no destructive or lytic lesions. CT head with contrast: No abnormal enhancement is seen on post contrast images. CT Angiography: No evidence of flow-limiting stenosis within the circle Willis. There is 9 x 12 x 11 mm fusiform aneurysm arising off the inferior portion of the basilar artery. The branches of the AICA appear to arise superiorly from the aneurysm. The bilateral vertebral arteries appear unremarkable and are not involved. The size of the aneurysm is difficult to compare given differences in technique. 1. 9 X 12 X 11 mm fusiform aneurysm of the inferior portion of the basilar artery. Of note, the bilateral AICA arteries arise from the superior portion of the aneurysm. 2. The aneryxm appears grossly similar in size compared with a prior MRI though exact comparison is difficult given differences in technique. 3. No acute intracranial findings. Summary: Technique: Sequential axial images were obtained of the head both before and after the uneventful intravenous administration of contrast. Additionally, noncontrast CT head was performed followed by contrast-enhanced CT angiography of the head and neck, after the uneventful administration of IV 60 mL of Isovue 370 contrast agent. Coronal, sagittal, curved planar, and volumetric reformations were performed on an independent workstation. Maximum intensity projection images were performed on an independent 3-D workstation.
369	S/P Motorcycle Accident		32	Male	Based on a 32 cm body phantom, the estimated radiation dose (CTDIvol [mGy]) for each series in this exam are: 63, 36, 45, 64 mGy. The estimated cumulative dose (DLP [mGy-cm]) is: 2939 mGy-cm. 32 year old male status post motorcycle accident. CT head without contrast: No acute intracranial hemorrhage or focal brain parenchymal lesion demonstrated. Gray-white matter differentiation is preserved. The ventricles are within normal limits in size and in position. No abnormal extra-axial collections present. No evidence of mid-line shift, herniation, or mass effect. There are mucus retention cysts or polyps in the right maxillary sinus. The visualized portions of the other paranasal sinuses, mastoid air cells, and orbits are clear. No calvarial or facial fractures demonstrated. Endotracheal and orogastric tubes are in place. There are right greater than left pulmonary consolidations which could represent m CT head with contrast: No abnormal enhancement is seen on post contrast images. CT Angiography: There is a 3-vessel right aortic arch. The origins of bilateral common carotid arteries and vertebral arteries are patent. Vertebral arteries are codominant. There is fenestration of the proximal basilar artery (S5, IM415-425). Bilateral carotid bifurcations are patent. Bilateral internal carotid arteries are patent. There is a 2 to 3 mm downward projecting outpouching of the right internal carotid terminus (S5,IM 469-472), this may and a small aneurysm or infundibulum. No evidence of flow-limiting stenosis within the circle Willis. No evidence of cerebral aneurysm. C-Spine: No acute fracture or compression deformity demonstrated. There is no prevertebral soft tissue swelling. The posterior elements appear intact. The facets are anatomically aligned. There is no evidence of acute subluxation or atlantooccipital dissociation. The cervical spine demonstrates normal lordosis. The disk spaces are preserved. There is no significant spinal or foraminal stenosis noted. T-spine: The vertebral body height, disc spaces, and alignment are preserved. The posterior elements appear intact. The facets are anatomically aligned. There is no evidence of fracture or subluxation. No significant facet joint arthropathy, spinal stenosis, or foraminal stenosis demonstrated. No prevertebral soft tissue swelling identified. L-spine: There is an avulsion fracture of the right L5 transverse process, which is distracted approximately 2 cm laterally with likely hematoma medially. There is also an avulsion fracture of the right sacral ala with widening of the right sacroiliac joint. There is a large retroperitoneal hematoma. The lumbar vertebral body height, disc spaces, and alignment are preserved. The posterior elements appear intact. There is widening of the facet joints at L4-5 and L5-S1, left greater than right. There is a posterior disc bulge at L4-5 with narrowing of the spinal canal at this level. 1. No acute intracranial pathology. 2. No acute vascular injury or flow limiting stenosis identified by CT angiography. 3. 2 to 3-mm downward projecting outpouching from the right internal carotid terminus, may represent a small aneurysm or infundibulum. 4. No cervical spine fracture or dislocation identified by CT. 5. L5 right transverse process avulsion fracture with 2 cm of distraction laterally. 6. Widening of the facet joints at L4-5 and L5-S1, left greater than right. 7. Avulsion fracture of the right sacrum with associated widening of the right sacroiliac joint. 8. Broad-based disc bulge at L4-5 with narrowing of the spinal canal at this level. Technique: Sequential axial images were obtained from skull base to the level of the vertex without contrast. Next, contrast-enhanced CT angiography of the head and neck was performed after the uneventful administration of IV 16 mL of Isovue-300 contrast agent. Then, post contrast sequential axial CT images were obtained from the skull base to the level of the vertex. Coronal, sagittal, curved planar, maximum intensity projection and volumetric reformations were performed on an independent 3-D workstation. Additionally dedicated coronal and sagittal reconstructions Dedicated coronal and sagittal reconstructions of the thoracic and lumbar spine were obtained during a separate CT examination of the chest abdomen and pelvis. Based on a 16-cm head phantom, the estimated radiation dose (CTDIvol [mGy]) for each series in the CT angiography of the head and neck exam are: 63.11, 34.47, 62.73, 32.32, 61.71, and 33.71 -mGy. The estimated cumulative dose (DLP [mGy-cm]) is: 2899.35-mGy-cm. NOTE: The radiation dose indicators for CT -- the 'volume CT Dose Index' (CTDIvol) given in milli-Gray (mGy), and the Dose Length Product (DLP) given in mGy-centimeters (mGy.cm) -- are generated from the CT scanner to estimate radiation exposure based on technical study parameters and a reference phantom. The CTDI and DLP may therefore substantially over- or underestimate an individual's absorbed dose based on patient size and other factors.
371	Sugarglider Skull	unknown		unknown	For the estimated radiation dose associated with the acquisition of the thoracic spine and lumbar spine images, please see the report associative with the CT chest abdomen and pelvis from the same day during which these images were obtained. From the SJSU Bird and Mammal Museum
372	Opposum Skull	unknown		unknown	c/o Stephanie Trowbirt, MS #2392
373	Horse Skull	unknown		unknown	c/o Stephanie Trowbirt, MS 2037
374	Beaver Skull	unknown		unknown	This skull is from the collection of Paul Brown, DDS, Stanford University
375	Penguin Skull	unknown		unknown	This skull is from the private collection of Tyler Johnson,MD, Stanford University
381	Horse Arthritic Limb	unknown		unknown	This CT scan was donated by Mathieu Spriet , DVM, UC Davis School of Veterinary Medicine. (trspriet@ucdavis.edu)
382	Pelican Beak	unknown		unknown	This skull is from the private collection of Tyler Johnson, Stanford University.
383	Full Body CT		44	Male	
384	Full Body MRI		44	Male	
385	Head MRI		44	Male	
386	Thorax MRI		44	Male	
387	Liver MRI		44	Male	
388	Abdomen MRI		44	Male	
389	Pelvis MRI		44	Male	
390	Thigh MRI		44	Male	
391	Upper Calf MRI		44	Male	
392	Lower Calf MRI		44	Male	
393	Foot MRI		44	Male	
424	Whitefoot Rabbit	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
425	Tortoise - Pokey	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
436	Swine – 7783	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
437	Swine - 7755 - with contrast	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
438	Canine - Kobe	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
439	Canine - Blazer	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
440	Canine - Angel	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
446	Sheep	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
447	Horse Hoof - Split Open	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
448	Horse Hoof - Diseased	unknown		unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.

Anatomage Table 9.0 Case Library Descriptions

449	Horse Hoof - Split Closed	unknown	unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
450	Horse Skull - Mare	unknown	unknown	Scanned and donated by Dawn Holley and James Ferguson, DVM.
469	Chimp Skull	unknown	unknown	Donated by Mary Marzke <Mary.Marzke@asu.edu>
470	Domestic Cat	unknown	unknown	Donated by Paul Brown.
471	Horse Skull	unknown	unknown	Donated by Paul Brown.
472	Dog Skull	unknown	unknown	Donated by Paul Brown.
473	Pig Head	unknown	unknown	Donated by Paul Brown.
474	Mastadon Tooth	unknown	unknown	Donated by Paul Brown.
475	Gorilla Hand	unknown	unknown	From the University of Kentucky.
476	Gorilla Knee	unknown	unknown	From the University of Kentucky.
477	Gorilla Foot	unknown	unknown	From the University of Kentucky.
480	Tiger Skull	unknown	unknown	Donated by Paul Brown.
481	Alligator Skull	unknown	unknown	Donated by Paul Brown.
605	Cerebral Angio	unknown	Male	604 axial slices taken from vertex of skull down to C5-6 without contrast. The lateral ventricles are moderately enlarged including temporal horns. Third and fourth ventricles also enlarged with general prominence of cortical sulci. No mass, infarction, abnormal fluid collection or shift of midline structures. Moderate posterior osteophytes at C3-4 with mild attenuation of the A-P dimension of the spinal canal at this level. There is a soft tissue dome-shaped density in the inferior portion of the left maxillary sinus. Mild soft tissue density in the left ethmoid sinus air cells. There are two large calcifications in the falx cerebri anteriorly, the largest measuring about 3 X 1 cm. Other calcifications noted in the tentorium and scattered elsewhere in the dura. 1. Probable communicating hydrocephalus related to general atrophic change in the brain. 2. Post-inflammatory soft tissue disease in left maxillary and left ethmoid sinuses 3. Scattered dural calcifications 4. Moderate degenerative change at C3-C4 Correlative slices: 1. 141 - 201 2. 242 - 258 and 308 - 320 3. 70 and 192
606	Skull with Hemorrhage	unknown	Male	530 axial slices taken from vertex of skull to C5 without IV contrast. There is a hyperdense fluid collection over the right hemisphere extending beneath the temporal lobe and outlining the right side of the tentorium. This measures about 8 mm in thickness lateral to the temporal lobe, and begins at the top of the lateral ventricles and is maximal over the temporal lobe. This causes a slight compression of the right lateral ventricle and shifts the third ventricle about 3-4 mm to the left. No intracerebral hemorrhage is seen and there is no evidence of subarachnoid bleeding in the basilar cisterns. No skull fracture is visualized and there is no prominence of soft tissues on either side of the skull to suggest trauma. The sinuses and mastoid air cells are all well-aerated. Acute intracranial hemorrhage, probably subdural, over the right hemisphere, maximal over temporal lobe, with mild compression of the right hemisphere and shift of the midline. Correlative slices: Hemorrhage - 186 - 232 Compression of R lateral ventricle - 198 Midline shift - 186 - 232 Hemorrhage over tentorium - 224 and 233 123 axial slices taken from skull vertex to C1 without IV contrast Moderately severe enlargement of lateral ventricles including temporal horns, and also enlargement of the third ventricle. Fourth ventricle appears normal in size. There is no cortical atrophy. No mass is seen and there is no shift of midline. Aqueduct appears narrow inferiorly but no displacement noted. Large falx calcification. Dome-shaped soft tissue density filling the posterior inferior left maxillary sinus. 1. Hydrocephalus, non-communicating vs. normal pressure hydrocephalus (NPH) 2. Post inflammatory soft tissue density in left maxillary antrum Diagnosis would need further testing such as MRI and lumbar puncture studies. Correlating slices: 1. 53 - 85 2. 114 and 116
607	Large Falx Calcification	unknown	Male	241 slices taken of the cervical spine, from level of third ventricle inferior to T2 without IV contrast. The cervical spine has a slight reversal of the normal lordotic curve. Vertebral bodies are of normal height and mineralization. Disc spaces are within normal limits without degenerative osteophytes. The posterior fossa of the cranium appears normal. The lung apices are normal. The soft tissues of the neck are normal. Slight reversal of the normal lordotic curve in the cervical spine possibly due to muscle spasm. Otherwise normal cervical spine.
612	Normal Cervical Spine	unknown	Female	Correlating slices: 244 - 254 on sagittal reconstruction views 285 axial slices were taken from the level of the third ventricle down to T3 without IV contrast. The third and fourth ventricles are normal. The temporal lobes, mid-brain, and posterior fossa are normal with no mass, shift of midline structures, and no extra-cranial fluid collection. There is a block vertebra with almost complete fusion across the disc space of C4-5. The disc spaces are otherwise normal. There is minimal scoliosis, concave to the right at C3-4-5. Lateral alignment is normal, spinal canal normal with no posterior osteophytes. The right maxillary sinus is small and nearly opaque. Lung apices are normal. 1. Congenital block vertebrae at C4-5 with fusion across the disc space 2. Minimal scoliosis, concave to the right at C3-4-5. 3. Moderately atrophic, small opaque right maxillary sinus, probably developmental Correlative slices: 1. 225 - 252 on sagittal reconstruction 2. 210 - 252 on frontal reconstruction 3. 90 - 122 on frontal reconstruction and 33 - 61 on axials
614	Moderate Atrophy	unknown	Female	474 axial slices were taken from vertex of skull to C4 during bolus infusion of IV contrast. Fronts carotid bifurcations to intracerebral arteries, all arteries are patent without stenosis, aneurysm, or malformation noted. The venous drainage is also normal. The brain shows mild prominence of the third and lateral ventricles, sparing the temporal horns and fourth ventricle from enlargement. Slight prominence of cortical sulci and basilar cisterns. Minimal soft tissue thickening in the inferior portion of the smaller left maxillary sinus and slight fluid in the posterior right side of the sphenoid sinus. Facial bones and upper cervical spine to C4 are normal. 1. Normal CT angiogram from carotid bifurcations to intracerebral arteries 2. Mild hydrocephalus ex vacuo (atrophy) 3. Minimal soft tissue disease in the small left maxillary sinus and in sphenoid sinus Correlative slices: 1. all 2. 81 - 113, 133 - 188 3. 311 - 320, 258 and 270
615	Mild Hydrocephalus Ex Vacuo	unknown	Male	541 axial slices were taken from vertex of skull to C5-6 during bolus infusion of IV contrast Calcifications noted in the right carotid bifurcation and proximal portion of internal carotid. Calcifications also noted in the intracranial portions of both internal carotids. Tortuosity and elongation seen in the cervical portion of the right internal carotid artery. Minimal stenosis at the origin of the right internal carotid artery. No other abnormality seen in the arterial or venous circulation. The ventricles of the brain are all slightly enlarged and associated with mild cortical atrophy. Minimal soft tissue thickening in right ethmoid sinus and inferior portion of the right maxillary sinus. Moderate narrowing of the C5-6 disc space with small posterior osteophytes at this level, without narrowing of the spinal canal. 1. Mild narrowing of the origin of the right internal carotid with calcification at that site and also in intracranial portion of both internal carotids. Tortuosity also noted in right carotid, all compatible with arteriosclerosis. 2. Mild hydrocephalus ex vacuo (atrophy) 3. Mild sinus disease, right ethmoids and right maxillary sinus 4. Moderate narrowing of the disc space at C5-6 with small posterior osteophytes Correlative slices: 1. 204 - 234 - 239, 338 - 340 2. 50 - 86, 127 - 210 3. 212 - 219, 117 - 142 4. 265 and293
616	Mild Hydrocephalus Ex Vacuo 2	unknown	Male	648 axial slices taken from arch of aorta to vertex of skull during bolus infusion of IV contrast The entire vascular system from arch of the aorta to intracranial vessels appears normal. The brain also appears normal with normal ventricles.
617	Normal CT Angio	unknown	Male	The sinuses and soft tissues are normal. Bones of the cervical spine would be better evaluated on lateral views by sagittal reconstruction. Normal CT angiogram of upper thoras, neck and head 270 axial slices taken from mid temporal lobes to T2 without IV contrast Normal alignment of the cervical spine. Disc spaces are normal. Minimal posterior osteophytes at C5-6. Minimal soft tissue thickening in both maxillary sinuses, in the left posterior ethmoid sinus, and right inferior sphenoid sinus. 1. No significant abnormality in the cervical spine 2. Minimal post inflammatory soft tissue disease in maxillary, ethmoid, and sphenoid sinuses Correlating slices: 1. 200 - 246 on sagittal reconstructions 2. 50 - 60, 16 - 26 on axials Normal anatomy: 1. axial 100 - sagittal 200 - 250 2. thyroid - sagittal 150 and 300
619	Neck Muscles and Veins	unknown	Female	410 axial slices were taken from level of sella turcica to T8 without IV contrast The primary finding is a transverse fracture through the body of T5 with anterior displacement of most of the body of T5 of about 1cm. The spinal cord appears slightly compressed to about 6mm by the anterior displacement of the inferior portion of T5. There is associated widening of the posterior mediastinum above and below the fracture and small pleural effusions layered posteriorly and in the major fissures, presumably from hemorrhage related to the fracture. There are also scattered small globules of air around the fracture site in the posterior mediastinum above and below the fracture, around the spinal cord, and scattered around the posterior eleme There are posterior degenerative osteophytes, moderate at C5-6, and mild at C6-7. There is soft tissue density noted in both maxillary sinuses, with only the inferior half of these sinuses visualized on this study. Probable deceleration accident (? automobile crash) resulting in: 1. Transverse fracture thru upper posterior body of T5 with forward displacement of the anterior body of T5 in relation to T4. 2. Widening of the posterior mediastinum and small pleural fluid collections bilaterally, probably due to hemorrhage. 3. Air in the posterior mediastinum, around the spinal cord and posterior spinous processes, possibly due to a laceration of the esophagus. 4. Possible compression of the spinal cord at mid T5 level 5. Bilateral maxillary sinus disease, unrelated to the trauma 6. Posterior osteophytes at C5-6 and C6-7, also unrelated to the trauma Correlative slices: 1. 240 - 260 on sagittal, 298 - 310 on axial 2. 254 - 323 coronal 3. 255 - 342 axial, 225 - 313 sagittal, 264 - 372 coronal 4. 305 - 325 axial, 247 - 262 sagittal 5. 310 coronal 6. 242 - 272 sagittal
620	Transverse T5 Fx.	unknown	Female	221 axial slices taken from mid frontal sinuses to C2 without IV contrast There is some clouding and soft tissue density in the left middle ear around the ossicles. The ecotum is not eroded. There is some soft tissue density and/or fluid in some of the mastoid air cells. The right middle ear and mastoids are normal. The large left sphenoid sinus is almost entirely filled with fluid density with an air-fluid level anteriorly in this supine position. The right frontal sinus is developmentally small. No abnormality in the facial bones and base of skull. Molar teeth slightly encroach upon the floor of both maxillary antra. 1. Left otitis media 2. Left mastoiditis 3. Inflammatory disease in the left sphenoid sinus with fluid Correlating slices: 1. L. axial 95 - 102 R. axial normal 105 - 110 L. sagittal 314 - 320 R. sag. normal 147 - 158 L. coronal 268 - 278 R. cor. normal 263 - 273 1. L. axial 125 - 167, sag. 325 - 348, cor. 287 - 313 R. sag. normal, cor. 317, R. axial 164 - 219 3. axial 53 - 104, sag. 227 - 263, cor. 193 - 232 Normal anatomy: The superior, middle, and inferior turbinates are well demonstrated on coronal slices 158 and 192 167 axial slices were taken from vertex to C2 without IV contrast There is mild prominence of all ventricles and mild prominence of cortical sulci and basilar cisterns. No mass, hemorrhage, infarct or shift of midline structures.
621	Otitis Media and Mastoiditis	unknown	Male	
622	Cranial Surface Vessels	unknown	Female	Sinuses clear. Bones unremarkable. Mild prominence of all ventricles, cortical sulci and cisterns compatible with atrophy. 251 axial slices taken from posterior fossa to T3 without IV contrast There is slight reversal of the normal lordotic curve in the cervical spine alignment. No fracture is seen. The vertebrae are of normal height and the disc spaces are normal. No significant osteophytes are seen. The spinal canal is normal and the cord appears normal. The cerebellum and fourth ventricle are normal. Soft tissues of the neck and lung apices are normal. Slight reversal of the normal lordotic curve of the cervical spine which may be compatible with muscular spasm.
623	Normal Cervical Spine	unknown	Female	Correlative slices: Sagittal 213 and 248 263 axial slices were taken from mid-orbits and third ventricle to T2 without IV contrast The bodies of C4 and C5 are fixed by an anterior metal plate with two screws into each mid vertebral body. Both vertebrae are mildly compressed anteriorly. The disc space is spread open anteriorly by a synthetic disc material with three metallic vertical markers anterior and posterior to the synthetic disc. There are moderate postero-lateral osteophytes of the left which narrow the neural foramen to a moderate degree. This does not impact the spinal cord. There is slight soft tissue prominence anterior to the metal plate. There is deviation of the nasal septum to the right. The lung apices are normal. The visualized portion of the brain shows enlargement of the basilar cisterns, the temporal horns of the lateral ventricles, and the third ventricle. 1. Previous anterior compression of the bodies of C4 and C5 with recent surgery placing an anterior metal plate fixed by two screws into both C4 and C5. 2. Synthetic disc in the anterior disc space at C4-5, spreading the space anteriorly with normal height posteriorly. 3. Moderate posterolateral osteophytes on the left with moderate narrowing of the neural foramen on the left. 4. Nasal septum deviation to the right. Correlative slices: 1. axial 150 - 168, sag. 197-247, cor. 195-248 2. axial 152-183, sag. 198-238, cor. 201- 228 3. sag. 222-240, axial 148-154 4. cor. 27-110
624	Anterior Metal Plate	unknown	Female	684 axial slices were taken from arch of aorta to vertex of skull during IV infusion of contrast. The entire arterial and venous system from the aortic arch to intracranial vessels is normal. No mass, hemorrhage, vascular malformation, or infarct noted. The ventricles are normal with no atrophic changes noted. The injection of the contrast was apparently done in a left arm vein and two small air bubbles are noted at the base of the left internal jugular vein. This was probably injected with the infusion of contrast. (see -247 - 252 mm) There is a 1.3 cm hypervascular nodule in the upper posterior portion of the left lobe of the thyroid. No cystic component and no irregularity of margins. The left lobe is slightly larger than the right lobe. There is a 1.2 cm hypervascular smooth mass in the posterior midline of base of tongue. No cystic component. Sinuses are normal. Upper third of both lungs appear normal. 1. Normal arterial and venous system from arch of aorta to intracranial vessels. 2. 1.3 cm hypervascular mass in left lobe of thyroid, most likely a benign adenoma. 3. 1.2 cm hypervascular mass in the midline posterior base of the tongue, most likely lingual thyroid. Correlative slices: These are in mm from top to bottom of scan, not # of slices. 1. The whole study 2. -247 - 252 mm 3. -247 - 182 mm
625	Multiple Hypervascular Masses		32 Female	427 axial slices were taken from the vertex of skull to C4 without IV contrast There are abundant calcifications of the dura overlying the interhemispheric fissure. In addition, there is exuberant bone formation from the inner table of the skull on either side of the frontal lobes, projecting into the cortical sulci of the frontal lobes. There is atrophy of the cortical sulci and basilar cisterns. The ventricles are upper range of normal, right lateral ventricle larger than the left. No other abnormality seen in the brain. The mandible is missing the second and third molars bilaterally. The sinuses are clear The nasal septum deviates to the left. 1. Abundant dural and inner table calcifications and ossifications bilaterally over the frontal lobes and interhemispheric fissure. This is a benign finding, partially related to older age. 2. Deviated nasal septum 3. Cortical atrophy Correlative slices: 1. axial 50-147 2. axial 243-272
626	Deviated Nasal Septum	unknown	Female	

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			586 axial slices taken from vertex of skull to C7 without IV contrast. No fracture in skull, facial bones or cervical spine. Brain shows no hemorrhage or fluid collection. Ventricles are normal. Cervical spine shows normal alignment. Disc spaces normal. Head positioned forward and tilted to the right. Sinuses normal. No abnormality in skull, brain, facial bones and cervical spine. Probably a young girl judging from hair braids and unerupted molars. Normal anatomy: 1. soft palate - sagittal 252 - 260 2. epiglottis - sagittal 240 - 267 3. unerupted molars - sagittal 191 - 208 4. adenoid tissue - sagittal 233 and 255
627	Normal Skull with Hair	unknown	Female	104 axial slices taken from vertex of skull to C2 without IV contrast There has been surgical removal of a large portion of the left cranial skull from almost to the vertex down to temporal bone, and including part of frontal and parietal bones. The parietal lobe of the brain bulges out thru the area of removed bone with hemorrhage, air, and metallic skin clips noted in these enrollen tissues covering the left frontal and parietal lobes. There is intracranial hemorrhage beginning at about the frontal horn of the left lateral ventricle and extending fan-shaped to the frontal cortex. The hemorrhage is surrounded by low density edema in the brain. The left lateral ventricle is essentially closed by the swollen brain with the septum pelluc
628	Traumatic Brain Injury	unknown	Male	There is a small amount of fluid layered in the sphenoid sinus without evidence of fracture in the facial bones. Traumatic skull and brain injury showing: 1. Removal of a large bone flap of the left cranium 2. Hemorrhage in the left frontal lobe with brain edema and swelling 3. Blood in the ventricular system 4. Mass effect of the brain swelling with shift of the midline to the right and extension of brain to the left in the area of the removed cranium Correlating slices: 1. axial 16-74 2. axial 42-66 3. axial 50-66 4. axial 56-66
629	Intubation	unknown	Male	237 axial slices were taken from posterior fossa to T2 without IV contrast Endotracheal and nasogastric tubes are noted in satisfactory position. The cervical spine is in normal alignment with no fracture seen. Mild degenerative changes noted with anterior osteophytes at several levels and calcifications in the anterior spinous ligament. Bones show moderate demineralization. The superior plate of T1 is indistinct but probably related to demineralization rather than fracture. No herniation of cerebellar tonsils into the foramen magnum. 1. No definite fracture seen in the cervical spine 2. Superior plate of T1 is indistinct, probably due to demineralization rather than fracture 3. Mild degenerative changes in cervical spine with anterior osteophytes and calcifications in the anterior spinous ligament 4. Endotracheal and nasogastric tubes in satisfactory position Correlative slices: 1. sagittal 162-213 2. sagittal 144-210 3. sagittal 103-210 4. sagittal 157-239
630	Clay-Shovelar Fracture of C7	unknown	Female	62 axial slices taken from level of lateral ventricles to T1-2 without IV contrast There is an oblique fracture through the spinous process of C7 with slight separation. No other definite fracture seen in the vertebral body. There is no soft tissue swelling to suggest that this is acute. Otherwise the alignment of the cervical spine is normal. Disc spaces are normal. There are degenerative changes with a few anterior osteophytes and calcifications in the anterior spinous ligament. There are soft tissue densities in the floor of both maxillary antra with small amount of fluid layered posteriorly in the left maxillary sinus. The opening into the nasal cavity is obscured by soft tissue thickening on the left, normal on the right. Moderate cortical atrophy, moderate enlargement of temporal and occipital horns of lateral ventricles, third and fourth ventricles, and basilar cisterns. Lungs apices are normal. Patient appears to be edentulous. 1. Clay-Shovelar Fracture of spinous process of C7, age indeterminate but probably not acute. Mild degenerative changes in cervical spine. 2. Mild post-inflammatory soft tissue disease in both maxillary sinuses, left more than right 3. Atrophic changes in the visualized portion of the brain. Correlating slices: 1. axial 208-223, sagittal 226-247, and 197-248 2. sagittal 100 - coronal 52-144 3. axial 0-70
631	Edentulous Skull	unknown	Male	305 axial slices were taken from above the frontal sinuses to C2 without IV contrast Facial bones are intact. Sinuses show minor focal mucosal thickening without fluid. Some tortuosity and deviation of the nasal septum. Mild atrophic changes in the visualized portion of the brain. Patient is edentulous. Septal deviation in the nasal cavity with no other significant abnormality Correlative slices: axial 170-220
633	Posterior Thoracic Tumor	unknown	Male	1172 axial slices were taken from middle of cranium to the mid kidney level during IV infusion of contrast. The primary abnormality is a posterior thoracic mass involving the left T3-5 area. The mass is about isodense with muscle and shows no enhancement with contrast. It appears to arise extramedullary and has completely eroded the left postero-lateral elements of T3-5 including the lamina, transverse processes, the left lateral wall of the arch, and posterior proximal left ribs. At T4, the smooth erosion also involves th There is no other lung abnormality or hilar mass. The liver, gall bladder, pancreas, spleen, stomach, upper half of kidneys, and visualized portions of small and large bowel all appear normal. The upper portion of the scan shows no abnormality in the arteries and veins of the neck and head. The lower half of the brain appears normal. The sinuses are normal. Posterior left thoracic mass involving bony elements of T3-5, extending into left posterior mediastinum with pleural effusion. This is most likely of neural sheath origin, such as Schwannoma, neurofibroma, meningioma. Much less likely would be bone tumors such as osteoblastoma, osteosarcoma, chondrosarcoma. This is an unusual tumor. An MRI scan would be very Correlative locations: (not by slice number but by location numbers) // mass and bone erosion and destruction -227mm to -297mm
634	Normal Heart Angio		57 Female	153 axial slices were taken through the heart during bolus infusion of IV contrast The technical factors were not optimal for evaluating the coronaries. The heart chambers appear normal in size with no evidence of valvular disease. The left main coronary, the anterior descending, circumflex, and diagonal branch appear normal. Likewise, within the limits of this study, the right coronary and posterior descending branch as well as venous drainage appear normal. No abnormality seen on CT coronary angiogram Normal Anatomy: 1. Left coronary artery - axial 59-128, sagittal 239-314, coronal 181-262 2. Left coronary artery - axial 54-103, coronal 118-251 3. Coronary sinus - sagittal 239-246
635	Diseased Lung	unknown	Male	321 axial slices taken from C7 to L1 without IV contrast On the right side there is a 5-6 cm spiculated mass adherant to the postero-lateral wall of the mid chest. There is also a large loculated pneumothorax or air collection with moderate fluid collection within it. This occupies the space of the usual right upper lobe, which is present but compressed by this air / fluid abnormal structure. This air space appears to be thin-walled. There is also bilateral chronic lung disease showing dilated bronchi almost all the way to the chest wall. There are also areas of honeycomb tiny blebs and interstitial fibrosis. There is a rounded 2.5 cm mass just superior to the left kidney near the position of the adrenal which could be a metastasis. The density appears to be that of solid tissue. The liver, gallbladder, pancreas, spleen, stomach and upper third of both kidneys all appear normal on this non-contrast scan. 1. A 5-6 cm spiculated mass is noted adherant to the postero-lateral mid chest wall on the right, most likely a malignant lung tumor. There is an associated antero-lateral loculated pneumothorax with moderate fluid collection also on the right. There is a background of bilateral chronic lung disease with probable bronchiectasis and tiny blebs with fibrosis. 2. 3 cm mass superior to the left kidney, possibly an adrenal metastasis. Correlative slices: 1. lung mass - coronal 296-382; loculated pneumothorax & fluid - sagittal 77-222 2. adrenal mass 292-320
636	Normal Chest CT Scan		58 Female	214 axial slices taken from C7 to L2 (mid-kidneys) with IV infusion of contrast The heart and great vessels are all normal. The lungs appear normal with no mass, infiltrate, fluid or pneumothorax. There is a 1 cm cyst on the mid-lateral surface of the right kidney and an 8 mm cyst in the subcortex slightly more superior. The left kidney is considerably smaller than the right but neither kidney is seen in its entirety. There is a 1 cm cyst in the subcortex of the superior pole, and a 2 cm cyst posteriorly in the lower pole. There are at least four tiny 2-3 mm calcifications in the central portion of the left kidney without evidence of obstruction. There is normal alignment of the thoracic vertebrae without fracture or disc space narrowing. Small anterior osteophytes are noted at T7-8 and T8-9. 1. Normal thorax including lungs, heart, and great vessels 2. Cysts in both kidneys 3. Tiny renal calculations, 2-3 mm, in the central portion of the slightly small left kidney without obstruction Correlative slices: 1. all 2. axial 200-214 (R kidney); axial 193-214 (L kidney) 3. axial 198-202
637	Kidney Cysts	unknown	Female	Normal anatomy: 1. Right lower lobe tissue outlining right middle lobe - sagittal 117-189 2. azygous vein - axial 57-136; coronal 270-326; sagittal 223-241 3. hemiazygous vein - axial 113-126; coronal 325-331; sagittal 254-275 4. right superior intercostal vein - coronal 306-317; sagittal 251-261 123 axial slices taken from C7 to T6 without IV contrast Scans include clavicles, shoulders, sternum, C7 - T6, and corresponding ribs. No fracture or dislocation noted. No acromio-clavicular or sterno-clavicular separation or soft tissue swelling in the vicinity. Lung apices are normal Normal CT scan of upper chest, particularly of clavicles, shoulders, and scapulae Normal anatomy: 1. Sterno-clavicular joints - axial 51-71; coronal 203-219; sagittal 217-238 & 267-286 2. Acromio-clavicular joints - axial 51-71; coronal 203-219; sagittal 217-238 & 406-438 3. Scapulae - axial 13-80; coronal 230-300; sagittal 39-169 & 328-468 4. Shoulder joint - axial 36-79; coronal 220-281; sagittal 31-78 & 425-476
638	Normal Chest CT Scan		58 Female	182 axial slices were taken to include just the left side from C7 to T7 without IV contrast No fracture or dislocation noted. No separation at either end of the clavicle. No soft tissue swelling noted. The medial epiphysis of the clavicle has not fused as yet. The fusion line of the head of the humerus to the shaft is still clearly visible. These findings suggest an age around 25 or less.
639	Epiphysis of Clavicle Not Fused	unknown	Male	The upper thoracic spine is normal. The lung apices are normal. Normal left shoulder girdle Normal anatomy: 1. epiphysis of medial end of clavicle not yet fused - axial 41-68; coronal 172-200 452 axial slices were taken from C1 to L1 with infusion of IV contrast There are bilateral breast implants. The injection of contrast was in the left arm and shows dense contrast in small veins in the left chest and left arm as well as the subclavian vein. The lungs are clear. The heart and great vessels are normal. The spine is quite straight with no lordotic curve in the cervical, no kyphotic curve in the thoracic and no lordotic curve in the lumbar spine. In addition there is a 15 degree scoliotic curve, concave to the left and centered at T7. There are moderate anterior osteophytes from T5-6 thru T12-L1 and lateral osteophytes from T3-9 bilaterally. There is minimal air in the disc spaces at T10-11, T11-12, and T12-L1. The left face
640	Uneven Size Breast Implants Angio		57 Female	The chest is narrow in AP diameter but this does not compress the heart or mediastinum. 1. Straight back syndrome 2. Mild scoliosis of the thoracic spine, concave to the left with degenerative changes throughout the thoracic spine. Correlative slices: 1. sagittal - 240-257 2. sagittal - 243 - 269 and coronal - 312-335 and 314-341 Normal Anatomy: 1. Both adrenal glands - axial R 402-427 and L 390-432 2. Portal vein - axial 414-452 3. Celiac axis - axial 407-452 4. Superior mesenteric artery - axial 424-452 5. L renal artery - axial 446-452 6. L renal vein - axial 435-452 7. Normal pancreas - axial 413-452 8. Pericardium - axial 272-335 9. R innominate artery, R common carotid, R vertebral, R subclavian arteries - axial 100-168 149 axial slices taken thru the heart (T7 - T12) during rapid bolus of IV contrast The resolution of this scanner is not sufficient to visualize fine detail in the coronary arteries. Both left and right coronary arteries are patent as well as branches of both arteries. The proximal portions of both arteries are normal and no stenoses or calcifications noted in the coronaries. There is minimal calcification in the anterior leaflet of the aortic valve. The cardiac chambers are normal in size. There is degenerative change in the disc spaces in the low thoracic spine with air in the discs at T9-10, T10-11, and T11-12, calcification in the disc at T9-10 and T11-12 and a Schmorl's node is seen in the inferior T9 vertebra. The lungs are normal in so far as visualized and the upper portions of stomach and liver appear normal. 1. Coronary arteries appear normal within the limits of the scanner resolution 2. Minimal calcification in the aortic valve 3. Degenerative changes in the discs in the lower thoracic spine. Correlative slices: 1. Left - axial 38-64; coronal 95-320; sagittal 232-334 Right - axial 53-111; coronal 124-199; sagittal 141-198 2. axial - 52-60; sagittal 195-217; coronal 183-200 3. axial 85-119; coronal 417-457; sagittal 141-198; Schmorl's - sagittal 185-194
641	Sternal Foramen		68 Male	Other normal anatomy: 1. Azygous vein - axial 2-89; sagittal 120-225 2. Hemiazygous vein - axial 54-110; sagittal 224-258 153 axial slices were taken from T7 to T12 (covering the heart) during an IV bolus of contrast The heart chambers are normal in size. Within the limits of resolution of this scanner, the left and right coronary and their major branches appear normal. No occlusions or stenoses are recognized. The lungs are normal. Upper portion of the liver is normal. The spleen shows irregular decreased blood flow centrally, probably just due to the timing sequence with incomplete circulation to the entire spleen. There are antero-lateral osteophytes on the right side at T9-10. 1. Normal coronary angiogram within limits of resolution. 2. Degenerative osteophytes at T9-10 Correlative slices: 1. L coronary - axial 40-153; sagittal 243-399; coronal 113-260 R coronary - axial 59-136; sagittal 143-196; coronal 196-274 2. axial 81-91; sagittal 187-277; coronal 390-420
642	Degenerative Osteophytes		57 Female	Normal Anatomy: 1. Papillary muscles of left ventricle - axial 62-120; coronal 176-273; sagittal 279-357 315 axial slices were taken from C7 to T12 without IV contrast Scattered calcification noted in the aortic arch. Heavy calcification noted throughout both coronary arteries from origin thru major branches. The heart and chambers are not enlarged. Lungs are clear except for minimal fibrotic stranding at the right posterior base. No pleural fluid. The upper abdomen, including liver, spleen, pancreas, stomach and adrenals, appears normal. There is extensive degenerative change throughout the thoracic spine. Alignment is normal. Anterior and lateral osteophytes are noted from T1-12 and posteriorly from T5-8 and T11-12. There is minimal air in the discs at T6-7 and T8-9. 1. Heavy calcification in the coronary arteries (this correlates with coronary disease) 2. Scattered calcification in the aorta 3. Extensive degenerative change in the thoracic spine 4. Minimal fibrotic stranding at the right lung base Correlative slices: 1. axial 159-224; sagittal 217-352; coronal 176-278 2. axial 102-116; sagittal 262-297; coronal 255-278 3. axial 93-261; sagittal 233-278; coronal 327-355 air in disc - axial 130-157; sagittal 246-258; coronal 331-355
643	Calcification of Coronary Arteries	unknown	Male	Normal Anatomy: 1. Esophagus - axial 30-282; sagittal 248-282 2. Gastro-esophageal junction - axial 258-280; coronal 247-265 158 axial slices were taken from above the shoulder joint to the elbow joint without IV contrast. There is an oblique fracture through the distal third of the humerus. No intermediate fragments are seen. Three intramedullary metal rods have been placed across the fracture from a medial, lateral, and posterior approach to the head of the humerus. The rods are all intramedullary and all cross the fracture. The distal fragment is displaced posteriorly at the fracture line by about 8-10 mm. One of the rods projects thru the cortex of the humerus, extending 5-6 mm into the olecranon fossa. No other fracture or soft tissue abnormality is seen. Internal fixation of the s
644	Humeral Fracture with Angio	unknown	Female	Correlative slices: 1. axial 90-138; sagittal 140-176; coronal 261-346 733 axillary slices taken from C6-7 to L2 without IV contrast There is calcification in the arch aorta, descending aorta and abdominal aorta. Tracheal and bronchial calcifications also noted. There is abundant calcification in both coronary arteries. There are antero-lateral osteophytes at T7 and T8-9. A Schmorl's node is seen in the T8 vertebra. Lungs are clear. Upper abdomen appears normal in this non-contrast scan. 1. Coronary calcifications, left and right 2. Calcifications in the thoracic and abdominal aorta 3. Degenerative changes in the thoracic spine Correlative slices: these are in- mm from starting point 1. -152 to -164; -172 to -178 2. -98 to -104; -130 to -161 3. -177 to -196
645	Coronary Calcifications	unknown	Female	160 axial slices were taken screened to the right shoulder and to the midline of the chest without IV contrast There is a four-part comminuted untreated fracture of the right proximal humerus. The articular head is located in the glenoid fossa and shows numerous fractures in the cortex of the head. The shaft is impacted slightly into the head and is displaced 1.2 cm anterior and medial to the head. In addition the lesser tuberosity is displaced 1 cm anterior and medial to the head and separate from it. The greater tuberosity is separated from the head and is displaced 0.8 cm postero-medially. There are degenerative changes in the thoracic spine with antero-lateral osteophytes on the right side of T4 to T8. 1. Comminuted four-part fracture in the proximal right humerus 2. Degenerative osteophytes in the thoracic spine Correlative slices: 1. axial 42-78; coronal 209-304; sagittal 102-195 2. axial 85-178; coronal 393-556; sagittal 445-476
646	Humeral Fracture	unknown	Female	

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			204 axial slices taken from C7 to L1 during IV infusion of contrast into a right arm vein. There is a slightly low density nodule in the lower anterior portion of the right lobe of the thyroid. There are degenerative changes at T7-8 and T11-12 and some vertical striated densities in the vertebral bodies of T3, T7 and T10.
647	Hiatal Hernia	unknown	Male	There is a moderate sized hiatal hernia just above the diaphragmatic hiatus. Otherwise the liver, spleen, stomach, pancreas, and right kidney appear normal. The left kidney is not seen at the lowest level of the scan. 1. Low density thyroid nodule, right lobe 2. Hiatal Hernia 3. Degenerative changes and possible hemangiomas in vertebral bodies. Correlative slices: 1. axial 17-29; coronal 254-261; sagittal 233-248 2. axial 129-179; coronal 227-260; sagittal 253-280 3. axial 66-172; coronal 316-339; sagittal 239-261
648	Interstitial Fibrosis	unknown	Male	325 axial slices taken from C7 to L1 without IV contrast There is patchy interstitial infiltrate scattered in both lower lobes. This appears as stranding density surrounding slightly dilated bronchi which extend to the pleural surface. There is no consolidation of segments, no abscess or effusion. No adenopathy noted in the hila or mediastinum. There are a few rounded structures arising from thoracic disc spaces projecting slightly into the body of the adjacent vertebrae. These are seen at T6 thru T8-9. 1. Interstitial fibrosis scattered in both lower lobes. Etiology unknown but would include infection, auto-immune diseases, and idiopathic. 2. Schmorl's nodes in mid-thoracic spine Scans suggest a young adult male. Correlative slices: 1. axial 190-263; coronal 292-391; sagittal L 325-444 and R 81-241 2. coronal 353-367; sagittal 259-278
649	Diffuse Parenchymal Lung Disease	unknown	Female	247 axial slices taken from C7 to L1 without IV contrast There is diffuse interstitial lung disease bilaterally, right greater than left. There a honeycomb pattern mixed with fibrosis. Some cystic spaces are up to 1 cm in size with a few larger bullae, some abutting the pleura. No abscess, fluid in either pleural space or in cysts, and no mass or adenopathy. There is a 5 mm calcified nodule in the right subapical area. The heart is mildly enlarged. There is calcification in the aorta and in both coronary arteries. The liver and spleen are normal in size. The gallbladder is hyperdense with no actual stones seen. Splenic artery calcifications noted. The right adrenal gland may harbor an adenoma but is right at the inferior margin of the scan. There are degenerative osteophytes, primarily right lateral, from T4-5 thru T9-10. 1. Diffuse parenchymal lung disease. This includes a long list of variations of Idiopathic Pulmonary Fibrosis as well as a long list of Nonidiopathic Interstitial Pulmonary Fibrosis diseases. 2. Benign calcified granuloma, right subapex. 3. Calcifications in coronary arteries and in the aorta and other large arteries 4. Hyperdense gallbladder, milk of calcium 5. Degenerative changes in the thoracic spine Correlative slices: 1. apex of the lungs 2. axial 71-90; coronal 350-361; sagittal 166-176 3. axial 129-185; coronal 247-308; sagittal 244-304 4. axial 212-246 5. axial 86-193; coronal 374-394; sagittal 229-258
650	Normal CT Scan	unknown	Female	635 axial slices were taken from C7 to L1 with shielding off both shoulders and out third of left chest. The lateral third of the right clavicle could not be seen, nor could the right shoulder joint. This appears to be a young adult, judging by the open epiphysis at the medial end of the clavicle. No abnormality seen in the thoracic spine or right ribs. The right lung is normal. Heart size normal with no calcifications. The liver, gallbladder, pancreas, spleen, and kidneys all are normal. No abnormality seen in this study of primarily the right chest and most of the left. Appears to be a young adult, judging by the open epiphysis at the medial end of the clavicle. 1765 axial slices were taken from C1 to hips and pelvis without IV contrast. Because of the large number of slices, the software would not allow reconstruction views. The entire spine is in good alignment without evidence of narrow discs or degenerative changes. The maxillary sinuses are clear. Lungs are clear, heart size normal. Stomach is quite full of food. The liver, gallbladder, pancreas, spleen and kidneys appear to be normal. In the left side of the pelvis, near where the ureter enters the bladder, there are three 2-3 mm calcifications. The more proximal ureter does not appear distended. The posterior portions of both hip joints are narrowed without other degenerative change. 1. Normal cervical, thoracic, and lumbar spine 2. Three tiny calcifications in the left side of the pelvis. These could be in the distal ureter, but more likely are phleboliths. 3. Posterior hip joints are slightly narrowed Correlative slices: by distance from starting point, rather than slice numbers 1. all of study 2. -672 to -686 3. -688 to -696
654	Lumbar Lordosis	unknown	Female	620 axial slices were taken from C7 thru the pelvis without IV contrast. There is an endotracheal tube in the trachea, a nasogastric tube in the upper stomach, a central venous line in the right subclavian vein and superior vena cava. There is also a urinary catheter in the bladder. Recent surgery in the abdomen with four wire sutures in the midline to close the incision. There are two ostomies in the right mid abdomen attached to external ostomy bags. One is probably small bowel and one large bowel. In the mid-abdomen there is a horizontal pattern of linear densities which may represent stretched mesenteric vessels and fluid filled small bowel. There is a moon-shaped fluid density subcapsular collection in the lateral aspect of the spleen. Both lungs show diffuse ground glass appearance and also heavier infiltrates with prominent air bronchograms. This is heaviest in peri-hilar and upper lobes. There is a large pleural effusion on the right. Heart is not enlarged. There appears to be a 3 mm calcification in the urinary bladder and a few small calcifications in the pelvis, probably phleboliths. 1. Diffuse pulmonary infiltrates with large right pleural effusion. Post-hiltrate would include ARDS (adult respiratory distress syndrome), non-cardiac pulmonary edema, and pneumonia. 2. Recent abdominal surgery, possibly for obstruction, Crohn's disease, tumor, etc. with ostomies, ET tube, NG tube, CVL, bladder catheter. 3. Abdominal pneumatosis; fluid collection, possibly a hematoma Correlative slices: by distance from starting point, not number of slice 1. all lung images 2. -371 to -505 3. -252 to -310
655	Tracheostomy	unknown	Male	424 axial slices taken from C7 to bottom of pelvis without IV contrast No scoliosis or abnormal alignment except for mild anterior slippage of L3 in relation to L2. This is only about 2 mm and no spondylolysis is seen in the pars interarticularis. There is minimal air in the disc at L4-5, otherwise no degenerative change is seen. There is bilateral fibrotic scarring at both lung bases and also pleural thickening at both bases, both abnormalities more prominent on the right. There is a 2 cm cystic or low density area in the caudate lobe of the liver. An 8 mm calcification is seen in the postero-lateral subcortex of the left kidney. The pancreas, gallbladder, adrenals, and right kidney are normal. The aorta and great vessels in the abdomen appear normal. Multiple small calcifications are seen scattered in the lower abdomen and pelvis. The prostate is moderately large at 5 cm in diameter. 1. Mild antero-listhesis of L3 in relation to L2, probably degenerative ligamentous change. 2. Post-inflammatory pleural thickening and fibrotic change at both lung bases. 3. 2 cm low density abnormality in the liver, probably cystic. 4. 8 mm calcification in the substance of the left kidney 5. Phleboliths in the pelvis 6. Moderate enlargement of the prostate-Correlative slices: 1. sagittal 251 2. axial 160-180 3. sagittal 177-197 4. axial 229-236; coronal 326-335 5. axial 327-334; 364-382 6. axial 353-373
656	Obesity	unknown	Male	282 axial slices taken from above the diaphragm thru the pelvis after IV infusion of contrast There is a 4 mm cyst in the periphery of the right lobe of the liver and a tiny calcification in the left lobe of the liver. The gallbladder and the entire common bile duct are moderately enlarged all the way to the ampulla of Vater. No stones are seen. Likewise the pancreatic duct is moderately dilated all the way to the ampulla. The overall size of the pancreas is normal and there is no reaction around the pancreas to suggest inflammation. The bones are quite demineralized. There are degenerative changes from L2-3 to L4-5, maximal at L3-4. Large osteophytes surround these disc spaces. Disc spaces are moderately narrowed with air in the discs at L2-3 and L3-4. 1. Enlargement of common bile duct and pancreatic duct down to ampulla of Vater without evidence of stone, mass, or pancreatitis. If the patient were jaundiced or had pancreatic enzyme increase, one would want further tests to rule out a stone or tumor of the ampulla of Vater. 2. Hypodense lesion in the liver, both probably insignificant. 3. Demineralization and degenerative changes in the lumbar spine from L2-3 to L4-5 4. Calcification in the abdominal aorta Correlative slices: 1. axial 70-109; coronal 240-304 2. axial 50-51 and 43-46 3. coronal 325-362; sagittal 245-283 4. axial 137-159; coronal 300-317
658	Enlarged Common Bile Duct	unknown	Male	309 axial slices were taken from above the diaphragma to the low pelvis after oral contrast and with IV contrast infusion. The appendix is retrocecal and mildly enlarged at 8 mm in diameter. The wall is slightly thickened at 2.2 mm. No appendicolith, abscess or perforation noted. The liver, gallbladder, pancreas, spleen and kidneys all are normal. No ureteral obstruction. The lung bases are normal with no infiltrate or pleural fluid. The spine and bones are normal. Compatible with early appendicitis Correlative slices: 1. axial 144-170; coronal 288-308; sagittal 153-164
659	Normal Abdomen CT Scan	unknown	Male	420 axial slices taken from C7 to the low pelvis without IV contrast There is mild fibrotic and pleural reaction at the left lung base. There is a 1.5 cm calcified lymph node above the right hilum in the aorto-pulmonary window. The liver, gallbladder, and spleen are normal. The pancreas is slightly generous in size throughout with no duct enlargement or surrounding inflammation. There are 3-4 tiny calcifications in the right kidney without any signs of obstruction. The entire spine is normal. The uterus is moderately enlarged, measuring about 9 cm in length by 8 cm in AP-dimension, and 6 cm in width. It impresses and deforms the upper left side of the bladder. There are four calcifications on the left side of the pelvis, probably phleboliths. 1. Enlarged uterus probably with myomata 2. Tiny calcifications in the right kidney not obstructing 3. Degenerative reaction at the left lung base 4. Calcified lymph node above the right hilum 5. Phleboliths in the left pelvis Correlative slices: 1. axial 582-367; coronal 262-334; sagittal 268-284 2. axial 232-244 3. axial 173-292; sagittal 308-407 4. axial 80-96; coronal 275-295; sagittal 228-258
660	Enlarged Uterus	unknown	Female	5. axial 353-357 07 axial slices taken from C5 thru the pelvis during bolus infusion of IV contrast. Minimal pleural thickening posteriorly in both lungs. Coronary arteries are normal. Lungs are clear. The pancreatic duct is dilated measuring about 7 mm thru the head and 3-4 mm in the body and tail. No pancreatic mass is seen. The common bile duct is also prominent in size, measuring about 9 mm. No intrahepatic bile ducts are dilated and no stones are seen. The gallbladder is normal in size. The liver shows a 7 mm cyst in the periphery of the right lobe. The spleen, adrenals, and kidneys are normal. The appendix is normal. Calcifications are noted in the distal abdominal aorta. The L2-3 and L3-4 disc spaces are narrowed, show air in the disc, and antero-lateral osteophytes are seen. 1. Mild dilatation of common bile duct and pancreatic duct without mass or stone being seen. Obstruction at the ampulla of Vater should be excluded by enzymes, ultrasound, and endoscopy. 2. Tiny cyst in the right lobe of the liver 3. Degenerative changes at L2-3 and L3-4 4. Mild calcification in the abdominal aorta 5. Normal appendix - not inflamed Correlative slices: 1. axial 192-232; coronal 292-303; sagittal 198-287 2. axial 172 3. axial 235-264; coronal 331-363; sagittal 244-267 4. axial 262-280; coronal 300-317
663	Mild Dilatation of Common bile Duct	unknown	Male	5. axial 290-310 312 axial slices taken from C7-T1 to L2 without IV or oral contrast. Thyroid is normal size. There are bilateral breast implants. Lungs are clear with no pleural fluid. Mediastinum normal. No coronary calcification. Liver, gallbladder, pancreas, spleen, and kidneys are normal. The spine is normal. Normal CT of the chest
666	Breast Implants	unknown	Female	Comment: Without IV contrast, this is not a good scan for normal structures. 313 axial slices were taken from T7 to the pelvis during bolus infusion of IV contrast. There are no additional abnormalities compared to the non-contrast scan #983. The common bile duct is well seen and is normal. The appendix is again normal. The degenerative changes at L3-4, L4-5 and L5-S1 are again noted. See also report of Case #67 - #983 1. Degenerative changes at L3-4, L4-5, and L5-S1 2. Normal appendix 3. Normal common bile duct Correlative slices: 1. see previous report 2. axial 184-208; coronal 199-229; sagittal 156-190 3. axial 74-102
668	Normal Ureter	unknown	Male	260 axial slices were taken from T12 thru the sacrum without IV contrast. There are central posterior osteophytes at T12 - L1 with about 5 mm projection of bone into the spinal canal. There is air in the posterior facet joints bilaterally at L3-4, L4-5, and L5-S1 with mild sclerosis adjacent to the joint spaces. There is air in both sacroiliac joints with some sclerosis next to the joint spaces. No abnormality is seen in the pelvis or soft tissues. 1. Mild degenerative changes in posterior facet joints of L3-4, L4-5, and L5-S1. 2. Mild degenerative changes in the sacroiliac joints 3. Posterior osteophytes at T12-L1 projecting 5 mm into spinal canal Correlative slices: 1. axial 119-178; coronal 280-342; sagittal 225-280 and 308-332 2. axial 183-224; coronal 275-337; sagittal 324-357 and 394-430 3. axial 27-61; coronal 287-308; sagittal 257-288
670	Mild Degenerative Changes	unknown	Female	349 axial slices taken from T11-12 thru the sacrum without IV contrast. There is mild narrowing of the facet joints and surrounding sclerosis at L3-4, L4-5, and L5-S1. The sacroiliac joints are normal. The bone mineralization, the alignment and the disc spaces are all normal. The visualized kidneys and pelvic structures including the uterus appear normal. There are two calcifications, 2-3 mm in size, in the right pelvis and centrally. There are aortic calcifications. 1. Posterior facet syndrome, narrowing and sclerosis at L3-4, L4-5, and L5-S1. 2. Aortic calcifications 3. Tiny calcifications in the pelvis, probably phleboliths Correlative slices: 1. axial 143-222; coronal 217-244 and 308-350 2. axial 107-122 & 180-166; coronal 164-193; sagittal 272-307 3. axial 286-293 & 320-332; coronal 197-206 & 225-232
671	Posterior Facet Syndrome	unknown	Female	299 axial slices taken from T12 thru the sacrum without IV contrast. Normal alignment of the lumbar spine. All disc spaces are normal. The facet joints and sacroiliac joints are normal. The central foramen is noted in the posterior central portion of the vertebral body, thru which the vertebra derives its blood supply. The kidneys, bladder and abdominal and pelvic vessels appear normal. 1. Normal CT lumbar spine 2. Normal discs 3. Normal sacroiliac joints 4. Normal anatomy showing central foramen of each vertebral body Correlative slices: 1. all 2. coronal 263-341; sagittal 246-290 & 322-331 3. coronal 207-287
672	Normal Lumbar Spine CT	unknown	Female	4. axial 28-165; coronal 322-331; sagittal 305-330

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			420 axial slices were taken from T1 thru the pelvis without IV contrast The kidneys are both shrunken with the right measuring 6.8 cm and the left 7.5 cm in length. There are abundant calcifications in all major arteries and also in the coronary arteries. There is a transplanted kidney in the right iliac fossa with the artery and vein anastomosed to the external iliac artery and vein. This kidney measure about 12 cm in length. There are degenerative osteophytes in the upper and mid thoracic spine and the upper lumbar spine. There is a small amount of patchy infiltrative disease in the anterior segment of the right upper lobe. 1. End stage renal disease 2. Calcifications in all major arteries and in coronary arteries secondary to #1 3. Renal transplant in the right iliac fossa 4. Degenerative changes in thoracic and lumbar spine 5. Small patchy infiltrate in the right upper lobe 6. Normal appendix Cornlative slices: 1. axial 195-243; coronal 298-327; sagittal 115-166 & 313-362 2. many 3. axial 288-348; coronal 176-270; sagittal 85-175 4. axial 61-91 & 114-172; coronal 349-379; sagittal 210-239 5. axial 65-69; coronal 183-219; sagittal 159-216 6. axial 278-287; coronal 200-217
673 End Stage Renal Disease	unknown	Male	
			308 axial slices taken from T11 thru the pelvis without IV contrast The lumbar spine shows normal alignment and good bone mineralization. All disc spaces are normal with no degenerative osteophytes. Facet joints and sacroiliac joints are normal. The kidneys, bladder and uterus appear normal. No pelvic mass. Normal appendix seen. 1. Normal lumbar spine 2. Normal appendix Cornlative slices: 1. all
674 Normal Pelvis CT Scan	unknown	Female	2. axial 194-242; sagittal 113-129
			340 axial slices taken from T11 thru the coccyx without IV contrast The patient does not lie flat on the table, keeping the right hip elevated from the table. Whether this is because of pain or other reason is not known. It should also be noted that the lateral portions of the patient were cosed off and not seen. No abnormality is seen in the bones. There appears to be normal structural alignment, allowing for position of the patient. The disc spaces are normal with no degenerative osteophytes. The facets and sacroiliac joints appear normal. There is a 4 cm slightly lobulated cyst in the posterior right lobe of the liver. This has no features which would suggest other than a simple benign cyst. The kidneys are normal. A few calcifications are seen in the aorta. Of interest, there are some 17 calcifications in the soft tissues of the left buttock, probably indicating numerous injections. 1. No abnormality seen in the lumbar spine 2. 4 cm cyst in the liver, probably benign simple cyst 3. Numerous calcifications in left buttock, probably injection sites Cornlative slices: 1. all
675 4 cm Cyst in Liver	unknown	Female	2. axial 42-71; coronal 167-207; sagittal 2-62 3. axial 173-200; coronal 343-451; sagittal 332-511
			325 axial slices taken from mid thorax to pelvis during infusion of IV contrast. Minimal compressive change at the lung bases. The bones and spine are normal. The kidneys, ureters, bladder and prostate are normal. The gallbladder has been removed with surgical clips in the gallbladder bed. The intrahepatic bile ducts are quite dilated, some with a bulbous appearance. There are two opaque stents placed probably by endoscopy into the common duct with the distal ends in the 2nd portion of duodenum. The pancreas appears normal in size with mild prominence of the mid portion of the pancreatic duct. 1. Post cholecystectomy 2. Marked dilatation of intrahepatic bile ducts with two stents placed by retrograde endoscopy into common duct and 2nd portion of duodenum 3. Mild dilatation of pancreatic duct in mid portion 4. Splenomegaly 5. Normal thoracic and lumbar spine Cornlative slices: 1. axial 97-103; coronal 251-260; sagittal 173-195 2. axial 17-126; coronal 193-354 & 269-300; sagittal 84-303 3. axial 110-116; coronal 253-270; sagittal 254-322 4. axial 51-122; coronal 321-417; sagittal 405-455 5. coronal 349-383; sagittal 261
676 Splenomegaly	unknown	Male	622 axial slices taken from C7 thru the pelvis during bolus infusion of IV contrast. The entire chest is visualized on this scan. The lungs are clear except for minimal compressive atelectasis at the bases. The heart is normal with normal coronary arteries by this technique. The rest of the scan is unchanged from the comparison scan #393 (Case06576) on the same patient. Cholecystectomy, dilated bile ducts, two stents in common duct to duodenum, splenomegaly, and mild prominence of the mid portion of pancreatic duct. Kidneys, ureters, bladder and prostate are normal. Same as previous scan (Case 0676) 1. Post cholecystectomy 2. Marked dilatation of bile ducts with two stents in place- common duct to duodenum 3. Mild dilatation of mid pancreatic duct 4. Splenomegaly
677 Splenomegaly	unknown	Male	343 axial slices taken from T9 thru the pelvis with infusion of IV contrast The lungs, bones, and spine are normal. The liver, gallbladder, pancreas, spleen, kidneys, bladder, adrenals and prostate are all normal. There is prominent dilatation of the small bowel down to about the junction of jejunum and ileum. From there distally, the small bowel and colon are of normal caliber. No mass, band or other cause of obstruction identified. 1. Partial small bowel obstruction probably junction of jejunum and ileum. 2. Otherwise all abdominal organs appear normal. 3. Bones and spine normal Cornlative slices:
678 Partial Small Bowel Obstruction	unknown	Male	1. axial 58-246; coronal 94-270; sagittal 134-449
			343 axial slices taken from T9 thru the pelvis during infusion of IV contrast This scan is identical to #78 - 3109, except for the infusion of contrast. The findings are the same, with dilated small bowel loops filled with air and fluid. The dilatation appears to extend thru the jejunum with normal non-distended ileum. There is again a sharply angulated narrower segment of small bowel in the posterior middle of the abdomen which appears to be the area of obstruction. No mass, polyp, or intussusception seen. 1. Partial small bowel obstruction unchanged compared to the previous non-contrast scan #78 - 3109. 2. The point of obstruction appears to be in the posterior central portion of the abdomen. Cornlative slices: 1. Same as previous report. 2. axial 162-231; coronal 191-233; sagittal 208-275
679 Partial Small Bowel Obstruction	unknown	Male	385 axial slices were taken from T9 thru the pelvis after oral contrast and IV infusion of contrast. Lung bases are clear. The liver is moderately enlarged and there is prominent dilatation of the intrahepatic bile ducts. The gall bladder is not seen, presumably removed although no surgical clips are seen. The spleen is also moderately enlarged measuring 18 cm in greatest dimension. The pancreas appears normal with no enlargement of the pancreatic duct. I believe that there has been anastomosis of the common duct to the duodenum but cannot be certain of this. There is mild distention of some of the proximal small bowel loops but there does not appear to b There is abundant gas in the colon. The kidneys, ureters, bladder and uterus are normal. The spine and sacroiliac joints are normal. 1. Hepatosplenomegaly with dilated bile ducts and portal hypertension. 2. Probable cholecystectomy and anastomosis of common duct to small bowel. Cornlative slices: 1. axial 48-103; coronal 225-314; sagittal 140-395
680 Hepatosplenomegaly	unknown	Female	829 axial slices taken from posterior fossa to the pelvis with oral contrast and a bolus infusion of IV contrast. Thyroid is normal. Lungs clear with no fluid. Coronary arteries appear normal in proximal portions. The liver, gallbladder, pancreas, spleen, adrenals, and kidneys all appear normal. The appendix and intestines are normal. The bladder and prostate are normal. A few degenerative osteophytes are noted in the mid thoracic spine. Otherwise the entire spine is normal with normal sacroiliac joints and hips. 1. Normal CT study of neck, chest, abdomen, and pelvis. 2. Many normal structures Cornlative slices: 1. Normal liver, gallbladder axial -175 to -472 2. Normal spleen axial -392 to -472 3. Normal pancreas axial -438 to -520 4. Normal renal arteries axial -475 to -497 5. Normal adrenals axial -428 to -471 6. Normal kidneys axial -458 to -568 7. Normal superior mesenteric artery axial -461 to -523 8. Normal celiac artery axial -420 to -452
681 Normal Thorax and Abdomen Angio	unknown	Male	1193 axial slices were taken from the dome of the liver down to the bottom of the foot during bolus injection of IV contrast. The liver, gallbladder, pancreas, and spleen are normal. Kidneys, adrenals, and bladder are normal. The uterus is absent. There is degenerative disc disease with osteophytes at L3-4, L4-5, and L5-S1. The facets, sacroiliac joints, and hips are normal. There are some calcifications in the soft tissues of the buttocks indicating past injection sites. In the scans of the lower extremities, there is some clot or plaque material partially occluding the lumen of the left common femoral artery. Other than that, there is satisfactory blood flow all the way to the feet. 1. Normal abdomen and pelvis 2. Degenerative changes in the lumbar spine 3. Clot in the left common femoral artery, partially filling the lumen 4. Calcifications in the buttocks from injections Cornlative slices: by mm from starting point, not number of slices 1. 2. axial -80 to -175 3. axial -361 to -530 4. axial -170 to -278
682 Femoral Arterial Clot	unknown	Female	1245 axial slices at 1 mm intervals were taken from T10 to the feet during bolus injection of IV contrast. The lung bases are clear with no pleural fluid. The liver, gallbladder, pancreas, spleen, adrenals and kidneys all appear normal. The bladder and prostate are also normal. The abdominal aorta shows moderate plaque and calcification without aneurysm. The common iliacs and external iliacs show some calcification. On the left side the superficial femoral is irregular without significant stenoses. The popliteal artery has one area of moderately severe stenosis. The posterior tibial artery is almost occluded just below the ankle. On the right side there is calcification in the femoral artery. The popliteal has a severe stenosis above the knee and the posterior tibial shows severe stenosis at the ankle. There are a few small osteophytes around the lumbar disc spaces and there is degenerative disc disease with air at L3-4 and L4-5. 1. Arteriosclerotic disease in the abdominal aorta with scattered stenoses in the arteries of both lower extremities. 2. Degenerative changes in the lumbar spine 3. Normal abdominal organs Cornlative slices: Measured by mm from starting point, rather than slice numbers 1. aorta -61 to -195 ; iliacs -195 to -338 ; femorals -338 to -369 ; superficial femorals -369 to -437 ; popliteal -437 to -770 ; anterior and posterior tibials -770 to -1119
683 Arteriosclerotic Disease in Aorta	unknown	Male	2. -163 to -205 3. -55 to -163
684 Normal Female Pelvis	unknown	Female	169 axial slices taken from L4 (umbilicus) to just below pelvis without IV contrast There is a foreign object in the vagina, probably a tampon. The uterus is normal in size with retroflexed fundus. Ovaries appear normal is size. Bladder and distal colon appear normal. The bones of the pelvis are normal. There is abnormality in the generous fatty tissue surrounding the pelvis. This is all in the dependent posterior portion, mainly the buttocks, and consists of strand-like and almost solid soft tissue density between the skin and gluteal muscle. It is symmetric and probably related to fluid or compressive change. Other possibilities to consider would be cellulitis or fasciitis. 1. Foreign object in the vagina, most likely a tampon 2. Normal pelvic organs 3. Diffuse density in the fat over the buttocks, most likely compression and edema in the fat. Cellulitis should be excluded. Cornlative slices: 1. axial 79-117; coronal 228-260; sagittal 249-277 2. axial 9-169; coronal 253-296; sagittal 254-303
685 Normal Pelvis	unknown	Female	3. axial 64-90
			607 axial slices taken at 0.5 mm intervals from L5 thru the proximal femur without IV contrast. There has been a complex fracture of the left hip and femur with a total hip replacement. The metal nail is within the cavity of the femur with some fracture fragments held together by three wires looped around the femur. The prosthetic hip joint is in satisfactory position but the medial wall of the acetabulum is also fractured. The bones in general are very demineralized. There are several exostoses arising from the lateral surface of the ilium and the neck and head of the right femur is deformed by exostoses. This hip joint is also severely narrowed with bone on bone appearance. The sacroiliac joints are partially fused and sclerotic. The facet joints of L5-S 1. Total left hip replacement for complex fracture of the hip, femur and acetabulum 2. Severe deformity of the right femoral head and neck with demineralization and degenerative change in the hip joint. 3. Probable metabolic bone disease with generalized demineralization and multiple exostoses 4. Degenerative osteoarthritis of facet joints and sacroiliac joints Cornlative slices: Numbers refer to mm from starting point 1. -104 to -346 2. -120 to -178 3. -22 to -63
686 Total Hip Replacement	unknown	Unknown	4. -99 to -89 and -34 to -45 206 axial slices taken from L4 thru the pelvis with oral and IV contrast The uterus is normal in size and is anteflexed. The cavity in the body of the uterus is slightly prominent consistent to post partum at some time. The round ligaments are well seen and the ovaries appear normal in size. The bladder and lower colon appear normal. The bones of the pelvis and hips are normal. 1. Normal uterus and ovaries 2. Bladder, colon normal and well visualized. Cornlative slices: 1. axial 89-120; coronal 255-360; sagittal 234-286
687 Normal Female Pelvis	unknown	Female	2. axial 103-106 217 axial slices taken from L4-5 to below the pelvis without IV contrast The bladder is slightly small and demonstrates diffuse thickening of the wall. to about 8 mm. No calcifications in the wall of bladder. No ureteral dilatation or calculi/stone. A few phleboliths are seen in the pelvis. The uterus is surgically absent. No ovarian mass seen. Bones are demineralized with degenerative changes in the facet joints. Sacroiliac joints show air bilaterally. Slight calcification in abdominal aorta and femoral arteries. 1. Thickening of the bladder wall consistent with chronic cystitis, possibly chronic interstitial cystitis. 2. Degenerative changes in facets and sacroiliac joints with demineralization Cornlative slices:
688 Normal Male Pelvis	unknown	Male	1. axial 121-170; coronal 246-320; sagittal 222-315 2. axial 66-95; coronal 343-382; sagittal 187-204 and 324-361
			310 axial slices taken from L3-4 thru the pelvis without IV contrast Small and large bowel are normal. No mass or fluid collection seen. The appendix is normal in size without inflammatory reaction noted. There is some slightly opaque material in the distal half of the appendix without actual appendicolith. The bladder, ureters and prostate are normal. Bones are normal. 1. Normal male pelvis 2. No evidence of appendicitis Cornlative slices:
689 Sacral Facture	unknown	Female	2. axial 77-88; coronal 194-210; sagittal 228-240
690 Scrotal Swelling	unknown	Male	1128 axial slices taken at 0.5 mm intervals from L2 to the feet during bolus infusion of IV contrast. The kidneys show some irregular vascularization of the lateral margins possibly representing mild scarring from previous infections. The bowel, bladder, and uterus are normal. The appendix is not definitely seen. The abdominal aorta, inferior mesenteric, renal, iliac, femoral, popliteal, and arteries to the feet all appear normal without occlusion or stenosis. The bones all appear normal. 1. Normal angiogram of abdominal aorta to the feet bilaterally. 2. Minimal scarring of periphery of kidneys possibly related to infections Cornlative slices: Given in mm from starting point 1. Right renal artery: -0 to -1 2. Left renal -16 to -30 3. Inferior mesenteric -90 to -152 4. Lumbar arteries -59 to -76 5. Common iliac -110 to -180 6. Internal iliac -110 to -180 7. External iliac -119 to -226 8. Femoral -226 to -516 9. Deep femoral -247 to -474 10. Popliteal -516 to -666 11. Anterior tibial -666 to end 12. Posterior tibial -675 to end 13. Peroneal -692 to 886
691 Femoral Artery Angio	unknown	Female	Comment: This study shows very clear normal anatomy of all the arteries. 1333 axial slices were taken at 0.5 mm intervals from T8 to the feet during bolus infusion of IV contrast. The abdominal aorta and all major branches are normal except for some tortuosity of the iliac arteries. There is however disease in the run-off in both legs. On the left, there are at least three moderate stenoses in the distal femoral, one in the distal popliteal and then severe stenoses and occlusion in the anterior and posterior tibials. There are short reconstitutions by collaterals but the circulation is quite poor to the left foot. On the right, there are again at least three moderate stenoses in the distal femoral artery and moderate stenosis in the mid popliteal at the knee. The popliteal shows occlusion distally with reconstitution of the anterior and posterior tibial and peroneal arteries. From there to the foot, these three arteries show occlusions and reconstitutions by collateral vessels with better circulation to the foot than on the left.
692 Lower Body Angio	unknown	Male	The lungs are clear. Liver, gallbladder, pancreas, spleen, kidneys and bowel appear normal. Bladder is normal with slight enlargement of the prostate. There is mild demineralization of the bones and mild osteophyte formation on some thoracic and lumbar vertebrae. 1. Arteriosclerosis in both legs with occlusive disease bilaterally below the knees. Circulation to the left foot appears worse than the right. Cornlative slices: measured in mm from starting point 1. Common iliac arteries -0 to -100; femoral -608, -666, -699; popliteal -652; anterior and posterior tibial -861, -888, -893 2. Stenoses or occlusions on the right — femoral -538, -581, -671; popliteal -764, -792 to -873; anterior and posterior tibial -875, -916
693 Right Flat Foot Angio	unknown	Female	104 axial slices taken from above ankle to bottom of foot without IV contrast There were marked co-registration errors making the reconstruction images unninterpretable. There is mild demineralization of the bones. There is pes planum, (flat foot) noted on sagittal views. Otherwise no significant abnormality is noted. 1. Pes planum (flat foot) 2. Technically unsatisfactory study

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				131 axial slices taken from above ankle to bottom of foot without IV contrast here is a tiny invaginating lucency with sclerotic borders in the proximal second metatarsal. It is located on the posterio-lateral border about 8 mm from the joint and the lesion itself is only about 3 mm in diameter. No soft tissue mass is seen. No other abnormality is seen in the right foot. 1. Benign appearing lesion in the proximal second metatarsal suggesting an intraosseous ganglion 2. Otherwise normal foot
694	Left Claw Foot Angio	unknown	Male	Correlative slices: 1. axial 70-75; coronal 423-444; sagittal 434-451 215 axial slices taken from above ankle to bottom of foot without IV contrast. The bones have normal minerality with no fracture seen. There is a tiny area of lucency on the medial posterior articular surface of the right talus. There is also a bipartite medial sesamoid bone beneath the first metatarsal of the left foot. No other abnormality is seen. 1. Possible tiny area of osteochondritis dessicans on the right talus 2. Bipartite sesamoid bone under left first metatarsal Comment: Both of these abnormalities are of questionable significance but in some instances do cause pain.
695	Both Feet Angio	unknown	Female	Correlative slices: 1. coronal 527-538; sagittal 287-296 2. axial 167-171; coronal 394-510; sagittal 405-426
696	Clubfoot Angio	unknown	Female	367 axial slices taken at 0.5 mm intervals without IV contrast. This appears to be a child with epiphyses unfused. No fracture or other bone abnormality seen on these images. Interpretation would be aided by reconstruction views. Normal study of the feet
697	Right Foot Fracture Angio	unknown	Male	200 axial slices taken from above the ankle to bottom of foot without IV contrast. There is a severely comminuted Sander's Type 4 crush fracture of the calcaneus. There are at least 10 separate fragments of bone. The posterior articular surface appears intact, articulating with the talus. There is a fracture thru the anterior articular surface where it articulates with the cuboid. The talus is intact and the tibio-talar joint is in satisfactory alignment. There is a fracture in the mid shaft of the second metatarsal with slight dorsal angulation. A similar fracture is noted in the third metatarsal also with dorsal angulation. The fourth metatarsal has a comminuted fracture in both the proximal and distal shaft with more dorsal angulation at the distal fracture. The fifth metatarsal has only a small lateral fracture in the proximal portion. 1. Severely comminuted Sander's type 4 ('lover's fracture') of the calcaneus, intra-articular with the cuboid. 2. Fractures of the second thru fifth metatarsal bones Correlative slices: 1. axial BD-TBE; coronal 322-418; sagittal 219-304 2. second axial 322-502; sagittal 234-322 3. third axial 538-589; sagittal 192-271 4. fourth axial 147-172; sagittal 172-218 5. fifth axial 122-150; sagittal 171-214
698	Left Foot Angio	unknown	Male	146 axial slices taken from above ankle to bottom of foot without IV contrast The arch is quite flattened, measuring only about 10 degrees. The talus is displaced medially from the navicular in the coronal view. The rest of the bones of the foot appear within normal limits with no evidence of old or new fracture and no degenerative changes. 1. Pes planus (flat foot) Correlative slices: 1. sagittal 290-316; axial 63-75
699	Right Foot Angio	unknown	Male	402 axial slices taken at 0.45 mm intervals from above ankle to bottom of foot without contrast. There is no acute fracture but significant degenerative changes in the mid foot. The talus shows mixed demineralization and cystic spaces with areas of sclerosis. Similar changes to a lesser degree noted in navicular, cuboid, and third cuneiform bones. There are small osteophytes at the margins of the talo-navicular and at cuboid articulations. These joint spaces are also narrowed with sclerotic margins. Small extra-ossicles are noted both medial to the navicular and lateral to the cuboid. No abnormality seen in first and second cuneiforms, metatarsals, and phalan 1. Degenerative changes in talus, navicular, cuboid and third cuneiform consisting of areas of cystic change, sclerosis, and narrowing of joint spaces in the mid foot 2. Possible old Lisfranc fracture or dislocation of the mid foot to explain the degenerative changes. Correlative slices: measured in mm from starting point 1. talo-calcaneous axial -59 to -64 2. talo-navicular axial -61 3. navicular axial -91 to -93 4. cuboid axial -86 to -114 5. third cuneiform axial -82 to -103
700	Left Foot with Joined Metatarsals	unknown	Male	289 axial slices taken from above ankle to bottom of feet without IV contrast There are old healed fractures of the distal portion of the second and third metatarsals. There is no significant angulation with the two bones joined together by the healed solid callus. No other fracture or joint abnormality seen. 1. Satisfactory healing of old Fractures of the second and third metatarsals Correlative slices: 1. axial 179-199; coronal 242-294; sagittal 225-272
701	Lymphoma (Liver) Follow-Up		48 Male	The patient has a prior diagnosis of non-Hodgkin's lymphoma. Patient initially presented with moderate RUQ abdominal pain, unintended weight loss & drenching night sweats. No family history of cancer. LABS: AST 467(15-41 U/L), ALT 207(14-54 U/L) Alkaline Phosphatase: 111(32-91 U/L) Total Bilirubin: 0.8 (0.3-1.2 mg/dL) WBC: 10.3 (4.0-11.0 x 103 / uL). 1. Large heterogeneous hepatic mass with internal hemorrhage and gas. 2. Small-moderate amount of hemoperitoneum 3. Foley catheter noted in bladder Patient admitted to ED for injuries related to MVA. Medical history was limited and pertinent laboratory findings included elevated AST 278(15-41 U/L) and ALT 503(14-54 U/L) and decreased Hematocrit: 30.7 (33.1%-44.5%) and Hemoglobin: 10.7 (11.0-15.1 g/dL). 1. Grade 3 laceration anterior right hepatic lobe, puncture of right and left hepatic lobes, along the middle hepatic vein 2. Grade 2 laceration inferior right hepatic lobe, segment 6 3. Small perihepatic hematoma 4. Multiple bilateral rib fractures 5. Tiny right hemothorax 6. Small amount of pelvic hemorrhagic fluid, presumably from liver lacerations
702	Liver Laceration		55 Female	7. Small uterine leiomyoma 8. Focal filling defect within the inferior vena cava, suspicious for nonocclusive thrombus, less likely mass 9. Tiny indeterminate left hepatic lobe hypodensity. Liver mass was found 8-9 months prior in Mexico The mass was diagnosed as hepatoblastoma stage IV with lung metastases. Labs: AST 32(15-41 U/L), ALT 38(14-54 U/L) Alkaline Phosphatase: 278(32-91 U/L) Total Bilirubin: 1.1(0.3-1.2 mg/dL) Alpha-fetoprotein 4922 (0.0-15.0 ng/mL). 1. Enlarged liver with multiple masses. Analysis: - Nasogastric tube - Free abdominal fluid - Hepatoblastoma on the apical portion of the right lobe. - Liver architecture is not homogenous. - Parenchimal consolidation in the left lower lobe - Cystic mass in the left lobe.
703	Hepatoblastoma	<5	Female	Analysis provided by Università degli Studi de L'Aquila (Prof. Maccharielli, Prof. Bianchi and Dr.Bernardi)
704	Polycystic Liver Disease and RLQ Renal Transplant		48 Female	Patient initially presented with hypertension and was diagnosed with polycystic kidney disease (PCKD) seven years prior. Status post renal transplant (4 months prior), due to continued symptoms, the patient underwent a bilateral nephrectomy. LABS: Normal LFTs, normal BUN and Creatinine, decreased H & H. 1. Status post bilateral nephrectomy and subsequential atelectasis 2. Polycystic Liver Disease 3. Post-native nephrectomies and right lower quadrant renal transplant 4. Abdominal, pelvic, and retroperitoneal fluid collections, cannot exclude hemorrhage
705	Choledochal Cyst	<5	Female	The patient's mother brought her in with suspicion of a sinus infection. Soon after a course of antibiotics were perused the patient experienced vomiting and right sided abdominal pain. An ultrasound was performed showing a cyst. LABS: AST 253(15-41 U/L), ALT: 388(14-54 U/L) Alkaline Phosphatase: 340(32-91 U/L) Total Bilirubin: 0.7 (0.3-1.2 mg/dL). 1. Focal dilation of the common hepatic and common bile duct compatible with choledochal cyst. There is suggestion of involvement of the remainder of the common hepatic duct as wellas portions of the proximal intrahepatic bile ducts and concerning for a type IV choledochal cyst. Distal 2 cm of the common bile duct appear relatively unenvolved. 2. Trace hepatic ascites and mildly abnormal liver morphology suggests potential liver disease. 3. Gallbladder sludge
706	Gallbladder Carcinoma		95 Female	Patient with a history of adenocarcinoma of the colon and a partial colectomy presented with hematuria. An ultrasound was performed showing a gallbladder mass. An MRCP was subsequently performed showing a 2.5x1.5 cm mass in the gallbladder invading segment V of the liver with periportal lymphadenopathy. AST 59(15-41 U/L) and ALT 129(14-54 U/L) Bilirubin: 1.2(0.3-1.2mg/dL) Alkaline Phosphatase: 166(32-91 U/L). 1.Small bowel loop thickening with stranding, suggestive of infectious versus inflammation. No obstruction, fluid collection, or free air 2. Known gallbladder mass, with increased hepatic invasion 3. Cholelithiasis 4. Distal aortic stenosis
707	Gallbladder Perforation		48 Male	Patient was awoken in the middle of the night with intense RUQ pain which persisted over the period of a weekend. History of Peutz-Jaghers syndrome. LABS: AST 38(15-41 U/L), ALT 9(14-54 U/L) Alkaline Phosphatase: 48(32-91 U/L) Total Bilirubin: 0.4(0.3-1.2 mg/dL) WBC 4.4 (4.0-11.0 x10E3/uL). 1. Markedly abnormal gallbladder with inflammation and contained perforation and/or intrahepatic abscess component. The patient presented with an altered mental status. Mental status was normal until a day before admission when she began to fade in and out of conversations. After admission she became progressively confused and disoriented. Her abdominal pain was described as being diffuse, sharp, and non-radiating. An abdominal sonogram found the gallbladder to be hydropic, measuring 6.3 cm with multiple gallstones and gallbladder sludge. She had a negative sonographic Murphy's sign, normal wall thickness, and no pericholecystic fluid seen. LABS: AST: 80(15-41 U/L) ALT: 38(14-54 U/L) Bilirubin: 2.0(0.3-1.2 mg/dL) Alkaline Phosphatase: 108(32-91 U/L). 1. Substernal Fluid collection, likely related to recent sternotomy, may represent a hematoma. 2. Small bilateral pleural effusions 3. Cirrhosis 4. Hydropic gallbladder with stones 5. Anasarca with increasing large ascites 6. Mild cardiomegaly, increased
708	Hydropic Gallbladder		50 Female	7. Diffuse mild colonic wall thickening, which is likely related to fluid overload and chronic liver disease. A Caucasian male presented with a known history of hepatitis C, elevated AFP and hepatocellular carcinoma. Additional imaging findings included splenomegaly, a horseshoe kidney with cysts, and periportal lymphadenopathy. The hepatocellular carcinoma was staged at cT1b cN1 cM0, IVA. The IR department was consulted for a possible chemoembolization, but it was deemed inappropriate at that time. Also, a transplant wasn't possible due to the patient's active hepatitis C and cancer. Labs: BUN: 10(6-20mg/dL) Creatinine: 0.6(0.64-1.27mg/dL). 1. Multifocal hepatocellular carcinoma, decreased in size 2. Moderate splenomegaly, unchanged 3. Horseshoe kidney with cysts
709	Horseshoe Kidney		58 Male	4. Stable periportal lymphadenopathy A young male presented with hypertension during a sports physical and was instructed to start a salt-restricted diet. The restricted diet was not successful in lowering the patient's BP. Upon further evaluation an ultrasound showed an abnormality of the right kidney. An MRI was ordered and noted a multiloculated mass in the right kidney that was compressing the renal tissue. The patient was diagnosed with a right renal hematoma which was compressing the renal vasculature and causing Page kidney-induced hypertension. Labs: BUN: 13.0 (6-20mg/dL) Creatinine: 0.95(0.64-1.27mg/dL) BP: 144/100mmHg Hemoglobin: 12.4 (13.3-17.3) Hematocrit: 37.7(39.0-52.0).
710	Page Kidney		15 Male	1. Reaccumulation of 12x8 cm right renal subcapsular fluid collection causing marked mass effect on the right kidney. Findings consistent with Page kidney from subcapsular hematoma though abscess not excluded given degree of surrounding stranding and free fluid in the pelvis. 2. Interval removal of pigtail drainage catheter The patient has a long history of polycystic kidney disease which presented in his 30's with flank pain and hypertension. Pre-transplant evaluation demonstrated multiple liver cysts, bilateral renal enlargement and multiple cysts on the kidneys. Labs: BUN: 77(7-20) Creatinine: 5.8(0.8-1.5) Hemoglobin: 11.7(13.0-17.0) Hematocrit: 35.2(38.0-52.0).
711	Polycystic Kidney		42 Male	1. Bilateral pleural effusions 2. Pericardial effusion 3. Indeterminate pulmonary nodules 4. Multiple liver cysts and markedly enlarged cystic kidneys consistent with polycystic kidney and liver disease 5. Few hyperdense renal cysts may be hemorrhagic, cannot exclude neoplasm 6. Small hiatal hernia 7. Pelvic ascites and peritoneal hemodialysis catheter
712	Renal Cell Carcinoma		80 Female	A 42 year old woman presented with unintended weight loss. The patient had a known history of breast cancer (30 years prior). A CT scan revealed a large 6cm heterogeneous solid mass in the right kidney, concerning for renal cell carcinoma. Lymphadenopathy was also noted, which caused concern for metastatic disease. A biopsy confirmed clear cell renal cell carcinoma of the right kidney; Fuhrman grade 3. Labs: BUN: 14(6-20mg/dL) Creatinine: 1.44(0.44-1.03mg/dL) BP: 162/62. 1. Large heterogeneous solid mass at the superior pole of the right kidney 2. Retroperitoneal lymphadenopathy, concerning for metastatic disease 3. Bilateral renal cysts 4. Diverticulosis 5. Enlarged bilateral ovaries of uncertain significance 6. Cholelithiasis 7. Bilateral moderate pleural effusions
713	Pancreatic Cancer		62 Female	A woman presented with a history of episodic epigastric pain, which was gradually worsening. The patient noted dark urine for 2-3 weeks at the time of the visit. An abdominal ultrasound showed a mass on the pancreatic head with bile duct dilation. A follow up abdominal/pelvis CT showed a 3.3x4.0cm mass in the pancreatic head. The mass didn't appear to encase the celiac axis, SMA, or portal vein. There was no obvious evidence of metastasis. An ERCP was performed with stent placement. A pancreatic neck biopsy showed malignant cells, consistent with adenocarcinoma. Approximately 5 months later, the patient underwent a diagnostic laparoscopy LABS: Hemoglobin: 10.4 (11.0-15.1 g/dL) Hematocrit: 31.4 (33.1-44.5 %) WBC: 5.2 (4.0-11.0 x 10E3/UL) Glucose: 149 (70-125mg/dL). 1. Multiple bilateral noncalcified pulmonary nodules. 2. Small bilateral pleural effusions 3. Cholelithiasis 4. Mass within the pancreatic head and neck with displacement of the surrounding vessels. 5. Postsurgical changes of Roux-en_Y hepatic jejunostomy. 6. Nodularity along the peritoneal lining and omentum with increased fluid. 7. Small splenic lesions, unchanged.
714	Pancreatic Pseudocyst		25 Female	Radiology Report Scan #5 (earlier scan) 1. Mass in the head of the pancreas with biliary and pancreatic ductal obstruction. Appearance consistent with pancreatic carcinoma. A female in her mid-20's suffered numerous episodes of pancreatitis linked with cholelithiasis. Medical history included a cholecystectomy and drainage of a pancreatic pseudocyst into her stomach. The patient now presents with pain in her left upper quadrant; the scan noted a recurrent pseudocyst. Labs: Hemoglobin: 13.2 (11.0-15.1 g/dL) Hematocrit: 39.7 (33.1-44.5%) WBC: 8.7 (4.0-11.0 x10E3/UL) Amylase: 55 (25-115 U/L) Lipase: 43 (14-51 U/L) Glucose: 82 (70-125 mg/dL). 1. Large cyst arising from the tail of the pancreas measuring 7.9-cm in AP, 8.1-cm in transverse, and 7.1-cm in craniocaudal dimension. This most likely represents a pseudocyst as a sequela of previous known pancreatitis. 2. Normal appendix right side of the pelvis.
715	Pancreatitis		62 Male	A male patient with a history of chronic a secondary to alcohol use presented with sever epigastric pain. The pain was worse than with previous pancreatitis flare ups, he rated the pain 10 out of 10. Labs: Hemoglobin: 12.3 (13.3-17.3 g/dL) Hematocrit: 35.2 (39.0-52.0%) WBC: 7.5 (4.0-11.0 x 10E3/UL) Amylase: 52 (28-100 U/L) Lipase: 35 (14-51 U/L) Glucose: 139 (70-125 mg/dL). 1. Findings of acute superimposed chronic pancreatitis with secondary inflammatory changes of the right upper quadrant, distal stomach, and duodenum. 2. Two pancreatic head pseudocysts. 3. Gallbladder wall thickening and layering sludge stone. No visible gallstones noted. 4. Mild to moderate intrahepatic biliary ductal dilation. 5. Borderline splenomegaly and left upper quadrant venous collaterals related to narrowing at the SMV/portal vein confluence. 6. Prominent retroperitoneal lymph nodes, likely reactive. 7. Right lower lobe atelectasis or consolidation with associated fluid and debris in the right lower segmental bronchus.
716	Hemorrhagic Pancreatitis		38 Male	A male in his late 30's presented to the hospital with dizziness and respiratory failure secondary to alcohol abuse. The patient has a known history of pancreatitis. The hospital course was complicated by seizures, diabetes with hyperglycemia, left lower extremity DVT, acute renal failure requiring dialysis, hemorrhagic pancreatitis, and sepsis. Labs: Hemoglobin: 10.8 (13.3-17.3 g/dL) Hematocrit: 34.4 (39.0-52.0%) WBC: 5.2 (4.0-11.0 x 10E3/UL) Glucose: 177 (70-125mg/dL). 1. Limited exam due to patient's inability to tolerate the exam. 2. Marked abnormality of the pancreas with very large complex peripancreatic fluid collection. 3. Mild intra and extrahepatic biliary ductal dilation. 4. Gallbladder sludge. 5. Splenomegaly
717	Chronic Pancreatitis		52 Female	A female in her early 50's was admitted with abdominal pain, nausea/vomiting, dehydration, and renal failure. She was an insulin-dependent diabetic that was unable to keep adequate food down. The patient had a history of alcohol abuse and pancreatitis. An abdominal CT was performed, which showed some changes of chronic pancreatitis and some distal esophageal thickening consistent with esophagitis. Labs: Hemoglobin: 15.5 (11.0-15.1 g/dL) Hematocrit: 43.6 (33.1-44.5%) WBC: 8.4 (4.0-11.0 x10E3/UL) Amylase: 98 (25-115 U/L) Lipase: 20 (14-51 U/L) Glucose: 299 (70-125 mg/dL). 1. Small hiatal hernia with distal esophageal thickening 2. Bilateral pulmonary nodules. 3. Fatty infiltration of the liver. 4. Chronic pancreatitis without evidence of acute pancreatitis. 5. Urethral diverticulum. 6. Mild nonspecific retroperitoneal wall thickening.
718	Necrotizing Pancreatitis 2 CT		78 Male	A male in his late 70's with a history of gallstone pancreatitis with resolution of necrotizing pancreatitis and pseudocyst. He presented with bilateral lower quadrant abdominal pain when receiving a TPN infusion from his home health nurse. He also reports that his belly is becoming larger. A pancreatic duct obstruction was discovered and a pancreatic duct stent was placed. Labs: Hemoglobin: 11.5 (13.3 -17.3 g/dL) Hematocrit: 34.5 (39.0-52.0%) WBC: 8.5 (4.0-11.0 x10E3/UL) Glucose: 158 (70-125 mg/dL). 1. Necrotizing pancreatitis with an acute necrotic collection located anterior to the pancreas, abutting the greater curvature. 2. Gastric wall thickening. 3. Small cystic lesions located in the pancreas tail, likely a pseudocyst from prior pancreatitis. 4. Splenic vein thrombosis and mural thickening of the transverse colon and proximal small bowel, likely sequela of local inflammation. 5. Cholelithiasis. 6. Multiple liver hemangiomas. 7. Bilateral pleural effusions with associated compressive atelectasis.

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719	Endometrioma 1	68	Female	A female in her late-60's presented with vaginal bleeding and bilateral lower extremity swelling after a fall. The patient reported vaginal bleeding over the last 2 months (needing 2 tampons a day). She also described intermittent lower abdominal pain since the onset of the vaginal bleeding, which felt like cramping pain that lasted for about an hour, 3-5 times a week. The patient noted having shortness of breath. An ultrasound was done which showed a large pelvic mass. A GYN-ONC consult with a pelvic exam found a fixed, extensive pelvic mass involving both pelvic sidewalls. The patient denied any issues related to urinating and defecating. A biopsy r 1. Patchy bilateral lung opacities with mildly enlarged mediastinal lymph nodes. 2. Bilateral pleural effusions. 3. Abnormal liver morphology, correlate with underlying liver disease. 4. Splenomegaly 5. Cholelithiasis 6. Moderate quantity of ascites 7. Indeterminate pelvic mass, not well-characterized on noncontrast exam. 8. Retroperitoneal, periportal and pelvic lymphadenopathy. 9. Mild bilateral renal hydronephrosis
720	Endometrioma 2	35	Female	A female in her mid-to-late 30's presented with abdominal pain which had become unbearable. The patient also noted dyspareunia & difficult/painful bowel movements. A CT was performed with showed a 15 cm x 13 cm abdominal/pelvic mass. Labs: CA 125: 51 (0-35 U/mL). 1. Heterogeneous Uterus 2. Large mass measuring 15cm x 13cm, appears low attenuation with small nodular thickening on left inferior border. 3. Right adrenal cyst 4cm x 3cm 4. No ascites, no carcinomatosis
721	Ovarian Cyst	15	Female	A female in her mid-teens presented with increasing abdominal girth and bloating over the past 1 - 2 months with subsequent weight gain of approximately 15 pounds. The patient had increasing abdominal pain over the past 2 - 3 weeks that increased with activity or movement. The patient denied having any vaginal discharge, changes in menstruation, or urinary symptoms. She underwent pelvic ultrasound as well as a CT which noted a large pelvic mass measuring 36 x 24 cm. An exploratory laparotomy with left salpingo-oophorectomy and omentectomy diagnosed a borderline mucinous cystadenoma. 1. Extremely large septated cystic mass in the abdomen and pelvis, most likely representing an ovarian cyst.
722	Cervical Cancer	45	Female	A female in her mid-40's presented with 1-2 months of vaginal spotting. The patient reported that she attributed the first spotting to normal menses, but the bleeding continued and was present most days. She denied heavy bleeding or passing clots and there was no pain associated with the bleeding. Upon examination a large cervical mass was noted. The cervical biopsy was consistent with squamous cell carcinoma. 1. Hypermetabolic cervical lesion consistent with malignancy. 2. Non-enlarged mildly metabolic retroperitoneal lymph node of questionable significance, but more likely benign.
724	Embryo Stage 13-23	unknown	unknown	University of Michigan (bvhsmith@umich.edu). NIH award MO~HD-0-5257 PO HH0637. Imaging performed at the Center for In-Vivo Microscopy Embryo Stage 13 (20-22 Days) Embryo Stage 14 (21-35 Days) Embryo Stage 15 (35-38 Days) Embryo Stage 16 (37-42 Days) Embryo Stage 17 (42-44 Days) Embryo Stage 18 (44-48 Days) Embryo Stage 19 (48-51 Days) Embryo Stage 20 (51-54 Days) Embryo Stage 22 (54-58 Days) Embryo Stage 23 (56-60 Days)
727	Fournier's Gangrene	58	Male	A male in his late 50's presented to the emergency department after experiencing scrotal pain for several days. Medical history was significant for obesity, untreated diabetes and nephrolithiasis. The pain originated at the perineum and radiated to the scrotum which was red. The patient had been having hematuria and difficulty urinating for several days due to swelling of the penis. He also complained of bilateral flank pain. A CT scan of the abdomen/pelvis demonstrated gas in the left groin and scrotum, consistent with necrotizing fasciitis. Thin raised concern for Fournier gangrene. The patient was taken to the operating room for an emergent incision and 1. 3mm left distal ureteral calculus 2. 1cm non-obstructing left renal calculus 3. Soft tissue gas and inflammatory changes in the left groin and scrotum, worrisome for Fournier's gangrene 4. Moderately atrophic left kidney with compensatory hypertrophy of the right kidney 5. Mild splenomegaly 6. Fatty Liver 7. Mild left external iliac lymphadenopathy, likely reactive.
728	Penile Implant	75	Male	A male in his early-70's presented with a history of mucinous appendiceal neoplasms and an appendectomy performed within the past year. A urethral pump for incontinence was noted in the right lower quadrant. All CT scans for the past year showed stable results. 1. Status post appendectomy and prostatectomy 2. Penile implant in place 3. Diverticulosis 4. Hiatal hernia 5. Minimal diffuse fatty infiltration of the liver 6. Nodular scar like abnormality in the midline anterior abdominal wall, unchanged.
729	Prostatic Adenocarcinoma	75	Male	A male in his mid 70's presented for a semi-annual follow up regarding benign prostatic hyperplasia. The patients PSA (prostate-specific antigen) was within normal limits at the time of the visit. The patient's frequency and urgency of urination were significant at this time. Flomax was prescribed and yearly visits to evaluate the prostate were suggested. Approximately 1.5 years later, the patient had an US guided biopsy due to a continued increase in PSA. 6/6 core samples came back positive and he was diagnosed with prostatic adenocarcinoma. The cancer was staged at T1c N0 M0. The patient had a Gleason score of 7.* After some discussion as to the a LABS: PSA (pre treatment): 8.67 NG/ML PSA (post treatment): 0.04 NG/ML (Normal range = 0.00-4.00 NG/ML) 1. Multiple foci of increased T1 signal abnormality, consistent with post biopsy hemorrhage, limiting evaluation of malignancy in these areas. 2. Area of T2 hypointensity in the right posterior peripheral zone, with associated nodular contrast enhancement, and mild restricted diffusion, which extends distorts the right lateral prostatic capsule. Findings are suspicious for neoplasm. 3. Additional areas of T1 signal abnormality, questionable contrast enhancement, and possible diffusion restriction within the left peripheral zone of the prostate. Findings are suspicious for neoplasm, although to a lesser extent than in the right posterior peripheral zone. 4. Small, indeterminate left external iliac node.
730	Seminoma (Early)	52	Male	A male in his early-50's presented for evaluation of a right testicular mass detected by the patient about a week prior. The mass was not painful and there was no recent trauma. On clinical exam, the left testicle was described as being soft/rubbery whereas the right testicle was hard on the lateral aspect. An ultrasound revealed a right testicular hypoechoic mass measuring 3.2 x 1.8 x 3.2 cm, with an additional hypoechoic nodule measuring 0.6 x 0.6 x 0.6 cm. A CT with contrast revealed a right testicular mass along with prostatomegaly. The patient underwent a right radical orchiectomy and pathology revealed a classic type Seminoma. 1. Right testicular mass. 2. No pathologic lymphadenopathy 3. Indeterminate right lower lobe pulmonary nodules 4. Bilateral renal hypo-densities, likely cysts 5. Bilateral renal calcifications 6. Hepatic steatosis 7. Prostatomegaly
731	Bezoar	52	Male	A male in his early-50's presented with left sided abdominal pain. Associated symptoms included nausea and vomiting (self-induced). Abdominal CT findings were suggestive of a large duodenal bezoar. The patient was subsequently admitted and GI was consulted for possible removal of the bezoar. 1. Distended proximal duodenum and distal gastric antrum with fluid, wall thickening and mild inflammatory changes. New development of distal stomach/proximal duodenal diverticulum containing a large bezoar. 2. No free air/ fluid in the abdomen or pelvis. 3. Probable annular pancreas. 4. Wedge-shaped splenic hypodensity. 5. Focal area of focalization in the jejunum 6. Adynamic ileus versus distal small bowel obstruction. 7. Fatty infiltration of the liver 8. Small non-obstructing left renal stone. 9. Hypodensity of the right kidney.
732	Bowel Obstruction	58	Male	A male in his late-50's presented to the hospital nausea, vomiting & abdominal pain. The patient was being treated for multiple conditions, which included bilateral aneurysms, hypertension, and leg edema (amongst others). The patient also had a history of pituitary adenoma. During a CT scan of the patient's pelvis, a suspect distal small bowel obstruction was noted. 1. Right lower lobe atelectasis and small right-sided pleural effusion. 2. Mild diffuse esophageal thickening. 3. Suspect distal small bowel obstruction. 4. Extra alimentary gas and gas adjacent to the descending aorta and left common iliac artery presumably postsurgical. 5. Moderate pelvic ascites. 6. Fluid density structure in the duodenum and anterior to the aorta, likely postsurgical. 7. Hyperattenuation of the liver lesion.
733	Crohn's Disease	32	Male	A male in his early 30's with a history of cirrhosis and Crohn's disease presented in the ED with intermittent abdominal pain for the last couple of months. The pain had increased over the last 24 hours specifically in the left flank area. He described the pain as crampy and wrenching with radiation to the left lower costal area on his back. The patient noted that his urine has been darker for the last week or so. 1. Distal ileal, cecal, descending colon, and lower extent proximal transverse colon thickening and surrounding inflammation consistent with known Crohn's disease. 2. Abnormal nodular liver. 3. Splenomegaly and numerous collateral vessels. 4. Cholelithiasis
734	Restaging Colorectal Cancer	58	Male	The patient was diagnosed 6 months prior with colorectal cancer. At the same time the patient was diagnosed with gangrene and had a colonostomy performed. 1. No significant interval change in large necrotic rectal mass with tumor expansion into the perineum. 2. Bilateral ureteral stents with mild hydronephrosis. 3. Diverting ostomy 4. Splenomegaly 5. Mild hepatic steatosis 6. Inguinal lymph nodes.
735	Non-Hodgkins Lymphoma	65	Male	A male in his mid-60's, with presented with a large left neck mass with ulceration to the skin surface. The patient was diagnosed with Non-Hodgkin's Lymphoma (subtype - diffuse large B-cell lymphoma). LABS: WBC: 5.4 (4.0-11.0x10E3/UL). 1. Soft tissue masses extending from the left occipital bone through the posterolateral neck to the left supraclavicular region. 2. Large ulceration in the upper left neck.
736	Non-Small Cell Lung Carcinoma, Stage IIIB	52	Female	A female in her early 50's presented for evaluation of a right supraclavicular mass. The patient experienced a cough, congestion, tightness in her chest a week prior which lead her to find a palpable mass in her right supraclavicular region. The patient also notes occasional right-sided otalgia and a 15 pounds weight loss over the past 6 months. An ultrasound noted enlarged cervical lymph nodes; chest X-ray showed a prominent right hilum pulmonary nodule. A fine needle biopsy of the right neck lymph node diagnosed non-small cell lung carcinoma; clinical stage IIIB. LABS: WBC: 8.4 (4.0-11.0x10E3/UL). 1. Right supraclavicular and mediastinal necrotic lymphadenopathy, prominent left supraclavicular lymph nodes. 2. Mild nasopharyngeal soft tissue fullness. 3 Prominent bilateral level IIA lymph nodes.
737	Parathyroid Adenoma	75	Male	A male in his mid -70's presented for evaluation of hypercalcemia/tyraldism. The patient had a history of hypertension and hypercalcemia. A prior ultrasound showed thyromegaly with heterogeneous echo texture and multiple bilateral nodules. Fine needle aspiration of the dominate right thyroid nodule found the nodule to be benign. LABS: WBC: 7.2 (4.0-11.0x10E3/UL) PTH: 480 (12-88pg/mL) Calcium: 7.6 (8.9-10.1 mg/dL). 1. Right parathyroid adenoma 2. Mild to moderate fluid in the distal esophagus with esophageal dilation.
738	Thyroid Cancer	42	Male	6. Multilevel degenerative disc disease, greatest at C5-6. Moderate central canal stenosis with bilateral neural foramina narrowing. 3. Multiple bilateral pulmonary nodules. 4. Right pleural effusion with atelectasis 5. Multiple hepatic hypodensities. 7. Tiny bilateral renal hypodensities. 8. Prostatomegaly
739	Rhabdomyosarcoma	15	Female	9. T8 vertebral body lesion. A male in his early 40's was diagnosed with Graves Disease. He later underwent a thyroidectomy with pathologic diagnosis of multi-focal, bilateral papillary thyroid cancer. Lymph nodes were positive for metastatic papillary carcinoma. LABS: WBC: 3.7 (4.0-11.0x10E3/UL) PTH: 32 (12-88pg/mL) T3: 6.8 (2.5-3.9 pg/mL) T4: 2.7 (0.6-1.5 ng/dL). 1. Indeterminate ground-glass nodule right lower lobe. 2. Antecedent granulomatous disease. NM Thyroid Cancer Scan - 1. Extensive activity within thyroid bed, cervical and upper mediastinal lymph nodes, suggesting thyroid remnant with local regional functioning neck and superior mediastinum metastatic disease. Medical History: A female in her early-teens present for evaluation of rhabdomyosarcoma. She has a history of a soft tissue retro-orbital and left ethmoid mass; confirmed to be alveolar rhabdomyosarcoma. The patient has been undergoing treatment including both radiation therapy and chemotherapy for about 2 years. The current CT scan demonstrates two left breast nodules and one right breast nodule. An ultrasound showed a 14cm mixed echogenic mass. Pathology of the left breast mass was consistent with recurrent rhabdomyosarcoma. Recurrence was also noted in the lymph node in the left axilla. 1. Left ethmoid and left orbital soft tissue mass. 2. Right maxillary sinus disease. 3. Small left mastoid effusion. 4. Unchanged left upper lobe pulmonary nodule. 5. Post radiation change upper lungs bilaterally. 6. At least two left breast nodules and one right breast nodules. Current Scan: The patient was previously diagnosed with a rhabdomyosarcoma affecting the left ethmoid and retro-orbital area. At the time of the scan, there were known metastasis to the breast and lungs. 1. Right gluteal soft tissue mass, nonspecific, metastatic not 2. Lung nodules. 2. Left axillary lymphadenopathy, increased. 3. Stable left upper lobe pulmonary nodule.
740	Diffuse Large B-Cell Lymphoma	58	Female	A female in her late 50's presents with a recently diagnosed diffuse large B-cell lymphoma (DLBCL) and a breast mass. The patient has been receiving R-CHOP treatments for the DLBLC. 1. Large right breast mass, consistent with known lymphoma. 2. Multiple bilateral pulmonary nodules. 3. Fatty hepatomegaly 4. Large, complex right renal cyst. 5. Colonic diverticulosis.
741	Phyllodes Tumor	55	Female	6. Indeterminate sclerotic lesion T11 Vertebral body. A female in her mid-50's presented with the chief complaint of a right breast lesion. A biopsy of the area notes no malignancy although there is current bleeding and pain noted in the right breast mass. 1. Right breast mass, consistent with known carcinoma until proven otherwise. 2. Nodular cervical thickening in an enlarged right axillary lymph node. 3. Right-sided aortic arch with an aberrant left subclavian artery. 4. Indeterminate pulmonary nodules. 5. Poorly defined hypodense hepatic lesions
742	Melanoma Surveillance	65	Male	A male in his mid-60's initially consulted 3 years prior with a diagnosis of melanoma. A biopsy of a right lower back lesion noted a malignant melanoma of the superficial spreading type. The patient underwent a wide re-excision and elected not to receive adjuvant interferon therapy. He now presents for a 6 month follow-up including a repeat CT chest. The CT showed bilateral benign gynecomastia 1. Unchanged left lung pulmonary nodules. 2. Granulomatous disease. 3. Left adrenal myelolipomas. 4. Bilateral renal hypodense lesions, likely cysts. 5. Mild hepatic steatosis/cirrhosis. 6. Colonic diverticulosis 7. Post-operative changes right axilla. 8. Bilateral benign gynecomastia.
743	Agenesis of Corpus Callosum	<1	Female	The patient is an infant born via C-section with no delivery complications. Multiple congenital abnormalities were noted on ultrasound during pregnancy & confirmed at birth. The mother has a history of ADHD and a diagnosis of fetal alcohol syndrome. 1. Agenesis of corpus callosum with colpocephaly and midline cyst.
744	Alobar Holoprosencephaly	<1	Female	A Caucasian female infant was diagnosed via fetal MRI with ventriculomegaly and macrocephaly. The patient was delivered by C~section with multiple congenital anomalies. Post-delivery, she was intubated and scheduled for a non-contrast brain MRI and a head ultrasound. The MRI revealed an absent corpus callosum, absent septum pellucidum, and alobar holoprosencephaly, a ventriculoperitoneal (VP) shunt was placed. 1. Alobar holoprosencephaly, with dilated monoventricle and posterior cyst. 2. Agenesis of Corpus Callosum (ACC) 3. Absent septum pellucidum
745	Glioblastoma	52	Male	A male in his early 50's presented with difficulty reading, expressive aphasia , and worsening headaches. A peripheral vision field deficit was noted. CT noted a suspicious mass. The pathology was consistent with glioblastoma. 1. Large area of vasogenic edema in the left parieto-occipital lobe. Question of enhancing mass in the left parietal lobe measures 2.8cm. 2. Significant edema with effacement of the sulci and mild midline shift to the right. Findings are most likely secondary to a primary brain neoplasm.
746	Subdural Hematoma	<1	Male	An infant male presented with left half sided head trauma. The patient was reported to having waxing consciousness, was minimally responsive during transport, and had a heart rate in the 50's. CT noted a subdural hematoma. No intervention was required; the patient was admitted for monitoring. 1. Mixed density subdural blood along the left cerebral hemisphere with fronto-parietal radial effacement. 2. Falcine hematoma and possible hypodensity along the left tentorium.
747	Aortic Aneurysm	75	Male	The patient presented with known history of coronary artery disease, hyperlipidemia, hypertension & previous stent placement. He had stopped smoking over 40 years ago. His medical issues were under control & the patient was living an active & healthy lifestyle when he began experiencing symptoms of reflux & indigestion. A CT showed a large abdominal aortic aneurysm beginning 1 cm below the take-off of the right renal artery and extending down to the bifurcation, but not into the iliacs. The aneurysm measures 9.3 cm in AP diameter at its maximum. A non-occlusive mural thrombus is seen within the aneurysm. Mild ectasia of the iliacs is noted, t 1. Large fatty lesion within the abductor magnus muscle, compatible with an intramuscular left lipoma. 2. 4 mm nodule, left lobe of the liver. Likely a cyst or hemangioma. 3. Mild stenosis of the left renal artery take-off.
748	Abdominal Aortic Aneurysm	35	Female	A female in her late 30's presented to the E.D. with abdominal pain. The patient had a history of alcohol, tobacco and recreational drug use. A CT scan noted a large abdominal aortic aneurysm originating at the level of the renal arteries & measuring 7.1 cm at its greatest AP diameter by 7 cm in transverse diameter. The aneurysm extends for approximately 13.5 cm of the vessel length. Emergent operative repair was ordered. 1. Large abdominal aortic aneurysm. 2. Marked diffuse fatty infiltration of the liver. 3. Simple splenic cysts. 4. Previous spinal surgery.
749	Inframural/Saccular Abdominal Aortic Aneurysm	85	Female	A female in her mid-80's presented with worsening SOB, fatigue, generalized weakness, decreased urine output, and decreased appetite. A CT was ordered to evaluate for pyelonephritis. An infrarenal abdominal aortic aneurysm was incidentally found on the CT. The aneurysm measured 4.3 cm in AP diameter. 1. Small bilateral pleural effusions. 2. Marked right hydronephrosis. 3. Infrarenal abdominal aortic aneurysm. 4. Hysterectomy. 5. Mild diverticulosis.
750	Plantar Fasciitis	38	Female	The exam was status post percutaneous tenotomy (6 weeks prior) 1. Abnormal signal central band plantar aponeurosis with adjacent edema and magnetic susceptibility artifact. Findings may represent expected perioperative appearance or severe plantar fasciitis. 2. Multiple tiny nonscompressive ganglia/synovial outpouchings. 3. Mild peritarsal tenosynovitis. 4. Nonspecific edema of the midfoot with mild first/second intermetatarsal bursitis.
751	Chondrosarcoma	28	Male	The patient presented with known chondrosarcomas within his pelvis that have been previously removed numerous times (about 25 total resections over the span of ~15 years). He received chemotherapy, which he tolerated well. He was initially experiencing back pain which has continued. It was later discovered that the patient had 1-4-5 vertebral body involvement. The patient has a history of smoking 0.5 pack/day for the past 20 years. He also has a significant family history for cancer. 1. 7 mm partially calcified left upper lobe pulmonary nodule. 2. Single AP window lymph node mildly enlarged, likely reactive although metastatic disease could not be entirely excluded. 3. Large resection, right iliac wing. Soft tissue with stippled calcification along resection margin is unchanged from previous study and could represent postoperative change or residual neoplasm. 4. 1.2 x 1 cm unchanged nodule with stippled calcification more laterally along the iliac wing resection margin consistent with osteochondroma or chondrosarcoma.
752	Lipoma	42	Male	A male patient presented with a two month history of a left thigh mass. An US and MR of the affected area noted a soft tissue mass residing with the muscular compartment on the medial aspect of the thigh. The mass measured 17 cm cranial caudal by 7.6 cm transverse by 7.6 cm AP. 1. Large fatty lesion within the abductor magnus muscle, compatible with an intramuscular left lipoma.
753	Focal Nodular Hyperplasia	32	Female	An obese female in her early 30's presented with upper quadrant pain, which worsened after eating. The patient notes nausea but no vomiting or diarrhea at the time of the visit. A sonogram, ordered to evaluate the pain, found a liver mass. Liver function tests were all normal. An MRI was scheduled to follow up on the abnormal liver mass. 1. Focal nodular hyperplasia in the right hepatic lobe. 2. Small splenic cyst.
754	Hepatocellular Carcinoma	75	Male	A male in his mid-70's was diagnosed with hepatocellular carcinoma (HCC) after a CT showed a large 22cm x 13cm abdominal mass and a biopsy confirmed diagnosis. The patient was not considered a candidate to have surgery/transplant, but had chemoembolization of the tumor. Liver function tests were elevated. LABS: AST: 201(15-41 U/L), ALT: 120 (14-54 U/L) Alkaline Phosphatase: 463 (32-91 U/L) Total Bilirubin: 4.5 (0.3-1.2 mg/dL) WBC: 9.7 (4.0~11.0 x 103 / uL) Hemoglobin: 10.9 (13.3-17.3 g/dL) Hematocrit: 35.7 (39.0-52.0 %). 1. Two large liver masses, consistent with known hepatocellular carcinoma. 2. Mildly significant motion artifact, difficult to elevate patency of the portal vein. 3. Ascites. 4. Small right pleural effusion. 5. Bilateral renal cysts. 6. Colonic diverticulosis.

Anatomage Table 9.0 Case Library Descriptions

755	Hemangioma	38	Male
756	Post Transplant Lymphoproliferative Disorder	<10	Female
757	Acute Cholecystitis	52	Male
758	Cholangiocarcinoma	48	Male
759	Cholangitis	55	Male
760	Gallbladder Cancer	38	Female
761	Bladder Rupture	48	Male
762	Transitional Carcinoma	42	Male
763	Medullary Sponge Kidney	62	Male
764	Phlegmon	25	Male
765	Liposarcoma	62	Female
766	Pancreatic Mass	65	Male
767	Pancreatic Mass	53	Male
768	Possible Adrenal Carcinoma	72	Male
769	Uterine Carcinosarcoma	52	Female
770	Endometrioma	25	Female
771	Ovarian Teratoma	45	Female
772	Possible Tuboovarian Abscess	28	Female
773	Gaucher Disease	58	Male
774	HELLP Syndrome	28	Female
775	Lymphoma	35	Male
776	Prostate Cancer	78	Male

A male in his late-30's presented with RUQ pain. Abdominal ultrasound showed hyperechoic liver masses (suspect for hemangiomas), a gallbladder polyp, and slight fatty infiltration of the liver. An MRI was then ordered for further evaluation. Liver function tests were all normal.
1. Two benign liver hemangiomas.
2. Two gallbladder polyps.
3. Left adrenal myelolipoma.
4. Small left renal cyst.

A female under the age of 10 with a history of a liver transplant for biliary atresia presents with abdominal pain and hypercalcemia. The transplant was performed prior to her turning 1 year old. Ultrasound showed renal calculi and multiple lesions which was concerning for PTLD. A CT scan was ordered & noted large mesenteric, retroperitoneal, and left renal masses consistent with PTLD.

LABS:
AST: 42 (15-41 U/L),
ALT: 23 (14-54 U/L)
Alkaline Phosphatase: 71 (110-360 U/L)
Total Bilirubin: 0.6 (0.3-1.2 mg/dL)
WBC: 10.3 (4.0-11.0 x 103 /uL).

1. Large mesenteric, retroperitoneal and left renal masses most consistent with post transplant lymphoproliferative disorder.
2. Left hepatic lobe liver transplant with cavernous transformation of the portal vein.
3. Splenomegaly.
4. Mild ascites.

A male in his early 50's was experiencing common and severe pain in his right upper abdomen after eating. The pain was described as being pressure-like and was accompanied by nausea & vomiting. An ultrasound showed acute calculus cholecystitis. An MRI was ordered for further evaluation.

LABS:
AST 91 (15-41 U/L)
ALT: 62 (14-54 U/L)
Alkaline Phosphatase: 98 (32-91 U/L)
Total Bilirubin: 1.0 (0.3-1.2 mg/dL)
WBC: 18.9 (4.0-11.0 x 10E3/uL).

1. Changes of acute cholecystitis without any obstructing cystic duct stone or common bile duct stone.
2. Dilated biliary tree as well as the pancreatic duct.
3. Mildly narrowed common bile duct as well as the pancreatic duct at the level of the ampulla, likely related to recent passed stone.

A male in his late 40's was previously diagnosed with cholangiocarcinoma, which was extra hepatic and had involvement of the celiac and portal nodes. The patient received 4 weeks of radiation and chemotherapy. The patient experienced recurrent disease, which required further treatment.

Labs:
AST 38 (15-41 U/L)
ALT 9 (17-63 U/L)
Bilirubin: 0.6 (0.3-1.2mg/dL)
Alkaline Phosphatase: 48 (32-91 U/L)
WBC: 15.5 (4.0-11.0 x10E3/uL)
Hemoglobin: 10.2 (13.3-17.3 g/dL)
Hematocrit: 30.2 (39.0-52.0 %)

1. Markedly abnormal gallbladder with inflammation and contained perforation and/or intrahepatic abscess component.

A male in his mid-50's with known primary sclerosing cholangitis was post-colectomy. He had slight elevation of his CA 19-9 in the absence of cholangitis, but that returned to baseline.

LABS:
AST 79 (15-41 U/L)
ALT 36 (17-63 U/L)
Alkaline Phosphatase: 332 (32-91 U/L)
Total Bilirubin: 1.7 (0.3-1.2 mg/dL)
WBC: 9.4 (4.0-11.0 x10E3/uL)
Hemoglobin: 12.4 (13.3-17.3 g/dL)
Hematocrit: 37.4 (39.0-52.0 %

A male in his mid-50's with known primary sclerosing cholangitis was post-colectomy. He had slight elevation of his CA 19-9 in the absence of cholangitis, but that returned to baseline.
A female in her late-30's presented with abdominal pain. Pain originated in the right upper quadrant and radiated across her abdomen to her left upper quadrant. The pain was also noted to be constant, sharp, and had started to radiate to her back. An abdominal ultrasound and CT showed a mass in the gallbladder. Final diagnosis was adenocarcinoma of the gallbladder.

LABS:
AST: 19 (15-41 U/L)
ALT: 22 (14-54 U/L)
Bilirubin: 0.8 (0.3-1.2 mg/dL)
Alkaline Phosphatase: 79 (32-91 U/L)
WBC: 10.1 (4.0-11.0 x 10E3/uL)

1. Irregular, heterogeneous gallbladder mass near the fundus with apparent contrast enhancement. The mass appears to extend beyond the gallbladder wall. This may represent an inflammatory mass of the gallbladder such as inflammatory myofibroblastic tumor; however, malignancy cannot be excluded with certainty.
2. Gallbladder wall thickening and pericholecystic fluid is also noted, which is suggestive of superimposed cholecystitis.

A male in his late 40's presented to the emergency department following a MVA. The patient arrived alert and responsive. He had open femur and tibia/fibula fractures on his left leg. A CT of the pelvis noted a bladder wall injury. A follow up cystogram showed a large bladder rupture.

Labs:
BUN: 12 (6-20mg/dL)
Creatinine: 0.75 (0.64-1.22mg/dL)
Hemoglobin: 13.5 (13.5-17.5)
Hematocrit: 25.7 (39.0-52.0)

1. Intraperitoneal rupture of the urinary bladder.
2. Small pneumoperitoneum.

A male in his early-40's presented with a history of hematuria and recurrent testicular pain. A CT of the abdomen found a left renal mass.

Labs:
BUN: 6.0 (6-20mg/dL)
Creatinine: 0.64 (0.64-1.27mg/dL)
Hemoglobin: 9.6 (13.5-17.5)
Hematocrit: 29.2 (39.0-52.0)
WBC: 13.2 (4.0-11.0 x10E3/UL)

1. Left kidney mass involving the renal pelvis and lower pole calices consistent with transitional carcinoma. Cystic lesion of the upper pole of the left kidney as well.
2. Thickened appearing urinary bladder wall likely related to lack of distention.
3. Paget's disease of the right iliac bone.

A quadriplegic male in his early-60's presented with elevated LFTs, hematuria, and leukocytosis. The patient had a history of nephrolithiasis, neurogenic bladder, pyelonephritis and recurrent UTIs which were secondary to a long-term Foley catheter. An ultrasound noted medullary nephrocalcinosis and a CT scan demonstrated bilateral non-obstructing renal stones.

Labs:
BUN: 77(7-20)
Creatinine: 5.8(0.8- 1.5)
Hemoglobin: 11.7(13.0-17.0)
Hematocrit: 35.2(39.0-52.0)
AST: 77 (15-41 U/L)
ALT: 79 (17-63 U/L)
Alkaline Phosphatase: 104 (32-91 U/L)
Albumin: 2.2 (3.4-4.7 g/dL)

1. Bilateral non-obstructing intrarenal calculi with bilateral renal cysts.
2. Markedly thickened bladder wall. Cystitis would be a consideration.

A male in his mid-20's presents with RLQ pain, intermittent fevers and night sweats. He was recently diagnosed with Crohn's disease of the terminal ileum, cecum, and descending colon. An abdominal/pelvic CT revealed multiple abnormalities including RLQ abscesses, urinary bladder wall thickening, and a large mass-like phlegmonous collection in the RLQ.

Labs:
BUN: 8 (6-20mg/dL)
Creatinine: 0.68 (0.44-1.03mg/dL)
WBC: 12.7 (4.0-11.0 x 10E3/uL)
Hemoglobin: 11.9 (13.17.3)
Hematocrit: 37.1 (39.0-52.0)

1. Markedly thick-walled adenomatous terminal ileum, consistent with active Crohn's disease.
2. Multiple abscesses in the right lower quadrant, largest focal abscess within abdominal wall musculature.
3. Large mass-like phlegmonous collection in the right lower quadrant, involving superior aspect of the urinary bladder.
4. Thick-walled urinary bladder.
5. Small ascites.
6. Small mesenteric ileus.
7. Mild splenomegaly.

A female in her early 60's presented with complaints of bloating. She also complained of that her abdomen had become larger and hard compared to several months prior. An ultrasound noted a massive multiloculated cystic and solid left retroperitoneal mass. A CT was ordered to further evaluate the mass and an ultrasound guided biopsy later concluded the mass to be a well-differentiated liposarcoma.

1. Large retroperitoneal mass containing fat suspicious for liposarcoma.
2. Ascites.
3. Diverticulosis.

A male in his mid-60s presented with a history of dull aching abdominal pain. The patient had also been experiencing nausea and a 25 pound unintentional weight loss. Labs: Hemoglobin: 10.3 (13.0-17.0 g/dL) Hematocrit: 31.7 (39.0-52.0%) WBC: 13.4 (4.0-11.0 x10E3/UL) Glucose: 171 (70-125 mg/dL).
1. Probable pancreatic mass with severe dilation of the pancreatic duct and involvement of the superior mesenteric vein, confluence of the portal vein, and gastroduodenal artery.
2. Diffuse changes of pancreatitis in the body and tail of the pancreas.
3. Prominent peripancreatic and periportal lymph nodes.
4. 2.9 cm fluid collection within the lesser sac.
5. Multiple indeterminant hepatic hypodensities.

A male in his mid-50's initially presented with intermittent abdominal pain which progressed to severe abdominal pain that could not be controlled by pain medication. The patient was diagnosed with a pancreatic body and tail mass (adenocarcinoma stage IV , cT3, cN1, pM1).

Labs:
Hemoglobin: 13.6 (13.3-17.3 g/dL)
Hematocrit: 40.8 (39.0-52.0%)
WBC: 5.4 (4.0-11.0 x 10E3/UL)
Glucose: 87 (70-125 mg/dL)
Cancer Antigen 19-9: 2024 (0-35U/mL)

1. Large pancreatic body mass obstructing the pancreatic duct in the tail.
2. Several peripancreatic lymph nodes.
3. Encasement of the hepatic artery and in the splenic vein with large collateral formation.
4. Mild fatty infiltration of the liver
5. Cholecystectomy.
6. Granulomatous disease of the lungs.

A male in his early-70's presented with abdominal distention and fullness. An MRI was ordered which noted a large left adrenal mass along with multiple hepatic masses. An ultrasound with Doppler also noted multiple hepatic masses and a left adrenal mass. Labs: Hemoglobin: 12.6 (13.3-17.3 g/dL) Hematocrit: 37.1 (39.0-52.0%) WBC: 3.4 (4.0-11.0 x 10E3/UL) Glucose: 106 (70-125mg/dL) AST: 167 (15-46 U/L) ALT: 131 (11-66U/L) Alkaline Phosphatase: 155 (38-126 U/L) AFP/CA: 26.1 (<15.0 NG/ML).

1. Large left adrenal mass, suspicious for adrenal carcinoma.
2. Changes of cirrhosis with multiple hepatic masses.
3. Large ascites.
4. Splenic vein gastral effusion.
5. Splenomegaly
6. Enlarged prostate.

A female in her early-50's presented in an outpatient setting with pain around the rectum and vagina, constipation, spotting, and left sided pelvic pain that was greater than the right side. The patient had a history of breast cancer, and was treated with Tamoxifen for 2 years. An ultrasound was ordered which showed a large cystic and solid pelvic mass, thickened endometrium, and loculated ascites. A couple of days later the patient came to the ER with extreme pain. Another ultrasound was performed, followed by an abdominal/pelvic CT. The CT showed multiple enlarged retroperitoneal enhancing lymph nodes, worrisome for metastatic disease, right hepat

Labs:
CA 125: 499 (0-35U/mL)
WBC: 15.5 (4.0-11.0x10E3/UL)
Hemoglobin: 9.4 (11.0-15.1 g/dL)
Hematocrit: 28.2 (33.1-44.5%)

1. Large solid and cystic pelvic mass, worrisome for ovarian neoplasm.
2. At least on presacral left ureau nodule, worrisome for metastatic disease.
3. Mild inferior omental fat infiltration, may be due to edema, but carcinomatosis not excluded.
4. Multiple enlarged retroperitoneal enhancing lymph nodes, worrisome for metastatic disease.
5. Indeterminate right hepatic lobe hypodensity.
6. Small indeterminate right lower lobe pulmonary nodule.
7. Small ascites.

A female in her mid-20's presented with LLQ pain and a palpable lump for the past 6 months. The patient reported that the intensity of the pain and size of the lump would vary with menstrual cycles. An ultrasound was ordered and noted a 1.5cm, hypoechoic mass. The lesion's appearance was non-specific; an MRI was ordered to better characterize the lesion. The results of the MR suggested a biopsy which confirmed the diagnosis of endometrioma.

1. Nonspecific enhancing nodule in the subcutaneous fat of the left lower quadrant abdominal wall just superficial to the rectus sheath. Diagnostic considerations include a granuloma, fat necrosis, and a neuroma. This would be amenable to percutaneous core needle biopsy, as clinically indicated. Imaging appearances are not typical of an abscess although phlegmon could be considered in the appropriate clinical context.

A female in her mid-40's was diagnosed with a grade 2 coilo are moderately differentiated, clinical IB (tumor has spread to one-half or more of the myometrium) endometrial adenocarcinoma. She presented with bleeding, heavier than her usual periods along with shortness of breath and dizziness. Endocervical and endometrial curettings showed complex endometrial hyperplasia with fragments of benign endocervical mucosa. Further testing showed endometrial cancer extending through the endometrium and into the posterior wall of the uterus. The mass was noted to extend more than halfway through the total thickness of the wall and into the internal o

1. Enlarged uterus, stable in appearance.
2. Left ovarian endometrioma/hemorrhagic.
3. Mildly prominent bilateral inguinal lymph nodes.

A female in her late 20's presented to the emergency department after experiencing RLQ pain radiating to the back for about a week. It started as intermittent pain and then progressed. The patient has a history of appendectomy and denies any vaginal symptoms. The patient was noted to have an elevated WBC. An ultrasound was performed and showed a dilated fallopian tube representing pyosalpinx or hydrosalpinx. A CT scan was also ordered and noted inflammation and a cystic mass of the right ovary.

Labs:
WBC: 15.1 (4.0-11.0x10E3/UL)

1. Cystic mass adjacent to or arising form the right ovary. Possibilities include ovarian cyst, markedly dilated fallopian tube, cystic neoplasm, or abscess.
2. Small pelvic ascites.
3. Punctate non-obstructing left renal calculus.

A male in his late 50's presented for his annual check-up for Gaucher Disease. He was diagnosed in his late teens. At the time of the visit, the patient was not experiencing any complications related to the disease. Labs: AST: 22 (15-41 U/L) ALT: 26 (17-63 U/L) Alkaline Phosphatase: 59 (32-91 U/L) Total Bilirubin: 0.7 (0.3-1.2 MG/DL) Albumin: 4.2 (3.4-4.7 G/DL)
1. Mild hepatomegaly with classic segment VII hamartoma.
2. Massive splenomegaly with multiple focal splenic lesions that can be seen in the setting of Gaucher's Disease.
3. Mild bone marrow changes of Gaucher's disease.
4. Cholelithiasis and small gallbladder sludge.

A female in her late-20's, G1, P2-0-1-2 presents with a recent history of a c-section. Prior to delivery, the patient was diagnosed with a UTI and she now complains of fevers, chills, rigors, and right flank pain; thought to be pyelonephritis. Labs were found to be abnormal and the patient was diagnosed with HELLP syndrome.

Labs:
BUN: 41 (6-20 MG/DL)
Creatinine: 4.47 (0.44-1.03 MG/DL)
AST: 116 (15-41 U/L)
ALT: 126 (14-54 U/L)
Alkaline Phosphatase: 430 (32-91 U/L)
Total Bilirubin: 25.4 (0.3-1.2 MG/DL)
Calcium: 8.4 (8.9-10.3 MG/DL)
Total Protein: 5.4 (5.9-7.5 G/DL)
Albumin: 1.6 (3.4-4.7 G/DL)
Hemoglobin: 8.5 (11.0-15.1 G/DL)
Hematocrit: 23.2 (33.1-44.5%)

1. Recent C-section with small residual pneumoperitoneum.
2. Diffuse anasarca seen in the abdominal wall musculature as well as in the subcutaneous tissues.
3. Hemoperitoneum.
4. No definite intrahepatic hematoma or laceration.
5. Bibasilar atelectasis with bilateral pleural effusion.

A male in his mid-30's with a history of diffuse large B-Cell lymphoma. The patient was initially diagnosed 6 months prior presenting with an epidural lesion. The lesion was removed and at the time the CSF was also found to be involved. Post-surgery, the patient received radiation and started on inpatient chemotherapy. Over the period of 6 months the patient's health gradually degraded as the disease spread. Labs: WBC: 0.0 (4.0-11.0x10E/UL) RBC: 2.14 (4.30-5.90x10E6/UL) Hemoglobin: 6.4 (13.3-17.3 g/dL) Hematocrit: 17.7 (39.0-52.0%) Platelet Count: 1 (150-400x10E3/uL).
1. Wide spread aggressive lymphoma relapse involving the central nervous system at several locations, along with the liver, pancreas, and kidneys. There is also nodal involvement in the chest and left inguinal station along with extensive multifocal osseous lymphoma involvement.
2. There is a large right lower lobe cavitary mass with intense FDG uptake.
3. SUV max 21.6 in the right lower lobe cavitary lesion.
4. Deauville score is 3.

A male in his late 70's presented for evaluation of high prostate-specific antigen (PSA) levels (15.8 ng/mL). The patient had an episode of gross hematuria; a cystoscopy proved unremarkable. Several months later a trans-rectal ultrasound guided biopsy was performed. The pathology was found to be a Gleason 3+4 prostatic adenocarcinoma. A month post biopsy, a bone scan did not reveal any evidence of metastatic disease. Treatment options were discussed with the patient and it was decided to perform an MRI of the prostate prior to beginning radiation therapy.
1. Infiltrative high-grade prostate cancer in the left mid-gland extending to the base of the prostate. This measures approximately 1.5 x 1.3 cm and involves the left prostatic capsule, with evidence of mild extracapsular extension. It is very close to the left seminal vesicle, but does not frankly invade this structure. It also extends into the adjacent central gland.
2. No gross macroscopic tumor identified in the right prostate.
3. No suspicious pelvic lymphadenopathy or focal bone lesion.

Anatomage Table 9.0 Case Library Descriptions

				A male in his mid-50's presented to the ER with RLQ abdominal pain. The pain had started a day prior, was constant and aggravated by changes in position. The patient was found to have acute appendicitis with an abscess and peritonitis. The patient was scheduled for an appendectomy. Labs: WBC: 22.7 4.0-11.0 x10E3/UL 1. Non-visualized appendicitis at the level of the umbilicus. 2. Moderately distended urinary bladder. 3. Scattered diverticula sigmoid colon. 4. Small hiatal hernia. 5. Severe coronary arterial calcification.
777	Appendicitis		53 Male	6. Small amount of free fluid within the left paracolic gutter.
778	Hernia		82 Female	A female in her early 80's presented with a lump in the upper part of her abdomen. Over the last few days it was tender to the touch and getting larger while also moving down her abdomen. An ultrasound noted a large ventral hernia. The patient did have a prior history of 2 hernia surgeries performed decades earlier. Further evaluation via a CT scan noted an abscess contained in the hernia. The patient underwent surgery to correct the hernia and a drain was placed for the abscess. 1. Ventral hernia containing nondistended loops of small bowel and colon. 2. Fluid density along right lateral inferior aspect of hernia adjacent to normal bowel and indurated skin. 3. Large amount of fecal material in colon. 4. Cholelithiasis. 5. Right pelvic kidney with hydronephrosis. 6. 2.2cm right hepatic lobe cyst. 7. Severe scoliosis with severe degenerative joint disease of left hip.
779	Rectal Mass and Right Inguinal Hernia		78 Male	A Caucasian male in his late 70's presented with rectal bleeding along with frequent bowel movements. A colonoscopy found a large sessile villous-appearing polyp in the proximal right colon just distal to the cecum, and a second semi-pedunculated polyp was seen immediately adjacent to the other. Samples were obtained from the two polyps, and a diagnosis of invasive moderately-differentiated adenocarcinoma was made. 1. Irregular rectal wall thickening, consistent with known rectal adenocarcinoma. 2. Multiple pathologic lymph nodes worrisome for nodal metastatic disease. 3. Multiple liver metastases and a simple right hepatic lobe cyst. 4. Small indeterminate right adrenal nodule. 5. Small benign-appearing cystic splenic lesion. 6. Diverticulosis. 7. Small fat-filled right inguinal hernia, containing nonobstructed loops of small bowel. 8. Cardiomegaly with right and left atrial enlargement. 9. Several small indeterminate pulmonary nodules. 10. Bilateral renal cysts. 11. Mild prostatomegaly.
780	Left Sided Neck Abscess		48 Female	12. Indeterminate sclerotic lesion left proximal humerus. A female in her late 40's presented with swelling to her left throat along with a mass the size of a golf ball. The mass was noted to be painful, but the patient denied difficulty with breathing or swallowing. An ultrasound was performed and showed a heterogeneous mass in the left submandibular space. A CT of the mass indicated a probable abscess. The mass was confirmed to be an abscess; incised and drained. The patient was also treated with antibiotics. Labs: WBC: 12.2 (4.0-11.0 x 10E3/UL). 1. 3.4cm x 3.3cm x 2.8cm mass inferior to the left mandibular body concerning for abscess or neoplasm. 2. Left submandibular lymphadenopathy. 3. Mandibular and maxillary periapical lucencies. No clear communication with mass. 4. Severe emphysema.
781	Acinic Cell Carcinoma		52 Male	A male in his early-50's presented with a mass in his right parotid region. The patient notes that he experienced pain about a month and a half prior to the visit, but did not notice a lump until recently. At the current time, the patient notes that the lump is mostly painless; he also denies any fevers, chills, dry mouth, dysphagia, a twitching sensation, or a loss of appetite. He does have a recent history of a 15-20 lbs weight loss. An ultrasound guided biopsy indicated that the mass was suspicious for malignancy, after which it was scheduled to be removed. Upon resection of the mass, pathology showed no signs of metastatic carcinoma. The patient was diagnos 1. Right prestyloid parapharyngeal mass, most likely a deep parotid gland origin, suspicious for carcinoma. 2. Numerous small and borderline sized lymph nodes, though none clearly suspicious for metastases.
782	Right Thyroid Mass		75 Male	A male in his mid-70's presented with a complaint of feeling overly tired for the past month. He had a history of COPD and congestive heart failure. He was experiencing shortness of breath with dyspnea on exertion, but had no chest pain. ACT of the thorax was ordered which noted a right thyroid mass. A fine needle biopsy of the mass found it to be benign. Treatment at this time is close observation. 1. Right thyroid mass. 2. Bilateral pleural effusions. 3. Ground-glass opacities and septal thickening, likely edema. 4. Bilateral perisplenic infiltration. 5. Peripheric ascites. 6. Reactive mediastinal lymph nodes.
783	Squamous Cell Carcinoma		85 Male	A male in his early 80's presented with a history of an oral papilloma of the left retromolar trigone. When initially biopsied, the mass was found to be a benign squamous mucosa with underlying salivary gland tissue without histopathologic abnormality. After about a year from the initial diagnosis, the mass had increased in size and shown more extensive changes along the buccal mucosa. A second biopsy noted well differentiated squamous cell carcinoma of the left side retromolar trigone with metastasis to the bilateral cervical nodes. The mass was staged as T3N2cM0. Treatment options include of resection and radiation therapy. 1. Enhancing soft tissue mass spanning from the left posterior mandibular rim/ramus to the hard palate; extends 4.3cm. Mass to be concerning for squamous cell carcinoma. 2. Left level 2 and 3 cervical lymphadenopathy, worrisome lymph nodes. 3. Mildly enlarged superior mediastinal lymph nodes.
784	Lung Tumor with Extensive Mets		38 Female	A woman in her late-50's presented with intermittent left shoulder and back pain. Conservative musculoskeletal treatment only improved symptoms short term. She was prescribed physical therapy and a plain film of her left shoulder was ordered. The x-ray revealed a permeative lytic humeral head lesion. Upon further evaluation and imaging, the patient was found to have a right upper lobe mass along with numerous hepatic masses. The primary cancer was noted to evolve from the upper lobe of the right lung and the histology was moderately-differentiated adenocarcinoma, stage cT3 cN3 pM1b, with a group stage of IV. Labs: WBC: 21.5(4.0-11.0x10E/UL). 1. Right apical lung mass. 2. Innumerable bilateral lung nodules, concerning for metastasis. 3. Left lower lobe consolidation. 4. Innumerable liver lesions, concerning for metastasis. 5. Moderate amount of ascites and dilated bowel loops raise the possibility of bacilar carcinomatosis. 6. Lytic lesion involving posterior aspect of the left humeral head. Multiple lumbar vertebral bodies show wedge-shaped deformities that are concerning for pathologic fractures; particularly at T12, L2, and L3 are suspicious. 7. Left humeral head is also concerning for osseous disease.
785	Non-Small Cell Carcinoma		72 Male	A male in his early-70's presented with left chest pain for the past week. A CT angio of the chest showed a large left-sided mediastinal mass with bilateral hilar lymphadenopathy, consistent with malignancy. A biopsy of the mass diagnosed non-small cell carcinoma, staged at cT4 cN3 cM0 IIIB. The patient was scheduled for radiation therapy. 1. Hypermetabolic left upper lobe paramediastinal mass compatible with malignancy. 2. Markedly hypermetabolic FDG-avid mediastinal and left hilar lymphadenopathy. 3. Small left pleural effusion. 4. Old trauma sequela of the right anterior fourth, fifth, and sixth ribs.
786	Pneumonia and Bilateral Pleural Effusions		65 Male	A male in his mid-60's presents with SOB; medical history includes COPD, peptic ulcer disease, and vitamin B12 anemia. The patient is one week post-op total gastrectomy and pancreaticoduodenectomy with Roux-en-Y reconstruction and feeding tube placement. The patients pCO2 level was slightly elevated, and a chest x-ray showed a right lower lobe consolidation and right lower lobe pleural effusion. A right chest tube was placed, and resolved that issue. Also, a left upper lobe consolidation was noted on x-ray. It was noted that the patient had hospital-acquired pneumonia. The patient was started on chest physiotherapy to help clear up secretions fro 1. No PE. 2. Extensive pneumonia right lung, volume loss middle and lower lobes. 3. Bilateral pleural effusions.
787	Right Hilar Mass		42 Male	A male in his early-40's presented with a history of shortness of breath and hemoptysis. This started about 2 months prior to the visit, and that the hemoptysis ranges from a small amount of bright red blood to a quarter-size blood clot. The patient had increased frequency of coughs, chest pressure, and a 15 pound weight loss over the last 3 weeks. A chest x-ray noted a right pulmonary mass that was confirmed with CT. Biopsy of the right mainstem bronchus noted atypical cells favoring non-small cell carcinoma. 1. Large right hilar mass with right pulmonary artery, pulmonary vein, left atrial and right bronchial involvement 2. Numerous bilateral pulmonary nodules. These may be infectious or malignant. 3. Mild emphysema.
788	Inflammatory Breast Cancer		55 Female	A female in her mid-40's presented with a palpable breast lump. The patient noted some regression of the nipple for a few weeks prior, and at the time of the visit her breasts were swollen, red, and painful. She is gravida 6; para 6. After a full workup was complete, the patient was diagnosed with inflammatory breast cancer with a T4 N2 M0 ER positive, PR negative, HER2-positive breast cancer. The patient also has chronic renal failure, which limits her chemotherapy regimen. 1. Hypermetabolic left breast mass with hypermetabolic skin thickening and adjacent breast satellite lesions. Left axillary, left supraclavicular and contralateral right superior mediastinal enlarged hypermetabolic lymph nodes, consistent with known clinical history of breast cancer with nodal metastasis 2. Hypermetabolic soft tissue mass in the right pelvis ilium of uncertain significance and etiology. 3. Small left pleural effusion. 4. Polycystic functioning kidneys.
789	Invasive Ductal Adenocarcinoma		52 Female	A female in her early-50's with a history of ductal carcinoma complains of night sweats, dry coughs in the morning, and headaches. Approximately 3 months prior, the patient palpated a small breast lump. A mammographic study revealed a lump which was biopsied along with an axillary lymph node. The biopsies came back positive for stage 2 T2 N1 invasive ductal adenocarcinoma. 1. Hypermetabolic lateral right breast mass consistent with known invasive ductal adenocarcinoma. 2. Hypermetabolic right axillary lymphadenopathy, consistent with nodal metastasis. 3. Left adrenal adenoma.
790	Hydrocalpes		42 Female	A female in her early 40's presented for a regular checkup. She had been experiencing abdominal pain for the past several years along with an enlarged abdomen which was disproportionate to the rest of her body. Clinical exam noted uterine enlargement. An abdominal CT revealed bilateral hydrocalpins and a 1 4cm mass in the inferior right breast. A breast ultrasound suggested a probable benign mass, and the patient was scheduled to follow up in 6 months. 1. Bilateral hydrocalpins. 2. Indeterminate 1.4-cm right inferior breast nodule. Recommend ultrasound to further assess. 3. Diastasis recti, with small umbilical fat containing hernia
791	Right Breast Areola Mass		65 Male	A male in his mid-60's presented with a history of non-ischemic cardiomyopathy. He was also recently diagnosed with melanoma which he had excised and was noted to have no evidence of residual disease. At this 3 month follow up and surveillance PET scan, the patient is doing well. The PET scan showed no evidence of malignant involvement. However, there was found to be a soft tissue density in the right breast areola. The patient was scheduled for a mammogram and ultrasound of the right breast. 1. Indeterminate, hypermetabolic activity corresponding to a soft tissue density in the right breast areola. Consider infection. 2. Limited evaluation of liver due to body habitus related artifact generation. 3. No convincing evidence of malignant involvement otherwise.
792	Head Trauma (GSW)		18 Female	A female in her late teens presented to the emergency department with a gunshot wound to the left side of her head. The bullet appeared to enter through the left eye and temple, and the likely exit site was the right temple. When the patient arrived to ED, she was moving all four extremities, was intubated and saturating at 100%. A CT showed involvement of the frontal and ethmoid sinus along with a large right frontal hematoma with a depressed frontal skull fracture. A decompressive craniotomy with evacuation of the hematoma was ordered. 1. Bullet tract entering the left orbit traversing the ethmoids entering the cranium through the roof of the right orbit and exiting the right skull adjacent to the frontal lobe with comminuted fractures of all bones along the path with intracranial hemorrhage and diffuse brain swelling with mild transtentorial herniation as described. 2. Ruptured left globe.
793	Right Frontoparietal Meningioma		48 Male	A male in his late--40's presents to the ED with new onset of seizures. He has a history of a recent motor vehicle accident, along with a diagnosis of diabetes, coronary artery disease, hyperlipidemia, and hypertension. Upon evaluation, a right-sided frontoparietal mass consistent with meningioma was discovered. The patient was scheduled to have the mass removed a week following the visit. 1. Hyperdense right superior sagittal sinus thrombosis or clear invasion, though the sinus is slightly effaced by the large right superior frontal meningioma.
794	Tuberous Sclerosis		18 Female	A female in her late 20's was discovered to have tuberous sclerosis after having some facial lesions evaluated by a dermatologist. She presented to the hospital a month following diagnosis with complaints of occasional headaches. A CT scan of her head noted evidence of tuberous sclerosis. An MRI of the brain was recommended. CT Findings: 1. Right frontal cellulitis. 2. Trace amount of mucous membrane thickening at the ethmoid sinus. 3. Asymmetrically choroid plexus at the frontal horn of the right lateral ventricle versus subependymal nodules associated with tuberous sclerosis. MR Findings: 1. 1.2-cm right frontal horn intraventricular mass consistent with subependymal giant cell astrocytoma versus hamartoma in patient with tuberous sclerosis. No hydrocephalus. 2. Other findings of tuberous sclerosis.
795	Vein of Galen Malformation	<1	Female	A woman in her late 20's gave birth to a baby girl previously diagnosed via prenatal ultrasound with a vein of Galen malformation, abdominal calcification, and cardiomegaly. The infant was delivered via C-section, secondary to failure to tolerate induction. Upon delivery, the infant was cared for in the NICU for concerns of possible heart failure, secondary to her AVM. Two endovascular embolization procedures were performed in which coils and an embolic agent were used to correct the AVM of the vein of Galen. Upon completion of the second procedure the patient's cardiovascular, respiratory, and renal issues stabilized. The patient was subsequently 1. Large vein of Galen formation with arterial supply from anterior and posterior circulation. 2. Moderately thinned splenium of the corpus callosum.
796	Germ Cell Carcinoma		22 Male	A male in his early-20's presented with a recently diagnosed mediastinal mass found during a routine echocardiogram. The patient was asymptomatic, but had a history of spina bifida, paraplegia, and idiopathic cardiomyopathy. Following a CT and MRI of the thorax, a biopsy of the mass noted germ-cell carcinoma & the patient underwent radiation therapy to treat the disease. 1. Large anterior mediastinal mass lesion compresses the superior vena cava and most likely represents a thymoma but could also represent a lymphoma, teratoma or thyroid tumor.
797	Non-Small Cell Carcinoma		72 Male	A male in his early-70's with a history of lung disease and nodules presented for evaluation of a persistent cough. ACT scan revealed a left hilar lesion with mediastinal adenopathy. A lung biopsy of the left upper lobe endobronchial mass noted invasive squamous cell carcinoma. A biopsy of a left supraclavicular node was positive for non-small cell carcinoma. The patient was then evaluated for treatment consisting of chemotherapy and radiation therapy. 1. Left upper lobe pulmonary mass, consistent with known malignancy. 2. Increased right lower lobe nodularity, concerning for progression of disease.
798	Non-Small Cell Carcinoma		72 Male	A male in his early-70s presented with a history of h-4b, testicular cancer, hypertension, diabetes, and several other medical issues. The patient was evaluated for a right upper lobe pulmonary mass initially seen on a chest x-ray. A CT scan showed a noncalcified pulmonary nodule measuring 2cm x 1.4cm. A CT needle biopsy revealed a non-small cell cancer. It was determined to perform surgery and remove the mass, which didn't appear to be metastatic. 1. Large right upper lobe mass, suspect carcinoma. 2. Mediastinal lymphadenopathy. 3. Emphysema. 4. Left lower lobe indeterminate pulmonary nodule.
799	Sarcoma		22 Female	5. Bronchial wall thickening and patchy bibasilar opacities.
800	Aneurysm (Marfan's Syndrome)		52 Female	A female in her early-20's presented with a history of cerebral palsy along with a known large mediastinal mass. Over the course of the past month, the patient had experienced a 30lb weight loss. A lymph node biopsy showed undifferentiated sarcoma. Follow up imaging noted osseous involvement with destruction of T1 and lumbosacral disease. Esophageal disease with complete obstruction was also noted. The patient was referred to radiation oncology for palliative radiation treatment. 1. Moderate right pneumothorax. 2. Hypodescent aerated portion of the right lung, likely related to obstruction at the right mainstem bronchus. 3. Large mediastinal mass producing occlusion of the right mainstem bronchus, narrowing of the carina, engulfing and obstructing the appreciable pulmonary embolism. 4. Multiple pathologic lymph nodes, consistent with metastatic disease. 5. Supraclavicular and retrocrural lymphadenopathy. 6. Large liver mass.
801	Bilateral Carotid Aneurysm		45 Male	A female in her early 50's presents with a history of Marfan's syndrome and is three years S/P heart transplantation. The patient had a slightly elevated pulmonary pressure
802	High-Grade Narrowing of SMA		68 Male	A male in his mid-40's presented with a history of HIV, hypertension, and tobacco use. He complained of a right sided neck lump that had been present for the past week. The patient had been experiencing severe night sweats but denied having any fever, chills, or other recent illnesses. An ultrasound of the neck noted an aneurysm of the right common carotid measuring 1.5 cm in diameter. 1. Left greater than right distal common carotid artery and internal carotid bulb ectasia, of unknown significance. Calcified plaque in the left carotid bulb, though without significant stenosis. 2. Severe emphysema.
803	Retroperitoneal Hematoma		72 Male	A male in his late-60's presented with complaints of chronic RUQ pain. Medical history included non-ischemic cardiomyopathy, atrial fibrillation, hypertension, and a recent inguinal hernia repair. A CT scan revealed severe stenosis of the patient's SMA. The patient underwent an aortogram and a stent was placed in the SMA due to the stenosis, which was greater than 50% occluded. 1. Mild septal thickening in the lung bases, may be seen with mild pulmonary edema. 2. Surgical changes from bilateral inguinal hernia repair with small postoperative seroma. 3. Moderate to advanced atherosclerotic vascular disease. 4. Cortical defects on the left kidney, may be from prior infarcts or infection. 5. Cholecystectomy. 6. Stable duodenal lipoma.
804	Spinal Accessory Schwannoma		42 Female	7. High-grade narrowing of the superior mesenteric artery approximately 0.8 cm from its takeoff.
805	Thrombophlebitis		38 Female	A male in his early 50's presented with a history of distal pancreatectomy, splenectomy, and left nephrectomy about 3 weeks prior for a neuroendocrine tumor. The patient had been experiencing increasing abdominal pain for several days which prompted a CT of the abdomen revealing a retroperitoneal hematoma, pneumatosis, and portal venous gas. 1. Pneumatosis intestinalis in multiple small bowel loops with associated mesenteric and portal venous gas, concerning for small bowel ischemia. 2. Retroperitoneal hematoma. 3. Moderately distended stomach and small bowel loops, no evidence of mechanical small bowel obstruction. 4. Moderate ascites. 5. Bilateral pleural effusions and bibasilar atelectasis. 6. IVC Filter. 7. Absent left kidney.
806	Angiomyolipoma		48 Female	8. Status post distal pancreatectomy and splenectomy.
807	Hep C Cirrhosis	Early 50s	Female	A female in her early 40's was seen for consultation in regards to right spinal accessory neuropathy. She reported right-sided weakness for the past 15 months and at the time of the visit was experiencing weakness of her arm, inability to abduct her arm above horizontal line or above 90 degrees, pain and spasms of the trapezius. An MRI noted a mass centered at the jugular foramen on the right, which was suspicious for meningioma or schwannoma. A CT was then ordered to better visualize the pathology. The CT results were consistent with a right spinal accessory schwannoma. 1. Mass within the right jugular foramen consistent with schwannoma. 2. Severe right sternocleidomastoid muscle atrophy and mild right trapezius muscle atrophy. 3. Bilateral TMJ disease.
808	Schistosomiasis	Early 60s	Male	A female in her late 30's presented to the ED with right breast pain and redness. An ultrasound of the right breast was performed and the patient was found to have superficial thrombophlebitis. There was no evidence of DVT's or an abscess. A CT scan was ordered to further evaluate the thrombophlebitis. 1. Right lower lobe nodular opacity with calcification,likely a granuloma though indeterminate. 2. Prominence of the azygos vein with numerous upper abdominal and subcutaneous abdominal wall collaterals, suggestive of inferior vena cava or iliac vein thrombosis below the level included on today's study, unchanged in appearance compared to the last exam.
809	Hep C Cirrhosis	Early 50s	Female	A female in her late 40's presents with a history of HIV and nodal marginal zone lymphoma. The patient was asymptomatic and a "wait and watch" approach was administered. During a routine follow up, a left renal mass and pulmonary nodules were found. The left renal mass was biopsied and found to be angiomyolipoma. Labs: Creatinine: 0.92 (0.44-1.3 MG/DL) BUN: 7.6 (10.0-20.0 MD/CN/MGCR). A male in his early 60's presented with chronic epigastric and abdominal pain; on further work-up, a cystic mass was noted in his liver. A repeat scan showed an increased number of lesions in the liver. A biopsy was done and demonstrated echinococcosis of the left liver lobe. Several months later, this follow-up MRI was ordered to evaluate the infection. LABS: AST: 25 (15-41 U/L, ALT: 23 (17-63 U/L), Alkaline Phosphatase: 50 (32-91 U/L), Conjugated bilirubin: <0.1 (0.1-0.5 mg/dL) 1. Decreased cystic lesion in the left hepatic lobe, consistent with resolving echinococcal infection. 2. Cirrhotic liver. 3. Resolved distal esophageal wall thickening.
810	Echinococcosis	Early 60s	Male	A female in her early-50's presented with a 6 year history of a giant hemangioma of her liver. She had been experiencing increased abdominal pain on the right side. A CT scan of her abdomen showed an increase in size of the hemangioma compared to previous scans. A liver resection was recommended. Labs: Platelet: 92 (150-400 x103/uL), Hemoglobin: 8.3 (11.5-15.5 g/dL), Hematocrit: 25.8 (33.1-44.5%), AST: 195 (15-41 U/L), ALT: 137 (14-54 U/L), Alkaline Phosphatase: 26 (32-91 U/L), Bilirubin: 1.4 (0.3-1.2 mg/dL) 1. Giant hemangioma predominantly in the right hepatic lobe. 2. Several smaller hepatic cysts and hemangiomas are not significantly changed. 3. Numerous small bilateral renal cysts.
811	Giant Hemangioma	Early 50s	Female	A male in his early-50's presented with a 13 year history of a metastatic neuroendocrine tumor involving his liver. The primary site was the head of the pancreas. His history involving the tumor includes chemotherapy and a liver transplant. Four years post-transplant, an MRI noted a large, solid hepatic lesion, consistent with metastatic disease. He underwent a biopsy, and the results showed an intermediate grade well-differentiated neuroendocrine tumor. 1. Multiple liver lesions containing embolization material. 2. Several lesions on the left side of the liver with embolization material and possibly also a tiny amount of gas based on a prior procedure. 3. No evidence of fluid collections or abscesses. 4. Splenomegaly. 5. IDD changes.
812	Liver Metastasis	Early 50s	Male	A female in her early-30's presented with severe right upper quadrant pain for 2 months. She was 31 weeks pregnant at the time. An ultrasound and MRCP both showed a choledochal cyst and sludge in the gallbladder. She underwent a cholecystectomy and removal of the common bile duct one month after she delivered her baby. LABS: WBC: 7.6 (4-11) x103/UL Alkaline Phosphatase: 112 (32-91) U/L
813	Choledochal Cyst	Early-30s	Female	1. 7-cm choledochal cyst with wide neck communicating with the CBD. 2. Sludge within the distal CBD, gallbladder, and choledochal cyst.
814	Gallbladder Carcinoma	Mid-60s	Male	A male in his mid-60's with a history of Laennec's cirrhosis presented with progressive dyspnea over two weeks. An ultrasound and MRCP showed a large mass that appeared exophytic and was mostly likely gallbladder carcinoma. Liver lesions were also noted; presumably due to metastasis from his gallbladder carcinoma. The results of a biopsy showed hepatocellular carcinoma. LABS:WBC: 4.8 (4-11) x103/UL AST: 156 (15-41) U/L Alkaline Phosphatase: 361 (32-91) U/L ALT: 140 (17-63) U/L Bilirubin: 2.7 (0.3-1.2) mG/dL 1. Cirrhotic liver with splenomegaly, portal hypertension, recanalization of falciform ligament with caput medusa & distal esophagus varices. 2. Large mass in the gallbladder fossa, highly suspicious for gallbladder carcinoma with extension to segment 4. 3. Multiple enhancing liver lesions; most likely intrahepatic metastases from gallbladder carcinoma. 4. One suspicious enhancing area at the right controversthetal angle of T31. 5. MRCP images show irregularity of the biliary tree suggesting underlying biliary tree disease, cirrhosis is likely sequels of underlying biliary tree disease; recommend clinical correlation. 6. Right pleural effusion. 7. Tiny amount of perihepatic ascites.
815	Gallbladder Cancer	Early-70s	Female	8. Right renal cyst.
816	Biliary Duct Dilatation	Mid-40s	Female	A female in her early 70's with a medical history of aortic insufficiency and hypertension presented with severe abdominal pain starting in the upper part of her abdomen and radiating throughout the abdomen. The patient's hemoglobin was found to be dramatically low compared to prior labs. A CT scan showed probable gallbladder cancer with numerous nodes and probable mets. The patient was diagnosed with adenocarcinoma of the gallbladder via an endoscopic needle biopsy. WBC: 13.9 (4.0-11.0) X10E3/UL RBC: 3.11 (3.70-5.10) X10E6/UL Hemoglobin: 8.8 (11.0-15.1) G/DL Hematocrit: 27.2 (33.1-44.5) %
817	Horseshoe Kidney	Mid-20's	Male	1. Findings concerning for gallbladder carcinoma with nodal metastasis. A large heterogeneous mass is noted within the gallbladder. Necrotic adenopathy in the gastrohepatic ligament measuring 3.6 cm. 2. Ill-defined 1.3 cm hepatic hypodensity, uncertain if this represents metastatic lesion vs. Artifact. 3. Hepatic cysts & renal cysts.
				A female in her mid-40's presented for a follow up of her cadaveric kidney transplant which was done 23 years prior due to glomerulonephritis-induced renal disease. Her renal function had progressively deteriorated since her transplant. An ultrasound and CT scan noted moderate intrahepatic & severe extrahepatic ductal dilatation. LABS: WBC: 4.8 (4-11) x103/UL, AST: 143 (15-41) U/L , Alkaline Phosphatase: 662 (32-91) U/L , ALT: 68 (17-63) U/L, BUN: 37 (6-20 mg/dL), Creatinine: 5.21 (0.44-1.03 mg/dL), Hemoglobin: 9.4 (11.0-15.1 g/dL), Hematocrit: 30.5 (33.1-44.5 %), UA: proteinuria, hematuria 1. Right lower quadrant kidney transplant, unchanged. 2. Moderate intrahepatic and severe extrahepatic ductal dilatation. 3. Cholecystectomy. 4. Moderate left and small right pleural effusions with bibasilar atelectasis. 5. Atrophic native kidneys.
				A male in his mid 20's presented with a long-standing history of abnormal liver function tests. An abdominal ultrasound and CT noted a horseshoe kidney with a tiny hypodensity, which was likely a cyst. Liver function tests were found to be due to dietary supplements that the patient had been taking. Labs: AST: 84 (15-41 U/L) ALT: 97 (17-63 U/L) Alk Phos: 102 (32-91 U/L) BUN: 12 (6-20mg/dL) Creatinine: 0.83 (0.44-1.27mg/dL) Hemoglobin: 16.1 (13.3-17.3g/dL) Hematocrit: 46.5 (39.0-52.0%) 1. Normal appendix. 2. no acute abnormalities to explain abdominal pain. 3. Horseshoe kidney with a tiny hypodensity, likely cyst.

Anatomage Table 9.0 Case Library Descriptions

818	Polycystic Kidney Disease	Early-50's	Male	A male in his early-50's presented with an 11 year history of renal disease and stage 5 chronic kidney disease secondary to polycystic kidney disease. He was being evaluated for a possible kidney transplant. An abdominal ultrasound and CT showed evidence of his polycystic kidney disease. The patient received a cadaveric kidney transplant 2 years later. Labs: BUN: 48 (6-20mg/dL) Creatinine: 4.55 (0.64-1.27mg/dL) Hemoglobin: 12.2 (13.3-17.7) Hematocrit: 37.2 (39.0-52.0) WBC: 6.9 (4.0-11.0 x10E3/UL) RBC: 6.9 (4.0-11.0 x10E3/UL) 1. Adult Polycystic Kidney Disease and likely also Adult Polycystic Liver Disease. 2. Normal cystic bone anatomy for hemorrhage type. 3. No apparent calcification in the external iliac arteries.
819	Pyelonephritis	Mid-20's	Female	A female in her mid-20's presented with right flank pain. A CT of her abdomen revealed bilateral pyelonephritis along with tiny renal calculi that were non-obstructive. She was prescribed steroids and broad-spectrum antibiotics. Labs: BUN: 6 (6-20) mg/dL Creatinine: 0.93 (0.44-1.03) mg/dL Hemoglobin: 10.8 (11.0-15.1g/dL) Hematocrit: 32.6 (33.1-44.5%) 1. Findings of bilateral pyelonephritis. 2. Tiny non-obstructive bilateral renal calculi.
820	Transitional Cell Carcinoma	Late-80's	Female	A female in her late-60's presented with a headache and vomiting after having gone to the ED over the weekend for UTI symptoms. A CT scan showed an enhancing mass with right ureteral obstruction, which was likely a carcinoma. She underwent a right nephroureterectomy for transitional cell carcinoma of the right kidney one month later. Labs: WBC: 7.2 (4-11) x103/UL BUN: 8 (6-20) mg/dL Creatinine: 0.95 (0.44-1.03) mg/dL Hemoglobin: 12.6 (11.0-15.1g/dL) Hematocrit: 35.5 (33.1-44.5%) 1. Enhancing mass right ureter with chronic obstruction, likely carcinoma. 2. No pulmonary embolism. 3. Normal aorta, no dissection or aneurysm. 4. Calcified pulmonary nodule, left lower lobe. 5. AV fistula or malformation near gallbladder fossa. 6. Cholelithiasis. 7. Splenic hypodense and enhancing foci, indeterminate. 8. Large uterus with leiomyoma and endometrial enlargement or fluid.
821	Islet Cell Tumor	Mid-40's	Female	A female in her mid-40's presented with a one year history of LLQ pain. An ultrasound and CT scan showed a hypervascular mass in the body of the pancreas, which was suspicious for an islet cell tumor. A distal pancreatectomy and splenectomy were performed to remove the well-differentiated neuroendocrine mass of the pancreas. Labs: WBC: 5.5 (4.0-11.0 x103/uL), Lipase: 131 (14-51 u/L) 1. 1.1 x 1.4cm hypervascular mass in body of pancreas corresponding to ultrasound abnormality; suspicious for islet cell tumor. 2.Two left adrenal lesions. 3. 0.5 x 0.5cm hypodense liver lesion in segment VII - indeterminate. 4. Mildly prominent portal vein.
822	Pancreatic Metastases	Mid-20's	Male	A male in his mid-20's presented with a seven-month history of metastatic desmoplastic small round cell tumor of the liver with liver and mediastinal nodal metastases. A restaging ultrasound and CT were performed which noted known metastatic disease in both the liver and the pancreas along with a soft tissue mass in the left upper quadrant. LABS: WBC: 2.5 (4.0-11.0 x103/uL), Platelet: 61 (150-400 x103/uL), Hemoglobin: 13.1 (11.5-15.5 g/dL), Hematocrit: 39.6 (33.1-44.5%), AST: 26 (15-41 U/L), Alkaline Phosphatase: 57 (32-91 U/L), ALT: 28 (17-63 U/L) 1. No evidence of new or worsening metastatic disease in the chest, abdomen, or pelvis. 2. Slightly decreased size of spiculated pulmonary nodules within the left upper lobe. 3. Extensive liver metastatic disease is present. 4. Splenomegaly and splenic vein thrombosis with extensive varetas collateral formation in the upper abdomen. 5. Status post splenectomy. Previously noted mass within the pancreatic tail and spleen is minimally decreased in size. 6. Hypodense metastases within the pancreas. 7. Mildly enlarged mesenteric lymph nodes. 8. Stable sclerotic lesion within the posterior elements of L4, indeterminate.
823	Cervical Cancer	Late 40's	Female	A female in her late 40's presented with right lower quadrant abdominal pain for over a month. A pelvic ultrasound and PET CT indicated a 5cm mass within her cervix. Biopsy revealed the mass as non-small cell carcinoma, likely stage II. The oncologist recommended external beam radiation therapy to the whole pelvis. LABS: BUN: 7 (6-20 mg/dL), WBC: 15.9 (4.0-11.0 x103/ul), Hemoglobin: 12.5 (11.0-15.1 g/dL), Hematocrit: 35.3 (33.1-44.5%), Platelet: 491 (150-400 X103/uL), UA: RBC >50 (<3HPF) 1. Hypermetabolic uterine cervical mass consistent with primary malignant process. 2. No locoregional metastasis identified. 3. Mildly hypermetabolic focus at T10 thoracic vertebrae involving left transverse process and/or adjacent left costovertebral junction. 4. Nonmetabolic left adrenal nodule suggest adenoma. 5. Hepatic cysts. 6. Nonmetabolic right kidney inferior pole cyst.
824	Pelvic Mass	Late 40's	Female	A female in her late 40's presented with a one year history of fatigue and shortness of breath. A CT scan revealed a pelvic mass extending to both side walls of the pelvis; bladder involvement was also noted. She underwent a total hysterectomy with tumor resection. The pathology of the mass was consistent with a benign leiomyoma. LABS: WBC: 9.3 (4.0-11.0 x103/uL), Hemoglobin: 2.4 (11.0-15.1 g/dL), Hematocrit: 35.8 (33.1-44.5%), BUN: 9 (6-20 mg/dL) 1. 10x14x17 cm pelvic mass, which could be extrauterine/adnexal versus lower uterine/cervical mass. 2. Very large left ovarian vein measuring up to 1.7cm. 3. Small left ovarian cyst 4. Right hydronephrosis. 5. Body wall edema. 6. Nonvisualization of right common iliac vein flow, likely due to severe compression versus thrombosis.
825	Hematometrocolpos	Early Teen's	Female	A female in her early teen's presented with intermittent low back pain, abdominal pain, occasional nausea, and low-grade fever for five months. She was diagnosed with a urinary tract infection for two consecutive months after she first observed these symptoms. A pelvic ultrasound showed hematometrocolpos and endometriomas. Physical examination found an imperforate hymen. The physician recommended an excision of her imperforate hymen and cervical dilation to relieve the hematometrocolpos. LABS: WBC: 4.8 (4.0-11.0 x103/ul), Hemoglobin: 13.4 (11.0-15.1 g/dL), Hematocrit: 40.1 (33.1-44.5%), Platelet:317 (150-400 X103/uL), UA: Trace of ketones 1. Marked hematometrocolpos. 2. Multiple bilateral endometriomas.
826	Intrauterine Device (IUD)	Mid 30's	Female	A female in her mid 30's presented to the emergency department with sharp, cramping abdominal pain. One week prior she had an episode of vomiting and general malaise along with vaginal bleeding and increasing low back pain. She had a Mirena IUD placed 3 years prior. A CT scan revealed an abnormal placement of the IUD. An ultrasound showed the IUD within the uterine cavity with an arm penetrating into the myometrium. Her doctor recommended hysteroscopic removal of the intrauterine device. LABS: WBC: 8.4 (4.0-11.0 x103/ul), Hemoglobin: 13.6 (11.0-15.1 g/dL), Hematocrit: 39.3 (33.1-44.5%), Platelet: 238 (150-400 X103/uL), UA: Mod 1. Abnormal position of IUD. 2. Collapsed right ovarian cyst with small amount pelvic ascites.
827	Osteosarcoma Tropine	Early-20's	Male	A male in his early-20's presented with midline back pain in the thoracic region. A CT scan showed a destructive bony lesion concerning for sarcoma. An MRI was also performed which showed a large heterogeneous mass within the posterior left T5 vertebra and rib, with involvement of the T4 vertebra and T6/T6 posterior ribs. Biopsy of the lesion diagnosed Stage II Osteosarcoma. Treatment consisted of chemotherapy and surgery. 1. Extensive soft tissue mass with ossification involving T4 and T5 with greater extent posteriorly to the left thoracic cavity and soft tissue of the back. Extensive involvement of the left fifth rib.
828	Retrolisthesis	Mid-50's	Female	A female in her mid-50's presented with postoperative pain after having a right L4-L5 hemilaminectomy and micro discectomy for a large extruded disk herniation approximately one year prior. The pain extended into the right buttock, posterolateral thigh and lower leg with occasional paresthesia in the plantar aspect of the right foot. A postmyelogram CT showed decreased filling of the right S1 nerve root at L5-S1 and right L4-L5 postoperative changes. It also showed left-sided disc protrusion and severe facet arthritis on the left, L3-L4. The patient underwent a right L5-S1 hemilaminotomy, medial facetectomy ,foot foraminotomy. 1. Retrolisthesis, L4-L5 as described with neural foraminal narrowing but filling of the nerve root sheaths although left is better than right. 2. Disc protrusion, L5-S1 but filling of the nerve root sheaths but narrowing of the right neural foramen. 3. Left-sided disc protrusion, severe facet arthritis on the left, L3-L4. 4. Left-sided disc protrusion and prominent facet degenerative change on the left and to a lesser extent the right, L2-L3.
829	Spinal Fusion	Late-50's	Male	A male in his late-50's presented for a follow-up after having back surgery. He recently underwent an L2 through S1 posterior laminectomy with pedicle screw stabilization and L3/L4 through L5/S1 interbody fusion with prostheses. On the third day after surgery, he noticed an onset of pain into the right anterior thigh region. A CT scan revealed medial pedicle breach by the pedicle screw of L2 on the right. He underwent repositioning of the screw and subsequently had improvement of pain. This CT scan conducted five months postoperatively revealed evidence of the surgery as well as L2/L3 degenerative disc disease with bilaterally narrowed neural fora 1. Previous L3/L4 through L5/S1 interbody fusion with prostheses. 2. Previous L2 through S1 posterior laminectomy with pedicle screw stabilization. 3. L2/L3 degenerative disc disease with bilaterally narrowed neural foramina.
830	Type III Odontoid Fracture	Mid-50's	Male	A male in his mid-50's came into the ER with complaints of neck pain. The patient recently experienced a construction accident in which a piece of machinery fell onto his head (patient had on hard hat). The patient had no loss of consciousness, and initially had little pain which has increased since. A CT scan showed a type III dens fracture extending into the transverse foramen and right traumatic vertebral artery occlusion. 1. Type III dens fracture with extension into the right transverse foramen, cannot exclude injury to the right vertebral artery.
831	Prostate Cancer Metastasis	Early-80's	Male	A male in his early-80's presented with pain in his right shoulder which radiated across his back. An MRI of the thoracic spine showed multiple abnormalities consistent with metastatic disease. A biopsy of the T7 vertebral body showed metastatic adenocarcinoma that was positive for prostatic acid phosphatase staining. Prostate biopsy diagnosed adenocarcinoma Gleason score 10. 1. Diffuse metastatic disease though out the cervical spine and ribs, most severe at C4, C5, and C6. 2. Multilevel moderate to severe degenerative disease.
832	T-Spine Vertebral Fracture	Mid-40's	Male	A male in his mid-40's presented to the emergency department after falling approximately 30 feet from a ladder. His main complaints were chest pain and inability to move his lower extremities. A CT scan revealed comminuted T4 and T5 vertebral fractures with displacement along with bilateral 1 through 4 rib fractures. He also suffered a right hemopneumothorax and paravertebral hematoma. The thoracic vertebrae fracture and dislocation caused an incomplete spinal cord injury resulting in paralysis in his lower extremities with some minimal sensation returning in his left leg. 1. Comminuted T4 and T5 vertebral fractures with displacement. 2. Bilateral 1 through 4 rib fractures. 3. Right hemopneumothorax. 4. Paravertebral hematoma. 5. Hypodense hepatic nodule.
833	Stage IIIC Nonseminoma	Early-20's	Male	A male in his early 20's presented with a left-sided neck mass. On examination, the physician noticed a right testicular mass as well. An ultrasound was ordered to evaluate the mass along with a surgical biopsy. The patient was diagnosed with advanced stage nonseminoma (stage IIIC). The patient was recommended to undergo chemotherapy after undergoing a radical inguinal orchiectomy. LABS: AFP: 285.6 (<15.0 NG/mL) LDH: 676 (313-618 U/L) Beta HCG: <1 (<5 mIU/mL) 1) Heterogeneous right testicle, clinical correlation is suggested. Labs: Lipase: 813 (14-51U/L), AST: 42 (15-41U/L), Albumin: 3.0 (3.4-4.7G/DL) Amylase: 638 (36-128U/L)
834	Sarcoidosis	Early-20's	Male	1. Subsegmental atelectasis lung bases. 2. Right pleural effusion, new. 3. Pulmonary nodules lung bases, decreased. 4. Upper abdominal adenopathy, decreased. 1. Indeterminate high attenuation within the bladder, hemorrhage vs. Mass. 2. Proctostrosigaly. 3. Diverticulosis. 4. Multicystic left kidney, unchanged.
835	Transitional Cell Carcinoma	Mid-60's	Male	1. Mild splenomegaly. 2. Possible left testicular mass.
836	Testicular Cancer	Mid-30's	Male	A male in his late 30's presented for evaluation after a MVC. The patient denied any loss of consciousness, and was hemodynamically stable during transport to the E.D. The patient has an extensive medical history including chronic kidney disease, L4 and L5 fusions with persistent nerve pain, hypertension, and a known ACA aneurysm(anterior communicating artery aneurysm) awaiting elective repair. A CT scan was ordered to evaluate the injuries related to the MVC. LABS: Hemoglobin: 11.2 (13.3-17.3 g/dL); RUN: 51 (6-20 mg/dL); Creatinine: 4.95 (0.64-1.27 mg/dL); GFR: 13 (>59) 1. Bilateral chronic renal disease with massive native kidneys containing multiple hemorrhagic cysts and scattered small calcifications.
837	Diverticulosis and PKD	Late-30's	Male	2. Normal appendix. 3. Diverticulosis without diverticulitis. 4. An area with stranding in the left lower anterior abdominal wall; likely related to prior injections; recommend clinical correlation.
838	Metastatic Neuroendocrine Tumor	Mid-60's	Female	A female in her mid-60's presented with a past medical history of a liver transplant secondary to sclerosing cholangitis and a kidney transplant due to focal segmental glomerular sclerosis. Over the past several months she had developed fatigue, decreased appetite, 30 pound weight loss, epigastric pain, and a positive hemoccult test. An ultrasound scan showed a nodular liver with a mass in the right lobe, suspicious for a malignancy. Liver biopsy revealed a high grade metastatic neuroendocrine carcinoma of the duodenum with metastasis to the liver and lymph nodes. A PET/CT scan showed a dominant hypermetabolic lesion in the third portion of the duo 1. Dominant hypermetabolic lesion in the third portion of the duodenum, with multiple nearby hypermetabolic lymph nodes. Findings compatible with known metastatic neuroendocrine tumor. 2. Multiple hypermetabolic hepatic lesions, consistent with metastasis. 3. Marked splenomegaly. 4. Small amount of simple ascites.
839	Incarcerated Hernia	Early-50's	Female	A female in her early 50's presented to the emergency department with complaints of constant right lower quadrant pain. She was found to have acute hyperkalemia, increased BUN and creatinine, and decreased GFR likely due to her missed dialysis treatment. A CT scan showed a large anterior abdominal wall hernia. She underwent an exploratory laparotomy, small bowel resection, right hemicolectomy, and debridement of necrotic abdominal wall. LABS: WBC: 17.1 (4.0-11.0 x103/ul.) RBC: 3.43 (3.7-5.1 x106/uL) BUN: 91 (6-20 mg/dL) Creatinine: 12.24 (0.44-1.03 mg/dL) GFR: 3 (>59) Potassium: 9.4 (3.6-5.1 mmol/L)
840	Ventral Hernia	Mid-50's	Female	1. Dilated small bowel loops are visible in the lower abdomen with a large anterior abdominal wall hernia associated with extensive subcutaneous fatty stranding and skin thickening; findings may be related to incarcerated hernia with bowel obstruction; recommend clinical correlation. 2. Cholelithiasis without evidence for cholecystitis. A female in her mid-50's presented to the emergency department with a history of acute-onset abdominal pain with multiple episodes of vomiting. She has a history of a kidney transplant secondary to polycystic kidney disease. A CT scan showed evidence of her polycystic kidney and liver disease as well as a large ventral hernia in the lower abdomen with obstructed small bowel loops. LABS: WBC: 16.0 (4.0-11.0 x103/uL) RBC: 3.71 (3.7-5.1 x106/uL) Hemoglobin: 10.2 (11.0-15.1 g/dL) Hematocrit: 32.6 (33.1-44.5 %) Potassium: 3.1 (3.6-5.1 mmol/L) Albumin: 2.5 (3.4-4.7 g/dL) 1. Large ventral hernia in the lower abdomen with obstructed small bowel loops as described. 2. Right lower quadrant kidney transplant, grossly normal. 3. Hysterectomy. A male in his early 50's presented with shortness of breath and chest discomfort. A CT scan noted a large fungating mass within the gastric cardia concerning for malignancy. The mass was biopsied by upper endoscopy and revealed small cell carcinoma. The patient was treated with chemotherapy followed by an esophagectomy. LABS: WBC: 16.3 (4.0-11.0 x103/uL). Platelet: 120 (150-400 x103/uL) 1. Large fungating mass within the gastric cardia, highly concerning for malignancy. 2. Pathologic regional lymphadenopathy, concerning for metastasis. 3. Indeterminate left supraclavicular lymph node 4. Findings of chronic calcific pancreatitis. 5. Indeterminate pleural-based pulmonary nodules. 6. No evidence of pulmonary embolism. 7. Emphysema.
841	Gastric Small Cell Carcinoma	Early-50's	Male	A male in his mid-50's presented with dysphagia along with soreness in the throat. A PET CT scan showed a long segment hypermetabolic circumferential distal esophageal thickening, consistent with esophageal adenocarcinoma along with multiple hypermetabolic gastrohepatic lymph nodes, suspicious for metastatic involvement. LABS WBC: 6.9 (4.0-11.0 x103/uL) Hemoglobin: 14.8 (13.3-17.3 g/dL) Platelet: 208 (150-400 x103/uL) 1. Long segment hypermetabolic circumferential distal esophageal thickening, consistent with known esophageal adenocarcinoma. 2. Multiple mildly hypermetabolic gastrohepatic lymph nodes, suspicious for metastatic involvement. 3. Multiple additional mildly hypermetabolic bilateral retroperitoneal lymph nodes, may represent reactive lymph nodes though indeterminate.
842	Esophageal Adenocarcinoma	Mid-50's	Male	4. Hypermetabolic focus in the left lobe of the thyroid gland, which may be related to prior trauma though is indeterminate, and malignant involvement cannot be completely ruled out by PET imaging. Follow-up recommended. A male in his mid-50's presented to a new primary physician to establish his care and refill some prescriptions. He noted a new mass on the left side of his neck and worsening COPD. The CT and ultrasound images showed an enlarged level II-A lymph node on the left side of his neck with likely necrosis. A biopsy confirmed a mucoepidermoid carcinoma, graded T4 N2b M0. A composite resection of the intermolar trigone, buccal wall, and mandible with neck dissection and a tracheostomy were performed. He later underwent a mandibular reconstruction with bone grafts from the fibula. LABS: WBC: 14.1 (4-11) x103/UL
843	Mucoepidermoid Carcinoma	Mid-50's	Male	1. Large lymph node left level II-A with likely necrosis. There are multiple other small lymph nodes in the left neck without necrosis and not enlarged by size criteria but their visualization is markedly greater than on the right and this is concerning for representing other areas of adenopathy. 2. Soft tissue fullness on the left buccal mucosa with extension into the buccal space. The margins are quite indistinct.
844	Parathyroid Adenoma	Mid-70's	Male	A male in his mid-70's presented for follow-up of his hyperparathyroidism. He complained of nausea/vomiting, weakness, and constipation. He was found to have hypercalcemia and significantly elevated PTH. A thyroid ultrasound and thoracic CT revealed a right parathyroid adenoma. He underwent a right inferior parathyroidectomy a few days later which resolved his hyperparathyroidism. LABS: WBC: 6.9 (4.0-11.0 x103/uL) Hemoglobin: 14.8 (13.3-17.3 g/dL) Platelet: 208 (150-400 x103/uL) Calcium: 14.1 (8.6-10.3 mg/dL)
845	Thyroglossal Duct Cyst	Mid-50's	Female	1. Mild thickening of the fluid-filled tectosigmoid with loss of haustra and focal narrowing, as described and may represent infection or inflammatory process. 2. Right parathyroid adenoma, unchanged. 3. Reflux of contrast in the distal esophagus with esophageal dilation, likely gastroesophageal reflux disease. A female in her mid-50's presented for further evaluation of a left neck mass. She began having pressure symptoms with swallowing and having the feeling of something getting stuck in her throat. A CT scan indicated a mass in her left neck, most consistent with a thyroglossal duct cyst. One month later she returned to have the mass excised. 1. Thyroglossal duct cyst.
846	Vocal Cord Mass	Early-60's	Male	A male in his early-60's presented with increasing hoarseness that has progressively worsened over the last three months. He also had a longstanding history of dysphagia with liquids; recently experiencing left otalgia that presented as a dull ache. A CT scan revealed a lesion involving his vocal cords bilaterally with extension to the epiglottis and into the subglottis. A biopsy noted invasive squamous cell carcinoma of the supraglottic larynx. A month later he had a total laryngectomy, partial pharyngectomy, and a permanent tracheal stoma created. He was scheduled to begin radiation therapy after surgery. 1. Vocal cord mass with involvement anterior to the thyroid cartilage. 2. Marked pulmonary emphysema. 3. Prominent irregularly enhancing soft palate and uvula, likely incidental accessory salivary gland tissue.
847	Squamous Cell Carcinoma of Mandible	Early-60's	Male	A male in his early-60's presented with complaints of an ulceration which he attributed to his dentures. A CT scan revealed a necrotic mass involving the anterior mandible at the symphysis with extension into the overlying soft tissues, anterior floor of mouth and tongue. A biopsy confirmed the mass to be invasive squamous cell carcinoma. He underwent a partial mandibulectomy, resection of the floor of the mouth, glossectomy, and tracheostomy. He then completed 2 cycles of cisplatin chemotherapy. His radiation treatment was discontinued due to suffering respiratory failure and septic shock. He passed away 4 months after his initial diagnosis due to o LABS: WBC: 11.9 (4.0-11.0 x103/uL) Calcium: 10.9 (8.0-10.3 mg/dL) 1. Enlarged necrotic mass involving the anterior mandible at the symphysis with extension into the overlying soft tissue, anterior floor of mouth and tongue. 2. Multiple necrotic lymph nodes right level IIb.
848	Ductal Adenocarcinoma	Late-40's	Female	3. Mildly enlarged nodes using superior to inferior dimension bilateral level IIa. There do not appear necrotic. A female in her late-40's presented for an annual screening mammogram which then led to an ultrasound for focal asymmetry in her right breast. The ultrasound displayed a lobulated mass. The radiologist recommended a biopsy which noted invasive ductal adenocarcinoma. An MRI was ordered to further evaluate the breast lesion. The patient underwent a lumpectomy followed by radiation therapy treatments, which she tolerated well. 1. 1.6cm x 1.4cm x 1.3cm mass (containing a clip) in the right breast at 12 o'clock middle depth 16.5cm from the nipple and 10.5cm from the chest wall.
849	BRCA1 Positive	Early-40's	Female	A female in her early-40's presented after she tested positive with the BRCA1 gene mutation. She has a strong family history of breast cancer which prompted her to have a total hysterectomy and bilateral salpingo-oophorectomy to reduce the risks associated with this mutation. She also had a reduction mammoplasty. This exam was ordered as a follow up due to her increased risk of breast cancer. 1. Status post reduction of both breasts. 2. No masses or areas of abnormal contrast enhancement seen.
850	Follow up of Lobular Carcinoma in Situ	Late-40's	Female	A female in her early-40's presented for an annual screening mammogram due to a family history of the BRCA1 mutation and a history of lobular carcinoma in situ in the left breast. An MRI was done due to the appearance of dense breast tissue and multiple calcifications in the right breast on her mammogram. The MRI noted the lumpectomy, but showed no masses or areas of abnormal contrast enhancement. Bilateral breast cysts were noted. A 1 year screening mammogram was recommended. 1. No masses or areas of abnormal contrast enhancement seen.
851	Hydrocephalus	Less than 1 year	Male	A male has lost one year of age was born prematurely. He suffered from anemia, apnea, retinopathy, patent ductus arteriosus, and bronchopulmonary dysplasia. A neurosonogram showed moderate ventriculomegaly with interval improvement from previous sonograms. A brain MRI showed a marked decrease in the size of the ventricles with diffuse subdural fluid collections overlying the cerebral hemispheres, most noted in the parietal regions. LABS: RBC: 2.9 (3.7-5.1 x106/uL), Hematocrit: 27.7 (30.0-52.0%), Lymphocytes: 76 (25-75%) 1. Marked improvement in visualization of the gyri. Gyri continue to be diffusely abnormal & small. 2. White matter is diffusely thinned, but somewhat greater in the parietal regions with associated gradient echo hypointensities. 3. The ventricles are markedly decreased in size with a catheter entering from the right parietal approach. 4. There are unencumbered bilateral fluid collections, slightly greater in the frontal regions -- particularly on the left. 5. Mild gradient echo hypointensity present right superior parietal lobe. Could represent a small area of hemosiderin staining versus calcifications. 6. Mild to moderate gradient echo hypointensity adjacent to the ventricles could represent periventricular calcifications. 7. Superficially enhancing and thickened corpus callosum.
852	Right Cranio-orbital Mass	Mid-40's	Male	A male in his mid-forties presented to the emergency department with right periorbital pain and proptosis. He had progressive worsening of the periorbital pain for over 2 days, and proptosis that started earlier that week. He has a history of blindness in the right eye due to an accident, but no other neurological problems. A CT scan showed a right anterior cranial fossa mass that follows the optic nerve and extends into the orbit on the right side. A cerebral angiogram was ordered along with a biopsy which provided a final diagnosis of meningioma. A craniotomy was scheduled to resect the tumor. LABS: WBC: 12.5 (4.0-11.0 x 103/UL). 1. Dumbbell right cranio-orbital large mass through the right optic canal. Differential diagnosis may include pericoptic meningioma, schwannoma, an unusual ophthalmic aneurysm, or a hemangioma. **Note that the scan does display motion artifact which does degrade the imaged mildly.
853	Multiple Sclerosis	Late-40s	Female	This case involves a female in her late forties with a history of multiple sclerosis. In the past she has experienced symptoms of MS including headaches, nausea, vomiting, photophobia, nystagmus and tremors. Many of these symptoms have become more frequent over the past year. An MRI was ordered as follow-up and to look for signs of MS exacerbation. LABS: Platelet: 527 (150-400x103/uL); Alkaline Phosphatase: 129 (32-91 U/L); WBC: 13.5 (4.0-11.0x103/uL)
854	Normal Brain	Mid-50's	Male	1. Slight interval progression of multiple brain parenchymal lesions compatible with the patient's reported clinical history of demyelinating disease from multiple sclerosis. 1. Limited diagnostic images of the brain are normal.
855	IIA Atherosclerosis	Late-60's	Female	A female in her late 60's presented with stage 5 chronic kidney disease secondary to polycystic kidney disease. An abdominal ultrasound and CT showed evidence of her polycystic kidney disease along with focal calcification of her external iliac arteries. She later underwent a kidney transplant & is doing well. Labs: BUN: 59 (6-20mg/dL) Creatinine: 3.79 (0.44-1.03mg/dL) Hemoglobin: 10.8 (11.0-15.1g/dL) Hematocrit: 32.5 (33.1-44.5%) 1. Severe focal calcification right external iliac artery. 2. Minimal calcification left external iliac artery. 3. Polycystic kidney disease with multiple hepatic cysts. 4. Cholecystectomy.
856	Aortic Dissection	Late-40's	Male	A male in his late-60's presented to the Emergency Department complaining of chest pain along with palpitations, nausea & vomiting. He was also experiencing shortness of breath and numbness and tingling in his right lower extremity. A CT angio of the chest revealed an aortic dissection of the ascending aorta to the bilateral common iliac arteries with false lumen supplying many vessels. Decreased perfusion in his right lower extremity, as well as, an atrophic right kidney suggestive of chronic kidney disease was also noted. LABS: Hemoglobin: 12.5 (13.3-17.3g/dL); Hematocrit: 36.4 (39.0-52.0%); BUN: 22 (6-20mg/dL); Creatinine: 1.78 (0.44-1.03mg 1. Aortic dissection extending from the ascending aorta to the bilateral common iliac arteries with the false lumen supplying many vessels. 2. Atrophic right kidney. 3. Patchy bilateral pulmonary consolidations, may represent hemorrhage, infection, or edema. 4. Small right pleural effusion. 5. Tiny scattered pancreatic calcifications in an otherwise normal-appearing pancreas, may represent sequela of prior pancreatitis.
857	Cavernous Carotid Aneurysm	Late teens	Male	A male in his late-teens presented with a one-week history of worsening headache & intermittent blurry vision on the right. A CT angiogram noted a large right cavernous carotid aneurysm with apparent communication with the internal jugular vein. Surgical intervention included a right internal carotid artery occlusion using endovascular placed coils & embolization of multiple feaders of the carotid cavernous fistula through the external carotid branches. LABS: WBC: 17.3 (4.0-11.0 x103/uL). 1. Large right cavernous carotid aneurysm with apparent communication with the internal jugular vein. 2. Atrophic right lateral rectus muscle likely due to right 6th nerve compression.

Anatomage Table 9.0 Case Library Descriptions

859	IVC Thrombosis	Late 60's	Female	A female in her late-60's presented with onset of swelling & discomfort in her calf & proximal right thigh. She had a history of extensive calf & deep femoral venous thrombosis & was undergoing warfarin therapy. She continued to have extensive swelling in the right leg making it uncomfortable to walk. A vascular ultrasound showed extensive thrombosis of the infrarenal IVC & complete thrombosis of the right iliac veins. A CT was ordered to further evaluate the thrombus. LABS: RBC: 2.9 (3.7-5.1 x1010/uL); Hemoglobin: 8.6 (11.0-15.1 g/dL); Hematocrit: 26.8 (33.1-44.5%); Platelet: 122 (150-400 x 103/uL); AST: 46 (15-41 U/L); Alkaline Phosphatase 1. Left lobe of liver smaller than typical with associated small left portal vein. 2. Dilated main portal vein. 3. Inferior vena cava filter extends from common iliac veins to the intrahepatic IVC with probable thrombus, however; this is obscured by artifact from the filter. 4. Gallbladder sludge. 5. Small bilateral pleural effusions.
860				
861	Cave-dwelling Centipede	Adult	Female	"Eupolybothrus cavernicolus Komericki & Stoev sp. n. (Chilopoda: Lithobiomorpha: Lithobiidae)"
862	Earthworm "Grey worm, Aporrectodea caliginosa (Savigny, 1826)"	Adult	Male	We demonstrate how a classical taxonomic description of a new species can be enhanced by applying new generation molecular methods, and novel computing and imaging technologies. A cave-dwelling centipede, Eupolybothrus cavernicolus Komericki & Stoev sp. n. (Chilopoda: Lithobiomorpha: Lithobiidae), found in a remote karst region in Krsi, Croatia, is the first eukaryotic species for which, in addition to the traditional morphological description, we provide a fully sequenced transcriptome, a DNA barcode, detailed anatomical X-ray microtomography (micro-CT) scans, and a movie of the living specimen to document important traits of its ex-situ
863	Earthworm "Grey worm, Aporrectodea caliginosa (Savigny, 1826)"	Adult	Male	
864	Earthworm "Grey worm, Aporrectodea caliginosa (Savigny, 1826)"	Adult	Male	
865	Earthworm "Grey worm, Aporrectodea caliginosa (Savigny, 1826)"	Adult	Male	
866	Abdomen (52-year-old male)		52 Male	CT scan
867	Head Scan (56-year-old female)		56 Female	
868	Head Scan (58-year-old female)		58 Female	
869	Full Torso (48-year-old male)		48 Male	CT scan
870	Abdomen (40-year-old female)		40 Female	CT scan
871	Abdomen (60-year-old female)		60 Female	CT scan
872	Head Scan (70-year-old male)		70 Male	
873	Head Scan (52-year-old female)		52 Female	
874	Pelvis (46-year-old female)		46 Female	
875	Thorax and Pelvis (50-year-old female)		50 Female	
876	Abdomen (64-year-old male)		64 Male	CT scan
877	Abdomen (77-year-old female)		77 Female	CT scan
878	Thorax and Abdomen (45-year-old female)		45 Female	
879	Head Scan (79-year-old male)		79 Male	
880	Abdomen (80-year-old male)		80 Male	CT scan
881	Torso (48-year-old male)		48 Male	CT scan
882	Knee Joint		66 Female	CT scan
883	Orbital Rim Fracture		79 Male	CT scan
884	Bone Anomaly of the Knee		78 Male	CT scan
885	Broken Mandible		57 Male	CT scan
886	Facial Anomaly		25 Male	CT scan
887	Bloated Female		47 Female	CT scan
888	Abdomen (11-year-old Male)		11 Male	CT scan
890	Head and Neck Brain Mass (60-year-old Female)		60 Female	CT scan
891	Brain Operation I		70 Male	CT scan
892	Brain Operation II		70 Male	CT scan
893	Brain Operation III		70 Male	CT scan
894	Skull Reconstruction		45 Female	CT scan
895	Abdomen and Pelvis (68-year-old female)		68 Female	
896	Zygomatic Injury		15 Male	CT scan
897	Head Scan (17-year-old female)		17 Female	
898	Abdomen (33-year-old Female)		33 Female	CT scan
899	Neck (39-year-old Male)		39 Male	CT Scan
900	Torso (18-year-old female)		18 Female	
901	Knees (24-year-old female)		24 Female	
902	Head and Neck (73-year-old female)		73 Female	
903	Brain Mass Post-Op		25 Male	CT scan
905	Head Scan (75-year-old female)		75 Female	
906	Thorax and Abdomen (75-year-old female)		75 Female	CT Scan
907	Thorax and Abdomen (58-year-old Male)		58 Male	CT Scan
908	Brain Mass II		25 Male	
909	Forehead Anomaly		42 Male	
910	Abdomen (54-year-old Male)		54 Male	
911	Facial Reconstruction		42 Male	
912	Thorax and Abdomen (30-year-old Male)		30 Male	
913	Tracheostomy		28 Male	
914	Neck Anomaly		44 Male	
915	Abdomen and Pelvis (38-year-old Male)		38 Male	
916	Full Body (72-year-old Male)		72 Male	
917	Thorax and Abdomen (27-year-old Male)		27 Male	
918	Facial Swelling		27 Male	
919	Thorax and Abdomen (52-year-old Female)		52 Female	
920	Abdomen and Pelvis (63-year-old Female)		63 Female	
921	Abdomen (48-year-old Male)		48 Male	
922	Head Scan (1-year-old Male)		1 Male	
923	Thorax and Pelvis (60-year-old Female)		60 Male	
924	Head and Neck (70-year-old Male)		70 Male	
925	Abdomen and Pelvis (61-year-old Male)		61 Male	
926	Abdomen (45-year-old Female)		45 Male	
927	Thorax and Pelvis (30-year-old Female)		30 Female	
928	Abdomen (32-year-old Male)		32 Male	
929	Abdomen (34-year-old Female)		34 Female	
930	Abdomen (22-year-old Female)		22 Female	
931	Abdomen (29-year-old Male)		29 Male	
932	Head Scan (48-year-old Male)		48 Male	
933	Head and Neck (4-year-old Male)		4 Male	
934	Head and Neck (62-year-old Male)		62 Male	
935	Head Scan (46-year-old Male)		46 Male	
936	Head and Neck II (62-year-old Male)		62 Male	
937	Head Scan (64-year-old Male)		64 Male	
938	Full Body (50-year-old Male)		50 Male	
939	Head (69-year-old Male)		69 Male	
940	Abdominal Mass (40-year-old Female)		40 Female	
941	Abdomen (55-year-old Male)		55 Male	
942	Abdomen (45-year-old Male)		45 Male	
943	Abdomen (67-year-old Female)		67 Female	
944	Full Body (76-year-old Male)		76 Male	
945	Abdomen (71-year-old Male)		71 Male	Catheter
946	Head and Neck (39-year-old Female)		39 Female	
947	Head and Neck (53-year-old Male)		53 Male	
948	Abdomen (55-year-old Female)		55 Female	
949	Abdomen (60-year-old Female)		60 Female	
950	Head Sutures		32 Male	
951	Full Body (85-year-old Male)		85 Male	
952	Skull Opening		31 Male	
953	Abdomen (60-year-old Male)		60 Male	
954	Abdomen (14-year-old Male)		14 Male	
955	Full Body (30-year-old Male)		30 Male	
956	Head and Neck (5-month-old Male)	5 Months	Male	
958	Thorax and Abdomen (52-year-old Male)		52 Male	
959	Head Scan (60-year-old Female)		60 Female	
960	Abdomen (87-year-old Male)		87 Male	
961	Abdomen (56-year-old Female)		56 Female	
962	Lower Limb (47-year-old Female)		47 Female	
963	Abdomen (63-year-old Male)		63 Male	
964	Head Scan (10-year-old Female)		10 Female	
965	Abdomen (38-year-old Female)		38 Female	
966	Abdomen (12-year-old Female)		12 Female	
967	Head Scan (45-year-old Male)		45 Male	
968	Abdomen (67-year-old Male)		67 Male	
969	Heart (60-year-old male)		60 Male	
970	Thorax (62-year-old Female)		62 Female	
971	Hip Surgery (SP Trauma)		22 Female	
972	Brain Operation (63-year-old male)		63 Male	
973	Abdomen and Pelvis (70-year-old Male)		70 Male	
974	Abdomen (56-year-old Female)		56 Female	
975	Abdomen (50-year-old Female)		50 Female	
976	Torso (5-year-old Female)		5 Female	
977	Throat Device		65 Male	
978	Macrocephaly		2 Male	
979	Head and Neck (36-year-old Female)		36 Female	
981	Facial Swelling (56-year-old Male)		56 Male	
982	Abdomen and Pelvis			
983	Thorax and Abdomen			
984	Abdomen (59-year-old Male)		59 Male	
985	Facial Swelling (80-year-old Male)		80 Male	Breathing tubes
986	Thorax and Abdomen			
987	Head and R Arm	unknown	unknown	
988	Abdomen (42-year-old Female)		42 Female	
989	Thorax and Abdomen			
990	Head (80-year-old Male)		80 Male	
991	Thorax and Abdomen			
992	Abdomen (69-year-old Male)		69 Male	
993	Thorax and Abdomen	unknown	unknown	
994	Brain Mass (67-year-old Male)		67 Male	
995	Full Torso (57-year-old Male)		57 Male	
996	External Swelling (72-year-old Male)		72 Male	
997	Brain Operation (50-year-old Male)		50 Male	
998	Neck Scan	unknown	unknown	
999	Thorax	unknown	unknown	
1000	Skull Operation (47-year-old Male)		47 Male	
1001	Brain Mass and Swelling (61-year-old Male)		61 Male	
1002	Abdomen (63-year-old Male)		63 Male	
1003	Thorax and Upper Limbs (51-year-old Male)		51 Male	
1004	Facial Swelling (62-year-old Male)		62 Male	
1005	Head Scan	unknown	unknown	
1006	Amputated Lower Limb	unknown	Male	
1007	Abdomen (Female)	unknown	Female	
1008	Thorax and Abdomen			
1009	Abnormal Head Shape	unknown	Male	
1010	Abdomen	unknown	unknown	
1011	Thorax and Abdomen	unknown	unknown	
1012	Thorax (Female)	unknown	Female	
1013	Lower Limbs (Female)	unknown	Female	
1014	Kidney Masses	unknown	Male	
1015	Abdomen (Female)	unknown	Female	
1016	Lower Limbs (Male)	unknown	Male	
1017	Lower Limb with Cast	unknown	Male	
1018	Abdomen (Female)	unknown	Female	
1019	Head and Neck (Female)	unknown	Female	
1020	Torso (Female)	unknown	Female	
1021	Renal System (Male)	unknown	Male	
1022	Head MRI		73 Male	
1023	Rat Eye	unknown	unknown	Rat eye arteriovenogram using BriteVu™ contrast, Scarlet Imaging, LLC, www.scarletimaging.com
1024	Tooth 1	unknown	unknown	
1025	Tooth 2	unknown	unknown	
1026	Tooth 3	unknown	unknown	
1027	Right Arm Angio	unknown	unknown	Image provided by Dr. Bruce Waisman, Education Program in Anatomy, McMaster University. Perfused with BriteVu™. www.Scarletimaging.com
1028	Left Hand Angio	unknown	unknown	Image provided by Dr. Bruce Waisman, Education Program in Anatomy, McMaster University. Perfused with BriteVu™. www.Scarletimaging.com

Anatomage Table 9.0 Case Library Descriptions

1029	Colcun Baby Gator	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1030	Argentine Black and White Tegu	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1031	Pigeon Eyes and Brain	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1032	Pigeon Heart	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1033	Pigeon Kidneys and Ovary	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1034	Pigeon Lung	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1035	Pigeon Skin and Feathers	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1036	Human Head	unknown	unknown	Perfused and scanned by Dr. Bruce Wainman Education program in Anatomy McMaster University with BriteVu® contrast agent from Scarlet Imaging (www.scarletimaging.com)
1037	Grey Parrot Head High Resolution	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1038	Grey Parrot Vasculature	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1039	Grey Parrot Caudal to Neck	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1040	Grey Parrot Head	unknown	unknown	Perfused with BriteVu™ www.ScarletImaging.com
1041	Complex Skull Fractures M/V Accident 1		21 Female	INDICATION: Fall Trauma - auto versus pedestrian FINDINGS: There is a complex skull base fracture including fractures of the sphenoid that involve both carotid canals and extend to the sphenoid sinuses. A fracture line extends through the left mastoid process with associated opacification of mastoid air cells with blood products. Blood products in the right mastoid air spaces indicate probable additional fracture, although this is not well demonstrated. The left medial pterygoid plate is fractured, as well as the right medial and lateral pterygoid plates. There is a fracture through the posterior aspect of the orbital roof on the left with extension into the left orbital walls. The right zygomatic arch is fractured. There are nondisplaced fractures of the inferior and medial orbital walls as well. No demonstrated associated herniation or evidence of entrapment. The right globe is small and has peripheral calcifications, likely chronic. There are peripheral calcifications in the left globe as well, and heterogeneous internal attenuation that may be chronic. There is a nonspecific prosthesis in or adjacent to the left superior rectus muscle. No definite left orbit fracture. There is a moderate volume of pneumocephalus underlying the frontal fracture, and scattered additional intracranial air including anterior to the temporal lobes and in teh sella turcica. There is a small volume of subarachnoid blood products including in the quadrigeminal cistern and lateral cerebello-medullary cisterns. There may be a small volume of subarachnoid hemorrhage in the right parietal lobe. No demonstrated territorial infarct or definite intraparenchymal hemorrhage. No significant mass effect. IMPRESSION: 1. Complex skull, skull base and facial fractures as described. 2. Small volume of subarachnoid hemorrhage. 3. Atrophic and peripherally calcified right globe, likely chronic. Scattered peripheral calcifications in teh left globe and heterogeneous internal attenuation may be chronic as well. Scan contributed by: North Colorado Medical Center
1042	Complex Pelvic Fractures M/V Accident 2		21 Female	INDICATION: Fall Trauma - auto versus pedestrian FINDINGS: Contrast enhanced chest, abdomen, and pelvis CT performed during the injection of 70 mL of Isovue 370. Chest: Thyroid: Grossly normal. Thoracic inlet: No adenopathy Heart and great vessels: Normal Mediastinum and hila: Normal Lungs and pleura: Endotracheal tube terminates directly above the carina. There are bilateral pulmonary contusions, right greater than left. No pneumothorax. Abdomen and pelvis: Liver and hepatic vasculature: There is a small hypodensity that likely represents hematoma or laceration, measuring 11 x 4 mm. Small focus of hyperattenuation within this hypodensity could represent the degree of active extravasation. Gallbladder and bile ducts: Normal Spleen: Normal. Small splenule noted. Pancreas: Normal. Adrenals: Normal. Kidneys, ureters, and bladder: The medial aspect of superior pole right kidney is hypoattenuating, and there is apparent laceration. No large perirenal hematoma. Retroperitoneum and aorta: Abdominal aorta is normal in course and caliber. The IVC is diminutive. GI tract, mesentery, and peritoneum: Several loops of small bowel in the left midabdomen appear mildly thickwalled and hyperenhancing. Esophagogastric tube terminates in the body of the stomach. Lymph nodes: No adenopathy Bones and soft tissues: There are complex pelvic fractures including comminuted fracture of the right sacrum involving the sacroiliac joint and extending to the right ilium. The right SI joint appears mildly diastased. There is a nondisplaced vertically oriented fracture through the left sacrum. There are also right inferior and superior pubic ramus fractures, with distraction of the inferior fracture. There is also a fracture of the left pubic body. There is a hematoma superior to the pubic symphysis that mildly displaces the urinary bladder, and enlargement of the right psoiliformis due to additional hematoma. There are nondisplaced posterior fractures of the right 11th and 12th ribs and the lateral fractures of the right 10th rib. There are anterior fractures of the right 2nd and 3rd ribs. No definite acute fracture of the left ribs. IMPRESSION: 1. Complex pelvic fractures as described with associated hematomas. No definite active extravasation. 2. Multiple right rib fractures as described. 3. Small left pneumothorax. Pneumomediastinum. 4. Right renal contusion and laceration without active extravasation, likely grade 1. No hematoma or evidence of active extravasation. 5. Small hepatic laceration or subcapsular hematoma. Focus of hyperattenuation within this lesion could represent small amount of active extravasation. 6. Hyperenhancing loops of thickened small bowel and diminutive inferior vena cava could indicate shock bowel. 7. Endotracheal tube terminates immediately above the carina. Scan contributed by: North Colorado Medical Center Chest: Unremarkable Liver: Unremarkable Gallbladder: Decompressed Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: Normal caliber. The stomach is moderately distended with fluid. Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable
1043	29-Year Old Male		29 Male	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Decompressed Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: There are prominent bilateral peripelvic cysts Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable
1044	54-Year Old Female		54 Female	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: There is a 1.5 cm stone within the upper pole of the left kidney. There is mild right hydroureteronephrosis with a 2 mm stone at the right ureterovesical junction. Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable
1045	Hydroureteronephrosis		36 Male	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Gallbladder sludge within the gallbladder Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: There are multiple right-sided renal stones, nonobstructing Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable. There are scattered pelvic phleboliths Vasculature: Mild atherosclerotic calcifications Bones: Unremarkable
1046	Nonobstructing Nephrolithiasis		52 Female	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: There is a 2 mm stone within the mid to lower left ureter without obstruction Adrenal Glands: Normal Bowel: Normal caliber. There are scattered colonic diverticula. Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable. Vasculature: Normal Bones: Unremarkable
1047	Ureteral Stone (No Obstruction)		35 Male	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: There is a 0.6 cm stone within the left renal pelvis with associated mild to moderate dilation of the pelvis and mild stranding of the surrounding retroperitoneum. Adrenal Glands: Normal Bowel: Normal caliber. Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable. Vasculature: Normal Bones: Unremarkable
1048	Hydronephrosis		42 Male	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: There is a 1.6 cm cyst in hepatic segment 8. Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: Unremarkable Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: There is a large 10.0 x 14.5 cm efot-tissue density heterogeneously enhancing mass within the lower pelvis extending into the abdomen, which appears to arise from the fundus of the uterus Vasculature: Normal Bones: Unremarkable
1049	Pedunculated Fibroid		44 Female	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: There is a punctate non obstructing right renal stone Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: There are moderate atherosclerotic calcifications Bones: There are moderate degenerative changes
1050	Colonic Diverticulosis		60 Male	No clinical history or reported symptoms available for this patient Chest: There is subsegmental atelectasis at the lung bases Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: There is a 4 mm stone within the proximal left ureter. There is moderate to severe left hydronephrosis. There are scattered sub 2 mm stones within the left renal collecting system. There is scarring of the left kidney and there is chronic appearing loss of volume of the renal parenchyma. Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable
1051	Ureteral Stone (Left-side Obstruction)		57 Female	No clinical history or reported symptoms available for this patient

Anatomage Table 9.0 Case Library Descriptions

			Chest: Unremarkable Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: There is a 15.2 x 9.5 cm heterogeneous mass arising in the pelvis and extending into the abdomen, which appears to connect to the uterus. There is a separate 4.3 cm right ovarian cyst. Vasculature: Normal Bones: Unremarkable
1052	Ovarian Cyst	38 Female	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: There is a punctate non-obstructing left renal stone Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable. There are degenerative changes at the sacroiliac joints, left greater than right.
1053	Nephrolithiasis (Non-obstructing)	38 Female	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Normal morphology and size Gallbladder: No calcified gallstones Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: Multiple right-sided renal stones the largest one measuring 1.5cm at the interpolar region of the right kidney. Additional stones are present through out the right kidney. There is a 2.5cm stone within the distal right ureter causing upstream dilation of the ureter and renal collecting system (Hydroureteronephrosis). There is thickening of the distal ureter at the site of the obstruction suggesting inflammation. Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: No free fluid or air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Normal Vasculature: Normal Bones:Normal
1054	Hydroureteronephrosis	23 Male	No clinical history or reported symptoms available for this patient Chest: Normal Liver: Normal Gallbladder: No calcified gallstones Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: Normal Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: No free fluid or air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: The right ovary is enlarged when compared to the left and displaced from its normal position to the left Vasculature: Normal Bones: Soft tissue nodules within the buttock likely represent injection granulomas. Soft tissue stranding within the anterior lower abdominal wall.
1055	Ovarian Torsion	42 Female	No clinical history or reported symptoms available for this patient Chest: Dependent atelectasis Liver: Normal Gallbladder: Normal Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: Large staghorn calculi within the right renal pelvis measuring 3.5cm. Additional smaller calculi are present within the right renal collecting system. The calyces are dilated giving a multiloculated appearance (bear's paw sign) Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: No free fluid or air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Normal Vasculature: Normal Bones: Normal
1056	Xanthogranulomatous Pyelonephritis (XGP)	29 Male	No clinical history or reported symptoms available for this patient Chest: Normal Liver: Normal morphology and size Gallbladder: A 5mm calcified gallstone. No pericholecystic fluid or gallbladder wall thickening to suggest acute calculous cholecystitis. Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: Normal Adrenal Glands: Normal Bowel: A 4.2 x 2.7cm hypodense mass arising from a proximal small bowel loop within the upper mid abdomen Mesentery & Peritoneum: No free fluid or air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Normal Vasculature: Normal Bones: Sclerotic focus within the right ilium representing a bone island
1057	Neuroendocrine Tumors	46 Male	No clinical history or reported symptoms available for this patient. Possible differential diagnosis for this finding include neuroendocrine tumors such as carcinoids Chest: Normal Liver: Normal morphology and size Gallbladder: Normal Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: An 8mm stone within the left distal ureter with associated mild hydroureteronephrosis consistent with obstructive uropathy. There is a 6mm nonobstructive stone within the lower pole of the right kidney Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: No free fluid or air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Normal Vasculature: Normal Bones: Normal
1058	Mild Hydroureteronephrosis (Left-Side)	34 Male	No clinical history or reported symptoms available for this patient Chest: Normal Liver: Normal morphology and size Gallbladder: Normal Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: An 2mm stone within the right distal ureter with associated mild hydroureteronephrosis consistent with obstructive uropathy. There is a 5mm nonobstructive stone within the lower pole of the left kidney Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: No free fluid or air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Normal Vasculature: Normal Bones: Normal
1059	Mild Hydroureteronephrosis (Right-Side)	23 Male	No clinical history or reported symptoms available for this patient Chest: Small bilateral pleural effusion. Linear atelectasis at the right lung base. Scattered sub 5mm lung nodules some of which are calcified. Interlobular septal thickening mainly involving the bilateral upper lobes. Liver: Nodular contour. A 4mm hypodense lesion within the right hepatic lobe likely a hepatic cyst Gallbladder: No calcified gallstones Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: Normal Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Large amount of ascites (free fluid) through out the abdomen and pelvis. Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Foley catheter within a decompressed bladder. Nodular soft tissue mass along the right lateral aspect of the bladder Vasculature: Minimal atherosclerotic calcifications of the abdominal aorta Bones: Sclerotic foci within the right ilium and right aspect of T7 vertebral body
1060	Bladder Cancer	60 Female	No clinical history or reported symptoms available for this patient Lungs: Innumerable bilateral pulmonary nodules measuring up to 2cm with a dominant larger mass measuring 7x6cm located within the right upper lobe encasing the right upper lobe bronchus Pleura: Small right sided pleural effusion Mediastinum and Hila: Enlarged mediastinal lymph nodes Heart: Normal in size Vessels: Atherosclerotic calcification of the aortic arch Chest wall: Normal Bones and Soft Tissue: Diffuse osteopenia and degenerative changes of the thoracic spine Lower Neck: Enlarged supraclavicular lymph nodes Abdomen: Multiple bilateral simple renal cysts the largest one measuring 2.1cm on the right and 2.5cm on the left. Other visualized abdominal organs are unremarkable.
1061	Primary Lung Cancer with Mets	90 Female	No clinical history or reported symptoms available for this patient. Findings are most consistent with primary lung cancer with bilateral metastasis. Alternatively this could represent metastatic lung disease from a different primary source with a hematogenous spread. Lungs: Near complete collapse of the right upper lobe with cavitary confluent consolidations. Cavitary lesions and consolidations are also present within the superior segment of the right lower lobe. Additional scattered nodular opacities are noted within the left upper and lower lobes Pleura: No pleural effusions Mediastinum and Hila: Enlarged mediastinal lymph nodes Heart: Normal in size Vessels: Normal course and caliber Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen demonstrate ventral abdominal wall hernia
1062	Cavitary Pulmonary Lesions	72 Female	No clinical history or reported symptoms available for this patient. Possible differential diagnoses for cavitary pulmonary lesions with bilateral consolidations include malignancy such as squamous cell carcinoma or infectious disease such as necrotizing pneumonia or tuberculosis, if the patient is immunocompromised Chest: Normal Liver: Normal Gallbladder: No calcified gallstones Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: A 1.8cm right renal simple cyst Adrenal Glands: Normal Bowel: Large rectal mass with associated abnormal rectal wall thickening and surrounding stranding Mesentery & Peritoneum: No free fluid or air Lymph Nodes: Enlarged perirectal lymph nodes Pelvic Organs: Normal Vasculature: Normal Bones: Normal
1063	Rectal Carcinoma	40 Male	No clinical history or reported symptoms available for this patient. Within these limitations Chest: Normal Liver: Normal Gallbladder: No calcified gallstones Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: Bilateral 5mm renal stones located within the lower pole of the right and upper pole of the left kidney Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: No free fluid or air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Distended bladder Vasculature: Normal Bones: Normal
1064	Renal Calculi (5mm Non-obstructive)	48 Male	No clinical history or reported symptoms available for this patient Chest: Normal Liver: Normal Gallbladder: No calcified gallstones Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: Normal Adrenal Glands: Normal Bowel: Normal caliber. Appendix is normal. Evidence of prior surgery at the rectosigmoid colon with apparent intact anastomosis. Mesentery & Peritoneum: No free fluid or air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Bilateral fat containing inguinal hernias Vasculature: Moderate atherosclerotic calcification of the abdominal aorta Bones: Normal
1065	62-Year Old Male	62 Male	No clinical history or reported symptoms available for this patient

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			Chest: Normal Liver: Normal Gallbladder: No calcified gallstones Bile ducts: Normal Pancreas: Normal Spleen: Normal Size Kidneys: Multiple bilateral low density masses almost entirely replacing the normal renal parenchyma Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: No free fluid or air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Normal Vasculature: Normal Bones: 8mm sclerotic focus within the right sacrum representing a bone island
1066	Lymphoma	52 Male	Age: 52 Sex: Male No clinical history or reported symptoms available for this patient. Within these limitations differential diagnosis in this 52-year-old male include lymphoma and adult polycystic kidney disease. Lungs: Nodular opacities within the left upper lobe Pleura: No pleural effusions Mediastinum and Hila: A 19 x 1 cm peripherally calcified anterior mediastinal cystic mass Heart: Unremarkable Vessels: Normal Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1067	Cystic Teratoma	45 Female	No clinical history or reported symptoms available for this patient Chest: Bronchiectasis and emphysematous changes within the right lower lobe Liver: Unremarkable except for a small hepatic hemangioma Gallbladder: Gallbladder wall thickening and mild peri-portal edema. No calcified gallstone Bile ducts: Mild peripartial edema Pancreas: There is a 5cm mass within the head of the pancreas with associated dilation of the pancreatic duct distal to the mass. There is surrounding stranding Spleen: Upper limits of normal measuring 14mm in craniocaudal dimension Kidneys: Normal Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Small amount of perihepatic ascites and small amount of free fluid in the pelvis. No free air Lymph Nodes: No enlarged peripancreatic lymph nodes Pelvic Organs: Normal Vasculature: Minimal atherosclerotic calcifications of the abdominal aorta Bones: Minimal degenerative changes of the thoracolumbar spine
1068	Adenocarcinoma	63 Male	No clinical history or reported symptoms available for this patient Chest: There are heavy coronary artery calcifications and evidence for prior stent grafting Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: 1.0 cm left renal cyst in the upper medial pole Adrenal Glands: Normal Bowel: Distended by air, per CT colonography protocol Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Atherosclerotic calcifications Bones: Moderate degenerative disc disease
1069	80-Year Old Male	80 Male	No clinical history or reported symptoms available for this patient Chest: Normal Liver: Normal morphology and size Gallbladder: No calcified gallstones Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: Normal Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: There is a 5.4cm soft tissue mass in the pelvis arising from the lower uterine segment/cervix region. There is a separate 3.5 x 2.0 cm right ovarian cyst. Vasculature: Normal Bones: Unremarkable
1070	Cervical Cancer	38 Female	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: There are multiple bilateral non-obstructive small renal stones Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable. In the subcutaneous fat underlying the right gluteal musculature, there is an area of fat necrosis, likely post traumatic in etiology.
1071	Bilateral Nephrolithiasis (Non-obstructing)	28 Female	No clinical history or reported symptoms available for this patient Chest: There are trace bilateral pleural effusions and atelectasis at the lung bases Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: There is significant fat stranding and fluid surrounding the pancreas, particularly around the body of the pancreas. There is hypoattenuation of the body of the pancreas seen on arterial phase imaging. Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Small volume ascites, reactive Lymph Nodes: Scattered prominent lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable
1072	Acute Necrotizing Pancreatitis	29 Male	No clinical history or reported symptoms available for this patient Lungs: There is subplatural reticulation, fibrotic change, and tracton bronchiectasis in an apical basilar gradient. There is mild honeycombing at the lung bases. Pleura: No pleural effusions Mediastinum and Hila: There are prominent mediastinal lymph nodes not meeting criteria for size enlargement Heart: Unremarkable Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1073	Idiopathic Pulmonary Fibrosis	72 Male	No clinical history or reported symptoms available for this patient Lungs: There is consolidation of much of the left lower lobe and scattered areas of nodular and ground glass opacities within the left upper lobe. Pleura: Small left and trace right pleural effusion Mediastinum and Hila: Unremarkable Heart: Unremarkable Vessels: Heavy calcifications of the aortic valve and vasculature Chest wall: Normal Bones and Soft Tissue: Moderate degenerative disc disease and scoliosis Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1074	Lung Malignancy	72 Female	No clinical history or reported symptoms available for this patient Chest: There is bandlike atelectasis within the right lung. There are coronary artery calcifications. There is a trace right pleural effusion. Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: There is a large sliding and paraesophageal hernia. There is evidence for gastroesophageal reflux. Mesentery & Peritoneum: Small amount of perihepatic ascites and small amount of free fluid in the pelvis. No free air Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable
1075	Paraesophageal Hernia	44 Female	No clinical history or reported symptoms available for this patient Lungs: Unremarkable Pleura: No pleural effusions Mediastinum and Hila: Unremarkable Heart: Unremarkable Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1076	26-Year Old Female	26 Female	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: There are two subcentimeter livers cysts, one in hepatic segment 2 and the other at the hepatic dome. Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable
1077	48-Year Old Female	48 Female	No clinical history or reported symptoms available for this patient Lungs: There is an azygos lobe, a normal variant Pleura: No pleural effusions Mediastinum and Hila: There is fluid within the esophagus Heart: Unremarkable Vessels: There is an aberrant right subclavian artery, a normal variant. There is ectasia of the ascending thoracic aorta. There are moderate coronary artery calcifications. Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen demonstrate a jejunostomy feeding tube.
1079	65-Year Old Female	65 Female	No clinical history or reported symptoms available for this patient Lungs: Mild subsegmental atelectasis at the lung bases Pleura: No pleural effusions Mediastinum and Hila: Unremarkable Heart: Unremarkable Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Mild to moderate degenerative disc disease Lower Neck: Normal Abdomen: There are scattered colonic diverticula.
1080	70-Year Old Male	70 Male	No clinical history or reported symptoms available for this patient Lungs: There is consolidative opacity occupying the nearly all of the right middle lobe and much of the right upper lobe with air bronchograms. There are surrounding groundglass and more nodular opacities within the right upper lobe. In addition, there are consolidative and nodular opacities in both lower lobes. Pleura: No pleural effusions Mediastinum and Hila: Mediastinal lymphadenopathy Heart: Normal in size Vessels: Normal Chest wall: Normal Bones and Soft Tissue: Moderate degenerative disc disease Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1081	Tuberculosis	70 Female	No clinical history or reported symptoms available for this patient

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				Chest: There is segmental atelectasis within the left upper lobe. Mild atherosclerotic calcifications of the coronary arteries. Liver: Normal Gallbladder: No calcified gallstones Bile ducts: Normal Pancreas: Normal Spleen: Enlarged Kidneys: 2.6 cm left renal cyst in the lower pole Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Trace perihepatic ascites Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Normal
1082	Left Lung Atelectasis	72	Male	No clinical history or reported symptoms available for this patient Lungs: Multifocal nodular and ground glass opacities within all lobes of both lungs Pleura: No pleural effusions Mediastinum and Hila: Normal Heart: Normal in size Vessels: Normal Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1083	Bronchopneumonia	6	Female	No clinical history or reported symptoms available for this patient. Lungs: Unremarkable Pleura: No pleural effusions Mediastinum and Hila: Normal Heart: Normal in size Vessels: Normal Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1084	25-Year Old Male	25	Male	No clinical history or reported symptoms available for this patient Lungs: Unremarkable Pleura: No pleural effusions Mediastinum and Hila: Normal Heart: Normal in size Vessels: Normal Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1085	36-Year Old Male	36	Male	No clinical history or reported symptoms available for this patient Chest: There are bilateral subcentimeter lung nodules within all lobes of both lungs Liver: There are multiple low density lesions within the both lobes of the liver, measuring up to 8.9 cm. Gallbladder: There are gallstones Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: 2.1 m left renal cyst in the lower pole, 1.3 cm right renal cyst in the lower pole Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: There is a destructive/lytic lesion in the left iliac bone
1086	Widespread Metastatic Disease	75	Male	No clinical history or reported symptoms available for this patient Lungs: Unremarkable Pleura: No pleural effusions Mediastinum and Hila: Unremarkable Heart: Unremarkable Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Normal Head and Neck: The images include the head and neck. There is evidence for prior right frontal parietal hemicraniectomy, likely remote given lack of other findings. Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1087	Frontoparietal Hemicraniectomy	45	Male	No clinical history or reported symptoms available for this patient Lungs: Unremarkable Pleura: No pleural effusions Mediastinum and Hila: There is a large soft tissue density anterior mediastinal mass without calcification or fat. The mass encases the vasculature without significant displacement. Heart: Unremarkable Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1088	Anterior Mediastinal Mass	8 Months	Female	No clinical history or reported symptoms available for this patient Lungs: There is subsegmental atelectasis in the right middle lobe Pleura: No pleural effusions Mediastinum and Hila: Unremarkable Heart: There is enlargement of the heart, with disproportionate enlargement of the right ventricle with flattening of the RV wall. Vessels: There is a large embolus within the right pulmonary artery with a large embolus within the left lower lobar pulmonary artery. There is enlargement of the heart, with disproportionate enlargement of the right ventricle with flattening of the RV wall. Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1089	Pulmonary Embolism	64	Female	No clinical history or reported symptoms available for this patient Chest: Normal Liver: Normal Gallbladder: Normal Bile ducts: Normal Pancreas: Normal Spleen: Normal Kidneys: Normal Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Normal Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Normal Vasculature: Normal Bones: Normal
1090	26-Year Old Male	26	Male	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Mild atherosclerotic calcifications of the aorta and its branches Bones: Unremarkable
1091	62-Year Old Male	62	Male	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: There are gallstones Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: 4.3cm left renal cyst Adrenal Glands: Normal Bowel: The descending colon, sigmoid colon and rectum and fluid-filled and there is subtle pericolonic fat stranding. Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Mild atherosclerotic calcifications of the aorta and its branches Bones: Unremarkable
1092	Fluid-Filled Colon	36	Male	No clinical history or reported symptoms available for this patient Lungs: There are scattered multifocal ground glass opacities within all lobes of both lungs Pleura: No pleural effusions Mediastinum and Hila: There are bilateral calcified hilar lymph nodes. There is mediastinal lymphadenopathy. Heart: Unremarkable Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
1093	Pulmonary Infection	55	Male	No clinical history or reported symptoms available for this patient Lungs: Unremarkable Pleura: No pleural effusions Mediastinum and Hila: Unremarkable Heart: Unremarkable Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: The esophagus on the pre-contrast imaging is moderately distended and fluid filled. Following the oral administration of contrast, there is significant contrast present within the esophagus and in the stomach. The stomach is moderately distended with enteric contrast and no obstructing lesion is identified.
1094	Slowed Gastric Transit	35	Female	No clinical history or reported symptoms available for this patient Lungs: There are mild linear areas of subpleural reticulation within the lung bases that persist on prone imaging. Pleura: Trace bilateral pleural effusions Mediastinum and Hila: Unremarkable Heart: Moderately enlarged Vessels: Moderate vascular calcifications Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: 2.2cm right thyroid nodule Abdomen: Limited images through the upper abdomen demonstrate no abnormality
1095	Pneumonia (Nonspecific Interstitial)	65	Female	No clinical history or reported symptoms available for this patient Lungs: There is a 5.8 cm mass in the right upper lobe with adjacent satellite nodules/ masses. There is moderate emphysema. Pleura: No pleural effusions Mediastinum and Hila: There is right hilar and mediastinal lymphadenopathy Heart: Unremarkable Vessels: Mild atherosclerotic disease. Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen demonstrate a 2.1cm left renal cyst
1096	Lung Adenocarcinoma	75	Male	No clinical history or reported symptoms available for this patient Lungs: There are multiple nodular opacities, predominantly within the upper lobes, left slightly greater than right. Some of those nodules have internal calcification and there is left apical pleural scarring. Pleura: No pleural effusions Mediastinum and Hila: There is mediastinal adenopathy, partially calcified Heart: There are moderate coronary artery calcifications Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen demonstrate no abnormality.
1097	Granulomatous Infection	50	Male	No clinical history or reported symptoms available for this patient Lungs: Unremarkable Pleura: No pleural effusions Mediastinum and Hila: Unremarkable Heart: Unremarkable. No evidence for RC strain Vessels: There are segmental pulmonary emboli involving several lung segments, including the apical and posterior segments of the right upper lobe, the superior, posterior basal and lateral basal segments of the right lower lobe and the posterior basal and lateral basal segments of the left lower lobe. Chest wall: Normal Bones and Soft Tissue: Mild degenerative disc disease Lower Neck: Normal Abdomen: Limited images through the upper abdomen demonstrate 2.5cm left renal cyst
1098	Bilateral Segmental and Subsegmental Pulmonary Emboli	65	Male	No clinical history or reported symptoms available for this patient

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			Chest: There are moderate coronary artery calcifications Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: There is peripancreatic fat stranding and fluid. There is a 2.9 cm cystic lesion within the body of the pancreas. Spleen: Unremarkable Kidneys: There are multiple bilateral renal stones which are nonobstructing Adrenal Glands: Normal Bowel: Normal caliber. There are scattered areas of mild small bowel wall thickening, likely reactive. Mesentery & Peritoneum: There is moderate to large volume ascites Lymph Nodes: No enlarged lymph nodes Pelvic Organs: There is calcification of the vas deferens, which can be seen in diabetes Vasculature: Normal Bones: Unremarkable
1099	Acute Pancreatitis	40 Male	No clinical history or reported symptom available for this patient Lungs: There is a consolidative opacity within the right middle lobe immediately adjacent to a 5.0 cm cavitary lesion. There is surrounding ground glass abnormality. There are additionally nodular opacities within the right upper lobe and lingula. Pleura: No pleural effusions Mediastinum and Hilar: Unremarkable Heart: Unremarkable Great Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Mild degenerative disc disease Lower Neck: Normal Abdomen: Limited images through the upper abdomen demonstrate subcentimeter cyst in the left lobe of the liver
1100	Fungal Infection	75 Male	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: Normal caliber. Mesentery & Peritoneum: There is a soft tissue mass in the left paraspinal retroperitoneum, which is being targeted for biopsy. Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Mild atherosclerotic calcifications Bones: Unremarkable
1101	Retroperitoneal Mass	61 Female	No clinical history or reported symptoms available for this patient Chest: Unremarkable Liver: Unremarkable Gallbladder: There are gallstones Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: Normal caliber. Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: There is a destructive lytic lesion with associated compression deformity of the L4 vertebral body. There is moderate degenerative disc disease.
1102	Compression of L4	55 Female	Cerebral Parenchyma: Normal visualized portion Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: Minimal mucosal thickening of both maxillary sinuses Visualized Orbits: Normal Brain Stem/Skull Base: Normal visualized portion Visualized Upper Cervical Spine: Normal visualized portion
1103	Mild Sinus Disease (Maxillary Sinuses)	52 Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Two punctate foci of calcifications within the right centrum semiovale. Calcification along the Falx cerebri Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No skull fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1104	Skull (35-year-old Female)	35 Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Foci of encephalomalacia within the right posterior parietal and occipital lobes likely related to prior insult. Foci of calcification within the bilateral basal ganglia. Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No skull fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1105	Traumatic Brain Injury	55 Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: There is mild to moderate patchy hypoattenuation of the white matter Intracranial Hemorrhage: None Ventricular System: There is moderate global enlargement of the CSF spaces Extra-axial spaces: There is moderate global enlargement of the CSF spaces Midline shift: None Cerebellum: Normal Calvarium: No skull fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1106	Chronic Small Vessel Ischemic Disease	65 Female	No clinical history or reported symptom available for this patient. Findings most likely represent prior insult such as old infarction Cerebral Parenchyma: Visualized portion is normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: There is slight mucosal thickening of the right maxillary sinus Visualized Orbits: Normal Brain Stem/Skull Base: Visualized portion is normal Visualized Upper Cervical Spine: Visualized portion is normal
1107	Sinus Disease (Minimal)	36 Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: Normal Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1108	Skull (10-year-old Male)	10 Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1109	Skull (14-year-old Male)	14 Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: There is a 9 mm left frontotemporal epidural hematoma Ventricular System: Normal for age Extra-axial spaces: There is a 9 mm left frontotemporal epidural hematoma Midline shift: None Cerebellum: Normal Calvarium: There is a linear fracture through the left frontotemporal over the epidural hematoma Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1110	Frontotemporal Skull Fracture	21 Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: Normal Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: Mucous retention cyst within the left maxillary sinus Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1111	Mucous Retention Cyst	26 Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: Normal Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1112	Normal Skull (3-year-old Female)	3 Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: There is moderate global enlargement of the CSF spaces, compatible with involutional change Extra-axial spaces: Mild to moderate global enlargement of the CSF spaces, compatible with involutional change Midline shift: None Cerebellum: Normal Calvarium: There is a diffuse mixed lytic and sclerotic appearance to the calvarium Sinuses & Mastoid Air Cells: Mucous retention cyst within the left maxillary sinus Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1113	Osseous Metastatic Disease	85 Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: Mild global enlargement for age Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1114	Head and Neck (52-year-old Female)	52 Female	No clinical history or reported symptoms available for this patient

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				Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures. There is a small subgaleal hematoma overlying the left frontal bone Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1115	Subgaleal Hematoma	50	Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: Extensive subarachnoid and intraventricular hemorrhage. Arising between the supraclinoid portion of the left internal carotid artery and left posterior communicating artery, there is a 6 mm inferiorly directed aneurysm. Ventricular System: The ventricles are moderate enlarged. There is layering blood within the occipital horns of both lateral ventricles, blood within the third ventricle and blood within the fourth ventricle. Extra-axial spaces: There is extensive subarachnoid hemorrhage involving nearly all of the subarachnoid space. Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures. There is a small subgaleal hematoma posteriorly Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1116	Ruptured Aneurysm	65	Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures. Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: There is a 1.3 x 2.8 cm soft tissue mass centered at the left masticator space immediately adjacent to the mandible and masticator muscle. There is mild stranding of the fat adjacent.
1117	Deep Soft Tissue Mass	5	Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures. Sinuses & Mastoid Air Cells: There is mucosal thickening of the right greater than left maxillary sinuses and within the anterior right ethmoid air cells. Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1118	3 Year Old Female	3	Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Punctate foci of high density is present within the posterior aspect of the right frontal lobe. Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures. Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1119	Petechial Hemorrhage	14	Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: Slight prominence of the CSF spaces Midline shift: None Cerebellum: Normal Calvarium: There is asymmetry of the calvarium with apparent discontinuity of the left parieto occipital lobe Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1120	Congenital Craniosynostosis	3 Months	Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Area of hypodensity within the right caudate exerting mass effect on the adjacent right lateral ventricle Intracranial Hemorrhage: None Ventricular System: Effacement of the right lateral ventricle resulting from mass effect from the surrounding vasogenic edema Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: Normal Sinuses & Mastoid Air Cells: Small mucous retention cyst within the right maxillary sinus Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1121	Right Caudate Infarction	77	Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: There is fluid within the right maxillary sinus Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1122	Head and Neck (32-year-old Male)	32	Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1123	Head and Neck (68-year-old Male)	68	Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Patchy periventricular foci of hypodensity consistent with chronic white matter small vessel ischemic changes Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Focus of encephalomalacia within the left cerebellar hemisphere likely related to prior insult Calvarium: No fractures Sinuses & Mastoid Air Cells: Partial opacification of the right maxillary sinus Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1124	Cerebellar Encephalomalacia	57	Male	No clinical history or reported symptom available for this patient Cerebral Parenchyma: Foci of encephalomalacia within the bilateral basal ganglia and bilateral cerebellar hemispheres likely related to prior insult Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Foci of encephalomalacia within the bilateral cerebellar hemispheres likely related to prior insult Calvarium: No fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1125	Prior Brain Injury	54	Female	No clinical history or reported symptom available for this patient. Within these limitations Cerebral Parenchyma: Large area of encephalomalacia within the left cerebral hemisphere likely related to prior insult Intracranial Hemorrhage: None Ventricular System: Ex-vacuo dilation of the left lateral ventricle secondary to encephalomalacia within the left cerebral hemisphere Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No fractures Sinuses & Mastoid Air Cells: Mucosal thickening and partial opacification of the left maxillary sinus. Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1126	Infarction (MCA Territory)	40	Female	No clinical history or reported symptom available for this patient. Within these limitations Cerebral Parenchyma: Mild periventricular chronic white matter small vessel ischemic changes Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No fractures Sinuses & Mastoid Air Cells: Mild mucosal thickening and partial opacification of the right maxillary sinus. Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1127	Head and Neck (56-year-old Male)	54	Male	No clinical history or reported symptom available for this patient. Within these limitations Cerebral Parenchyma: Mass effect on the right cerebral hemisphere from a right-sided epidural hematoma Intracranial Hemorrhage: None Ventricular System: Effacement of the frontal horn of the right lateral ventricle secondary to mass effect from right epidural hematoma Extra-axial spaces: A right frontotemporal epidural hematoma measuring 9 mm in maximum dimension. Midline shift: None Cerebellum: Normal Calvarium: No fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1128	Right Epidural Hematoma	64	Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Encephalomalacia within the left basal ganglia adjacent to the left lateral ventricle likely related to prior insult. Global volume loss consistent with age related involutional changes Intracranial Hemorrhage: None Ventricular System: Mildly prominent consistent with age related involutional changes Extra-axial spaces: Normal Midline shift: None Cerebellum: Normal Calvarium: No fractures Sinuses & Mastoid Air Cells: Mucosal thickening and partial opacification of the right maxillary sinus. Leftware nasal septal deviation. Visualized Orbits: Left-sided lens replacement Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Mild degenerative changes of the upper cervical spine
1129	Prior Cerebrovascular Insult	71	Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Global volume loss consistent with age related involutional changes Intracranial Hemorrhage: None Ventricular System: Mildly prominent consistent with age related involutional changes Extra-axial spaces: Bifrontal low density extra-axial collection consistent with subdural hematoma Midline shift: None Cerebellum: Normal Calvarium: No fractures Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1130	Bifrontal Subdural Hematoma	75	Male	No clinical history or reported symptoms available for this patient. Within these limitations

Anatomage Table 9.0 Case Library Descriptions

				Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: Partial opacification of the left maxillary sinus and ethmoid air cells Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1131	Head and Neck (8-year-old Male)		8 Male	No clinical history or reported symptoms available for this patient. Within these limitations Cerebral Parenchyma: Foci of calcification within the right frontal left posterior parietal and left posterior paralalcine region. Asymmetric prominence of the right transverse venous sinus likely congenital variant Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: Normal Sinuses & Mastoid Air Cells: Opacification of the left maxillary sinus. Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1132	Head and Neck (17-year-old Male)		17 Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Hypodensity and loss of gray-white differentiation within the left insula likely representing left MCA vascular territory infarction. Focus of calcification at the left occipito-parietal junction Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: Normal Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1133	Left MCA Infarction		44 Male	No clinical history or reported symptoms available for this patient
1134	Head and Neck (45-day-old Male)	45 Days	Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Prominent subci and global volume loss secondary to age related involutional changes. Mild periventricular white matter small vessel ischemic changes Intracranial Hemorrhage: None Ventricular System: Mildly prominent related to involutional changes Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: Normal Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Right-sided lens replacement Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Mild degenerative changes of the upper cervical spine
1135	Head and Neck (67-year-old Female)		67 Female	This is a very limited study due to significant motion artifact. Within the limitations of the study there is no intracranial hemorrhage Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No depressed skull fractures Sinuses & Mastoid Air Cells: Partial opacification of the right mastoid air cells Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1136	Head and Neck (4-year-old Female)		4 Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Calcified focus within the right posterior parietal lobe Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: Normal Sinuses & Mastoid Air Cells: Partial opacification of the bilateral maxillary sinuses Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Mildly prominent cervical lymph nodes
1137	Head and Neck (54-year-old Female)		54 Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: No fracture. A 1.5cm soft tissue nodule anterior to the left nasal bridge Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1138	Soft Tissue Mass (Left Nasal Bridge)		30 Female	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: Normal Sinuses & Mastoid Air Cells: Partial opacification of the bilateral maxillary sinuses Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1139	Head and Neck (9-year-old Male)		9 Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Mineralization within the bilateral basal ganglia Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: Normal Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1140	Head and Neck (61-year-old Male)		61 Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Large area of hypodensity within the left cerebral hemisphere and loss of gray-white differentiation involving the left MCA vascular territory Intracranial Hemorrhage: None Ventricular System: Effacement of the left lateral ventricle resulting from mass effect from the surrounding vasogenic edema Extra-axial spaces: No extra-axial collection Midline shift: A 6mm rightward midline shift Cerebellum: Normal Calvarium: Normal Sinuses & Mastoid Air Cells: Mucous retention cyst within the left maxillary sinus Visualized Orbits: Normal Brain Stem/Skull Base: Patient is intubated and a nasogastric tube is noted Visualized Upper Cervical Spine: Normal
1141	Left MCA Infarction		68 Male	No clinical history or reported symptoms available for this patient Cerebral Parenchyma: Normal Intracranial Hemorrhage: None Ventricular System: Normal for age Extra-axial spaces: No extra-axial collection Midline shift: None Cerebellum: Normal Calvarium: Normal Sinuses & Mastoid Air Cells: Normal Visualized Orbits: Normal Brain Stem/Skull Base: Normal Visualized Upper Cervical Spine: Normal
1142	Head and Neck (59-year-old Male)		59 Male	No clinical history or reported symptoms available for this patient
1143	Pancreatic Cancer		80 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1144	Thymoma		47 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1145	Suspect Thymoma		78 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1146	Epigastric Hernia		61 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1147	Epigastric Hernia		50 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1148	Left Maxillary Sinus Cancer		60 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1149	Dermoid Cyst		31 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1150	Coarctation of the Aorta		18 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1151	Lung Cancer		86 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1152	Aortic Dissection		72 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1153	Aortic Dissection		24 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1154	Peripheral Artery Disease		84 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1155	Carotid Stenosis		75 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1156	Renal Artery Stenosis		67 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1157	Aortic Aneurysm		79 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1158	Coarctation of the Aorta with Stent		36 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1159	Peripheral Artery Stenosis		80 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1160	Aortic Dissection		59 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1161	Carotid Stenosis		88 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1162	Aortic Aneurysm		76 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1163	Biliary Pancreatitis		77 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1164	Gallbladder Syndrome		9 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1165	Breast Cancer		71 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1166	Fractures, Luxation Radius		27 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1167	Infrarenal Abdominal Aortic Aneurysm		63 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1168	Osteonecrosis Mandible		60 Female	- Lesion in the right mandibular body (AP length about 18 mm) with loss of spongiosa trabeculation in the residual lower bone and involvement of the mandibular canal. - Dental implants in 3.5 and 4.4-4.5, bilateral posterior edentulous areas Analysis provided by Università degli Studi di L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi)
1169	Gallstone In The Cecum		80 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni" - Well circumscribed oval mass in the right suprarenal space, measuring 106 x 76 x 74 mm. Analysis provided by Università degli Studi di L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi)
1170	Adrenal Lipoma		43 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1171	Hepatocellular Carcinoma		82 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni" - Enlargement of the proximal portion of left popliteal artery (29x21x30 mm) at level of lateral condyle. - Diffuse calcific arteriopathy. - An exophytic oval mass (35x26x35) is present in the right kidney, suggesting a renal cyst. - Lesion in right thigh, at level of posterior muscles (55x44x110 mm). Analysis provided by Università degli Studi di L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi)
1172	Left Popliteal Fossa Aneurysm		68 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni" - Right shoulder, separation of the humerus from the glenoid of the scapula at the glenohumeral joint. - In particular, the humeral head is displaced medially and overlies the glenoid, so the dislocation is anterior. Analysis provided by Università degli Studi di L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi)
1173	Shoulder Dislocation		68 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni" - Pelvic adnexal mass with inhomogeneous content (70x74x90 mm). The lesion is rounded and capsulated and it probably derives from right ovary. - Bilateral renal cysts - Diffuse calcification of the abdominal aorta. - Lumbar spondyloarthropathy. Analysis provided by Università degli Studi di L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi)
1174	Dermoid Cyst		66 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"

Anatomage Table 9.0 Case Library Descriptions

1175	Compound Supracondylar Fracture	90	Female	- Scan of right lower limb at knee level. - Presence of skeletal traction device involving proximal part of tibia and fibula. - Fracture of the lower third of femoral diaphysis with misalignment of fragments. The lesion is oblique, starting about 43 mm above the lateral condyle and ending at level of medial condyle. - Just above the medial condyle, a smaller triangular fragment is detectable. - Diffuse calcification of femoral and popliteal arteries. Analysis provided by Università degli Studi de L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi) Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1176	Ehlers-Danlos Syndrome	43	Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1177	Expansive Right Kidney Process	48	Male	Right Kidney: - Cortical cyst at superior pole - In the lower third of the anterior face an exophytic, "ball-shaped" mass is present (33x33x30 mm) Analysis provided by Università degli Studi de L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi) Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1178	Expansive Process of the Superior Lobe of Left Kidney	45	Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1179	Peripheral Vessel in Knee Fracture	57	Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1180	Horseshoe Kidney	53	Male	- Lesion in medial part of right hepatic lobe, with an irregular profile (40x35x35 mm) - Note the renal tissue on each side of the midline with a central isthmus that passes anteriorly to the aorta and inferior vena cava. This configuration represents the fusion of the kidneys at their lower pole. Analysis provided by Università degli Studi de L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi) Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1181	Angiography of Carotid Artery Stenosis	69	Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1182	Peripheral Vessel Occlusion	80	Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1183	Colon Tumor	85	Female	- Stenotic lesion in the left colic flexure region, which may be due to carcinoma of left colic flexure. The lesion causes a displacement of the left kidney that appears moved down. - Diffuse calcification of aorta. Analysis provided by Università degli Studi de L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi) Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1184	Lung Tumor	69	Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1185	Aortic Aneurysm	67	Male	- Fusiform enlargement of the wall of abdominal aorta below the renal arteries (55x50x105 mm). - Inside the lesion a dense rim is visible suggesting the presence of a mural thrombus. - Diffuse calcification of aorta and iliac arteries. Analysis provided by Università degli Studi de L'Aquila (Prof. Macchiarelli, Prof. Bianchi and Dr.Bernardi) Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1186	Coronary Artery Abnormalities	69	Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1187	Thoracic Aortic Aneurysm	48	Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
1200	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1201	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1202	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1203	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1204	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1205	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1206	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1207	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1208	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1209	Recurrent Glioblastoma	unknown	unknown	Data Citation: Barboriak, Daniel. (2015). Data From RIDER_NEURO_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.VOSN3HN1 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1210	Glioblastoma	unknown	Male	Data Citation: Scarpace, L., Mikkelsen, T., Cha, soonmee, Rao, S., Tekchandani, S., Gutman, D., … Pierce, L. J. (2016). Radiology Data from The Cancer Genome Atlas Glioblastoma Multiforme [TCGA-GBM] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.RNYFUYE9 TCGA Attribution: The data generated by the TCGA Research Network: http://cancergenome.nih.gov/. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1211	Glioblastoma	unknown	Female	Data Citation: Scarpace, L., Mikkelsen, T., Cha, soonmee, Rao, S., Tekchandani, S., Gutman, D., … Pierce, L. J. (2016). Radiology Data from The Cancer Genome Atlas Glioblastoma Multiforme [TCGA-GBM] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.RNYFUYE9 TCGA Attribution: The data generated by the TCGA Research Network: http://cancergenome.nih.gov/. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1212	Glioblastoma	unknown	Female	Data Citation: Scarpace, L., Mikkelsen, T., Cha, soonmee, Rao, S., Tekchandani, S., Gutman, D., … Pierce, L. J. (2016). Radiology Data from The Cancer Genome Atlas Glioblastoma Multiforme [TCGA-GBM] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.RNYFUYE9 TCGA Attribution: The data generated by the TCGA Research Network: http://cancergenome.nih.gov/. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1213	Glioblastoma	unknown	Female	Data Citation: Scarpace, L., Mikkelsen, T., Cha, soonmee, Rao, S., Tekchandani, S., Gutman, D., … Pierce, L. J. (2016). Radiology Data from The Cancer Genome Atlas Glioblastoma Multiforme [TCGA-GBM] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.RNYFUYE9 TCGA Attribution: The data generated by the TCGA Research Network: http://cancergenome.nih.gov/. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1214	Glioblastoma	unknown	Male	Data Citation: Scarpace, L., Mikkelsen, T., Cha, soonmee, Rao, S., Tekchandani, S., Gutman, D., … Pierce, L. J. (2016). Radiology Data from The Cancer Genome Atlas Glioblastoma Multiforme [TCGA-GBM] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.RNYFUYE9 TCGA Attribution: The data generated by the TCGA Research Network: http://cancergenome.nih.gov/. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1215	Glioblastoma	unknown	Female	Data Citation: Nameeta Shah, Ph.D., Xu Feng, Ph.D., Michael Lankerovich, Ph.D., Ralph B. Puchalski, Ph.D., Bart Keogh, M.D., Ph.D. (2016). Data from Ivy GAP. The Cancer Imaging Archive. http://dx.doi.org/10.7937/K9/TCIA.2016.XLwaN6nL TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1216	Glioblastoma	unknown	Male	Data Citation: Nameeta Shah, Ph.D., Xu Feng, Ph.D., Michael Lankerovich, Ph.D., Ralph B. Puchalski, Ph.D., Bart Keogh, M.D., Ph.D. (2016). Data from Ivy GAP. The Cancer Imaging Archive. http://dx.doi.org/10.7937/K9/TCIA.2016.XLwaN6nL TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1217	Glioblastoma	unknown	Male	Data Citation: Scarpace, L., Mikkelsen, T., Cha, soonmee, Rao, S., Tekchandani, S., Gutman, D., … Pierce, L. J. (2016). Radiology Data from The Cancer Genome Atlas Glioblastoma Multiforme [TCGA-GBM] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.RNYFUYE9 TCGA Attribution: The data generated by the TCGA Research Network: http://cancergenome.nih.gov/. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1218	Glioblastoma	unknown	Male	Data Citation: Scarpace, L., Mikkelsen, T., Cha, soonmee, Rao, S., Tekchandani, S., Gutman, D., … Pierce, L. J. (2016). Radiology Data from The Cancer Genome Atlas Glioblastoma Multiforme [TCGA-GBM] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.RNYFUYE9 TCGA Attribution: The data generated by the TCGA Research Network: http://cancergenome.nih.gov/. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1219	Head and Neck Carcinoma	unknown	Male	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1220	Head and Neck Carcinoma	unknown	Male	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1221	Head and Neck Carcinoma	unknown	Male	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1222	Head and Neck Carcinoma	unknown	Male	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1223	Head and Neck Carcinoma	unknown	Male	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1224	Head and Neck Carcinoma	unknown	Female	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1225	Head and Neck Carcinoma	unknown	Male	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1226	Head and Neck Carcinoma	unknown	Male	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1227	Head and Neck Carcinoma	unknown	Male	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1228	Head and Neck Carcinoma	unknown	Male	Data Citation: Beichel R R, Ulrich E J, Bauer C, Wahle A, Brown B, Chang T, Plichta K A, Smith B J, Sunderland J J, Braun T, Fedorov A, Clunie D, Onken M, Riesmeier J, Pieper S, Kikinis R, Graham M M, Casavant T L, Sonka M, Buatti J M. (2015). Data From QIN-HEADNECK. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.K0F5CGLI Publication Citation: Fedorov A, Clunie D, Ulrich E, Bauer C, Wahle A, Brown B, Onken M, Riesmeier J, Pieper S, Kikinis R, Buatti J, Beichel RR. (2016) DICOM for quantitative imaging biomarker development: a standards based approach to sharing clinical data and structured PET/CT analysis results in head and neck cancer research. PeerJ 4:e2057 https://doi.org/10.7717/peerj.2057 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1229	Esophageal Carcinoma	unknown	Male	TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1230	Esophageal Carcinoma	unknown	Male	TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1231	Esophageal Carcinoma	unknown	Female	TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1232	Esophageal Carcinoma	unknown	Male	TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1233	Esophageal Carcinoma	unknown	Female	TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1234	Esophageal Carcinoma	unknown	Female	TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1235	Esophageal Carcinoma	unknown	Male	TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1236	Esophageal Carcinoma	unknown	Male	TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1237	Esophageal Carcinoma	unknown	Male	TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.

Anatomage Table 9.0 Case Library Descriptions

				TCGA Attribution: The data sets generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lucchesi, F. R., & Aredes, N. D. (2016). Radiology Data from The Cancer Genome Atlas Esophageal Carcinoma [TCGA-ESCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VPTNRGFY
1238	Esophageal Carcinoma	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Frontal Lobe Tumor Grade: G2 Histologic Diagnosis: Astrocytoma Supratentorial Localization: Cerebral Cortex Clinical History: - No history of other malignancy - History of seizures - No history of headaches - No history of asthma - No history of eczema - Allergic to dogs and cats Family history of cancer and brain tumor. First Presenting Symptom: Seizures Symptom Changes: - No reported mental status changes - No sensory changes - No motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
1239	Low Grade Glioma	30s	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Frontal Lobe Tumor Grade: G2 Histologic Diagnosis: Astrocytoma Supratentorial Localization: Cerebral Cortex Clinical History: - No history of other malignancy - History of headaches - No history of asthma - No history of eczema - No history of seizures - No noted allergies First Presenting Symptom: Headaches TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
1240	Low Grade Glioma	60s	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Temporal Lobe Tumor Grade: G2 Histologic Diagnosis: Astrocytoma Supratentorial Localization: Cerebral Cortex Clinical History: - No history of other malignancy - No history of headaches First Presenting Symptom: Mental status change Symptom Changes: - No visual changes - No sensory changes - No motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
1241	Low Grade Glioma	50s	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, parietal Lobe Tumor Grade: G2 Histologic Diagnosis: Oligodendroglioma Supratentorial Localization: Cerebral Cortex Clinical History: - No history of other malignancy - No history of seizures No family history of cancer and brain tumor. First Presenting Symptom: Sensory Changes Symptom Changes: - No reported mental status changes - Motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
1242	Low Grade Glioma	40s	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Temporal Lobe Tumor Grade: G3 Histologic Diagnosis: Oligodendroglioma Supratentorial Localization: Cerebral Cortex Clinical History: - History of other malignancy - No history of seizures - History of headaches No family history of cancer or brain tumors. First Presenting Symptom: Headaches Symptom Changes: - No reported mental status changes - No sensory changes - No motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
1243	Low Grade Glioma	40s	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Parietal Lobe Tumor Grade: G2 Histologic Diagnosis: Oligodendroglioma Supratentorial Localization: White Matter Clinical History: - No history of other malignancy - History of seizures - No history of headaches - History of shellfish allergy - History of allergy to processed food Family history of cancer; no family history of brain tumors. First Presenting Symptom: Seizures Symptom Changes: - No reported mental status changes - No sensory changes - No motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
1244	Low Grade Glioma	60s	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Parietal Lobe Tumor Grade: G3 Histologic Diagnosis: Oligodendroglioma Supratentorial Localization: White Matter Clinical History: - No history of other malignancy - History of seizures - History of headaches - History of shellfish allergy No family history of cancer or brain tumors. First Presenting Symptom: Seizures Symptom Changes: - No reported mental status changes - No sensory changes - No motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
1245	Low Grade Glioma	30s	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Frontal Lobe Tumor Grade: G3 Histologic Diagnosis: Astrocytoma Supratentorial Localization: White Matter Clinical History: - No history of other malignancy - History of seizures - No history of headaches No family history of cancer or brain tumors. First Presenting Symptom: Seizures Symptom Changes: - No reported mental status changes - No sensory changes - Motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
1246	Low Grade Glioma	30s	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)

Anatomage Table 9.0 Case Library Descriptions

				Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Temporal Lobe Tumor Grade: G3 Histologic Diagnosis: Astrocytoma Supratentorial Localization: Not listed in medical record Clinical History: - No history of other malignancy - History of seizure - No history of headaches Family history of cancer: no family history of brain tumors. First Presenting Symptom: Seizures Symptom Changes: - No reported mental status changes - No seizure changes - No motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
1247	Low Grade Glioma	60s	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1248	Benign Lung Nodule	70	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1249	Benign Lung Nodule	70	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1250	Benign Lung Nodule	84	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1251	Malignant Lung Nodule	50	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1252	Malignant Lung Nodule	62	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1253	Malignant Lung Nodule	64	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1254	Malignant Lung Nodule	73	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1255	Benign Lung Nodule	42	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1256	Malignant Lung Nodule	65	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSI3FL Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
1257	Benign Lung Nodule	37	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Fedorov, Charles, McNitt-Gray, Michael F., Clunie, David, Gavrielides, Marios A., Petrick, Nicholas, Samei, Ehsan, ... Sharak, Katherine. (2016). Data from QIBA CT-1C. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YqKr0HdU
1258	Lung Cancer	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Patient Race: African American or Black No history of other malignancy. History of smoking tobacco for 20 years. Stage IV, T2 tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Linehan, M., Gautam, R., Kirk, S., Lee, Y., Roche, C., Bonaccio, E., ... Jarosz, R. (2016). Radiology Data from The Cancer Genome Atlas Cervical Kidney renal papillary cell carcinoma [KIRP] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.ACWOGBEF
1259	Papillary Renal Cell Carcinoma	50	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Patient Race: White; not Hispanic No history of other malignancy. History of smoking tobacco for 46 years. T2a tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Linehan, M., Gautam, R., Kirk, S., Lee, Y., Roche, C., Bonaccio, E., ... Jarosz, R. (2016). Radiology Data from The Cancer Genome Atlas Cervical Kidney renal papillary cell carcinoma [KIRP] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.ACWOGBEF
1260	Papillary Renal Cell Carcinoma	72	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Patient Race: White; not Hispanic No history of other malignancy. Stage I, T1b tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Linehan, M., Gautam, R., Kirk, S., Lee, Y., Roche, C., Bonaccio, E., ... Jarosz, R. (2016). Radiology Data from The Cancer Genome Atlas Cervical Kidney renal papillary cell carcinoma [KIRP] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.ACWOGBEF
1261	Papillary Renal Cell Carcinoma	39	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Patient Race: White; not Hispanic History of synchronous/bilateral malignancy Stage I T1b tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Linehan, M. W., Gautam, R., Sadow, C. A., & Levine, S. (2016). Radiology Data from The Cancer Genome Atlas Kidney Chromophobe [TCGA-KICH] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YUBHG2CN
1262	Chromophobe Renal Cell Carcinoma	31	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Patient Race: African American or Black No history of other malignancies Stage III T3a tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Linehan, M. W., Gautam, R., Sadow, C. A., & Levine, S. (2016). Radiology Data from The Cancer Genome Atlas Kidney Chromophobe [TCGA-KICH] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YUBHG2CN
1263	Chromophobe Renal Cell Carcinoma	38	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. History of synchronous/bilateral malignancy Stage II T2 tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Linehan, M. W., Gautam, R., Sadow, C. A., & Levine, S. (2016). Radiology Data from The Cancer Genome Atlas Kidney Chromophobe [TCGA-KICH] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YUBHG2CN
1264	Chromophobe Renal Cell Carcinoma	39	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Patient Race: White; not Hispanic No history of other malignancies Left GI tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov Data Citation: Akin, O., Elnajjar, P., Heller, M., Jarosz, R., Erickson, B. J., Kirk, S., ... Filippini, J. (2016). Radiology Data from The Cancer Genome Atlas Kidney Renal Clear Cell Carcinoma [TCGA-KIRC] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VtI9WVTDR
1265	Clear Cell Renal Carcinoma	76	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Patient Race: White No history of other malignancies Right GI tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov Data Citation: Akin, O., Elnajjar, P., Heller, M., Jarosz, R., Erickson, B. J., Kirk, S., ... Filippini, J. (2016). Radiology Data from The Cancer Genome Atlas Kidney Renal Clear Cell Carcinoma [TCGA-KIRC] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.VtI9WVTDR
1266	Clear Cell Renal Carcinoma	47	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Left ductal carcinoma in situ Patient positive for ER and PR; HER2 negative Data Citation: Bloch, B. Nicolas, Jain, Anhali, & Jaffe, C. Carl. (2015). Data From BREAST-DIAGNOSIS. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.SDNRQXXR
1267	Ductal Carcinoma in Situ	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Right ductal carcinoma in situ Patient tested positive for ER, PR, HER2, and E-Cadherin IMPRESSION: Post lumpectomy changes in the right breast. Residual cluster of indeterminate calcifications in the upper-outer quadrant of the right breast. Data Citation: Bloch, B. Nicolas, Jain, Anhali, & Jaffe, C. Carl. (2015). Data From BREAST-DIAGNOSIS. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.SDNRQXXR
1268	Ductal Carcinoma in Situ	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Left ductal carcinoma in situ Patient tested negative for ER and PR; positive for HER2 Data Citation: Bloch, B. Nicolas, Jain, Anhali, & Jaffe, C. Carl. (2015). Data From BREAST-DIAGNOSIS. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.SDNRQXXR
1269	Ductal Carcinoma in Situ	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.

1270	Ductal Carcinoma in Situ	50	Female	Left ductal carcinoma in situ; solid type; nuclear grade III/III Patient tested positive for ER and HER2; negative for PR IMPRESSION: 1) 1cm mass at the 11:00 position in the left breast with suspicious enhancement adjacent to a surgical clip at site of biopsy proven invasive ductal carcinoma 2) Second surgical clip the upper, inner quadrant of the right breast at the area of a second site of invasive ductal carcinoma. There is only a minimal residual amount of progressive enhancement surrounding the clip. 3) No suspicious appearing lymph nodes in either axilla. 4) No evidence of malignancy in the right breast. Data Citation: Bloch, B. Nicolas, Jain, Ashali, & Jaffe, C. Carl. (2015). Data From BREAST-DIAGNOSIS. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.SDNRQXXR TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1271	Invasive Intraductal Carcinoma	45	Female	Left invasive intraductal carcinoma Patient history of left breast cancer (invasive ductal carcinoma) Status: post left partial mastectomy Expected post-treatment findings in the left breast with a seroma at the surgical site. No suspicous enhancement in the lumpectomy bed nor in the remainder of the left breast. Data Citation: Bloch, B. Nicolas, Jain, Ashali, & Jaffe, C. Carl. (2015). Data From BREAST-DIAGNOSIS. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.SDNRQXXR TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1272	Benign Breast Tumor	unknown	Female	Benign breast tumor. Data Citation: Bloch, B. Nicolas, Jain, Ashali, & Jaffe, C. Carl. (2015). Data From BREAST-DIAGNOSIS. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.SDNRQXXR TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1273	Post-Mastectomy Invasive Ductal Carcinoma	unknown	Female	Post-mastectomy right invasive ductal carcinoma Patient tested positive for ER, PR, and E-Cadherin; negative for HER2 Mastectomy show invasive ductal with axillary mets Data Citation: Bloch, B. Nicolas, Jain, Ashali, & Jaffe, C. Carl. (2015). Data From BREAST-DIAGNOSIS. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.SDNRQXXR TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1274	Tumor Free Breast	68	Female	Tumor free breast. TCGA Attribution:The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Lingle, W., Erickson, B. J., Zuley, M. L., Jarosz, R., Bonaccio, E., Filippini, J., … Gruszauskas, N. (2016). Radiology Data from The Cancer Genome Atlas Breast Invasive Carcinoma [TCGA-BRCA] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.AB2NAZRP TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1275	Breast Cancer	26	Female	Data Citation: David Newitt, Nola Hylton, on behalf of the I-SPY 1 Network and ACRIN 6657 Trial Team. (2016). Multi-center breast DCE-MRI data and segmentations from patients in the I-SPY 1/ACRIN 6657 trials. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HdHpgJLK Publication Citation: Hylton NM, Gatsonis CA, Rosen MA, et al: Neoadjuvant Chemotherapy for Breast Cancer: Functional Tumor Volume by MR Imaging Predicts Recurrence-free Survival-Results from the ACRIN 6657/CALGB 150007 I-SPY 1 TRIAL. Radiology 279:44-55, 2016. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1276	Breast Cancer	31	Female	Data Citation: David Newitt, Nola Hylton, on behalf of the I-SPY 1 Network and ACRIN 6657 Trial Team. (2016). Multi-center breast DCE-MRI data and segmentations from patients in the I-SPY 1/ACRIN 6657 trials. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HdHpgJLK Publication Citation: Hylton NM, Gatsonis CA, Rosen MA, et al: Neoadjuvant Chemotherapy for Breast Cancer: Functional Tumor Volume by MR Imaging Predicts Recurrence-free Survival-Results from the ACRIN 6657/CALGB 150007 I-SPY 1 TRIAL. Radiology 279:44-55, 2016. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1277	Breast Cancer	38	Female	Data Citation: David Newitt, Nola Hylton, on behalf of the I-SPY 1 Network and ACRIN 6657 Trial Team. (2016). Multi-center breast DCE-MRI data and segmentations from patients in the I-SPY 1/ACRIN 6657 trials. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HdHpgJLK Publication Citation: Hylton NM, Gatsonis CA, Rosen MA, et al: Neoadjuvant Chemotherapy for Breast Cancer: Functional Tumor Volume by MR Imaging Predicts Recurrence-free Survival-Results from the ACRIN 6657/CALGB 150007 I-SPY 1 TRIAL. Radiology 279:44-55, 2016. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1278	Breast Cancer	52	Female	Data Citation: David Newitt, Nola Hylton, on behalf of the I-SPY 1 Network and ACRIN 6657 Trial Team. (2016). Multi-center breast DCE-MRI data and segmentations from patients in the I-SPY 1/ACRIN 6657 trials. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HdHpgJLK Publication Citation: Hylton NM, Gatsonis CA, Rosen MA, et al: Neoadjuvant Chemotherapy for Breast Cancer: Functional Tumor Volume by MR Imaging Predicts Recurrence-free Survival-Results from the ACRIN 6657/CALGB 150007 I-SPY 1 TRIAL. Radiology 279:44-55, 2016. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1279	Breast Cancer	58	Female	Data Citation: David Newitt, Nola Hylton, on behalf of the I-SPY 1 Network and ACRIN 6657 Trial Team. (2016). Multi-center breast DCE-MRI data and segmentations from patients in the I-SPY 1/ACRIN 6657 trials. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HdHpgJLK Publication Citation: Hylton NM, Gatsonis CA, Rosen MA, et al: Neoadjuvant Chemotherapy for Breast Cancer: Functional Tumor Volume by MR Imaging Predicts Recurrence-free Survival-Results from the ACRIN 6657/CALGB 150007 I-SPY 1 TRIAL. Radiology 279:44-55, 2016. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1280	Breast Cancer	65	Female	Data Citation: David Newitt, Nola Hylton, on behalf of the I-SPY 1 Network and ACRIN 6657 Trial Team. (2016). Multi-center breast DCE-MRI data and segmentations from patients in the I-SPY 1/ACRIN 6657 trials. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HdHpgJLK Publication Citation: Hylton NM, Gatsonis CA, Rosen MA, et al: Neoadjuvant Chemotherapy for Breast Cancer: Functional Tumor Volume by MR Imaging Predicts Recurrence-free Survival-Results from the ACRIN 6657/CALGB 150007 I-SPY 1 TRIAL. Radiology 279:44-55, 2016. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1281	Breast Cancer	48	Female	Data Citation: David Newitt, Nola Hylton, on behalf of the I-SPY 1 Network and ACRIN 6657 Trial Team. (2016). Multi-center breast DCE-MRI data and segmentations from patients in the I-SPY 1/ACRIN 6657 trials. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HdHpgJLK Publication Citation: Hylton NM, Gatsonis CA, Rosen MA, et al: Neoadjuvant Chemotherapy for Breast Cancer: Functional Tumor Volume by MR Imaging Predicts Recurrence-free Survival-Results from the ACRIN 6657/CALGB 150007 I-SPY 1 TRIAL. Radiology 279:44-55, 2016. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1282	Breast Cancer	28	Female	Data Citation: David Newitt, Nola Hylton, on behalf of the I-SPY 1 Network and ACRIN 6657 Trial Team. (2016). Multi-center breast DCE-MRI data and segmentations from patients in the I-SPY 1/ACRIN 6657 trials. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HdHpgJLK Publication Citation: Hylton NM, Gatsonis CA, Rosen MA, et al: Neoadjuvant Chemotherapy for Breast Cancer: Functional Tumor Volume by MR Imaging Predicts Recurrence-free Survival-Results from the ACRIN 6657/CALGB 150007 I-SPY 1 TRIAL. Radiology 279:44-55, 2016. TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1283	Breast Cancer	unknown	Female	Data Citation: Meyer, Charles R, Chenevert, Thomas L., Galbán, Craig J, Johnson, Timothy D, Hamstra, Daniel A, Rehemtulla, Alnawaz, & Ross, Brian D. (2015). Data From RIDER_Breast_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.H1SXNUXL TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1284	Breast Cancer	unknown	Female	Data Citation: Meyer, Charles R, Chenevert, Thomas L., Galbán, Craig J, Johnson, Timothy D, Hamstra, Daniel A, Rehemtulla, Alnawaz, & Ross, Brian D. (2015). Data From RIDER_Breast_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.H1SXNUXL TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1285	Breast Cancer	unknown	Female	Data Citation: Meyer, Charles R, Chenevert, Thomas L., Galbán, Craig J, Johnson, Timothy D, Hamstra, Daniel A, Rehemtulla, Alnawaz, & Ross, Brian D. (2015). Data From RIDER_Breast_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.H1SXNUXL TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1286	Breast Cancer	unknown	Female	Data Citation: Meyer, Charles R, Chenevert, Thomas L., Galbán, Craig J, Johnson, Timothy D, Hamstra, Daniel A, Rehemtulla, Alnawaz, & Ross, Brian D. (2015). Data From RIDER_Breast_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.H1SXNUXL TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1287	Breast Cancer	unknown	Female	Data Citation: Meyer, Charles R, Chenevert, Thomas L., Galbán, Craig J, Johnson, Timothy D, Hamstra, Daniel A, Rehemtulla, Alnawaz, & Ross, Brian D. (2015). Data From RIDER_Breast_MRI. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.H1SXNUXL TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1288	Breast Cancer	27	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1289	Breast Cancer	39	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1290	Breast Cancer	62	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1291	Breast Cancer	56	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1292	Breast Cancer	65	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1293	Breast Cancer	46	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1294	Breast Cancer	33	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1295	Breast Cancer	41	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1296	Breast Cancer	35	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1297	Breast Cancer	39	Female	Data Citation: Huang, Wei, Tudorica, Alina, Chui, Stephen, Kemmer, Kathleen, Naik, Arpana, Troxell, Megan, … Holtorf, Megan. (2014). Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2014.A2N1IXOX TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Publication Citation: Huang W, Li X, Chen Y, Li X, Chang MC, Oborski MJ, Malyarenko DI, Muzi M, Jajamovich GH, Fedorov A, Tudorica A, Gupta SN, Laymon CM, Marro KI, Dyvorne HA, Miller JV, Barbodiak DP, Chenevert TL, Yankeelov TE, Mountz JM, Kinahan PE, Kikinis R, Taouli B, Fennessy F, Kalpathy-Cramer J. Variations of dynamic contrast-enhanced magnetic resonance imaging in evaluation of breast cancer therapy response: a multicenter data analysis challenge. Trans Oncol 2014;7:153-166. PubMed PMID: 24772219; PubMed Central PMCID: PMC3998693.
1298	Colon Adenocarcinoma	unknown	Male	Race: White; not Hispanic or Latino No history of other malignancy. Stage III tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Kirk, S., Lee, Y., Sadow, C. A., Levine, S., Roche, C., Bonaccio, E., & Filiippini, J. (2016). Radiology Data from The Cancer Genome Atlas Colon Adenocarcinoma [TCGA-COAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HJJHBOXZ TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1299	Colon Adenocarcinoma	unknown	Female	Race: White; not Hispanic or Latino No history of other malignancy. Stage IV tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Kirk, S., Lee, Y., Sadow, C. A., Levine, S., Roche, C., Bonaccio, E., & Filiippini, J. (2016). Radiology Data from The Cancer Genome Atlas Colon Adenocarcinoma [TCGA-COAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HJJHBOXZ TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1300	Colon Adenocarcinoma	unknown	Female	Race: White; not Hispanic or Latino No history of other malignancy. Stage IIB tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Kirk, S., Lee, Y., Sadow, C. A., Levine, S., Roche, C., Bonaccio, E., & Filiippini, J. (2016). Radiology Data from The Cancer Genome Atlas Colon Adenocarcinoma [TCGA-COAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HJJHBOXZ TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1301	Prostate Cancer	unknown	Male	Data Citation: Kurdziel, Karen A, Apolo, Andrea B., Lindenberg, Liza, Mena, Esther, McKinney, Yolanda Y., Adler, Stephen S., … Choyke, Peter L. (2015). Data From NaF_PROSTATE. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.ISOQTHKO Publication Citation: Kurdziel, K. A., Shih, J. H., Apolo, A. B., Lindenberg, L., Mena, E., McKinney, Y. Y., … Choyke, P. L. (2012, June 22). The Kinetics and Reproducibility of 18F-Sodium Fluoride for Oncology Using Current PET Camera Technology. Journal of Nuclear Medicine. Society of Nuclear Medicine. http://doi.org/10.2967/jnumed.111.100883 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper)
1302	Virtual Colonography	unknown	Female	Colonography - no polyp found. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., … Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1303	Virtual Colonography	unknown	Male	Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., … Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1304	Virtual Colonography	unknown	Male	Colonography - no polyp found. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., … Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
1305	Virtual Colonography	unknown	Female	Colonography - no polyp found. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., … Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.

Anatomage Table 9.0 Case Library Descriptions

			Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1306	Virtual Colonography	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1307	Virtual Colonography	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 55mm polyp present in cecum. Lesion histology: adenocarcinoma Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1308	Virtual Colonography	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Colonography - no polyp found Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1309	Virtual Colonography	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Colonography - no polyp found Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1310	Virtual Colonography	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1311	Virtual Colonography	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 30mm polyp present in cecum. Lesion histology: adenocarcinoma Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1312	Virtual Colonography	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 10mm polyp present in ascending colon. Lesion histology: tubular adenoma 6mm polyp present in transverse colon 3mm polyp in rectum Lesion histology: hyperplastic Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1313	Virtual Colonography	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 10mm polyp present in rectum. Lesion histology: tubulovillous adenoma 6mm polyp present in ascending colon. Lesion histology: tubular adenoma Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1314	Virtual Colonography	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 2mm polyp present in ascending colon. Lesion histology: tubular adenoma 6mm polyp present in transverse colon. Lesion histology: tubular adenoma 15mm polyp present in ascending colon Lesion histology: tubular adenoma Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1315	Virtual Colonography	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 30mm polyp present in rectum. Lesion histology: tubulovillous adenoma 5mm polyp present in transverse colon. Lesion histology: tubular adenoma Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1316	Virtual Colonography	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 10mm polyp present in sigmoid colon. Lesion histology: tubulovillous Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1317	Virtual Colonography	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 30mm polyp present in cecum. Lesion histology: tubulovillous adenoma Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
			Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
1318	Virtual Colonography	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/."
1319	Prostatic Acinar Adenocarcinoma	unknown	Male	Data Citation: Zuley, M. L., Jarosz, R., Drake, B. F., Rancilio, D., Klim, A., Rieger-Christ, K., & Lemmerman, J. (2016). Radiology Data from The Cancer Genome Atlas Prostate Adenocarcinoma [TCGA-PRAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YXOGKM4Y TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/."
1320	Prostatic Acinar Adenocarcinoma	unknown	Male	Data Citation: Zuley, M. L., Jarosz, R., Drake, B. F., Rancilio, D., Klim, A., Rieger-Christ, K., & Lemmerman, J. (2016). Radiology Data from The Cancer Genome Atlas Prostate Adenocarcinoma [TCGA-PRAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YXOGKM4Y TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/."
1321	Prostatic Acinar Adenocarcinoma	unknown	Male	Data Citation: Zuley, M. L., Jarosz, R., Drake, B. F., Rancilio, D., Klim, A., Rieger-Christ, K., & Lemmerman, J. (2016). Radiology Data from The Cancer Genome Atlas Prostate Adenocarcinoma [TCGA-PRAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YXOGKM4Y TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/."
1322	Prostatic Acinar Adenocarcinoma	unknown	Male	Data Citation: Zuley, M. L., Jarosz, R., Drake, B. F., Rancilio, D., Klim, A., Rieger-Christ, K., & Lemmerman, J. (2016). Radiology Data from The Cancer Genome Atlas Prostate Adenocarcinoma [TCGA-PRAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YXOGKM4Y TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/."
1323	Prostatic Acinar Adenocarcinoma	unknown	Male	Data Citation: Zuley, M. L., Jarosz, R., Drake, B. F., Rancilio, D., Klim, A., Rieger-Christ, K., & Lemmerman, J. (2016). Radiology Data from The Cancer Genome Atlas Prostate Adenocarcinoma [TCGA-PRAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YXOGKM4Y TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/."
1324	Prostatic Acinar Adenocarcinoma	unknown	Male	Data Citation: Zuley, M. L., Jarosz, R., Drake, B. F., Rancilio, D., Klim, A., Rieger-Christ, K., & Lemmerman, J. (2016). Radiology Data from The Cancer Genome Atlas Prostate Adenocarcinoma [TCGA-PRAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YXOGKM4Y TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/."
1325	Prostatic Acinar Adenocarcinoma	unknown	Male	Data Citation: Zuley, M. L., Jarosz, R., Drake, B. F., Rancilio, D., Klim, A., Rieger-Christ, K., & Lemmerman, J. (2016). Radiology Data from The Cancer Genome Atlas Prostate Adenocarcinoma [TCGA-PRAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YXOGKM4Y TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/."
1326	Prostatic Acinar Adenocarcinoma	unknown	Male	Data Citation: Zuley, M. L., Jarosz, R., Drake, B. F., Rancilio, D., Klim, A., Rieger-Christ, K., & Lemmerman, J. (2016). Radiology Data from The Cancer Genome Atlas Prostate Adenocarcinoma [TCGA-PRAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YXOGKM4Y TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/."
1327	Prostatic Acinar Adenocarcinoma	unknown	Male	Data Citation: Zuley, M. L., Jarosz, R., Drake, B. F., Rancilio, D., Klim, A., Rieger-Christ, K., & Lemmerman, J. (2016). Radiology Data from The Cancer Genome Atlas Prostate Adenocarcinoma [TCGA-PRAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YXOGKM4Y TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Kurdziel, Karen A, Apolo, Andrea B., Lindenberg, Liza, Muna, Esther, McKinney, Yolanda Y., Adler, Stephen S., . . . Choyke, Peter L. (2015). Data From NaF_PROSTATE. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.BOQTHKO
			Publication Citation: Kurdziel, K. A., Shih, J. H., Apolo, A. B., Lindenberg, L., Mena, E., McKinney, Y. Y., . . . Choyke, P. L. (2012, June 22). The Kinetics and Reproducibility of 18F-Sodium Fluoride for Oncology Using Current PET Camera Technology. Journal of Nuclear Medicine. Society of Nuclear Medicine. http://doi.org/10.2967/jnumed.111.100883
1328	Prostate Cancer	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Kurdziel, Karen A, Apolo, Andrea B., Lindenberg, Liza, Muna, Esther, McKinney, Yolanda Y., Adler, Stephen S., . . . Choyke, Peter L. (2015). Data From NaF_PROSTATE. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.BOQTHKO
			Publication Citation: Kurdziel, K. A., Shih, J. H., Apolo, A. B., Lindenberg, L., Mena, E., McKinney, Y. Y., . . . Choyke, P. L. (2012, June 22). The Kinetics and Reproducibility of 18F-Sodium Fluoride for Oncology Using Current PET Camera Technology. Journal of Nuclear Medicine. Society of Nuclear Medicine. http://doi.org/10.2967/jnumed.111.100883
1329	Prostate Cancer	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Holger, Roth, Lu, Le, Seff, Ari, Cherry, Kevin M, Hoffman, Joanne, Wang, Shijun, . . . Summers, Ronald M. (2015). Anew 2.5 D representation for lymph node detection in CT. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.AQIEICNM
			Publication Citation: Roth, Holger R and Lu, Le and Seff, Ari and Cherry, Kevin M and Hoffman, Joanne and Wang, Shijun and Liu, Jiamin and Turkbey, Evrim and Summers, Ronald M. A new 2.5 D representation for lymph node detection using random sets of deep convolutional neural network observations. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p520-527, 2014.
			Publication Citation: Seff, Ari and Lu, Le and Cherry, Kevin M and Roth, Holger R and Liu, Jiamin and Wang, Shijun and Hoffman, Joanne and Turkbey, Evrim B and Summers, Ronald M. 2D view aggregation for lymph node detection using a shallow hierarchy of linear classifiers. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p544-552, 2014.
			Publication Citation: A Seff, L Lu, A Barbu, H Roth, HC Shin, RM Summers. Leveraging Mid-Level Semantic Boundary Cues for Automated Lymph Node Detection. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2015, 53-61 (http://link.springer.com/chapter/10.1007/978-3-319-24571-3_7)
1330	Lymphadenopathy	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Data Citation: Holger, Roth, Lu, Le, Seff, Ari, Cherry, Kevin M, Hoffman, Joanne, Wang, Shijun, . . . Summers, Ronald M. (2015). Anew 2.5 D representation for lymph node detection in CT. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.AQIEICNM
			Publication Citation: Roth, Holger R and Lu, Le and Seff, Ari and Cherry, Kevin M and Hoffman, Joanne and Wang, Shijun and Liu, Jiamin and Turkbey, Evrim and Summers, Ronald M. A new 2.5 D representation for lymph node detection using random sets of deep convolutional neural network observations. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p520-527, 2014.
			Publication Citation: Seff, Ari and Lu, Le and Cherry, Kevin M and Roth, Holger R and Liu, Jiamin and Wang, Shijun and Hoffman, Joanne and Turkbey, Evrim B and Summers, Ronald M. 2D view aggregation for lymph node detection using a shallow hierarchy of linear classifiers. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p544-552, 2014.
			Publication Citation: A Seff, L Lu, A Barbu, H Roth, HC Shin, RM Summers. Leveraging Mid-Level Semantic Boundary Cues for Automated Lymph Node Detection. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2015, 53-61 (http://link.springer.com/chapter/10.1007/978-3-319-24571-3_7)
1331	Lymphadenopathy	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Data Citation: Holger, Roth, Lu, Le, Seff, Ari, Cherry, Kevin M, Hoffman, Joanne, Wang, Shijun, . . . Summers, Ronald M. (2015). Anew 2.5 D representation for lymph node detection in CT. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.AQIEICNM
			Publication Citation: Roth, Holger R and Lu, Le and Seff, Ari and Cherry, Kevin M and Hoffman, Joanne and Wang, Shijun and Liu, Jiamin and Turkbey, Evrim and Summers, Ronald M. A new 2.5 D representation for lymph node detection using random sets of deep convolutional neural network observations. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p520-527, 2014.
			Publication Citation: Seff, Ari and Lu, Le and Cherry, Kevin M and Roth, Holger R and Liu, Jiamin and Wang, Shijun and Hoffman, Joanne and Turkbey, Evrim B and Summers, Ronald M. 2D view aggregation for lymph node detection using a shallow hierarchy of linear classifiers. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p544-552, 2014.
			Publication Citation: A Seff, L Lu, A Barbu, H Roth, HC Shin, RM Summers. Leveraging Mid-Level Semantic Boundary Cues for Automated Lymph Node Detection. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2015, 53-61 (http://link.springer.com/chapter/10.1007/978-3-319-24571-3_7)
1332	Lymphadenopathy	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Data Citation: Holger, Roth, Lu, Le, Seff, Ari, Cherry, Kevin M, Hoffman, Joanne, Wang, Shijun, . . . Summers, Ronald M. (2015). Anew 2.5 D representation for lymph node detection in CT. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.AQIEICNM
			Publication Citation: Roth, Holger R and Lu, Le and Seff, Ari and Cherry, Kevin M and Hoffman, Joanne and Wang, Shijun and Liu, Jiamin and Turkbey, Evrim and Summers, Ronald M. A new 2.5 D representation for lymph node detection using random sets of deep convolutional neural network observations. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p520-527, 2014.
			Publication Citation: Seff, Ari and Lu, Le and Cherry, Kevin M and Roth, Holger R and Liu, Jiamin and Wang, Shijun and Hoffman, Joanne and Turkbey, Evrim B and Summers, Ronald M. 2D view aggregation for lymph node detection using a shallow hierarchy of linear classifiers. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p544-552, 2014.
			Publication Citation: A Seff, L Lu, A Barbu, H Roth, HC Shin, RM Summers. Leveraging Mid-Level Semantic Boundary Cues for Automated Lymph Node Detection. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2015, 53-61 (http://link.springer.com/chapter/10.1007/978-3-319-24571-3_7)
1333	Lymphadenopathy	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Data Citation: Holger, Roth, Lu, Le, Seff, Ari, Cherry, Kevin M, Hoffman, Joanne, Wang, Shijun, . . . Summers, Ronald M. (2015). Anew 2.5 D representation for lymph node detection in CT. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.AQIEICNM
			Publication Citation: Roth, Holger R and Lu, Le and Seff, Ari and Cherry, Kevin M and Hoffman, Joanne and Wang, Shijun and Liu, Jiamin and Turkbey, Evrim and Summers, Ronald M. A new 2.5 D representation for lymph node detection using random sets of deep convolutional neural network observations. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p520-527, 2014.
			Publication Citation: Seff, Ari and Lu, Le and Cherry, Kevin M and Roth, Holger R and Liu, Jiamin and Wang, Shijun and Hoffman, Joanne and Turkbey, Evrim B and Summers, Ronald M. 2D view aggregation for lymph node detection using a shallow hierarchy of linear classifiers. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2014, p544-552, 2014.
			Publication Citation: A Seff, L Lu, A Barbu, H Roth, HC Shin, RM Summers. Leveraging Mid-Level Semantic Boundary Cues for Automated Lymph Node Detection. Medical Image Computing and Computer-Assisted Intervention–MICCAI 2015, 53-61 (http://link.springer.com/chapter/10.1007/978-3-319-24571-3_7)
1334	Lymphadenopathy	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.

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				Publication Citation: Seff, Ari and Lu, Le and Cherry, Kevin M and Roth, Holger R and Liu, Jiamin and Wang, Shijun and Hoffman, Joanne and Turkbey, Evrim B and Summers, Ronald M. 2D view aggregation for lymph node detection using a shallow hierarchy of linear classifiers. Medical Image Computing and Computer-Assisted Intervention--MICCAI 2014, p544-552, 2014.
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1335	Lymphadenopathy	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
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1336	Lymphadenopathy	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
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1337	Lymphadenopathy	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
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1338	Lymphadenopathy	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
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1339	Lymphadenopathy	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
2013	Embryo Stage 13 (28-32 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2014	Embryo Stage 14 (31-35 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2015	Embryo Stage 15 (35-38 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2016	Embryo Stage 16 (37-42 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2017	Embryo Stage 17 (42-44 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2018	Embryo Stage 18 (44-48 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2019	Embryo Stage 19 (48-51 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2020	Embryo Stage 20 (51-53 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2022	Embryo Stage 22 (54-58 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2023	Embryo Stage 23 (56-60 Days)	unknown	unknown	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2024	Fetal Brain Cyst	22	Female	Image Data Source: Brad Smith, University of Michigan (bsbsmith@umich.edu). NIH award N01-HD-9-3257 P1G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University
2025	Umbilical Cord Cysts	22	Female	A female in her early 20's (G1P0) at 24wkd presented for a follow up MRI after an ultrasound showed complications with the pregnancy. The MRI confirmed the ultrasound findings. The pregnancy was complicated by allantoic-urachal complex and a Low Grade Squamous Intraepithelial Lesion (LGSIL) pap smear. Four cysts are identified along the course of the umbilical cord consistent with allantoic cysts. The cyst closest to the fetal abdominal wall communicates directly with the urinary bladder (measures 3 cm in size). The largest cyst measures 6x6 cm. A c-section was suggested to avoid dissection of the umbilical cord or avulsion. 1. Single male fe
2026	Tutorial Hematoma	22	Female	A female in her mid-20's (G2P0001), 28 weeks gestation, presented for an MRI and blood work after an abnormal ultrasound. The ultrasound diagnosed a fetal intracranial mass consistent with intracranial bleeding. MRI findings were consistent with a large subdural hematoma of the posterior aspect of the brain consistent with a large hematoma involving the tentorium and posterior falx. A small focal clot was also noted on the left side of the tentorium. Elevation of the occipital lobes is noted due to the hematoma along with compression of the posterior fossa & cerebellar hemispheres. 1. Single male fetus in the vertex loc 2. Large subdural hematoma
2027	Dandy Walker Malformation	35	Female	A female in her mid-30's(G4P3003 at 25wkd) presented with an elevated maternal serum alpha-fetoprotein assay (MSAFP) of 2.19 MoM at 17 weeks gestation An ultrasound and amniocentesis were ordered. The ultrasound noted a dilated fourth ventricle in the fetal posterior fossa. Imaging with MRI was recommended to assess the cerebellar vermis and fetal brain anatomy. 1. A single fetus is noted in vertex loc. 2. Mild dilation of the fourth ventricle without evidence of obvious cerebellar abnormality.
2028	Fetus (26 Weeks)	26 Weeks	Female	
2029	Fetus (16 Weeks)	16 Weeks, 5 Days	Female	
2030	Fetus (17 Weeks)	17 Weeks, 6 Days	Female	
2031	Fetus (18 Weeks)	18 Weeks, 6 Days	Male	
2032	Fetus (16 Weeks) 2	16 Weeks, 4 Days	Male	
2033	Fetus (31 Weeks)	31 Weeks, 4 Days	Male	
2034	Fetus (31 Weeks) 2	31 Weeks, 2 Days	Male	
				60-year-old male with Sjt fall; comminuted fracture of LT iliac bone on OSH film
				Technique: Multiple contiguous axial non-contrast CT images were obtained of the pelvis, with retrospective coronal and sagittal reformats.
				Impression: 1. Comminuted fracture of the left iliac wing, without intra-articular extension. 2. Transitional anatomy of the lumbar spine, which is not well evaluated on this dedicated pelvic CT. There is a left-sided pars defect, likely at the L5 level.
2580	Comminuted Iliac Fracture	60	Male	Findings: - There is a comminuted fracture of the left iliac wing, with mild lateral displacement of the fracture fragments. - There is no intra-articular extension of the fracture, and the acetabulum is not involved. No other fractures are seen within the pelvis. There is a large hematoma adjacent to the fracture within the iliacus and gluteal muscles. - There is likely transitional anatomy, with apparent partial lumbarization of S1. This is not well evaluated on this pelvic CT, as the entire lumbar spine is not visualized. There is a pars defect noted within the fovea lumbar spine on the left, likely at the L5 level. There are also degenerative changes of the visualized lower lumbar spine. - Enthesophytes are noted at the insertion of the bilateral hamstring muscles. There is also irregularity at the insertion of the left gluteal muscles. A small hematoma pit is incidentally noted within the right femoral head.
				76 year-old female with history of tachycardia and hemoptysis
				Technique: Multiplanar contrast-enhanced angiogram of the chest in pulmonary arterial phase was obtained after the uneventful administration of IV contrast.
				Impression: 1. No evidence of pulmonary embolism. 2. Evaluation limited by motion. Groundglass opacities most prominent in the upper lobes, for which differential includes alveolar hemorrhage, drug reaction, and atypical infection. Aspiration is also possible, though less likely given the upper lobe predominant distribution. 3. Small bilateral pleural effusions.
2581	Possible Pulmonary Embolism	76	Female	Findings: - Evaluation of the pulmonary arteries demonstrates no filling defects to suggest pulmonary emboli. - Evaluation of the heart demonstrates normal heart size. - No pericardial effusions. - Coronary arteries show calcification. - Evaluation of the axilla, mediastinum, and hilum demonstrates prominent subcarinal, right hilar, and pretracheal lymph nodes. - Evaluation of the lungs is limited by respiratory motion. Despite this, there are diffuse groundglass opacities bilaterally, most clearly seen in the upper lobes, although the opacities are seen within all lobes. There are scattered areas of atelectasis, predominantly at the bases. There are no areas of focal consolidation. There are small bilateral pleural effusions. A granuloma is seen within the right apex. - Evaluation of the osseous structures demonstrates no suspicious appearing lesions.
				75-year-old female with history of ascending aortic aneurysm.
				Technique: Multiple contiguous axial images were obtained from the thoracic inlet to the iliac bifurcation following the uneventful administration of 98 mL of Isovue 370 utilizing the standard CT angiogram protocol with gating of the chest. Additional 3-D reformatted images were performed and reviewed on an independent workstation.
				Impression: 1. Stable ascending thoracic aortic aneurysm, maximal diameter 47-MM. Orthogonal.
2582	Stable Thoracic Aneurysm	75	Female	Findings: Mediastinoglenous thyroid gland, containing low-density nodularity. No enlarged axillary or paraclavicular lymph nodes. Stable aneurysmal dilatation of the thoracic aorta, maximal diameter of 47-mm x 47-mm within the ascending segment. The aortic root, including the annulus and sinuses of Valsalva, remains unchanged in dimension and configuration. The thoracic aorta measures 38-mm x 38-mm at the sinotubular junction, also unchanged from prior examination. Multivessel coronary arteriosclerotic calcification with evidence of percutaneous coronary intervention. Specifically, there is a stented vessel within the expected distribution of an obtuse marginal branch.
				55-year-old gentleman presenting for possible stroke.
				Technique: Contiguous noncontrast axial CT images of the head were obtained.
2583	Carotid Artery Stenosis	55	Male	Impression: 1. No acute intracranial hemorrhage. 2. Old infarction in the anterior limb of the left internal capsule extending into the left insular and centrum semi-ovale white matter. No definite large vessel territory acute infarction. 3. No steno-occlusive disease nor dissection of the cervical vessels. Marked ectasia of the cervical carotid arteries with mild calcific atherosclerosis. 4. Focal stenosis of the right paraclinoid carotid artery with normal contrast filling in the remainder of the right anterior circulation. No other steno-occlusive disease nor aneurysm noted in the remainder of the circle of Willis. 5. Small pseunothoracies laterally within the right lung apex. Bilateral small pleural effusions.
				Eighteen-year-old female referred for evaluation of extra tooth resulting in crowding with possible need for surgical removal.
				Technique: Multiple axial sections of the maxillofacial region were obtained with sagittal and coronal reconstructions performed.
2584	Mandibular Asymmetry	20	Female	Impression: 1. Mandibular asymmetry with additional nonspecific findings. 2. Mildly prominent ventricles. 3. Mildly prominent adenoid and tonsilar tissue, which may be reactive. 4. Chronic-appearing maxillary ear cell and paranasal sinus disease, likely congestive or inflammatory, as described above.
				86-year-old man one day status post abdominal aortic aneurysm stent grafting.
				Technique: A routine spiral CT angiogram of the abdomen and pelvis was performed.
2585	Aortic Aneurysm with Stent	86	Male	Impression: 1. Status post placement of abdominal aortic aneurysm stent grafts with an endoleak seen posterior to the graft approximately 4 CM distal to the proximal origin of the stent graft. 2. The overall dimensions of the aneurysm are unchanged from a prior study, measuring roughly 6 CM in greatest diameter. 3. Patent celiac, SMA, bilateral renal and inferior mesenteric arteries.
				A dual limb stent graft has been placed beginning just distal to the takeoffs of the renal arteries and terminating in the bilateral common iliac arteries. The noncontrast images show a suggestion of high attenuation posterior to the stent graft approximately 4 cm distal to its origin.
				Following the administration of intravenous contrast, an endoleak is demonstrated posterior to the limbs of the graft roughly 4 cm distal to the proximal origin of the stent. The endoleak tracks distally for several centimeters and then terminates. The exact origin is difficult to determine; it may be arising from a lumbar artery. The overall dimension of the aneurysm is unchanged from the prior examination. A few foci of gas is seen within the thrombus of the aneurysm, likely postoperative.
				75-year-old male with history of repair of aortic aneurysm. Follow-up stent graft repair. Follow-up pulmonary nodule.
				Impression: 1. Endovascular stent graft repair of infrarenal abdominal aortic aneurysm and left external to internal iliac artery bypass, right groin seroma. 2. Three subcentimeter indeterminate nodular opacities in the right middle lobe, grossly unchanged compared to previous CTs. 3. Postsurgical changes of coronary artery bypass grafting with patent small caliber lima graft and with three saphenous vein grafts. 4. Multiple bilateral renal calculi without hydronephrosis. 5. Left renal artery stenosis. 6. Diverticulosis.
				Findings: CHEST: 3 x 6 mm noncalcified indeterminate nodular opacity in the right middle lobe (series 2, image 61, and series 3, image 196) is grossly unchanged compared to onevious CTs. Two additional nodular opacities, each 3 mm or less, on the same axial slices in the right middle lobe are also unchanged compared to the previous CT's. No new pulmonary nodules identified.
				Interval resolution of previously seen small bilateral pleural effusions, with improvement in bibasilar atelectasis. No pathologically-enlarged mediastinal or hilar lymph nodes identified.
				Calcifications present within the native coronary arteries. Postsurgical changes of median sternotomy and coronary artery bypass grafting noted, with small caliber but patent LIMA graft to the left anterior descending artery, and with three saphenous vein grafts arising anteriorly from the aorta. A venous graft to the circumflex is occluded approximately 1.5 cm past its origin. Metallic stent is present proximally in a patent small caliber venous graft which likely supplies a marginal or diagonal branch.
				Additional patent venous graft supplies a marginal or diagonal branch.
				Atherosclerotic calcifications present in normal caliber thoracic aorta. The supra-arch vessels are tortuous and there is mild ectasia of the right brachiocephalic artery, measuring up to 1.7 cm in diameter. Left vertebral artery arises directly from the aortic arch, with calcifications present near the origin of the vertebral artery. Degenerative changes in the thoracic spine.
				ABDOMEN AND PELVIS: As on the prior two examinations there are postsurgical changes of endovascular stent graft repair of an infrarenal abdominal aortic aneurysm. The graft lumen is patent with no intraluminal thrombus identified. No evidence of endoleak.
				Maximum transaxial diameter of the aneurysm sac grossly unchanged at approximately 4.7 cm. The proximal stents of the stent graft are in close proximity to the origins of both the right and left renal arteries. Distal limbs extend into bilateral external iliac arteries. There has been a left external-to-internal artery bypass. The right internal iliac artery is nonopacified proximally but demonstrates retrograde opacification. Celiac artery and superior mesenteric artery are patent. Embolization coil present within the inferior mesenteric artery which is nonopacified proximally. Bilateral single renal arteries are patent, though there is apparent stenosis near the origi
				Retroperitoneal hematoma/seroma which extends from just below the left kidney to the left superior pubic ramus has decreased slightly in size with maximum transaxial dimensions of 5.1 x 8.8 cm, decreased from 6.1 x 11.2 cm. Decreased attenuation of this collection compared with the prior examination consistent with evolution of blood products. 2.0 x 2.5 cm seroma anterior to the right common femoral artery is slightly more discrete and slightly increased in size compared with the prior examination. Unchanged small amount of fluid attenuation in the left groin at prior incision site.
				As on the right examination there are multiple bilateral renal calculi, measuring up to 6 mm in the lower pole of the left kidney, and 5 x 11 mm in the upper pole of the right kidney. Immediately caudal to an 8 x 9 mm calculus located in the right lower pole renalsinus, there is an approximately 6 x 8 mm hypoattenuating structure which is surrounded by contrast material within a prominent lower pole calyx. This hypoattenuating structure is in apparent contact with the adjacent calculus but does not demonstrate continuity with the walls of the calyx. Accounting for differences in technique, this is grossly unchanged compared to the 09/03/03 CT. Gossel
				Liver, spleen, adrenal glands appear normal. Pancreas is atrophic. Gallbladder is mildly prominent with transaxial dimensions of 10.2 x 3.3 cm but no pericholecystic inflammatory stranding or fluid. Multiple diverticula arise from the colon along its entire length. No pericolonic inflammatory changes that would be suggestive of acute diverticulitis. No pathologically-enlarged lymph nodes.
2586	Stent Repair for Abdominal Aortic Aneurysm	75	Male	Degenerative changes in the lumbar spine with dextroscoliosis lumbar curvature.
2587	Thoracic and Abdominal Aortic Stent	unknown	Female	
				73-year old male for evaluation of abdominal aortic aneurysm, stent graft repair.
				Impression: 1. Type 2 endoleak involving a bifurcated aortic stent graft. There is also a patent jump graft between the right external and internal iliac arteries, with a right common iliac artery aneurysm as described. More complete measurements of the aneurysms will be given once the 3D reconstructions are available. 2. Large right retroperitoneal fluid collection and fluid attenuation soft tissue density in the pelvis, likely representing hematoma. Additional 3D reformations confirm the findings discussed based on the source images. The orthonormal maximal diameter of the aorta at the L3-4 level is 3.57 X 3.53 CM. The right iliac artery aneurysm measures 4.1 X 4.0 CM. In addition, there is narrowing of the celiac axis origin which is likely on the basis of immediate arcuate ligament compression.
				Findings: A bifurcated aortic stent graft is seen with the proximal anastomosis located just below the renal arteries, and the right limb extending into the external iliac artery and the left limb into the common iliac artery. There is a Type 2 endoleak, which appears to be secondary to lumbar arteries. The maximal diameter of the aneurysm is approximately 3.5 cm; however, more complete measurements will be given once the 3-Dimensional images are available. There is also a right common iliac artery aneurysm, measuring approximately 4 cm in maximal diameter. A jump graft is seen extending between the right external and right internal iliac arteries involving thai
2588	Bifurcated Aortic Stent Graft	73	Male	A Foley catheter is in place. A few scattered colonic diverticula are identified. There is a small upper pole cyst involving the right kidney, measuring approximately 1.5 cm. In addition, there is a very large right peripelvic cyst, which measures approximately 6 x 7 cm. Recommend sonography; while this most likely represents a peripelvic cyst, a ureteropelvic junction obstruction is possible. There is no definite calculustate.
				75-year-old male for abdominal aortic aneurysm status post stent graft placement.
				Impression: 1. Status post stent graft placement for infrarenal abdominal aortic aneurysm. 2. Small right lower pole infarction from occlusion of the accessory renal artery covered by the stent graft. 3. No evidence of endo leak.
2589	Abdominal Aortic Stent	75	Male	Findings: - The images demonstrate abdominal aortic aneurysm infrarenal in location measuring 5.5 x 5.1 cm. - There is endo graft placement without evidence of endo leak. - Inferior right accessory renal arteries are identified originating from a portion of the aorta that is covered by the endo graft. - There is a small infarction in the right lower pole. - Demonstrates residual contrast in the gallbladder.

Anatomage Table 9.0 Case Library Descriptions

2510 Bilateral Femoral Head Prominence	28 Male	Impression: 1. There is bony prominence of the femoral head/neck junctions bilaterally. 2. No fibrocystic change is visualized. The patient is a ninety-year-old male referred for protocol evaluation.
		Impression: 1. Calcified aortic valve cusps with severely restricted motion/valvular stenosis. 2. Atherosclerotic changes of the aorta and bilateral iliac arteries, with the right common iliac artery, external iliac artery, and common femoral artery. 3. Extensive coronary artery calcification with a tiny right coronary artery that is not definitely opacified through its course, and may be occluded distally. 4. Right lower lobe consolidation, which is nonspecific, and could reflect atelectasis or infectious etiology.
		Findings: VASCULAR: The ascending, transverse, and descending thoracic aorta demonstrate atherosclerotic changes. The ascending aorta measures up to 3.6 cm. The abdominal aorta demonstrates atherosclerotic changes. There is a small chronic atherosclerotic ulcer noted in the infrarenal abdominal aorta. The celiac artery and SMA are patent, with normal branching anatomy. The right and left renal arteries are patent. The inferior mesenteric artery demonstrates mild stenosis at the origin. The right common iliac artery measures 7 mm in diameter at the narrowest dimension. The internal iliac artery is patent on the right. The right external iliac artery measures 7 a
		CHEST: There are several mediastinal, hilar, and infrahilar lymph nodes, which measure less than 1 cm in short axis. The cardiac size is enlarged, with an enlarged left ventricle. There is a two-lead cardiac pacemaker. There are mitral annulare calcifications and aortic valve calcifications. There are heavy calcifications of the coronary arteries, with note of a tiny right coronary artery, which is not definitely opacified through its course, and may be occluded more distally. The main pulmonary artery is normal in caliber. No pericardial effusion. Evaluation of the pulmonary parenchyma demonstrates consolidation in the right lower lobe. Tl
		ABDOMEN/PELVIS: Small hiatal hernia. The liver is normal in size and contour, with homogeneous attenuation. There are cholecystectomy clips in the gallbladder fossa. The spleen is borderline enlarged. Pancreas demonstrates diffuse fatty atrophy. The right adrenal gland demonstrates a diffusely thickened anterior limb, with no discrete nodule. The left adrenal gland is unremarkable. The left kidney demonstrates a cyst arising in the interpolar region, measuring 3.7 x 3.9 cm in axial dimension, and extending along much of the length of the kidney. There is an additional cyst noted laterally in the inferior left renal pole, measuring 2.7 x 1.1 cm in axial d
2511 Calcified Aortic Valve Cusps	90 Male	Regional osseous structures demonstrate extensive degenerative changes.
2512 Abdominal Aortic Stent	65 Female	21 year old male with right hip pain History of bilateral FAI surgeries, last surgery right hip involved arthroscopic partial synovectomy, debridement ligamentum teres, partial labrectomy, labral repair with 3 anchors, cheilectomy, arthroscopic acetabuloplasty right hip, capsulotomy, and chondroplasty and micro-fracture of the acetabulum. Impression: 1. Post surgical changes of cheilectomy and acetabuloplasty in the right and left hips. The anterior head neck junction is slightly more prominent at the anterior margin of the prior right cheilectomy site relative to the left side. Findings: Postsurgical changes of cheilectomy and acetabuloplasty are present in the right and left hips. The right anterior head neck junction is slightly more prominent particularly at the anterior medial margin of the prior cheilectomy site, relative to the left hip (best appreciated on axial series 2, image 122). There are no ossicles or fracture.
2513 Cheilectomy and Acetabuloplasty	21 Male	Limited evaluation of the abdomen is within normal limits. 30-year-old man, status post fall from standing onto bricks on patient's right side. Continued pain and bleeding from right flank/right upper-buttock wound. Evaluate for extent/depth of wound. Impression: 1. Comminuted fracture through the right iliacus bone with larger bone fragment embedded medially/anteriorly in the right iliacus muscle, and smaller bone fragments embedded laterally/posteriorly in the right gluteus medius muscle. 2. Muscular hematomas in the right iliacus and right gluteus medius muscles adjacent to the above-described fracture. 3. Right flank/right upper-buttock skin defect and soft tissue wound extends approximately 1 CM into subcutaneous fat with mild underlying fat stranding. Findings: A comminuted fracture through the right iliac bone is identified, with a large bone fragment positioned medially/anteriorly in the right iliacus muscle and smaller bone fragments positioned laterally/posteriorly in the right gluteus medius muscle. There is asymmetric enlargement of the right iliacus and right gluteus medius muscles adjacent to the fracture, consistent with muscular hematomas. Fat stranding is seen extending superiorly into the right extraperitoneal fat. A right flank/right upper-buttock skin defect and soft tissue wound (series 102/image 294) extends approximately 1 cm into subcutaneous fat with mild underlying fat stranding. No significant underlying subcutaneous hematoma is identified.
		There has been an interval increase in the diameter of the patient's left common iliac artery since 2007, currently measuring approximately 20 mm in short axis diameter just proximal to its bifurcation (previously measuring approximately 16-17 mm). The visualized portion of the GI tract appears normal.
2514 Comminuted Iliac Fracture	30 Male	The urinary bladder and pelvic organs are unremarkable. Sacral insufficiency fracture. Impression: 1. Vertically oriented fracture through the right sacral ala involving the anterior cortex with surrounding sclerosis suggesting subacute chronicity. Subtle buckling of the anterior cortex of S2 seen on sagittal reformations. Though no displaced fracture of the left sacrum is identified, MRI scan, reported separately, shows a nondisplaced left sacral fracture. No evidence of destructive lesion. Findings: A vertically oriented fracture is seen through the right sacral ala which disrupts the anterior cortex of the sacrum. There is associated sclerosis around the fracture line suggesting subacute chronicity. Subtle buckling of the anterior cortex of S2 on sagittal reconstructions. No displaced fracture of the left sacrum. Mild sclerosis is seen on both sides of the right sacroiliac joint, likely degenerative in nature. There is also mild to moderate facet hypertrophy and sclerosis in the visualized lower lumbar levels. The hip joints are unremarkable. Minimal degenerative change is noted at the pubic symphysis. Musculature and soft tissues are unremarkable.
2515 Vertical Sacral Fracture	73 Female	Visualized internal pelvic structures are unremarkable. Hunter's syndrome with possible tracheal stenosis. Difficulty with intubation. Evaluate airway. Impression: 1. Prominent nasopharyngeal soft tissue, presumably representing the adenoid tonsils, and mild prominence of the palatine tonsils without evidence of upper airway compromise. 2. Anteroposterior narrowing of the thoracic trachea. 3. Fluid and/or soft tissue within the left middle ear cavity, extending to the epitympanum and Prussak's space with poor visualization of the tegmen tympani and anterior wall about the genu of the geniculate ganglion. 4. Degenerative change of the bilateral temporomandibular joints. Findings: NECK: Prominent soft tissue is noted within the posterior nasopharynx, presumably representing mildly prominent adenoid tonsils. The palatine tonsils are mildly prominent. The oropharynx,hypopharynx, larynx and subglottic cervical trachea are otherwise within normal limits. There is mild flattening of the visualized thoracic trachea. Surgical changes are identified within the cervical spine, including C1 through C7 laminectomies consistent with the patient's history of status post cervical decompression. The visualized brain parenchyma is within normal limits. The orbits are normal in appearance. Minimal mucosal thickening is present within the left maxillary sinus. The remainder of the paranasal sinuses are clear. Of note, the frontal sinuses are non-pneumatized. RIGHT TEMPORAL BONE: The external auditory canal and internal auditory canal are within normal limits. The middle ear structures are within normal limits. Minimal fluid is noted within the mastoid air cells. LEFT TEMPORAL BONE: The external and internal auditory canals are patent and within normal limits. Fluid and/or soft tissue are present within the epitympanum, including Prussak's space. The scutum appears intact. There is absence and/or dehiscence of the tegmen tympani, a large portion of which is not visualized. There is poor visualization and/or absence of the bony covering of the genu of the facial nerve geniculate ganglion (see image 43 of series 14). The malleus and incus are visualized and appear intact. There is poor visualization of the stapes. Fluid and/or soft tissue is seen abutting the oval and round windows.
2516 Prominent Adenoid Tonsils (Hunter's Syndrome)	36 Male	The mandibular condyles demonstrate degenerative change bilaterally. 53 -year-old man with a very complicated cardiac course who was set for cardiac surgery at an outside hospital but was not able to be intubated. The endotracheal tube was not able to be passed in the OR and the surgery was canceled. There was some question of subglottic stenosis. The patient was transferred here for further care and is getting this examination to evaluate airway anatomy. Impression: 1. There is short segment narrowing of the airway measuring 7 X 8 MM in smallest axial diameter, located approximately 5 CM below the glottis. No surrounding masses are noted. 2. Degenerative changes in the cervical spine, most pronounced at C4-5. At this level there is mild disc narrowing and a posterior disc osteophyte.
2517 Narrowing Airway	53 Male	Findings: There is a short segment of narrowing of the airway measuring approximately 7 x 8 mm in smallest axial diameter. This area is approximately 5 cm below the glottis. No cervical mass or collection is seen. The submandibular and parotid glands are normal. No aerodigestive tract mass is identified. No lymphadenopathy is identified. There are degenerative changes at C4-5 with mild disc narrowing and a posterior osteophyte.
		79-year-old male evaluate for stroke. Impression: 1. Large area of hypoattenuation in the right MCA and PCA distributions with perfusion parameters suggesting completed infarct in a large volume of this territory. There is preservation of normal cerebral blood volume and gray white distinction in the setting of markedly delayed perfusion in the pontos-superior right MCA and anterior aspect of the right MCA distribution which may reflect viable tissue at risk. 2. Severe flame shape narrowing of the right internal carotid artery just distal to the bifurcation most consistent with a severe flow-limiting right internal carotid artery dissection. Flow is not demonstrated on the CTA portion of the exam; however, delayed head CT demonstrates some contrast opacification of the vessels distally, so the dissection may be flow limiting, but not occlusive. 3. Small dissection and pseudoaneurysm in the left internal carotid artery at the skull base. 4. Findings consistent with large right retinal detachment Findings: - Evidence of acute stroke involving the R MCA territory with dense MCA sign, partial loss of insular ribbon, increased sulcal effacement and diffuse loss of gray-white matter differentiation. No midline shift or herniation. - Angio shows occlusion of R ICA shortly after the bifurcation. Only minimally reconstituted in its cavernous and petrous portions. Most flow arises from patent AcommA. - Occlusion of MCA at its origin with an occluded segment measuring approximately 1.5 cm with distal branches becoming reconstituted by collateral flow. - Incidental note is made of possible focal intimal tear/dissection of the L ICA just proximal to its petrous portion. - Perfusion demonstrates R MCA territory hypoperfusion. - Perfusion demonstrates elevated MTT in R MCA territory predominantly with decreased CBV indicated infarcted tissue. - DJD of spine. L thoracic deformity.
2518 Internal Carotid Artery Occlusion	78 Male	The ascending aorta is markedly dilated measuring approximately 5 cm in greatest transaxial dimension on the limited provided images. No stenosis at the origin of the great vessels. There is occlusion of the right internal carotid artery approximately 1.8 cm from the bifurcation with a characteristic flame-shaped appearance suggesting a dissection. No distal flow in is seen on CTA. The left carotid bifurcation is open. The course of the left internal carotid artery is markedly tortuous and retropharyngeal. There is a shelf-like filling defect with associated pseudoaneurysm in the left internal carotid artery at the skull base (image 60 series 501). Appropriate do
		A 79-year-old male, five-year followup for abdominal aortic aneurysm stent graft. Prior history of endoleak which spontaneously resolved. Impression: 1. Interval redevelopment of an endoleak closely abutting the proximal aortic stent graft fabric marker, consistent with possible type I endoleak. There has been minimal distal migration of the stent graft over approximately 1-2 MM since the prior exam. 2. Stable appearance of left renal artery stent which appears patent and projects 1-2 MM into the aortic lumen. Findings: Evaluation of the vasculature redemonstrates left renal artery stent as well as an aortobiliac stent graft with the proximal end arising at the level of the left renal artery. Both stents appear patent. There is slightly increased size of the abdominal aortic aneurysm sac, now measuring approximately 45 mm in comparison with 42 mm on the prior study. There has been minimal migration of the stent graft approximately 1-2 mm distally. The left renal artery stent projects approximately 1-2 mm into the aortic lumen. There has been interval redevelopment of an endoleak which closely abuts the proximal fabric marker of the aortic stent graft.
		The liver and spleen demonstrate multiple punctate calcifications which are not changed in comparison with the prior study. The liver is otherwise normal in contour without focal abnormalities. There is no intrahepatic biliary ductal dilatation. There is cholelithiasis without evidence of cholecystitis. The CBD is normal in caliber. The spleen, adrenal glands and pancreas are otherwise unremarkable. The bilateral kidneys are symmetric in size and demonstrate symmetric contrast enhancement. The bladder is partially distended with urine and unremarkable. The small and large bowel demonstrate multiple high-density objects, likely corresponding to ingesta
2519 Renal and AAA Stents	78 Male	The visualized portions of the mediastinum and lower lung fields are grossly unremarkable. The soft tissues are within normal limits. Degenerative changes of the visualized spine are noted. No acute osseous abnormality. 86-year-old male with Type-II-A endoleak of infrarenal abdominal aortic aneurysm repair. Patient had an open replacement of the stent graft body portion with a tube graft. Impression: 1. Interval replacement of the body of the abdominal stent-graft with a tube graft with anastomosis of the common iliac limbs to the prior stent graft. 2. Redemonstration of celiac stenosis but remainder of other aortic branches are patent. 3. Evidence of prior granulomatous disease with multiple splenic and hepatic calcified granulomas. 4. Splenic hemangioma stable in appearance. 5. Enlarged prostate with heterogeneous enhancement in arterial phase. Findings: There is redemonstration of pericardial calcifications and coronary artery calcifications. There is no significant pericardial effusions. Evaluation of the non-contrast portion of the study demonstrates small bilateral pleural effusions. A stable left lower lobe pulmonary nodule is seen on series 3, image 12, unchanged from the prior study. There is a small amount of bibasilar atelectasis or consolidation with adjacent small pleural effusions. The aorta shows interval replacement of the stent graft with a tube graft extending from the level of the infrarenal aneurysm and is anastomosed with the common iliac artery stent graft. The aorta is patent throughout its course and the limbs of the tube graft as well as the stent graft are patent. The common, external, and internal iliac arteries are patent. There is again seen an approximately 50% stenosis of the celiac artery. The superior mesenteric artery and the renal arteries are patent with an accessory right renal artery again noted. Calcifications are noted at the renal origin but there is no significant stenosis and kidneys are of normal size.
2520 Stent to Tube Graft	86 Male	Around the aortic stent graft, there is soft tissue, hematoma, and multiple surgical clips as well as a small amount of adjacent fluid inferior to the pancreas, all consistent with post-operative change. Contrast images and delays demonstrate no leak at either the proximal or distal anastomosis. A stable left internal iliac artery aneurysm is noted. 83-year-old male for follow-up of abdominal aortic aneurysm status post stent graft repair. Impression: 1. Stable aortobiliac stent graft without clear evidence of endoleak. Aortic aneurysm sac is approximately stable with maximum diameter of 42 MM. 2. Focal right external iliac artery dissection, unchanged. 3. Two small hypervascular liver lesions with imaging characteristics suggestive of hemangiomas. Findings: Aortobiliac stent graft appears grossly unchanged in position and configuration. There is no contrast opacification appreciated in the aneurysm sac. The aneurysm sac measures approximately 42 mm in maximal diameter, which is stable when compared at an equivalent level on the prior study. Additional orthogonal and volumetric measurements will be provided subsequently by the Three-dimensional Laboratory. A focal linear filling defect within the proximal right external iliac artery is unchanged. Mild irregularity of the left external iliac artery is also stable. Two right renal and a single left renal arteries are again seen. Celiac and superior mesenteric a
2521 Aortobiliac Stent Graft	83 Male	Limited evaluation of the abdomen and pelvis is notable for a 16 mm x 13 mm enhancing lesion in the medial aspect of the right hepatic lobe (Series 3, Image 76). When compared with prior studies, the enhancement characteristics are suggestive of hemangioma. A smaller subcentimeter enhancing focus in the left hepatic lobe is also seen (Series 3, Image 76). In retrospect, these lesions were present on prior studies and have not significantly increased in size. Additional subcentimeter hypodense foci are too small to characterize definitively, but remain unchanged. A large left renal cyst and multiple smaller hypodense foci in the bilateral kidneys are unch
		No acute osseous abnormalities are appreciated. A lucent focus in the left iliac bone is grossly stable. The patient is a 63 -year-old male with history of ansers stent graft repair of abdominal aortic aneurysm. Impression: 1. Prior ansers stent graft placement in the infrarenal abdominal aorta with limbs extending into the bilateral common iliac arteries. 2. Redemonstration of stable small endoleak adjacent to the origin of the inferior mesenteric. 3. The redemonstration of infrarenal abdominal aortic aneurysm sac which is stable in size measuring 5.3 X 5.2 CM. 4. Accessory right renal artery originating from the region of the aortic bifurcation with discrepant decreased enhancement of the lower pole of the right kidney. Findings: Comparison to a previous examination there is redemonstration of an ansers graft in place extending from the infrarenal abdominal aorta with both limbs extending into the bilateral common iliac arteries. The graft is patent with no evidence of migration. The proximal aspect of the graft is not flush with the aorta and begins 5 mm below the level of the left renal artery and is stable since the previous examination. There is redemonstration of a type 2 retrograde endoleak from the inferior mesenteric artery with no evidence of supply from adjacent lumbar arteries. The aneurysmal sac measures approximately 5.3 x 5.2 cm and is stable since the previous exami The celiac axis, superior mesenteric artery, bilateral renal arteries are patent and normal in caliber. Atherosclerotic vascular calcifications are present. Note is made of an accessory right renal artery from the region of the aortic bifurcation with a region of discrepant decreased enhancement of the lower pole of the right kidney. The bilateral iliofemoral arteries are patent and normal in caliber. The lung bases are clear. No pleural or pericardial effusion. The heart size is normal. Coronary artery calcifications are present. A small hiatal hernia is again noted. Several diverticuli are seen without evidence of diverticulosis.
2522 Ansears Stent Graft	63 Male	The prostate is mildly enlarged. Degenerative changes are seen in the spine. A small sclerotic focus is seen in the left femoral neck and is nonspecific. No pathologically enlarged lymph nodes are identified. Impression: 1. Left pleural effusion. 2. Patient is status post aortic stent graft repair with the distal aspect of the left side of the graft extending to the common iliac artery. The right common iliac artery is occluded. There is normal contrast opacification of the bypass graft from the level of the left common iliac artery to the fem-fem bypass, which demonstrates normal contrast opacification. There is no evidence for endovascular leak is seen. The maximum transverse diameter of the aneurysm sac measure 5 CM. 3. Left adrenal mass. Further evaluation is recommended. 4. The patient is status post distal antrectomy with gastrojejunostomy. 5. Occlusion of the proximal celiac artery with reconstitution via collateral blood supply. 6. Patent 1 left pleural effusion. 7. Patient is status post graft repair with the distal aspect of the left side of the graft extending to the common iliac artery. The right common iliac artery is occluded. There is normal contrast opacification of the bypass graft from the level of the left common iliac artery to the fem-fem bypass, which demonstrates normal contrast opacification. 8. Left adrenal mass. 9. The patient is status post distal antrectomy with gastrojejunostomy. 10. Occlusion of the proximal celiac artery with reconstitution via collateral blood supply. 11. Patent left renal artery stent. Left renal artery stent. Findings: A left pleural effusion is seen. Scarring is seen at the right lung base. The patient is status post aortic stent graft placement with the distal aspect of the left side of the stent extending into the left iliac artery. The right iliac artery is occluded at its origin.The proximal aspect of this stent starts at the level of just proximal to the renal arteries. The maximum transverse diameter of the aneurysmal sac measures 5 cm. The celiac artery is occluded at its origin and is reconstituted by collateral blood supply. There is significant atherosclerotic disease at the origin of the superior mesenteric artery likely representing greater than a 50% stenosis. There is atherosclerotic disease and narrowing at the level of a right renal artery ostium. A metallic stent is seen within the proximal left renal artery. Normal contrast opacification is seen throughout the left common iliac artery. There appears to be a graft from the level of the left external iliac artery to the left common femoral artery, which joins into the fem-fem bypass seen in the lower anterior abdomen. As previously mentioned, there is complete occlusion of the native common iliac artery on the right. However, there is retrograde flow through the right external iliac artery and right internal iliac artery, which is supplied from the fem-fem bypass. Examination of the abdominal visceral organs demonstrates a 2.5 cm left adrenal mass. The Hounsfield units of this are 17 and do not meet the criteria for a simple adrenal adenoma. Further evaluation can be obtained, as indicated, with MRI. There is a low density region within the dependent region of the gallbladder. Nonopaque gallstones cannot be excluded. Ultrasound can be obtained for further evaluation. The liver and pancreas are unremarkable. Multiple tiny renal cysts are seen bilaterally, which are too small to characterize. There are a few peripheral cortical shaped areas of decreased attenuation in both kidneys, which are likely to represent small infarcts given the patient's history of atherosclerotic disease. Examination of the bowel demonstrates evidence for prior distal antrectomy with gastrojejunostomy. The remainder of the bowel is unremarkable. No significant mesenteric or retroperitoneal adenopathy is seen.
2523 Adrenal Mass	85 Female	Examination of the soft tissue structures reveals some gas within the left iliac fossa region. There is a small fluid-collection within the mid lower abdomen likely postoperative in nature. A small amount of gas is seen in the anterior subcutaneous tissues. 27-year-old female with osteogenesis imperfecta experiencing chronic constipation and incontinence of fecal material. Findings: There is gross deformity of the pelvis with osteopenic, gracile bones. The femoral heads reside in a supermedial location from the usual location of the acetabula. Associated with this is significant medial displacement of the bilateral pubis bones. This medial deviation of the pubis bones results in significant narrowing the pelvic outlet. In the most narrow region, seen well on image no. 23 of series 602, the pelvic outlet is approximately 2.6 cm. This results in significant compression of the rectum through this region, though it was not obstructive as contrast was seen to extend retrograde into the sigmoid and distal descending colon.
2524 Osteogenesis Imperfecta	27 Female	Intramedullary rods are seen in the bilateral femurs, and metallic hardware is also seen in the lower lumbar/sacral spine. History of multiple hereditary exostoses with recurrent instability of the left shoulder. Impression: 1. At least three osseous excrescences projecting from the proximal humerus consistent with multiple osteochondromas given the patient's history of multiple hereditary exostoses. There is no evidence of pathologic fracture. Findings: This study demonstrates at least three osteochondroma arising from the left humerus. One is located within the medial metaphysis projecting caudally. The second is noted within the proximal medial diaphysis. There is also a third located within the lateral proximal diaphysis. There is no evidence of pathologic fracture.
2525 Humerus Osteochondroma	33 Female	The glenohumeral joint is intact without evidence of subluxation. No other osseous abnormalities are identified.

Anatomage Table 9.0 Case Library Descriptions

				40 year-old male with trauma to hip. Impression: 1. Comminuted fracture of the left acetabulum, involving both the anterior and posterior columns. The fracture extends superiorly into the iliac wing, where there is also a comminuted fracture. The undisplaced fracture of the left ischiopubic ramus can also be demonstrated.
2526	Comminuted Acetabular Fracture		46 Male	Findings: There is a comminuted fracture of the left acetabulum which extends into both the anterior and posterior columns and continues superiorly into the left iliac wing. Associated with this, is increased soft tissue density in the preacetal space, as well as along the lateral margin of the left iliac wing which most likely represents hematoma. The left femur is normally located within the acetabulum, and there is no left femur femoral fracture. Other than additionally noted small nondisplaced fracture of the left ischial pubic ramus, no additional fractures or malalignment noted in the pelvis.
				Incidentally noted is a hemangioma in the L5 vertebral body, and mild degenerative disease in the lumbosacral spine. Impression: 1. No evidence of pulmonary embolus or deep venous thrombosis. 2. Lateral thoracic meningocele, chest wall soft tissue masses and bony abnormalities, most suggestive of neurofibromatosis.
				Findings: No evidence of pulmonary embolus or DVT as clinically questioned. The examination is not significantly changed from previous year. There is no effusion, pneumothorax, or focal pulmonary parenchymal consolidation.
2527	Possible Neurofibromatosis		22 Female	In the right lateral chest wall, there is a 2.4 x 4 cm intercostal soft tissue mass. Along the margin of the right posterior fifth through eighth ribs, there are chronic erosive changes with soft tissue fullness. A 1.7 cm cyst is seen in the right neck between the jugular vein and carotid artery. Extensive spinal fixation hardware is seen in the thoracic spine. Limited views of the upper abdomen redemonstrate cholelithiasis and a 4 x 6 cm lateral meningocele. The previously reported hepatic laceration is not clearly seen on the current study.
2528	Cholelithiasis	unknown	Male	Impression: 1. Axi interval placement of an aortobiliac stent graft with evidence of a small endoleak. The closest connection is to the lumbar arteries with no definite side branch leak identified. A type II endoleak thus remains highest in differential. 2. Unchanged cholelithiasis with gallbladder wall thickening, correlate clinically for signs of cholecystitis. Gallbladder carcinoma is not excluded. 3. Stable infrarenal abdominal aortic aneurysm.
				Findings: The lung bases are clear and there are no pleural effusions. Visualized portions of the heart are normal in appearance and size. There is moderate coronary artery disease with a right coronary artery surgical graft in place that appears patent though cannot assess for stenosis on this study. No pericardial effusion. Evaluation of the abdominal solid organs is suboptimal due to the arterial phase of imaging. The liver is normal in appearance, without evidence of periportal edema or intrahepatic biliary ductal dilation. There is a large gallstone with associated wall thickening, unchanged in appearance compared to the previous study. The pancreas, spleen, adrenal glands, and kidneys are normal in appearance. There are multiple bilateral renal cysts are unchanged in size, appearance, and density. No nephrolithiasis or hydronephrosis. The small and large bowel are normal in course and caliber. The bladder wall is slightly thickened, and prostate appears within normal lim No abdominal, pelvic, or inguinal lymphadenopathy identified. There is moderate vascular disease visualized throughout the abdominal aorta. The abdominal aorta level of the hiatus measures 3.0 cm. The celiac axis and SMA are patent with moderate atherosclerotic disease at their origin. The IMA is occluded at its origin. The splenic artery demonstrates diminished caliber with wall thickening which can be seen with chronic dissection versus atherosclerotic disease. There is collateral arterial flow to the spleen supplied by branches of the left gastric artery. The remaining celiac axis appears unremarkable. There are bilateral single renal arteries which appear patent and unremarkable. There is an infrarenal abdominal a
2529	Penile Implant Full Body		71 Male	No suspicious bony lesions identified. Soft tissues are normal in appearance. 73-year-old male with history of squamous cell carcinoma of the left groin status post surgical excision, radiation, and chemotherapy. Impression: 1. Extensive postoperative changes in the left groin along the course of the left external iliac and left common femoral arteries without focal flg avidity. Findings are unchanged from prior exam and likely reflect postradiation changes. Findings (also from PET scan): HEAD AND NECK: Limited evaluation of the brain demonstrates intense FDG-uptake in the visualized cerebral cortex gray matter. This high physiologic background activity reduces the sensitivity of PET for pathologic processes. Physiologic FDG uptake is seen in the salivary glands, oropharynx, ocular muscles and vocal cords. There are no pathologically enlarged or hypermetabolic cervical or supraclavicular lymph nodes. THORAX: There are no pleural or pericardial effusions. There is no pulmonary parenchymal disease. Physiologic FDG uptake is seen in the myocardium. There are no pathologically enlarged or hypermetabolic axillary, mediastinal or hilar lymph nodes. ABDOMEN AND PELVIS: Physiologic FDG uptake is seen in the liver, spleen and bowel. Kidneys, ureters and urinary bladder are visualized per normal clearance of the radiotracer. Adrenal glands and pancreas are unremarkable on this limited non-contrast CT. Extensive atherosclerotic calcifications of the abdominal aorta and its branches are seen. A penile prosthesis and renal stent are again noted. As on the prior examination, there is soft tissue infiltration of the left groin, extending along the left common femoral and left external iliac vessels without focal FDG activity. Findings are unchanged from the prior examination and likely represent radiation changes. There are no pathologically enlarged or hypermetabolic abdominal, pelvic, or inguinal lymph nodes. MUSCULOSKELETAL: Physiologic FDG uptake is seen in the axial and proximal appendicular skeleton. 71-year-old male with history of squamous cell carcinoma of the left groin status post surgical excision, radiation, and chemotherapy.
2530	Penile Implant (Lower Body)		71 Male	Impression (also from PET scan): Physiologic FDG-uptake is seen in the liver, spleen and bowel. Kidneys, ureters and urinary bladder are visualized per normal clearance of the radiotracer. Adrenal glands and pancreas are unremarkable on this limited non-contrast CT. Extensive atherosclerotic calcifications of the abdominal aorta and its branches are seen. A penile prosthesis and renal stent are again noted. As on the prior examination, there is soft tissue infiltration of the left groin, extending along the left common femoral and left external iliac vessels without focal FDG activity. Findings are unchanged from the prior examination and likely represent radiation changes. There are no pathologically enlarged or hypermetabolic abdominal, pelvic, or inguinal lymph nodes. Impression: 1. Type 2 versus 3 endoleak. 2. Mild to moderate stenosis of the proximal right renal artery. 3. Stable 4.6 cm infrarenal aortic lumen, likely postoperative in nature. 4. Small bilateral pleural effusions.
2531	Dual-Chamber Pacemaker		80 Male	Findings: CHEST: The patient is status post median sternotomy for coronary artery bypass grafting. A dual-chamber pacemaker is present with leads in satisfactory position. Coronary artery calcifications are visualized. Small bilateral effusions and mild bibasilar atelectasis is demonstrated at the lung bases. A 2.2 cm cyst is present within the left lower lobe, possibly representing a small pneumatocele. ABDOMEN/PELVIS: The patient is status post metallic stent placement within an infrarenal abdominal aortic aneurysm extending from just below the renal arteries into the common iliac arteries. The abdominal aortic aneurysm measures 7.0 x 6.3 in maximal axial diameter. A focus of gas is present within the proximal portion of the native aortic lumen likely postoperative in nature. Inflammatory changes are visualized within the inguinal regions, likely secondary to prior arterial access. A linear focus of high attenuation is identified extending from the posterior aorta at the bifurcation consistent with an endograft leak. This contrast may represent focal ex Vicarious excretion of contrast is present within the gallbladder lumen. Multiple low density renal lesions are present bilaterally likely representing cysts.
2532	Bronchial Stent		90 Male	Impression: 1. Tracheomalacia with narrowing over 30 MM. Segment of the middle trachea. Left main stem bronchus stenosis with patent stent but bronchial wall present distally. Debris within bilateral main stem bronchi. 2. Bilateral central bronchiectasis in the upper lobes, right middle lobe, and lingual. Peripheral bronchiectasis present in the lower lobes. Reticulonodular opacity associated with more prominent airway thickening, most severe in the left lower lobe. Chronicity unknown consistent with sequelae of granulomatous disease, likely secondary to tuberculosis. Findings: The superior portion of the trachea is patulous. There is a posterior tracheal diverticulum present seen on series 2 image 256. There is narrowing of the trachea in its mid portion, which extends for approximately 38 mm. in length. The superior patulous segment just above the narrowing measures approximately 14 x 22.5 mm. in diameter. The diameter of the trachea just above the carina measures approximately 13 x 18.5 mm. The diameter of the proximal right main stem bronchus measures approximately 16.5 mm. x 14 mm. The diameter of the proximal left main stem bronchus measures approximately 6.6 x 6.7 cm. From the bottom of the portion of the There is central bronchiectasis that is prominently cylindrical in bilateral upper lobes, right middle lobe and the lingula. The lower lobes are incompletely evaluated but there is at least peripheral bronchiectasis present. There is bilateral apical scarring with some nodularity along the left posterior chest wall as well as nodular interstitium. The left lower lobe demonstrates wall thickening of lobar and segmental bronchi, with saccular bronchiectasis. There are reticulonodular opacities associated with more prominent airway thickening which is in the left upper lobe somewhat, more prominent in the lingula and most severe in the left lower lobe. The patient al
2533	Bronchial Stent		48 Male	There is no evidence of pleural effusion or pneumothorax. A 48-year-old male status post bilateral lung transplant with bronchial stenosis. The patient is status post placement of a right bronchial stent. Impression: 1. Status post placement of metallic stent within the bronchus intermedius as described. When compared to the prior examination, the stenosis immediately proximal to this stent as well as within the right upper lobe bronchus and left main stem bronchus has increased in severity. Additionally, there has been collapse of the proximal aspect of the right middle lobe bronchi as described. 2. Interval resolution of ground-glass opacifications with nodularity identified throughout the upper lungs. This is suggestive of interval resolution of a prior infection. 3. Gallbladder sludge. Findings: The heart and pericardium are unremarkable. A right peripherally inserted central catheter is present with its tip at the cavoatrial junction. There is no definite evidence of mediastinal, hilar, or axillary lymphadenopathy. Prominent soft tissue is present within the right hilum, however, this is likely post-surgical in nature and is not significantly changed when compared to the prior examination. There has been interval placement of a metallic stent within the bronchus intermedius. When compared to the prior examination, there has been interval improved aeration of the right lower lobe. Patchy areas of consolidation with air bronchograms remain present, however, are noted to a lesser extent when compared to the prior study. Immediately proximal to the stent within the bronchus intermedius, there is a focal stenosis present with a luminal diameter of 3 mm. The bronchi to the right middle lobe are collapsed proximally and are patent distally. The right middle lobe however is well aerated and not collapsed. The right upper lobe bronchus is also fo The stenosis proximal to the bronchus intermedius stent also demonstrates increased narrowing. Lastly, the right middle lobe bronchi were patent on the prior examination. There is also focal stenosis involving the left main stem bronchus. This has a maximal luminal diameter of 4 mm. When compared to the prior examination, this stenosis has also increased in severity. There has been interval improved aeration of the left lower lobe. Patchy areas of nonspecific opacification are present within the left lower lobe. There is a trace right pleural effusion. Additionally, when compared to the prior examination, the diffuse areas of centrilobular nodularity with peripheral ground glass opacification have resolved. Sternotomy wires are present compatible with the patient's prior bilateral lung transplant.
2534	Aortobiliac Stent		74 Male	The visualized upper abdomen demonstrates a percutaneous jejunostomy tube via the stomach is in standard position. Sludge is also present within the gallbladder. The remainder of the visualized upper abdominal organs is unremarkable. 74 year-old man two days status post aortobiliac stent grafting with a left distal iliac extender and ligation of a right internal iliac aneurysm. Impression: 1. Status post aortobiliac stent grafting with no endoleak identified. 2. Slight kinking of the proximal right common iliac artery limb, with narrowing of the flow lumen at this point to approximately 25%, and with normal diameter more distally. This likely results in decreased flow to the left leg, accounting for the decreased RLE ABI. 3. A possible focal dissection of the RT external iliac artery. Findings: Mild diffuse atheromatous disease is seen in the aorta and its branches. Scattered shallow ulcerations are seen, without evidence of penetration. The celiac artery is patent. Minimal scattered areas of narrowing are seen in the superior mesenteric artery, which is otherwise unremarkable. An aortobiliac endograft extends from the juxtarenal region to both common iliac arteries. No endoleak is identified. The left common iliac graft limb arises anteriorly and courses anteriorly relative to the right limb. The right limb terminates in the proximal right external iliac artery, and the left limb terminates at the distal common iliac bifurcation. At the gate for the poster The inferior mesenteric artery is occluded at its very origin but reconstitutes. The single right renal artery is patent. The main left renal artery is patent. A smaller caliber accessory left renal artery supplying the inferior pole demonstrates mild wall thickening but is patent, with relative cortical thinning of the left renal inferior pole as well as small, peripheral areas of decreased enhancement; this could represent chronic changes, with possible superimposed acute small cortical infarcts. Small, scattered areas of scarring are also seen elsewhere in the left kidney. Multiple tiny low density lesions in the right kidney are too small to further characterize are likely Postoperative changes are seen including a small retroperitoneal hematoma at the right external and internal iliac artery levels, with mixed foci of gas. Small amounts of gas are also seen in the anterior abdominal wall and at the right iliacus muscle.
2535	Tracheal Stenosis		60 Female	The thorax at the base shows trace bilateral pleural effusions and areas of subsegmental atelectasis posteriorly with a suggestion of bronchial wall thickening more centrally. The liver, spleen and pancreas are unremarkable. There is vicarious excretion of contrast by the gallbladder. Both adrenal glands were diffusely enlarged, possibly hypoplastic. A small umbilical hernia is seen, containing only fat. The prostate is enlarged. The urinary bladder contains contrast, likely from a recent stent grafting. Evaluate tracheal stenosis for stent planning, with 3D reconstructions focusing on trachea. Impression: 1. The tracheal narrowing is seen within the proximal portion of the trachea within the thoracic inlet over approximately a 4-CM distance. The minimum AP dimension is 1.0 CM. Comparison of this study to the prior study demonstrates improvement in this region of narrowing, perhaps suggesting a component of tracheomalacia. The right bronchus intermedius is also mildly attenuated. 2. Bilateral pleural effusions with associated atelectasis. 3. Debris within the esophagus. Findings: Within the proximal portion of the trachea in the region of the thoracic inlet there is narrowing of the trachea with mild wall thickening over approximately a 4-cm distance. This measures a minimum of approximately 1.0 cm in the AP dimension. When compared to the prior study, this region does not appear as narrowed suggesting there may be an element of tracheomalacia in this patient. The right bronchus intermedius is also slightly narrowed. There is debris present within the esophagus. Evaluation of the mediastinal structures demonstrate a normal-sized cardiac silhouette. There is extensive mitral annulus calcification, as well as calcification of the aortic valve. The main pulmonary artery and ascending aorta are normal in size. No significant mediastinal, hilar or axillary adenopathy. No significant pericardial effusion. Evaluation of the lung parenchyma demonstrates bronchial wall thickening. There are bilateral pleural effusions with associated atelectasis. No other significant parenchymal abnormalities are identified.
2536	Maxillary Sinus Disease		39 Female	Limited views of the upper abdomen demonstrate interval increase in the degree of ascites. Degenerative changes are R. noted within the bony structures, but no other significant bony pathology is seen. Patient presented with: AMI, neutropenic fever, swollen right side of face along with right lower molar gums associated with pain concerning for sinus process versus periodontal abscess, dental consulting. Impression: 1. Multiple dental caries and bilateral periapical lucencies predominantly affecting the molars with lateral bony erosion at teeth numbers 2, 29 AND 32. Recommend dental consult. 2. Maxillary sinus disease, right greater than left. Findings: Soft tissue swelling and fat stranding along the right mandible with multiple periapical lucencies involving ADA teeth numbers 2, 4, 28, 29 and 30 with no obvious abscesses. There is bony erosion around teeth number 2, 29 and 32. The crown appears missing on teeth 2 and 29. Bilateral reactive lymph nodes. There is maxillary sinus disease, right greater than left with mucoperiosteal reaction. The nasal cavity appears clear.
2537	Biphasic Pancreas	unknown	unknown	- Mass in body of pancreas. - Dilated pancreatic duct. - Large renal cyst (surgicos. 50x38mm) in LT kidney. - Liver cysts vs. lesions. - Abdominal and pelvic vessels appear normal. Impression: 1. Comminuted fracture involving the base of the middle phalanx of the third digit with intra-articular extension. A central dis-punch fracture fragment measuring 4 x 7 mm is depressed into the shaft 1 mm. 2. Single fracture lines exiting the ulnar, radial, and palmar aspects respectively. 3. Hairline minimally displaced tuft fracture involving the distal phalanx of the third digit along its ulnar aspect. Findings: There is a comminuted fracture involving the base of the middle phalanx of the third digit which extends into the proximal interphalangeal joint. There is a central dis-punch fragment measuring 4 x 7 mm, which is depressed into the shaft approximately 1 mm. Fracture lines exit into the ulnar, radial, and palmar aspects of the phalanx. There is approximately 2 mm of distraction of the volar fracture fragment.
2538	Phalanx Fracture		30 Male	In addition, there is a hairline tuft fracture, which is minimally displaced along the ulnar aspect of the tuft to the third digit. The patient is a 35-year-old male with pain in the left arm. Impression: 1. Large irregular bony excrescence arising from the anterior/medial proximal humerus most likely representing an osteochondroma. In view of the irregular appearance, and thickness of the cartilage cap, malignant transformation cannot be excluded.
2539	Humerus Osteochondroma		35 Male	Findings: There is an irregular bony excrescence is seen arising from the anteromedial aspect of the proximal humerus. The base of this lesion measures approximately 5.6 cm in diameter. The borders of this lesion are markedly irregular. There is a cap of soft tissue which is homogenous and of relatively smooth contour measuring up to 2.2 cm in thickness, likely representing a cartilaginous cap. The lesion involves the cortex of the bone with no definite medullary involvement. The remaining humerus appears normal. The visualized soft tissues in the arm appear normal apart for the mass effect caused the lesion. Impression: 1. Fractures through the Navicular bone and again noted and not significantly
2540	Navicular Fracture		19 Female	Findings: Again noted are three fixation screws through the navicular bone. Two fracture lines are again seen in a transverse, anteroposterior direction extending to the articular surface. The more superior one, that is dorsal, does demonstrate some bony bridging and healing. The more inferior one is essentially unchanged with the fracture line visible. No new fractures are identified. Incidental note made of flexor hallucis longus accessorium muscle. Impression: 1. 1. Neg acute. NO ICH or large territory infarct. No facial or calvarial fractures. 1. maxillary retention cyst. Minimal R maxillary mucosal thickening. 2. Cspine: No definite acute fracture or subluxation. Multiple deformities are present, favored to represent congenital anomalies and degenerative changes. Findings include fusion of VB and posterior elements of C5-6, possible hemivertebrae of C7, fusion of C7-T1 VB, possible hemivertebrae of T2. Acute angulation is demonstrated at C7-T2. No narrowing of spinal canal. No prevertebral soft tissue swelling.
2541	Possible Hemivertebrae Fracture		43 Male	Findings: BRAIN: The patient is intubated. The brain parenchyma is unremarkable without evidence of infarct, hemorrhage, mass, or mass-effect. The ventricles and extra-axial fluid spaces are normal in size and configuration. The visualized paranasal sinuses and mastoid air cells are clear. The calvarium is normal. C-SPINE: There is no acute fracture or dislocation. Vertebral body height is preserved. There is congenital fusion of the C5 and C6 vertebral bodies. There is a C7 hemivertebra that is fused to the T1 vertebral body. The preservical soft tissues are normal. T-spine: There is a C7 hemivertebra that is fused to the T1 vertebral body. There is a sharply angulated dextroscoliosis at the cervicothoracic junction. The T2 and T3 vertebral bodies are fused. Thoracic vertebral body stature is preserved. No central canal or neural foraminal narrowing is seen. The paraspinal soft tissues are normal. L-spine: The lumbar vertebral column is normally aligned. Vertebral body stature is preserved. No fractures are identified. Paraspinal soft tissues are normal.
2542	Metastatic Prostate Cancer		81 Male	81-year-old male with metastatic prostate CA and incidental abdominal aortic aneurysm. Impression: 1. Infrarenal abdominal aortic aneurysm extending to the aortic bifurcation with orthosomatal maximum diameter at L4 of 53.0 X 52.0 MM and total aneurysmal volume of 214 CM cubed. 2. Multiple sclerotic bony lesions within the pelvis and spine suspicious for metastatic prostate cancer. 3. Right inguinal hernia containing bowel without evidence of bowel obstruction. 4. Soft tissue fullness posterior to the prostate and in the region of the left seminal vesicle. Local spread of prostate cancer should be considered although this is incompletely evaluated on this examination. Findings: There is an infrarenal abdominal aortic aneurysm with eccentric intraluminal thrombus which extends inferiorly to the aortic bifurcation. Orthosomal diameter of the aorta at the level of L4 is 53.4 x 52.2 mm. There is no evidence of aortic dissection or rupture. There is mild atherosclerotic plaque of the aorta at the level of the celiac artery without hemodynamically significant stenoses. The superior mesenteric artery is patent without focal stenoses. The orthosomal diameter of the aorta just below the level of the renal arteries is 25.6 x 22.8 mm. There are two right renal arteries, the smaller of the two arteries arises from the aorta just anterior to the main: The inferior mesenteric artery appears occluded. The iliac arteries appear diffusely diseased bilaterally; however, without evidence for focal significant stenoses. Evaluation of the abdominal and pelvic viscera is slightly limited secondary to the timing of the contrast bolus. Two small low attenuation foci are seen within the periphery of the inferior liver (series 3, image 146), presumably representing cysts, although they are too small to characterize. A 5.0 cm simple left upper pole exophytic cyst is noted. There is a focal wedge-shaped cortical defect within the lower pole of the left kidney with an adjacent soft tissue nodular density with a central calcification. The wedge-like defect is suggestive of a prior infarction and the nodular density may represent infarcted renal parenchyma although its appearance is nonspe hernia containing small and large bowel loops extending into the right scrotal region. The bowel loops within the hernia sac do not appear thickened and there is no significant stranding or fluid to suggest bowel strangulation. No bowel obstruction. The prostate appears prominent and there is soft tissue fullness posterior to the prostate and in the region of the left seminal vesicle. There are multiple sclerotic foci within the skeleton including the left ischial tuberosity, left ilium adjacent to the SI joint, right iliac wing as well as multiple smaller foci throughout the ilium and ischium and sacrum. There are also multiple sclerotic foci within the vertebral bodies superimposed on a background of degenerative disease. A lesion is also seen within the left posterior elements at L1.

Anatomage Table 9.0 Case Library Descriptions

				Right hip pain. Anterior/inferior iliac spine avulsion. Impression: 1. Evidence of prior avulsion injury of the anterior inferior iliac spine with bony union of the fracture proximally as described. A small fracture fragment is seen within the gluteus minimus muscle laterally. Findings: There is evidence of a prior avulsion injury of the anterior inferior iliac spine which appears largely united superiorly. A small portion remains unsutured distally. A small linear fracture fragment is seen in the soft tissues laterally, which lies within the adjacent gluteus minimus muscle. Small bone islands are visualized in the right femoral head, right pubis, and left proximal femur. The remainder of the visualized osseous structures and muscles are unremarkable.
2543	Iliac Spine Avulsion		19 Male	The visualized pelvic contents are unremarkable. Evaluate for mass within the left thigh. Impression: 1. Multiple fusiform enhancing masses along the course of the bilateral sciatic nerves, left tibial nerve, and right deep peroneal nerve, likely representing multiple peripheral nerve sheath tumors. The largest mass is located at the upper left thigh measuring 3.5 X 2.2 X 3.2 CM. Findings: LEFT: There are four enhancing masses within the left upper leg along the course of the sciatic nerve. The largest mass is at the left upper thigh measuring 3.5 x 2.2 x 3.2 cm (series 14, image 31). There are smaller masses within the mid left thigh, one measuring 4 mm (series 14, image 54), a second measuring 0.8 x 1.4 cm (series 14, image 56), and a third measuring 0.5 x 0.6 cm (series 14, image 74). On the coronal images, these masses have an elongated fusiform shape. There are at least four enhancing masses within the left lower leg. The largest mass within the left lower leg is along the course of the tibial nerve measuring 2.7 x 2 x 2.3 cm (series 14 RIGHT: Within the right leg, there is a 1.3 x 1.1 cm mass along the course of the sciatic nerve at the upper right thigh (series 19, image 24), a second 0.5 cm mass along the course of the sciatic nerve at the level of the midthigh (series 19, image 77), and a third mass at the level of the mid right lower leg measuring 1.2 x 0.9 x 2.1 cm (series 19, image 228) along the course of the deep peroneal nerve.
2544	Peripheral Nerve Sheath Tumors		78 Female	BONES: Mild cystic change at the lateral aspect of the right talus. Regional osseous structures are otherwise unremarkable. LOWER PELVIS: Limited evaluation of the lower pelvis demonstrates evidence for prior anterior abdominal wall hernia repair. 31-year-old male, left hip pain Impression: 1. Bilateral geographic areas of sclerosis in the femoral heads, suspicious for avascular necrosis. Prominent subchondral cystic change in the left femoral head. 2. Prominent femoral head neck junctions are seen bilaterally, suggestive of a predisposition to femoral acetabular impingement. 3. No bony fragments are seen within the left hip joint. Findings: The right hip demonstrates geographic area of sclerosis in the subchondral region without surface collapse. The appearance is suspicious for avascular necrosis. There is minor subchondral cystic change seen in the anterior acetabulum with a small cysticle seen along the anterior right acetabulum. The left hip demonstrates a geographic area of sclerosis in the subchondral region extending past the epiphyseal scar with associated early flattening of the left femoral head and subchondral lucency, suspicious for avascular necrosis. A prominent intraosseous cyst measuring 2.0 x 1.0 cm is present, with small foci of internal vacuum phenomena. Cystic changes seen in the adjacent acetabulum. The joint space is mildly narrowed. Prominent femoral head neck junctions are seen bilaterally, suggestive of a predisposition to femoral acetabular impingement. No bony fragments are seen within the left hip joint.
2545	Femoral Head Necrosis		31 Male	Remaining visualized bones and soft tissues appear within normal limits. 60-year-old female status post clipping of bilateral MCA aneurysms. This is evaluation for the left cavernous carotid aneurysm. Impression: 1. 4 MM aneurysm arising from the inferior surface of the left internal carotid artery projecting anteriorly. 2. Status post clipping of bilateral MCA aneurysms with associated bilateral frontal craniotomies. 3. No acute findings. Findings: CT OF THE HEAD: The patient is status post bilateral frontal craniotomies for bilateral MCA aneurysm clipping. Clips are visualized in the expected regions. There is no evidence of acute hemorrhage. There is no mass effect or midline shift. The CSF containing structures are normal.
2546	Bilateral MCA Aneurysm Clips		60 Female	CT ANGIOGRAM: There is an approximately 4 mm aneurysm arising off the inferior surface of the the left cavernous internal carotid artery, projecting anteriorly. The neck measures approximately 2.5 mm. There are no other aneurysms. The remainder of the visualized vessels demonstrate normal caliber. Neck vessels are unremarkable. Impression: 1. Subglottic tracheal stenosis with caliber measuring 6 X 10 MM. 2. Mild bilateral maxillary sinus disease. Findings: Airway evaluation demonstrates subglottic tracheal stenosis with caliber measuring 6 x 10 mm. No additional regions of tracheal narrowing are identified. The proximal mainstem bronchi are also unremarkable bilaterally. Examination of the lung parenchyma demonstrates 2-mm left upper lobe pulmonary nodule (series 3, image 231). There is no focal consolidation in the image portions of the lungs. No enlarged mediastinal lymph nodes are identified to the level of the right pulmonary artery.
2547	Tracheal Stenosis		47 Female	Partial evaluation of the paranasal sinuses demonstrates a lobulated soft tissue density in the right maxillary sinus, possibly representing mucous retention cyst. Minimal opacity is seen in the inferior left maxillary sinus. The sphenoid sinuses, ethmoid air cells, and mastoid air cells are unremarkable. The visualized portions of the frontal sinuses are also unremarkable. Examination of the bony structures is unremarkable. Limited intracranial examination is normal. No enlarged lymph nodes are grossly visible within the neck. A 71-year-old male with history of intracranial aneurysm. Impression: 1. Dolichoectasia of the bilateral M1 MCA segments, which are somewhat fusiform in appearance. No discrete saccular intracranial aneurysm identified. 2. No evidence of acute intracranial pathology. 3. Cervical and cranial atherosclerosis, notably involving the bilateral carotid bulbs, without associated clinically significant stenosis. Findings: CT HEAD: No evidence of acute calvarial fracture, intracranial hemorrhage, midline shift, or herniation is identified. No abnormal intra-axial enhancement or enhancing mass lesion is identified on postcontrast images. Prominence is noted of the bilateral M1MCA segments. There is mild prominence of the ventricles and sulci consistent with generalized volume loss. Mild periventricular white matter hypoattenuation is identified, which is nonspecific. The gray-white differentiation is grossly preserved. Mild mucosal thickening is identified within the bilateral maxillary sinuses, and bilateral ethmoid and frontal sinuses which may be congestive or inflamm CT ANGIOGRAPHY: Please note the aortic arch is incompletely imaged on the CT angiogram. There is suggestion of a three-vessel origin at the aortic arch. Mild calcific and soft tissue atherosclerotic plaque is identified involving the visualized aorta. Calcific atherosclerotic plaque is present involving the bilateral carotid bulbs, without significant resultant narrowing. The bilateral common carotid arteries, cervical, petrous, cavernous, and supraclinoid internal carotid artery segments are widely patent. Minimal calcific atherosclerosis is present, involving the distal left cavernous internal carotid artery segment. Fusiform aneurysmal dolichoectasia is note
2548	Atherosclerosis		71 Male	The right vertebral artery is dominant. The left vertebral artery ends in the posterior inferior cerebellar artery. The bilateral vertebral arteries are widely patent. The basilar artery and bilateral posterior cerebral arteries are patent, without focal stenosis or aneurysm. Bilateral mildly prominent, subcentimeter cervical lymph nodes are identified in the anterior neck, which are nonspecific. No pathologically enlarged lymph nodes or neck masses are identified. The thyroid gland is within normal limits. The visualized airway is patent. The visualized lung apices are clear. Mild multilevel degenerative changes are identified within the cervical spine. No bony dem Impression: 1. Aortic-iliac stent graft is stable. Aneurysm is stable. Unchanged type II endoleak via a lumbar collateral. 2. Stable aneurysm in the mid left main renal artery at the segmental branch point. 3. Overall: no significant interval change. Findings: Infrarenal abdominal aortoiliac-iliac stent-graft is stable in position. The abdominal aortic aneurysm is stable in size measuring 5.9 x 5.3 cm in maximum diameter, unchanged compared to previous study. There is redemonstration of a type II endoleak from a lumbar artery, unchanged. No other endoleak identified. Throughout the aorta, there is mild atherosclerosis. Celiac and superior mesenteric artery are patent without significant stenoses. There are bilateral single renal arteries without stenosis. However, at the mid right renal artery at the segmental branch point, there is a stable 1.3 cm aneurysm. No other aneurysm is identified. Inferior mesenteric artery is not opacified. Bilateral common iliac, internal iliac and external iliac are patent without significant stenoses. Postoperative changes are seen in the groins bilaterally. Limited images of the abdominal viscera during this arterial phase study demonstrates an incidental replaced left hepatic artery. Otherwise, the liver is unremarkable. The patient is status post cholecystectomy. The spleen and pancreas are unremarkable. The kidneys demonstrate normal enhancement. There is an incidental minor peripancreatic stranding of unclear clinical significance. No evidence of obstruction. Postoperative clips are seen in the cecum. Sigmoid diverticulosis without evidence of diverticulitis. Otherwise, the bowel is unremarkable. The patient is status post prostatectomy. Surgical clips and right total hip prosthesis obscure evaluation of the pelvis secondary to metallic artifact.
2549	Abdominal Aortic Aneurysm Stent		73 Male	Degenerative changes are seen in the lower lumbar spine. Otherwise, remaining osseous structures are unremarkable. Impression: 1. Patent superior mesenteric artery with normal arterial supply to small bowel. 2. Marked narrowing of the celiac axis just inferior to the hiatus with post-stenotic dilation, finding is nonspecific though can be seen in median arcuate ligament syndrome. 3. Nonspecific intra-and extrahepatic biliary dilation in the setting of post cholecystectomy. Cause of ductal dilatation is unclear. Findings: The visualized abdominal aorta is normal in caliber and appears unremarkable. The celiac axis is patent with severe narrowing of its proximal portion at the level of the diaphragmatic hiatus. The celiac axis is displaced inferiorly under the diaphragmatic hiatus with significant narrowing at this region. There is mild post stenotic dilatation of the celiac artery to 8 mm. The branches of the celiac axis appear unremarkable, including the splenic artery, common hepatic vein, and left gastric artery. The SMA, bilateral single renal arteries, and IMA appear patent and within normal limits. The infrarenal abdominal aorta is normal in caliber. The bilateral common i There is minimal atelectasis at the right lung base. There is a nonspecific 2-mm lung nodule acute in the right lower lobe (2,5). The small nonspecific focus of peripheral ground glass opacity seen in the inferior right upper lobe (2,10). There is no pericardial or pleural effusion. The liver is normal in size and contour with evidence of moderate intrahepatic biliary dilatation. The common bile duct is dilated to 11 mm. There are surgical clips in the right upper quadrant consistent with a prior cholecystectomy. The pancreas, spleen, and adrenal glands appear unremarkable. The bilateral kidneys are symmetric in size with no evidence of stones, hydronephrosis, or
2550	Possible Mesenteric Ischemia		53 Female	The visualized osseous structures demonstrate mild degenerative changes of the lumbar spine. Moderate subcutaneous edema is noted. 85-year-old man with a history of abdominal aortic aneurysm. Impression: 1. AAA aortic aneurysm from renal arteries to the aortic bifurcation, eccentric mural thrombus. 2. Aortic stenosis. 3. Pericardial calcification, evidence of prior hemorrhage. 4. Multiple pulmonary nodules in the visualized lung bases. 5. Rim-enhancing lesion in the medial aspect of the spleen, the differential diagnosis includes infection or lymphoma. 6. Low density focus at the superior pole of the right kidney. Findings: VASCULAR: On noncontrast images, atherosclerotic calcifications are seen throughout the aorta and bilateral iliac vessels. There is an infrarenal abdominal aortic aneurysm with eccentric mural thrombus arising immediately below the take off of the renal arteries, with maximum axial dimension of 7.3 x 7.0 cm. On non-contrast images,subtle increased crescentic density within the mural thrombus (series 4, image 34) may represent acute clot. The abdominal aortic aneurysm extends to the level of the aortic bifurcation. No evidence of aortic dissection or contrast extravasation. There is extensive calcification in the bilateral iliac arteries. The right common iliac artery is 1.4 cm in maximum dimension, the left common iliac artery is 1.5 cm in maximum dimension. There is a focal dissection extending over a length of approximately 1 cm in the left internal iliac artery (series 5, image 404). Calcification at the origin of the celiac axis causes an approximately 50-70% stenosis. The superior mesenteric artery and single right and left renal arteries are patent. The inferior mesenteric artery is reconstituted distally (series 5, image 321). ABDOMEN AND PELVIS: Pericardial calcification is demonstrated at the visualized inferior aspect of the heart (series 4, image 1). Multiple small pulmonary nodules are seen in the visualized lung bases: 4- mm in the left lower lobe (series 5, image 4), 5-mm in the left lower lobe (series 5, image 23), and 3-mm in the right lower lobe (series 5, image 58). No consolidation. There is mild bronchial wall thickening in the visualized bilateral lower lobes, bronchitis versus aspiration. No pleural effusion. There is a small hiatal hernia. Punctate calcifications are seen in the liver and spleen, sequela of old granulomatous disease. A 1.4 cm rim-enhancing lesion in the medial spleen (series 6, image 14) may be a small hemangioma, although infection or lymphoma is not excluded. A 3-mm low density focus at the superior pole of the right kidney may be a small renal cyst, but is too small to characterize (series 6, image 21). There is bilateral perinephric stranding. The kidneys enhance symmetrically. No hydronephrosis. Bowel is nondilated. Multiple colonic diverticula are seen. The prostate is markedly enlarged.
2551	Aortic Aneurysm		85 Male	On bone window images, there are multilevel degenerative changes in the spine. An 8-mm sclerotic lesion is located in the right ilium, adjacent to the right sacroiliac joint (series 6, image 55).
2552	Polycystic Kidneys - Parenchymal Phase		31 Female	Autosomal kidney disease. Intrahepatic biliary dilatation and pancreatic ductal dilatation noted. This may be due to biliary/ampullary compression, though biliary stones or pancreatic cancer should be considered. Renal Cryoblation - post cryoxenia parenchymal phase Findings: A small cyst is seen in the posterior aspect of the spleen. A stable 1 cm nodule is seen in the lateral limb of the left adrenal gland.
2553	Renal Cryoablation		75 unknown	On follow-up CT there is no definite evidence of residual or recurrent cancer.
2554	High Heel Shoe	unknown	unknown	Donated by Paul Anderson (carvebeam.com)
2555	Pregnancy	unknown	Female	
2556	Laminectomy		53 Male	3 mo of neck pain with wound dehiscence at T1 spinous process protrusion. Impression: 1. Post surgical changes of the cervical & thoracic spine with persistent canal narrowing of the C spine due to ossification of the posterior longitudinal ligament. 2. Large L1 sided pleural effusion & bibasilar pulmonary opacity. 3. Pneumothila of uncertain etiology. Heavy calcification of the LAD.
2557	Lumbar Fracture	unknown	unknown	
2558	Thoracic Disc Injury		63 Male	66 yo male with history of incomplete Tx paraplegia and history of ossification of posterior longitudinal ligament (OPLL) and diffuse idiopathic skeletal hyperostosis (DISH). Impression: 1. Findings consistent with ossification of posterior longitudinal ligament (OPLL) with spinal stenosis at C2-C3 & C5-C6. 2. Remonstrations consistent with diffuse idiopathic skeletal hyperostosis (DISH). 3. Remonstration of T2 compression fracture deformity.
2559	Thoracic Paraplegia		66 Male	18 year old male post trauma Impression: 1. Comminuted scapular fracture with intact glenoid, as described. 2. Peribronchovascular consolidation medially, incompletely evaluated. Findings: There is a comminuted fracture of the scapula body, extending to the spine and acromial base (coronal image 40, series 400) superiorly, medial scapula body, and to the scapular angle inferomedially (coronal image 32, series 400). The inferior fragments are displaced approximately 1-2 cm posterior and superiorly (sagittal image 30, series 41), overlapping with the superior fragments, best appreciated in the sagittal plane. The glenoid and glenohumeral joint appear intact. There is an 8 mm cortical lucency near the acromial tip medially, may represent an os acromiale (axial image 39, series 2). The AC joint alignment appears anatomic.
2560	Comminuted Scapular Fracture		18 Male	Limited evaluation of the lung fields demonstrate consolidation in the right upper lobe medially with subpleural consolidation at lung bases. There is hematoma of the subscapularis muscle.
2561	Antelope Skull	unknown	unknown	
2562	Bear Skull	unknown	unknown	
2563	Bear Mandible	unknown	unknown	
2564	Camel Skull	unknown	unknown	
2565	Hyaena Mandible	unknown	unknown	
2566	Seal Skull	unknown	unknown	
2567	Vivarital Skull	unknown	unknown	
2568	Hyaena Skull	unknown	unknown	
2569	Hatasen Mummy	unknown	Male	- Mummy provided by the Fine Arts Museums of San Francisco. - Images acquired by Dr. Kerstin Mueller, Department of Radiology, Stanford University, using an Artis zeego with DynaCT, Siemens Healthcare GmbH at the zeego@Stanford laboratory.
2570	Intracranial Electrodes		31 Male	31-year-old male with medically refractory partial complex seizures since age 11 and left temporal pole mass on recent brain MRI with interval intracranial electrode placement. Findings: There is interval development of postoperative changes including left temporal parietal craniotomy, overlying scalp soft tissue swelling with gas, cutaneous surgical staples, small intracranial extra-axial fluid collection, and mild pneumocephalus. Metallic intracranial electrodes are visualized overlying the outer curvature of the left temporal and parietal lobes as well as along the medial aspect of the left temporal lobe. There is extensive associated scatter and spray artifact from the metallic electrodes somewhat limiting complete evaluation the brain parenchyma. Mild mass-effect is appreciated with slight compression of the left frontal horn and approxima Impression: 1. Interval right frontoparietal craniotomy with placement of an electrode grid over the right hemisphere and 4 electrode strips underlying the brain parenchyma. Limited evaluation of the brain parenchyma.
2571	Intracranial Electrodes		25 Male	Findings: Postoperative changes are seen along the right frontoparietal region with subcutaneous air and surgical skin staples in place. There's been interval right frontoparietal craniotomy with placement of an electrode grid over the right hemisphere and 4 electrode strips within the brain parenchyma. Evaluation of the brain parenchyma is limited on this exam secondary to technique and hardware artifact. The ventricles appear stable compared to prior. Evidence of a Chiari one malformation is again seen. The visualized portions of the paranasal sinuses, mastoid air cells, and orbits are clear. Male who is 24 years old with history of right temporoparietal parietal parenchymal signal abnormalities and Chiari type I malformation, and intractable epilepsy, now presenting for presurgical planning. Impression: 1. Interval right frontoparietal craniotomy with placement of an electrode grid over the right hemisphere and 4 electrode strips underlying the brain parenchyma. Limited evaluation of the brain parenchyma. Findings: There is redemonstration of the patient's previously seen Chiari type I malformation, with cerebellar tonsils again seen extending approximately 9 mm below the level of the foramen magnum without a definite separating CSF cleft around the brainstem or upper cervical cord. There is redemonstration of patchy parenchymal signal intensity abnormality within the right frontal lobe periventricular white matter and the right temporal parietal white matter with no associated diffusion abnormality. The overlying frontal lobe and temporal lobes again do not demonstrate any cortical thinning, and the Gray-white does appear intact in the overlying adjacent frontal lobe. The ventricles and sulcal size are normal for patient's age. There is no acute intracranial hemorrhage, mass effect , midline shift, or acute infarction. Abnormal intra-axial or extra-axial fluid collections are not present. Bilateral hippocampal formations and mammillary bodies are preserved in architecture and signal. There is mild bilateral paranasal sinus mucosal thickening
2572	Epilepsy		24 Male	The orbits, mastoid air cells, and flow-voids at the skull base are preserved. The calvarium demonstrates no abnormalities. There is redemonstration of the patient's previously seen Chiari type I malformation, with cerebellar tonsils again seen extending approximately 9 mm below the level of the foramen magnum without a definite separating CSF cleft around the brainstem or upper cervical cord.

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				Impression: 1. Multiple small pulmonary nodules measuring up to 3 MM are nonspecific and are too small to definitely represent metastases. 2. No evidence of metastatic disease within the abdomen or pelvis. 3. Periumbilical subcutaneous fluid collection measures up to 4.9 CM. If the patient has a history of prior laparoscopic abdominal surgery, this likely represents a postoperative perumbilical seroma. Findings: CHEST: Visualized thyroid gland is unremarkable. The heart is normal in size without significant pericardial effusion. The thoracic aorta and main pulmonary artery are normal in caliber. There are no large central pulmonary arterial filling defects. A prominent right hilar lymph node measures 9 mm in short axis diameter, but there is no significant mediastinal, hilar, or axial lymphadenopathy by CT size criteria. Partially calcified prottracheal and precarinal lymph nodes are noted. The trachea and central bronchi are patent. Five small pulmonary nodules are seen in the bilateral upper and left lower lobes, measuring up to 3 mm in the left lower lobe (4/217). The lungs are otherwise clear. No pleural effusion or pneumothorax. ABDOMEN AND PELVIS: The liver is normal in size and contour, with without focal suspicious mass lesion. Relative hypodensity adjacent to the falciform ligament likely reflects focal fat. A too small to characterize low-density lesion is seen within the right liver (8/59). The hepatic and portal veins are patent. There is no intra-or extrahepatic delayed dilatation. The gallbladder appears normal. The spleen, adrenal glands, and pancreas are normal. Two, too small to characterize low-density lesions are seen within the superior and inferior poles of the left kidney. Kidneys are otherwise normal. The urinary bladder is decompressed with a small amount of contrast within, limiting evaluation. An intrauterine device is present within the uterus. Two small 5 and 7 mm lesions within the fundal myometrium are compatible with small fibroids. Cystic lesions in the region of the cervix are compatible with nabothian cysts. Multiple follicles are seen on the right ovary. No suspicious adnexal masses identified. The large and small bowel loops are normal in caliber, without evidence of obstruction or wall thickening. No significant lymphadenopathy is seen within the abdomen or pelvis. No free fluid or free intraperitoneal gas. Peri-umbilical cystic lesion in the subcutaneous soft tissue measures 4.9 x 2.6 x 5.7 cm and has internal fluid density. There is a thin rim of enhancement and no significant adjacent soft tissue stranding.
2573 Thorax		49 Female	The visualized osseous structures and are intact without focal suspicious lesions. Fracture, on FORTEA for 2 months Impression: 1.Oblique distal tibial fracture with stable varus alignment. There is a questionable small area of the fracture anterolaterally where there may be increased callus, but the vast majority of the fracture is relatively unchanged. 2.Stable healed segmental fibular fracture. Findings: Similar to the prior study, an oblique fracture through the distal tibial diaphysis is again seen, with extensive peripheral nonbridging callus. The fracture line is still well visualized, with stable varus angulation, measuring approximately 20 degrees (series 601 image 51), not significantly changed from the prior study. Anterolaterally, there is a questionable small area of the fracture where the fracture line is less well defined than on the prior study, that may represent a small area of callus formation (series 601 image 54, series 603 image 30). The thin lucency along the medial aspect of the distal tibial fracture fragment again is questionable for a small nondisplaced fracture (series 601 image 51). Diffuse osteopenia of the distal tibia, fibula and foot is relatively unchanged. Healed segmental fracture of the distal fibular diaphysis is stable. Degenerative irregularity at the distal tibia and fibular syndesmosis is also unchanged. Multiple surgical clips between the distal tibia and fibular diaphysis, and along the medial aspect of the distal tibia and anterior soft tissues are stable.
2574 Tibia Fracture		59 Male	Mild subcutaneous edema is stable. Deformity of the anterior soft tissues from prior myocutaneous flap appears unchanged. Impression: 1. Multiple bilateral renal septated cysts, some contain thin calcifications, classified as bosniak IIF cysts. Follow up examination within 6 months is recommended to ensure stability. Follow-up examination may be performed as a noncontrast and contrast enhanced CT examination of the abdomen only. Findings: Limited evaluation of the lung bases appears within normal limits. Large cysts are identified in both kidneys. Several of these cysts demonstrate internal septations. For instance, a cyst in the superior pole of the left kidney measures 5.8 x 7.3 cm in greatest axial dimension (5; 27). The cyst demonstrates a thin septation with increased attenuation that likely represents minimal linear calcification. A similar complex cyst is noted about the inferior pole of the right kidney that measures 6.2 x 6.7 cm in greatest axial dimension (5; 76). This also demonstrates thin septations and a region of increased attenuation within one of the septations that likely represents calcification. No nodular enhancing components are identified. The The kidneys otherwise appear normal. Both kidneys enhance symmetrically and demonstrate normal excretion of contrast without evidence of hydronephrosis. The collecting systems in both kidneys appear normal. No urothelial lesions are identified. No renal masses are identified. The visualized portions of the ureters appear normal. The patient was placed prone to better evaluate the distal left ureter. Portions of the distal right ureter are not opacified with contrast, and are not well evaluated on this examination. However, no obvious abnormality is noted along both ureters. The bladder appears normal. No urothelial lesions or masses are identified within the bladder. Other portions of the abdomen are not well evaluated on this phase of contrast enhancement. However, the visualized portions of the liver, spleen, pancreas, and adrenal glands appear within normal limits. The gallbladder is normal. No evidence of biliary ductal dilatation. All visualized bowel appears normal. Incidental note of a high attenuation 16-mm linear structure within the right colon. This may represent a foreign body ingestion. No surrounding inflammatory process is noted. No evidence of obstruction. Calcified plaque is noted about the distal abdominal aorta consistent with atherosclerotic disease. No aneurysm is present.
2575 Renal Cysts		73 Male	Visualized bones appear within normal limits. Impression: 1. Status post right nephrectomy with no evidence of recurrent or residual disease. 2. Unremarkable left kidney without evidence of hydronephrosis, nephrolithiasis, or malignancy. 3. Bladder wall thickening and mild irregularity which may be secondary to cystitis. 4. 1.0 CM hypodensity within the uterus which is poorly evaluated on CT. If patient is symptomatic, recommend ultrasound for further evaluation. 5. Interval increase in size of a new 7MM T12 sclerotic lesion, consider skeletal scintigraphy for further evaluation. 6. Trace bilateral pleural effusions. Findings: The cardiac silhouette is within normal size limits. No pericardial effusion. Coronary artery atherosclerotic disease is present. The distal descending thoracic aorta is normal in course and caliber and demonstrates atherosclerosis. The gastroesophageal junction is grossly unremarkable. Trace bilateral pleural effusions are present. Evaluation of the lung bases demonstrates non-specific, non-calcified 1-2 mm pulmonary nodules adjacent to the right major fissure in the right lower lobe [series 3, image 15] and in the left lower lobe [series 3, image 18]. Reticular and ground glass opacities likely represent atelectasis. Evaluation of the solid abdominal organs is somewhat limited due to phase of imaging. The liver is normal in size, contour and attenuation. No gross hepatic mass or prominent intrahepatic biliary dilatation. Hepatic and portal venous patency are not well assessed on this exam. The gallbladder, spleen and adrenal glands are unremarkable. Evaluation of the pancreas demonstrates a punctate calcification within the pancreatic head. No pancreatic ductal dilatation or gross mass. The patient is status post right nephrectomy. No gross evidence of recurrence within the nephrectomy bed. The left kidney is unremarkable. No evidence of nephrolithiasis, hydronephrosis or gross renal mass. No filling defects within the renal pagilla or collecting system. The ureter is normal in course and caliber. No filling defects are identified. Evaluation of the bladder demonstrates bladder wall thickening and mild irregularity of the lumen which could be secondary to known cystitis and is possibly exaggerated by the relatively decompressed state of the bladder. Evaluation of the uterus demonstrates focal low density near the uterine fundus [series 9, image 82] which is poorly evaluated on CT. An exophytic calcified uterine fibroid is present. No adnexal masses. The stomach is within normal limits. Evaluation of the duodenum demonstrates a fat attenuation mass within the third portion of the duodenum compatible with a duodenal lipoma. No evidence of obstruction. The small bowel is otherwise unremarkable without evidence of bowel wall thickening, obstruction, or pneumatosis. The colon is normal in course and caliber. The appendix is identified and is within normal limits. No free fluid within the abdomen or pelvis. The abdominal aorta is normal in course and caliber and demonstrates atherosclerotic disease. No pathologically enlarged lymph nodes within the abdomen or pelvis.
2576 Right Nephrectomy		78 Female	Evaluation of the visualized osseous structures demonstrates interval increase in size of the sclerotic lesion involving the T12 vertebral body which now measures approximately 7 mm in size [series 2, image 27], previously measuring 4 mm in size. L5-S1 the pars defects are noted without evidence of anterolisthesis or retrolisthesis. High volume moderate, with tenderness medial to the tibial tuberosity. Impression: 1.No Stress Fracture Identified. Therefore, the CT is most compatible with stress reaction.
2577 Stress Reaction		23 Male	Findings: No acute osseous abnormalities are identified. No periosteal reaction. Bony alignment is normal. Even in the region of focal edema approximate 10 cm below the knee joint line seen on the MRI, no associated bony abnormalities identified. Of note, small perforating vessels are seen coursing through the cortex both anteromedially and posterolaterally within the middle third of the tibia. Soft tissues are normal in appearance. Impression: 1. Deformational posterior right plagiocephaly. The sutures appear open without synostosis. Addendum will follow regarding 3D reconstructions. 2. Paranasal sinus disease which may be congestive or inflammatory in nature.
2578 Plagiocephaly		9 Male	Findings: The brain is within normal limits. The gray-white matter differentiation appears preserved. The ventricles are appropriate in size and morphology. The extracerebral spaces appear intact. The sutures remain open without synostosis. There is deformational posterior right plagiocephaly. Bilateral maxillary and left sphenoid sinus mucous retention cysts are present. There is no air-fluid level. This may be congestive or inflammatory in nature.
2579 Complete Mandibular Fractures		21 Male	Evaluate for facial/right mandibular fracture. Impression: 1. Bilateral complete, minimally displaced and distracted mandibular rami fractures. No evidence of odontogenic loosening is noted. 2. Panorama mucosal thickening which may be congestive or inflammatory in etiology. Findings: Minimally distracted and slightly oblique fractures are identified involving the bilateral inferior mandibular rami, which are mildly distracted and posteriorly and inferiorly displaced. The fracture extends immediately posterior to the third mandibular molars bilaterally, without evidence of dental involvement. No dental fracture is identified. The fracture extends through and involves the bilateral inferior alveolar canals. No additional fracture is identified. The bilateral zygomas are normal in appearance. Mucosal thickening is identified within the bilateral maxillary, ethmoid, sphenoid and frontal sinuses. The airway is patent. 20 yr old M, very intoxicated, found walking around. Appears to have been assaulted and is missing his pants and shoes. Impression: 1. No acute intracranial disease. 2. Minimally comminuted nondisplaced fractures of the ramus of the right aspect of the mandible, and left mandibular body. 3. Focal mucosal abnormality subjacent to the floor of the right orbit may indicate a subtle nondisplaced fracture. However, please correlate with clinical examination. Findings: FACS: There is a comminuted right mandibular ramus fracture and left mandibular body fracture. Mucosal abnormalities noted under the floor of the right orbit. CERVICAL SPINE: No acute fracture or dislocation. Normal alignment. No abnormal prevertebral or paravertebral soft tissue swelling.
2580 Mandibular Fractures		20 Male	There is a large left parietal scalp hematoma. No acute intracranial hemorrhage, large vessel infarct or masses seen. The ventricles are normal in size. No abnormal extracerebral fluid collection. The calvarium is intact. A 24-year-old male who suffered a fall one weak earlier, with jaw pain. Impression: 1. Bilateral comminuted fractures of the mandibular condyles and slightly displaced fracture of the mandibular symphysis. Findings: Bilaterally, there are comminuted mandibular condyle fractures with anterior displacement of the superior fragments. There is additional dislocation at the left TMJ. There is additional fracture at the mandibular symphysis, it is slightly displaced. There is periapical lucency of tooth 25, which may possibly be loose. Paranasal sinuses are clear. Remaining visualized osseous structures are unremarkable.
2581 Mandibular Symphysis Fracture		24 Male	Impression: 1.Comminuted fractures of the right mandibular ramus and left anterior body with involvement of the mandibular foramen on the the right and the mental foramen on the left. The alveolar ridge on the left is also involved as described. 2.Minimally displaced horizontal oblique fracture of the maxillary ridge with involvement of the root of the left central incisor. 3. Right lateral pterygoid plate fracture. 4. Multiple maxillary periapical lucencies may be inflammatory or infectious, correlate with dental examination. Findings: Comminuted fractures are appreciated along the right ramus and left body of the mandible. There is a comminuted fracture of the ramus on the right that extends onto the posterior aspect of the coronoid process with a small separate fragment present from the coronoid process. The bulk of the process is intact. The fracture line extends through the mandible just posterior to the mandibular foramen. Injury to the second division of the trigeminal nerve on the right cannot be excluded. There is a second comminuted fracture of the body of the mandible on the left. The fracture line extends through the base laterally and up through the alveolar ridge medially. T An obliquely transverse fracture line is appreciated through the maxillary alveolar ridge on the left that includes the root of the left central incisor. The fracture line is minimally displaced. Prominent periapical lucency is appreciated about the 12th and 13th teeth (maxillary premolar teeth on the left). Much less prominent periapical lucency is seen about the sixth and fifth teeth (maxillary canine and premolar on the right).
2582 Facial Fractures		40 Male	The right lateral pterygoid plate is fractured and displaced 6 mm posteriorly along the fracture line. A metallic fragment is appreciated along the outer table of the left frontal bone just anterior to the left frontal sinus. No other fractures or injuries are appreciated. The visualized intracranial contents appear appropriate. Some soft tissue swelling and disruption is appreciated along the left mandibular fracture. Normal appearance of the orbits and globes. 79-year-old male found down in the base of the stairs, now with multiple injuries to the face and head . Impression: 1. Acute subarachnoid hemorrhage seen in multiple cerebral sulci near the vertex, the left sylvian fissure, and the left ambient cistern. Presumably traumatic, however, CTA should be considered to rule out aneurysm. No midline shift or herniation. 2. Minimally displaced fracture of the left lateral sphenoid sinus with extension into the carotid canal and cavernous sinus. Consider CTA for assessment of these vascular structures. 3. Large, comminuted left parasymphyseal mandibular fracture extending to the mental foramen. 4. Additional fractures of the left zygomatic arch, posterior lateral walls of the bilateral maxillary sinuses and left lateral pterygoid plate. 5. No acute fracture or malalignment of the cervical, thoracic, or lumbar spine. Findings: CT HEAD: There are multiple fractures of the facial bones, the details of which are described below. There are multiple foci subcutaneous air related to the facial bone fractures and soft tissue swelling over the left zygomatic arch. There is subarachnoid hemorrhage seen in multiple cerebral sulci near the vertex, within the left sylvian fissure in the left and in cistern. Hemorrhage is presumably traumatic, but CTA should be considered to rule out a left MCA branch aneurysm. There is no associated intraventricular hemorrhage. There is no mass effect, midline shift, or herniation. The gray-white differentiation is preserved and there is no evidence of large va CT C-SPINE: There is no acute fracture or malalignment of the cervical spine. There is bilateral neuroforaminal narrowing at C5-6, severe on the right and moderate on the left. Additionally there is mild neuroforaminal narrowing on the left at C3-4. No prevertebral soft tissue swelling. Hyoid bone is unremarkable. Visualized trachea is patent with an endotracheal tube in place. For details pertaining to the nonosseous structures please see the dictation for the CT chest abdomen pelvis. CT FACE: Slightly depressed left cisomatic arch fracture. Comminuted, significantly displaced fracture of the posterior lateral wall of the left maxillary sinus with some fat herniating into the sinus. The left maxillary sinus contains an air-fluid level, presumably hemorrhage pertaining to the adjacent fracture. Additionally, there is a nondisplaced, comminuted fracture of the posterior lateral wall of the right maxillary sinus as well, with several foci of gas adjacent to the fracture site outside of the sinus. The left lateral pterygoid plate is fractured. There is also a minimally displaced fracture of the left lateral sphenoid sinus with extension into the carotid canal CT T-SPINE: There is multilevel degenerative change of the thoracic spine, however no acute fracture or subluxation is present.
2583 Multiple Facial Fractures		79 Male	CT L-SPINE: There is multilevel degenerative change of the lumbar spine with associated facet joint arthropathy of L5-S1 bilaterally. There is mild bilateral neuroforaminal narrowing of L4-5 and L5-S1 with a broad-based bulge of the disk at L4-5. Nineteen-month-old male patient with history of a sympathetic chain neuroblastoma, status post resection. Impression: 1. The patient is status post resection of a retroperitoneal neuroblastoma. There is no evidence of abnormal soft tissue nodularity or enhancement within the surgical bed to suggest residual/recurrent local disease. 2. Nonspecific subcentimeter mesenteric lymph nodes are stable in size and distribution when compared to a previous study. Findings are likely reactive in etiology; however, recommend continued attention or follow up imaging. Findings: There is bilateral lower lobe dependent atelectasis. Otherwise, the lung bases are clear without focal consolidations or pleural effusions. The liver demonstrates homogenous signal without intra/extrahepatic biliary ductal dilatation or focal hepatic lesions. The hepatic and portal veins are patent. There is conventional hepatic arterially anatomy. The gallbladder is unremarkable without intraluminal filling defects. There is no splenomegaly or focal splenic lesions identified. The pancreas demonstrates normal signal without ductal dilatation or focal pancreatic lesions. The loops of small and large bowel are normal in caliber without evidence of obstruction or i The patient is status post resection of a retroperitoneal neuroblastoma. There is no abnormal enhancement or soft tissue nodularity within the retroperitoneum to suggest residual/recurrent local disease. There are no pathologically enlarged mesenteric, retroperitoneal, or pelvic sidewall lymph nodes by MRI criteria. Nonspecific subcentimeter mesenteric lymph nodes, possibly reactive in etiology, are stable in size and distribution when compared to study dated 02/14/2012. The index mesenteric lymph nodes are as follows: 1. Left upper quadrant mesenteric lymph node measures 7 mm in short axis (3/17), previously measuring 7 mm. 2. Right mid abdomen mesenteric lymph node measures 7 mm in short axis (3/18), previously measuring 8 mm. 3. Left mid abdomen mesenteric lymph node measures 4 mm in short axis (3/18), previously measuring 6 mm. 4. Left mid abdomen mesenteric lymph node measures 6 mm in short axis (3/19), previously measuring 7 mm. 5. Right ileocolic mesenteric lymph node measures 6 mm in short axis (3/21), previously measuring 6 mm. 6. Right ileocolic mesenteric lymph node measures 6 mm in short axis (3/20), previously measuring 5 mm. The adrenal glands are symmetric bilaterally without nodularity or hyperplasia. The kidneys demonstrate symmetric enhancement with hydroureteronephrosis or focal renal masses. The urinary bladder is unremarkable. The loops of small and large bowel are normal in caliber without evidence of obstruction or ileus. There is no free fluid. The abdominal aorta is normal in caliber without aneurysmal dilatation or focal dissection. The SMA, IMA, and celiac trunk are patent. There are single renal arteries bilaterally. The inferior vena cava is patent.
2584 Neuroblastoma – Post Resection	19 Months	Male	No suspicious osseous lesions are identified.

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				MRI for surgical planning. Impression: 1. Single normal caliber renal arteries. 2. There is a main and two accessory renal veins on the right. The left renal vein has a normal preaortic course. 3. Duplicated right ureter and single left ureter, no evidence of hydroureteronephrosis. 4. Normal and symmetric renal volumes with no evidence of a renal mass lesion. Findings: There is normal renal volume and cortical thickness bilaterally, with no evidence of renal mass or parenchymal scarring. There is a single left ureter, and a duplicated right ureter. There is no hydroureteronephrosis. RIGHT There is a single right renal artery of normal caliber with hilar branching. There is retrocaval branching, with the renal artery bifurcating posterior to the lateral most aspect of the IVC. There are no accessory or capsular renal arteries identified. There are two accessory renal veins located inferior to the main renal vein, each of which drains directly into the IVC. The more superior of these two accessory renal veins enters the IVC immediately adjacent to a small lumbar vein (series 7, image 100). LEFT There is a single left renal artery with hilar branching. No capsular or accessory renal arteries are identified. The left renal artery is normal in caliber with no stenosis. There is a single left renal vein with a normal preaortic course. The two tributaries of the main left renal vein converge approximately 1.1 cm from the lateral margin of the aorta. There is a 3-mm lumbar vein that drains directly into the posterior tributary of the left renal vein at the L2 level (series 7, image 97 and series 8, image 86). The left adrenal vein drains into the renal vein at the expected location, just lateral to the left lateral margin of the aorta. The 4-mm diameter left gonadal vein drains directly into the left renal vein approximately 1 cm from the lateral margin of the aorta.
2585	Potential Kidney Donor	43	Male	ABDOMEN AND PELVIS The visualized lung bases are clear, and no pericardial or pleural effusion is demonstrated. The liver, pancreas, gallbladder and biliary tree, spleen, adrenal glands, stomach and visualized bowel appear normal. Note is made of a common celiac/superior mesenteric artery common trunk. The left gastric artery arises directly from the aorta, and there is an accessory left hepatic artery arising from the left gastric artery. This is a normal anatomic variant.
2586	Navicular Fracture	46	Female	
2587	Heart MRI	35	Female	
2588	Sinus Infection	13	Male	
				Patient presented with severe pain and swelling. Eight-year-old male patient with a history of left multicystic dysplastic kidney. Evaluate for hydroureteronephrosis. Impression: 1. Hemolobar kidney. 2. Mild left hydroureteronephrosis with associated left renal moiety cortical thinning/parenchymal scarring. 3. Both kidneys demonstrate symmetric enhancement and excretion of contrast. However, the distal left ureter is moderately ectatic with delayed clearance of contrast compared to the contralateral side, possibly related to vesicoureteral reflux versus vesicoureteral obstruction. 4. Split renal function. Data will be obtained by the 3D lab and an addendum will be issued when this information becomes available. Findings: The visualized portions of the liver demonstrate homogeneous signal without intra/extrahepatic biliary ductal dilatation or focal hepatic lesions. The gallbladder is unremarkable without intraluminal filling defects. The visualized portions of the spleen are unremarkable without focal splenic lesions. The pancreas demonstrates normal signal without ductal dilatation or focal pancreatic lesions. The loops of small and large bowel are normal in caliber without evidence of obstruction or ileus. The adrenal glands are symmetric bilaterally without nodularity or hyperplasia. The abdominal aorta is normal in caliber without evidence of aneurysmal dilatation or focal dissection. The superior mesenteric artery, inferior mesenteric artery, and celiac trunk are patent. The inferior vena cava is patent. There are no pathologically enlarged mesenteric or retroperitoneal lymph nodes by MRI criteria. Nonspecific, subcentimeter mesenteric lymph nodes are more remarkable in number than in size. The L3-4 vertebral bodies are fused with levoscoliosis centered at this level, otherwise no suspicious osseous lesions are identified.
2589	Horseshoe Kidney	8	Male	Horseshoe kidney. The right renal moiety is malrotated with two small cysts within the interpolar region of the kidney (series 200; image 52: 6 mm, 8 mm). The left renal moiety crosses midline and communicates with the inferior pole of the right renal moiety. There is mild left hydroureteronephrosis to the level of the ureterovesicular junction with associated cortical thinning/parenchymal scarring. Both kidneys demonstrate symmetric enhancement and excretion of contrast. In addition, both kidneys demonstrate an appropriate response to Lasix challenge with increased clearance of contrast within the renal collecting systems, however, the distal left ure
3008	Skull of 38 year male	38	Male	Donated by the Smithsonian. Pathology Type: Congenital Lifespan: 1971 - 2009 Cause of death: Epilepsy, Down Syndrome Race: White Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3009	Tumor	40	Male	Donated by the Smithsonian. Pathology Type: Neoplasm Lifespan: 1968 - 1940 Cause of death: Carcinoma of Left Atrium Race: Black Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3010	Skull of 54 year old female	54	Female	Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1895 - 1949 Cause of death: Pneumonia, Th Race: Black Scan Date: 10/7/2009 Scanner: Hopkins c-arm
3011	Healed Fracture	57	Female	Donated by the Smithsonian. Pathology Type: Trauma Lifespan: 1883 - 1940 Cause of death: Cervical Cancer Race: White Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3012	Skull of 91 year old female	91	Female	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1849 - 1940 Cause of death: Coronary Disease Race: Black Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3013	Healed Frontal Bone Fracture	58	Male	Donated by the Smithsonian. Pathology Type: Trauma Lifespan: 1951 - 2009 Cause of death: Pellagra Race: Black Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3014	Paget's Disease	79	Female	Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1858 - 1937 Cause of death: Cerebral Hemorrhage Race: Black Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3015	Skull of 82 year old female	82	Female	Donated by the Smithsonian. Pathology Type: Unknown Lifespan: Unknown Cause of death: Unknown Race: White Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3016	Skull of Pituitary Dwarf	unknown	Female	Donated by the Smithsonian. Pathology Type: Congenital Lifespan: Unknown Cause of death: Unknown Race: White Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3017	Skull of 36 year old male	36	Male	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1904 - 1940 Cause of death: Unknown Race: White Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3018	Skull of 62 year old male	62	Male	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1947 - 2009 Cause of death: Cardiac, Senility Race: White Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3019	Skull of 28 year old male	28	Male	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1900 - 1928 Cause of death: Struck by train Race: Black Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3020	Skull of 26 year old male	26	Male	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1901 - 1927 Cause of death: Phthisis Race: Black Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3021	Rickets Disease	24	Female	Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1905 - 1929 Cause of death: Pulmonary TB Race: Black Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3022	Edentulous Skull of 80 year old male	80	Male	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1859 - 1939 Cause of death: Coronary Occlusion Race: White Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3023	Parietal Thinning	60	Female	Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1870 - 1930 Cause of death: Unknown Race: White Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3024	Skull of 32 year old female	32	Female	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1898 - 1930 Cause of death: Homicide by firearm Race: Black Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3025	Skull of 23 year old male	23	Male	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1908 - 1931 Cause of death: Pulmonary TB Race: Black Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3026	Temporomandibular Joint Dysfunction	52	Male	Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1887 - 1939 Cause of death: Unknown Race: White Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3027	Skull of 21 year old female	21	Female	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1911 - 1932 Cause of death: Pulmonary TB Race: Black Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3028	Occipital Protrusion	52	Male	Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1880 - 1932 Cause of death: Neck Cancer Race: White Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3029	Skull of 13 year old male	13	Male	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1898 - 1911 Cause of death: Pulmonary TB Race: Black Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3030	Skull of 24 year old female	24	Female	Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1909 - 1933 Cause of death: Drug addict, recto-vaginal fistula Race: White Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3031	Tuberculosis	39	Male	Donated by the Smithsonian. Pathology Type: Infection Lifespan: 1895 - 1934 Cause of death: TB sinuses Race: White Scan Date: 12/15/2009 Scanner: Hopkins c-arm

Anatomage Table 9.0 Case Library Descriptions

				Donated by the Smithsonian. Pathology Type: Trauma Lifespan: 1907 - 1971 Cause of death: Heart Disease Race: Asian Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3032	Calvarium Fracture		71	Male
				Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1909 - 1937 Cause of death: Nephritis Race: Asian Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3033	Ossicle on Right Mastoid Process		28	Female
				Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1885 - 1943 Cause of death: Pulmonary TB Race: Asian Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3034	Skull of 58 year old male		58	Male
				Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1894 - 1954 Cause of death: Unknown Race: Asian Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3035	Skull of 40 year old male		40	Male
				Donated by the Smithsonian. Pathology Type: Infection Lifespan: 1876 - 1935 Cause of death: Unknown Race: Black Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3036	Periodontal Disease		59	Male
				Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1871 - 1909 Cause of death: Lobar pneumonia Race: Black Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3037	Skull of 38 year old male		38	Male
				Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1856 - 1936 Cause of death: Angina Race: Asian Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3038	Enlarged Parietal Foramen		80	Female
				Donated by the Smithsonian. Pathology Type: Trauma Lifespan: 1897 - 1957 Cause of death: Unknown Race: Black Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3039	Skull of 60 year old female		60	Female
				Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1900 - 1941 Cause of death: Unknown Race: Black Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3040	Enlarged Parietal Foramen		41	Female
				Donated by the Smithsonian. Pathology Type: Trauma Lifespan: 1932 - 1962 Cause of death: Unknown Race: White Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3041	Gunshot Wound		30	Male
				Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1913 - 1993 Cause of death: Gunshot in chest Race: White Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3043	Skull of 20 year old male		20	Male
				Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1923 - 1964 Cause of death: Breast cancer Race: Black Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3044	Metal Fillings		41	Female
				Donated by the Smithsonian. Pathology Type: Developmental Lifespan: 1922 - 1960 Cause of death: Unknown Race: White Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3045	Peachinosian Pits		38	Female
				Donated by the Smithsonian. Pathology Type: Trauma Lifespan: 1927 - 1954 Cause of death: Stab wound Race: Black Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3046	Healed Nasal Fracture		27	Male
				Donated by the Smithsonian. Pathology Type: Normal Lifespan: 1884 - 1961 Cause of death: Cirrhosis of liver Race: Black Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3047	Skull of 77 year old female		77	Female
				Donated by the Smithsonian. Pathology Type: Congenital, Trauma Lifespan: 1911 - 1988 Cause of death: Unknown Race: Black Scan Date: 12/16/2009 Scanner: Hopkins c-arm
3048	Pituitary Dwarf Skull		59	Female
				Donated by the Smithsonian. Pathology Type: Trauma Lifespan: Unknown Cause of death: Unknown Race: Unknown Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3049	Missing Mandible	unknown		Male
				Donated by the Smithsonian. Pathology Type: Normal Lifespan: Unknown Cause of death: Unknown Race: Unknown Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3050	Fetal Skull	unknown		unknown
				Donated by the Smithsonian. Pathology Type: Normal Lifespan: Unknown Cause of death: Unknown Race: Unknown Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3051	Fetal Skull	unknown		unknown
				Donated by the Smithsonian. Pathology Type: Normal Lifespan: Unknown Cause of death: Unknown Race: Unknown Scan Date: 10/20/2009 Scanner: Hopkins c-arm
3052	Neonatal Skull	unknown		unknown
				Donated by the Smithsonian. Pathology Type: Unknown Lifespan: Unknown Cause of death: Unknown Race: Unknown Scan Date: Unknown Scanner: Hopkins MicroCT
3053	Cleft Palate	unknown		unknown
				Donated by the Smithsonian. Pathology Type: Trauma Lifespan: Unknown Cause of death: Unknown Race: Unknown Scan Date: 12/15/2009 Scanner: Hopkins c-arm
3054	Trephination	unknown		unknown
4001	4D - Heart	unknown		unknown
4002	4D - Lungs	unknown		unknown
4003	4D - Kidney	unknown		unknown
4004	4D - Kidney	unknown		unknown
4005	4D Embryo	unknown		unknown
4006	4D Cardiac Scan	unknown		unknown
4007	4D Brain	unknown		unknown
4008	4D - Heart	unknown		unknown
5000	Affenpinscher - Tequila Pro	unknown		Female
5001	Affenpinscher - Tequila Pure	unknown		Female
5004	Akita - Tigre-Tigger	unknown		Female
5006	Australian Cattle Dog - Sweet Pea	unknown		Female
5007	Australian Cattle Dog - Wally	unknown		Male
5010	Basset Hound - Jr	unknown		Male
5012	Belgian Malinois - Zion1	unknown		Male
5013	Belgian Malinois - Zion2	unknown		Male
5014	Bernese Mountain Dog - Gabbey	unknown		unknown
5015	Bernese Mountain Dog - Oscar	unknown		unknown
5016	Bichon Frise - Phoebe	unknown		unknown
5019	Boston Terrier - Tobias	unknown		Male
5020	Boxer - Dempsey	unknown		Male
5022	Boxer - Murphy	unknown		Male
5023	Brittany Spaniel - Penny	unknown		Female
5026	Bulldog - Lola	unknown		Female
5032	Chesapeake Bay Retriever - Raleigh	unknown		Male
5037	Chinese Crested - Tilly Pre	unknown		Female
5038	Chinese Crested - Tilly Post	unknown		Female
5040	Chow Chow - Ginger Snap	unknown		Not Recorded
5041	Cock A Poo - Bailey	unknown		Female
5043	Cocker Spaniel - Skipper	unknown		Male
5047	Dachshund - Chloe	unknown		Female
5048	Dachshund - Riley	unknown		Male
5049	Dachshund - Charlie	unknown		unknown
5050	Dutch Shepherd - Theo	unknown		unknown
5051	English Bulldog - Chunky	unknown		Male
5056	French Bulldog - Grandpa	unknown		Male
5057	French Bulldog - Miles	unknown		unknown
5058	German Shorthair Pointer - Buddy	unknown		Male
5059	German Shepherd - Bella	unknown		unknown
5060	German Shepherd - Blake	unknown		Male
5063	Golden Retriever - Libby	unknown		Female
5064	Golden Retriever - Carl	unknown		unknown
5067	Goldendoodle - Daisy	unknown		unknown
5068	Goldendoodle - Daisy2	unknown		unknown
5071	Greyhound - Thor	unknown		unknown

Image Data Source: Brad Smith, University of Michigan (bsheerin@umich.edu). NIH award NH-HD-6-3257 P/G F003637. Imaging performed at the Center for In-Vivo Microscopy, Duke University

A retrospectively cardiac-gated CT was acquired at 40x0.625mm with a cardiac rate driven variable pitch between 0.2 and 0.6 with helen tracking over the ascending aorta. Dose was modulated according to the patient's body habitus and temporally adapted by a cardiac cycle phase-related modulation algorighhm on the scanner. Images of the cardiac region were convolved at 0.9mm thickness at 0.6mm intervals with a limited field of view at 10 evenly spaced phases of the cardiac cycle.

Anatomage Table 9.0 Case Library Descriptions

5072	Havanese - Oscar	unknown		Male	
5076	Husky - Bruno	unknown		unknown	
5077	Italian Greyhound - Georgia	unknown		Male	
5078	Jack Russell Terrier - Rusty	unknown		Male	
5082	Lab - Tobey	unknown		Male	
5084	Labrador Retriever - Bella	unknown		Female	
5086	Labrador Retriever - River	unknown		Female	
5088	Lhasa Apso - Missy	unknown		unknown	
5089	Maltese - Tassel	unknown		Female	
5090	Maltese - Lolla	unknown		Female	
5091	Maltipoo - Teddy	unknown		Male	
5093	McNab - Sasha	unknown		Female	
5096	Mini Schnauzer - Jake	unknown		Male	
5097	Mix Breed - Luna	unknown		Female	
5098	Mix Breed - Riley	unknown		unknown	
5099	Mix Breed - Toby	unknown		Male	
5100	Newfoundland - Oakley	unknown		unknown	
5101	Newfoundland - Yogi	unknown		unknown	
5104	Norfolk Terrier - Dealer	unknown		unknown	
5108	Pekingese - Daisy	unknown		unknown	
5110	Petit Basset Griffon - Lucy	unknown		Female	
5114	Pitbull - Phinny	unknown		Male	
5117	Poodle - Benji	unknown		unknown	
5122	Retriever - Bailey	unknown		unknown	
5123	Rhodesian Ridgeback - Kasey	unknown		unknown	
5126	Russian Spaniel - Kava	unknown		Male	
5127	Schnauzer - Socrates	unknown		Male	
5130	Shar Pei - Sasha	unknown		unknown	
5131	Sheltie - Robbie	unknown		Male	
5132	Sheltie - Sadie	unknown		unknown	
5134	Shiba Inu - Hana	unknown		Female	
5135	Shih Tzu - Wicket	unknown		Male	
5136	Shih Tzu - Jenna	unknown		Male	
5138	Smooth Fox Terrier - Killer	unknown		unknown	
5140	Standard Poodle - Ducelle	unknown		Male	
5142	Terrier Mix - Greta	unknown		Female	
5144	Toy Poodle - Rose	unknown		unknown	
5145	Weimaraner - Roxie	unknown		unknown	
5147	West Highland Terrier - Duncan	unknown		unknown	
5148	Westie - Zero	unknown		Male	
5149	Whippet - Dee O Gee	unknown		unknown	
5150	Yorkie Mix - B'Ahtan	unknown		unknown	
5151	Yorkshire Terrier - Teddi	unknown		unknown	
5154	Abyssinian - Shelby	unknown		Female	
5157	American Shorthair - Oshi	unknown		Male	
5161	DLH - Cookie	unknown		Female	
5162	DLH - Ella	unknown		unknown	
5163	DLH - Cissy	unknown		unknown	
5164	DLH - Emmy	unknown		unknown	
5168	DMH - Lucy	unknown		Female	
5176	DSH - Dallas	unknown		unknown	
5177	DSH - Katie	unknown		Female	
5180	DSH - Spike	unknown		unknown	
5181	European Shorthair - Milo	unknown		unknown	
5184	Japanese Bobtail - Kiwi	unknown		Female	
5185	Maine Coon - Bittersweet	unknown		unknown	
5186	Maine Coon - Jasper	unknown		Male	
5190	Ocicat - Jerry	unknown		unknown	
5195	Savannah - Kala Polvit	unknown		Male	
5196	Savannah - Kala Thetos	unknown		Male	
5198	Siamese - Zorro	unknown		unknown	
5201	Siamese Mix - Flicka	unknown		Female	
5202	Siamese Mix Breed - Simon	unknown		Male	
5205	Aberrant Subclavian Artery (Arteria Lusoria)		68	Female	
5206	Aortic Dissection		65	Male	
5207	Aortic Coarctation		19	Male	
5208	Aortic Coarctation with Stent		21	Male	
5209	Subrenal Aortic Aneurysm		64	Male	
5210	Aortic Aneurysm with Endoprosthesis		64	Male	
5211	Celiac Tripod Aneurysm		77	Male	
5212	Duodenal Submucosal Lipoma		82	Male	
5213	Routine Chest CT		51	Female	
5214	Internal Carotid Artery Aneurysm		48	Female	
5215	Left Ventricle Aneurysm		66	Male	
5216	Left Subclavian Artery Aneurysm		46	Male	
5217	Right Coronary Artery Aneurysm with Stent		61	Male	
5218	Prostatic Cancer Metastasis		72	Male	
5219	Lung Cancer		54	Female	
5220	Proximal Humerus Fracture		41	Male	
5221	Lung Cancer		77	Female	
5222	Ovarian Cystadenoma		43	Female	
5223	Normal Coronary Arteries		49	Male	
5224	Lung Cancer		76	Male	
5225	Stenosis of the Iliac Arteries		54	Male	
5226	Middle Cerebral Artery Aneurysm		44	Female	
5227	Maxillar Bone Cyst		56	Male	
5228	Double Left Renal District with Ureter		51	Male	
5229	Lipoma at the Right Thigh		80	Female	
5230	Tracheal Squamous Cell Carcinoma		62	Male	
5231	Pulmonary Embolism 1		70	Female	
5232	Coronary Artery Aneurysm		73	Female	
5233	Coronary Stents		59	Male	
5234	Heart Cancer		76	Male	
5235	Stents at the Arteries of the Lower Limbs		62	Male	
5236	Dextrocardia		58	Female	
5237	Aortic Aneurysm		68	Male	
5238	Expansive Process of the Right Lung		72	Male	
5239	Pulmonary Embolism 2		70	Female	
5240	Mucocele		53	Male	
5241	Prolapsed Bladder		82	Male	
5242	Cancer of the Right Colon		68	Female	
5243	Lung Cancer		49	Female	
5244	Occluded Bypass of the Lower Limbs		76	Male	
5245	Carotid Stenosis		70	Male	
5246	Post-operative Aortic Aneurysm		71	Male	
5247	Ascending Aortic Aneurysm		79	Male	
5248	Stenosis of the Iliac Artery		54	Male	
					Death Certificate: - ventricular fibrillation - coronary heart disease - arteriosclerosis CT Findings: - TEP both sides - possible pneumonia and lung metastasis - osteosarcoma, sus both humeri heads, left more than right side - enlarged spleen - calcification of the plexus choroideus
6000	Cadaver B Vein Contrast		86	Female	Scan contributed by Heidelberg University. Death Certificate: - multi-organ failure - soft tissue infiltration after squamous epithelium tumor of the Glandula parotis with metastasis in the lung CT Findings: - parotid gland tumor left with open wound, infiltration of soft tissue - calcification of the plexus choroideus - multiple metastasis in the lung and liver and spleen - plate osteosynthesis: c.a. fractured tibia right - bone cyst left near head/collum of femur - osteosynthesis: c.a. fractured olecranon left - lung metastasis, pneumonia (pm?)
6001	Cadaver D Natural		78	Male	Scan contributed by Heidelberg University. Death Certificate: - mammary carcinoma with bone metastasis CT Findings: - intramedullary nail both femur and right humerus - osteotal fixator in right clavicula and right tibia (still fractured) - TEP in both knees - osteopenia in the spine, hole in left olecranon, very thin fossa infraspinata (possibly due to mamma ca) - osteoplastic arcas (see right humerus/femur and left shoulder/spina scapulae, acromion, head of humerus) - calcification of the plexus choroideus - arteriosclerosis - large gallbladder - pleural effusion
6002	Cadaver F Natural		79	Female	Scan contributed by Heidelberg University. Death Certificate: - cardiac decompensation (chronic insufficient) - coronary heart disease - arterial hypertension - c.a. myocardial infarct - tricuspid insufficiency - chronic insufficiency of the kidneys - 3-fold stenosis (ramus interventricularis anterior), RCX (ramus circumflexus), - peripheral artery desease CT Findings: - calcification of the plexus choroideus - large gall bladder - unclear calcification under right kidney - arteriosclerosis - osteochondrosis - fractured right Ramus inferior ossis pubis - calcifications of left wall of the uterus with cystic alteration close-by (maybe ovarian) - possible left coronary stent
6003	Cadaver H Natural		86	Female	Scan contributed by Heidelberg University.

Anatomage Table 9.0 Case Library Descriptions

			Death Certificate: - sepsis - pneumonia - lung cancer (adenocarcinoma left superior lobe stadium IV, metastasis in the brain) - z.n. ulcus pepticum jejuni, Z. n. Billroth II-operation - coronary heart disease - aneurysma spurium after Coronagiographie - z.n. Carotis-TEA rechts CT Findings: - calcification of the. plexus choroideus - hypodense tumor in left thyroid gland - arteriosclerosis - port on left hand side - lung cancer - enlarged gall bladder
6004	Cadaver I Natural	70 Male	Scan contributed by Heidelberg University. Death Certificate: - syncope, cardiac arrest - sepsis - urinary tract infection - Diabetes Mellitus Type II - dementia CT Findings: - intramedullary nail both femurs - gallstones - old traumatism bonfeches left & right side - maybe after subdural bleeding (still calcified areas)
6005	Cadaver J Natural	93 Female	Scan contributed by Heidelberg University. Death Certificate: - chronic obstructive pulmonary disease - pulmonary emphysema - Morbus Parkinson CT Findings: - calcification of the plexus choroideus - arteriosclerosis - possible uterus myoma/fibroid
6006	Cadaver L Arterial, Venous Contrast	68 Female	Scan contributed by Heidelberg University. Death Certificate: - kidney failure after insufficiency - Morbus Alzheimer - z.n. apoplexy CT Findings: - calcification of the plexus choroideus - arteriosclerosis - pleura effusion and pneumonia
6007	Cadaver M Arterial, Venous Contrast	93 Male	Scan contributed by Heidelberg University. Death Certificate: - sepsis - pneumonia - CUP syndrome CT Findings: - calcification of the plexus choroideus - broken pelvis - maddallary nail hip (right side) - pneumonia, pleura effusion
6009	Cadaver O Arterial, Venous Contrast	77 Male	Scan contributed by Heidelberg University. Death Certificate: -septic encephalopathy -pneumonia -liver cell carcinoma CT Findings: -coronary sclerosis, arteriosclerosis in general -possible pneumonia -Billau-Drainage - pneumothorax right, pleuraeffusion on both sides with still persistant drainage, CVC left -calcification of the choroid plexus -left hemisphere seems to be edematous and a bit enlarged -parotid gland is swollen -free liquid in abdomen: perihepatic, behind stomach, spleen and pelvis - ascites because of liver atrophy (cirrhosis - varicen near spleen) -kidney cyst right -hydrocele of the scrotum on both sides -calcification of thyroid glad left -edema in both legs
6010	Cadaver A Venous, Arterial Contrast	71 Male	Scan contributed by Heidelberg University. Death Certificate: -septic encephalopathy -pneumonia -liver cell carcinoma CT Findings: -coronary sclerosis, arteriosclerosis in general -possible pneumonia -Billau-Drainage - pneumothorax right, pleuraeffusion on both sides with still persistant drainage, CVC left -calcification of the choroid plexus -left hemisphere seems to be edematous and a bit enlarged -parotid gland is swollen -free liquid in abdomen: perihepatic, behind stomach, spleen and pelvis - ascites because of liver atrophy (cirrhosis - varicen near spleen) -kidney cyst right -hydrocele of the scrotum on both sides -calcification of thyroid glad left -edema in both legs
6011	Cadaver A Natural	71 Male	Scan contributed by Heidelberg University. Death Certificate: -septic encephalopathy -pneumonia -liver cell carcinoma CT Findings: -coronary sclerosis, arteriosclerosis in general -possible pneumonia -Billau-Drainage - pneumothorax right, pleuraeffusion on both sides with still persistant drainage, CVC left -calcification of the choroid plexus -left hemisphere seems to be edematous and a bit enlarged -parotid gland is swollen -free liquid in abdomen: perihepatic, behind stomach, spleen and pelvis - ascites because of liver atrophy (cirrhosis - varicen near spleen) -kidney cyst right -hydrocele of the scrotum on both sides -calcification of thyroid glad left -edema in both legs
6012	Cadaver A Venous Contrast	71 Male	Scan contributed by Heidelberg University. Death Certificate: - ventricular fibrillation - coronary heart disease - arteriosclerosis CT Findings: - TEP both sides - possible pneumonia and lung metastasis - osteosarcoma, sos both humeri heads, left more than right side - enlarged spleen - calcification of the plexus choroideus
6013	Cadaver B Venous, Arterial Contrast	86 Female	Scan contributed by Heidelberg University. Death Certificate: - ventricular fibrillation - coronary heart disease - arteriosclerosis CT Findings: - TEP both sides - possible pneumonia and lung metastasis - osteosarcoma, sos both humeri heads, left more than right side - enlarged spleen - calcification of the plexus choroideus
6014	Cadaver B Natural	86 Female	Scan contributed by Heidelberg University. Death Certificate: -lung edema -cardiac insufficiency -apoplexy -dementia CT Findings: -calcification of the choroid plexus -focal nodular tumor in liver (possible haemangioma) -diverticula in urinary bladder -hyperplasia of prostata (possible metastasis) -kidney cyst right -osteophytes (spine) -pneumonia (possible metastasis) -dementia
6015	Cadaver C Natural	78 Male	Scan contributed by Heidelberg University. Death Certificate: -lung edema -cardiac insufficiency -apoplexy -dementia CT Findings: -calcification of the choroid plexus -focal nodular tumor in liver (possible haemangioma) -diverticula in urinary bladder -hyperplasia of prostata (possible metastasis) -kidney cyst right -osteophytes (spine) -pneumonia (possible metastasis) -dementia
6016	Cadaver C Venous Contrast	78 Male	Scan contributed by Heidelberg University. Death Certificate: -lung edema -cardiac insufficiency -apoplexy -dementia CT Findings: -calcification of the choroid plexus -focal nodular tumor in liver (possible haemangioma) -diverticula in urinary bladder -hyperplasia of prostata (possible metastasis) -kidney cyst right -osteophytes (spine) -pneumonia (possible metastasis) -dementia
6017	Cadaver C Venous, Arterial Contrast	78 Male	Scan contributed by Heidelberg University. Death Certificate: -multi-organ failure -soft tissue infiltration after squamous epithelium tumor of the Glandula parotid with metastasis in the lung CT Findings: -parotid gland tumor left with open wound, infiltration of soft tissue (see. loss contrast agent) -calcification of the choroid plexus -large urinary bladder, gall bladder & spleen -plate osteosynthesis: z.n. fracutred tibia right -bone cyst left near head/collum of femur -osteosynthesis: z.n. fractured olecranon left -lung metastasis, possible pneumonia
6018	Cadaver D Venous Contrast	78 Male	Scan contributed by Heidelberg University.

Anatomage Table 9.0 Case Library Descriptions

			Death Certificate: -multi-organ failure -soft tissue infiltration after squamous epithelium tumor of the Glandula parotid with metastasis in the lung CT Findings: -parotid gland tumor left with open wound, infiltration of soft tissue (see: less contrast agent) -calcification of the choroid plexus -large urinary bladder, gall bladder & spleen -plate osteosynthesis: c.a. fractured tibia right -bone cyst left near head/collum of femur -osteosynthesis: c.a. fractured olecranon left -lung metastasis, possible pneumonia
6019	Cadaver D Venous, Arterial Contrast	78 Male	Scan contributed by Heidelberg University. Death Certificate: -hypoxia -cardiac failure -CHD CT Findings: -calcification of the choroid plexus -possible enlarged ventricles -external fixator spine -possible pneumonia -air in the guts
6020	Cadaver E Natural	85 Female	Scan contributed by Heidelberg University. Death Certificate: -hypoxia -cardiac failure -CHD CT Findings: -calcification of the choroid plexus -possible enlarged ventricles -external fixator spine -possible pneumonia -air in the guts
6021	Cadaver E Arterial Contrast	85 Female	Scan contributed by Heidelberg University. Death Certificate: -hypoxia -cardiac failure -CHD CT Findings: -calcification of the choroid plexus -possible enlarged ventricles -external fixator spine -possible pneumonia -air in the guts
6022	Cadaver E Arterial, Venous Contrast	85 Female	Scan contributed by Heidelberg University.0
6023	Cadaver F Arterial Contrast	79 Female	
6024	Cadaver F Arterial, Venous Contrast	79 Female	
			Death Certificate: -pulmonary embolism -Thrombosis -Hypertonia -Dementia -CHD CT Findings: -Dementia -Osteostructure ramification all over, skull with "holes" and very thin aereas (ex. occipitale) – possible osteoporosis/myeloma -kidney cyst -scoliosis with relocation of aorta, arteriosclerosis, aneurysm of aorta -air in guts -inguinal hernia right with guts -hydrocele right -aneurysm of popliteal artery both sides, right>li.
6025	Cadaver G Natural	96 Male	Scan contributed by Heidelberg University. Death Certificate: -pulmonary embolism -Thrombosis -Hypertonia -Dementia -CHD CT Findings: -Dementia -Osteostructure ramification all over, skull with "holes" and very thin aereas (ex. occipitale) – possible osteoporosis/myeloma -kidney cyst -scoliosis with relocation of aorta, arteriosclerosis, aneurysm of aorta -air in guts -inguinal hernia right with guts -hydrocele right -aneurysm of popliteal artery both sides, right>li.
6026	Cadaver G Arterial Contrast	96 Male	Scan contributed by Heidelberg University. Death Certificate: -pulmonary embolism -Thrombosis -Hypertonia -Dementia -CHD CT Findings: -Dementia -Osteostructure ramification all over, skull with "holes" and very thin aereas (ex. occipitale) – possible osteoporosis/myeloma -kidney cyst -scoliosis with relocation of aorta, arteriosclerosis, aneurysm of aorta -air in guts -inguinal hernia right with guts -hydrocele right -aneurysm of popliteal artery both sides, right>li.
6027	Cadaver G Arterial, Venous Contrast	96 Male	Scan contributed by Heidelberg University. Death Certificate: -pulmonary embolism -Thrombosis -Hypertonia -Dementia -CHD CT Findings: -Dementia -Osteostructure ramification all over, skull with "holes" and very thin aereas (ex. occipitale) – possible osteoporosis/myeloma -kidney cyst -scoliosis with relocation of aorta, arteriosclerosis, aneurysm of aorta -air in guts -inguinal hernia right with guts -hydrocele right -aneurysm of popliteal artery both sides, right>li.
6028	Cadaver Head G Natural	96 Male	Scan contributed by Heidelberg University. Death Certificate: -cardiac decompensation (chronic insuffient) -CHD -arterial hypertension -c.a. myocardio infarct -tricuspid insufficiency -chronic insufficiency of the kidneys -Stents: RIVA (ramus interventricularis anterior), RCX (Ramus circumflexus), -PAD CT Findings: -calcification of the choroid plexus -large gall bladder -unclear calcification under right kidney -coprostase -arteriosclerosis -fractured Ramus inferior ossis pubis right -calcification of left wall of the uterus with cystic alteration close-by (maybe ovary) -possible coronary stent left
6029	Cadaver H Arterial Contrast	86 Female	Scan contributed by Heidelberg University. Death Certificate: -cardiac decompensation (chronic insuffient) -CHD -arterial hypertension -c.a. myocardio infarct -tricuspid insufficiency -chronic insufficiency of the kidneys -Stents: RIVA (ramus interventricularis anterior), RCX (Ramus circumflexus), -PAD CT Findings: -calcification of the choroid plexus -large gall bladder -unclear calcification under right kidney -coprostase -arteriosclerosis -fractured Ramus inferior ossis pubis right -calcification of left wall of the uterus with cystic alteration close-by (maybe ovary) -possible coronary stent left
6030	Cadaver H Arterial, Venous Contrast	86 Female	Scan contributed by Heidelberg University. Death Certificate: -sepsis -pneumonia -lung cancer (adenocarcinoma left superior lobe stage IV, metastasis in the brain) -c.a. ulcus pepticum jejuni; Z. n. Billroth II-operation -CHD -aneurysma spurium after Coronagiography -c.a. Carotis-TEA rechts CT Findings: -calcification of the choroid plexus -hypodense tumor in left thyroid gland -arteriosclerosis -port on left hand side -lung carcinoma -enlarged gall bladder -arteriosclerosis
6031	Cadaver I Arterial Contrast	70 Male	Scan contributed by Heidelberg University. Death Certificate: -sepsis -pneumonia -lung cancer (adenocarcinoma left superior lobe stage IV, metastasis in the brain) -c.a. ulcus pepticum jejuni; Z. n. Billroth II-operation -CHD -aneurysma spurium after Coronagiography -c.a. Carotis-TEA rechts CT Findings: -calcification of the choroid plexus -hypodense tumor in left thyroid gland -arteriosclerosis -port on left hand side -lung carcinoma -enlarged gall bladder -arteriosclerosis
6032	Cadaver I Arterial, Venous Contrast	70 Male	Scan contributed by Heidelberg University.

Anatomage Table 9.0 Case Library Descriptions

				Death Certificate: -syncope, cardiac arrest -hypertonia -infection of the urinary tract -Diabetes mellitus Type II -Dementia CT Findings: -intramedullary nail both femur -gallstones -old trepanation boreholes left & right side - maybe after subdural bleeding (still calcified)
6033	Cadaver J Arterial Contrast		93 Female	Scan contributed by Heidelberg University. Death Certificate: -syncope, cardiac arrest -hypertonia -infection of the urinary tract -Diabetes mellitus Type II -Dementia CT Findings: -intramedullary nail both femur -gallstones -old trepanation boreholes left & right side - maybe after subdural bleeding (still calcified)
6034	Cadaver J Arterial, Venous Contrast		93 Female	Scan contributed by Heidelberg University. Death Certificate: -syncope, cardiac arrest -hypertonia -infection of the urinary tract -Diabetes mellitus Type II -Dementia CT Findings: -intramedullary nail both femur -gallstones -old trepanation boreholes left & right side - maybe after subdural bleeding (still calcified)
6035	Cadaver Head J Natural		93 Female	Scan contributed by Heidelberg University. Death Certificate: -pneumonia (aspiration because of dysphagia) -atrial fibrillation -apoplexy CT Findings: -kidney cyst, left side
6036	Cadaver K Natural		75 Male	Scan contributed by Heidelberg University. Death Certificate: -pneumonia (aspiration because of dysphagia) -atrial fibrillation -apoplexy CT Findings: -kidney cyst, left side
6037	Cadaver K Arterial Contrast		75 Male	Scan contributed by Heidelberg University. Death Certificate: -pneumonia (aspiration because of dysphagia) -atrial fibrillation -apoplexy CT Findings: -kidney cyst, left side
6038	Cadaver K Arterial, Venous Contrast		75 Male	Scan contributed by Heidelberg University. Death Certificate: -COPD -pulmonary emphysema -Morbus Parkinson CT Findings: -calcification of the choroid plexus -stent in gallbladder -maybe uterus myoma
6039	Cadaver L Natural		68 Female	Scan contributed by Heidelberg University. Death Certificate: -COPD -pulmonary emphysema -Morbus Parkinson CT Findings: -calcification of the choroid plexus -stent in gallbladder -maybe uterus myoma
6040	Cadaver L Arterial Contrast		68 Female	Scan contributed by Heidelberg University. Death Certificate: -kidney failure after insufficiency -Morbus Alzheimer -c.a. apoplexy CT Findings: -calcification of the choroid plexus -arteriosclerosis -pleura effusion and pneumonia
6041	Cadaver M Natural		93 Male	Scan contributed by Heidelberg University. Death Certificate: -kidney failure after insufficiency -Morbus Alzheimer -c.a. apoplexy CT Findings: -calcification of the choroid plexus -arteriosclerosis -pleura effusion and pneumonia
6042	Cadaver M Arterial Contrast		93 Male	Scan contributed by Heidelberg University. Death Certificate: -cardiac failure -apoplexy -CHD CT Findings: -possible shift of right hemisphere to the left -calcification of the choroid plexus -heart operation, wire in sternum -pleura effusion, pneumonia -external fixator spine
6043	Cadaver N Natural		92 Male	Scan contributed by Heidelberg University. Death Certificate: -cardiac failure -apoplexy -CHD CT Findings: -possible shift of right hemisphere to the left -calcification of the choroid plexus -heart operation, wire in sternum -pleura effusion, pneumonia -external fixator spine
6044	Cadaver N Arterial Contrast		92 Male	Scan contributed by Heidelberg University. Death Certificate: -sepsis -pneumonia -CUP syndrome CT Findings: -calcification of the choroid plexus -broken pelvis -medullary nail hip (right side) -pneumonia, pleura effusions
6045	Cadaver O Natural		77 Male	Scan contributed by Heidelberg University. Death Certificate: -sepsis -pneumonia -CUP syndrome CT Findings: -calcification of the choroid plexus -broken pelvis -medullary nail hip (right side) -pneumonia, pleura effusions
6046	Cadaver O Arterial Contrast		77 Male	Scan contributed by Heidelberg University. Death Certificate: -septic shock after infection -COPD -heart failure -atrial fibrillation CT Findings: -calcification of the choroid plexus -serial fractures of the ribs (possible reanimation), maybe pneumothorax -emphysema in soft tissue -effusion pleura -effusion/ perihepatic, pericolic
6047	Cadaver P Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -apoplexy -encephalopathy -liver cirrhosis -COPD CT Findings: -calcification of the choroid plexus -arteriosclerosis -aspiration of stomach content in trachea and bronchi -kidney cysts both sides -degenerative altered spine
6048	Cadaver Q Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -lung cancer (possible because of asbestos) -heart failure -Diabetes mellitus Type II CT Findings: -pneumonia -possible mesothelioma -arteriosclerosis -kidney cyst -osteotomies in spine
6049	Cadaver R Natural	Unknown	Male	Scan contributed by Heidelberg University.

Anatomage Table 9.0 Case Library Descriptions

				Death Certificate: -metastasis -heart failure CT Findings: -brain cancer anterior horn of lateral ventrical -pneumonia -penis prothesis -external fixator spine
6050	Cadaver S Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -COPD after infection -hypertonia -CHD -cardiac arrest, heart attack CT Findings: -calcification of the choroid plexus -digoid in sphenoidal sinus -degenerative osteoarthrosis on spine/osteophytes -varicos on both legs -pleura effusion - possible pneumonia -enlarged lymphnodes (lung) -emphysema, COPD -arteriosclerosis -kidney cysts (both sides), maybe cancer on right side
6051	Cadaver T Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -heart attack -CHD -renal failure -vascular dementia -Diabetes mellitus Type II CT Findings: -pacemaker -arteriosclerosis -gallbladder stones -pleura effusion -stent (coronary)
6052	Cadaver U Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -pneumonia -lung illnesss -hypertonia CT Findings: -calcification of the choroid plexus -humerus fracture with osteosynthesis -cors pulmonale, dilated right heart -sternotomy
6053	Cadaver V Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -kidney failure -chronic kidney disease CT Findings: -atrophic temporal lobe -calcification of the choroid plexus -struma nodosa bilobilis thyroid right side with calcification -atelectasis -pleura effusions -kidney cysts -possible suprarenalcortex cancer
6054	Cadaver W Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -vascular dementia -corpus uteri cancer -arterial hypertension -CHD -hyperthyreosis -adhesia CT Findings: -pneumonia, pleura effusion -arteriosclerosis
6055	Cadaver X Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -COPD -cachexia CT Findings: -calcification of the choroid plexus -emphysema of lung -pleura effusion, atelectasis -fracture of left acetabulum with osteosynthesis -pacemaker, heart failure -TEP (hip) right side
6056	Cadaver Y Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -CUP-syndrome -respiratory failure CT Findings: -calcification of the choroid plexus -Port -TEP hip right side -meningeoma
6057	Cadaver Z Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -stomach cancer -COPD -cachexia -kidney insuffiency CT Findings: -calcification of the choroid plexus -pacemaker -pleura effusion -liquid perihepatisch, perispleen, pelvis -possible kidney cysts -prostata hyperplasia
6058	Cadaver AA Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -multiorgan failure, sepsis -pancreas cancer CT Findings: -pleura effusion, pneumonia -arteriosclerosis -calcification of the choroid plexus -pericardio effusion
6059	Cadaver BB Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -sudden cardiac arrest -cachexia CT Findings: -calcification of the choroid plexus -aspiration of stomach content in trachea and bronchi -marrow nail right femur after fracture (bone fractures) -TEP (knee) right side
6060	Cadaver CC Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -aspiration and asphyxia -COPD -dementia -pneumonia -kidney failure CT Findings: -pacemaker -pleura effusion -pneumonia -congenital aorter left side
6061	Cadaver DD Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -multiple myeloma -bone metastasis -Diabetes mellitus Type II CT Findings: -pneumonia -arteriosclerosis -external fixator spine, metastasis spine
6062	Cadaver EE Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -urosepsis -chronic renal failure CT Findings: -calcification of the choroid plexus -pneumonia, pleura effusion -gallbladder stones -stent (aneurysma: infrarenal, iliac) -heart dilated (right side)
6063	Cadaver FF Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -heart attack -CHD -renal failure -vascular dementia -Diabetes mellitus Type II CT Findings: -pacemaker -arteriosclerosis -gallbladder stones -pleura effusion -stent (coronary)
6064	Cadaver GG Natural	Unknown	Male	Scan contributed by Heidelberg University.

Anatomage Table 9.0 Case Library Descriptions

			Death Certificate: -respiratory insufficiency -pneumonia on both sides -hypertonia -dementia -diabetes mellitus type II CT Findings: -calcification of the choroid plexus -arteriosclerosis -pneumonia -trapped air in liver and gam -possible congenital ureter -stoma -enlarged ventricles
6065 Cadaver HH Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -hemorrhagic shock -gastric bleeding CT Findings: -calcification of the choroid plexus -arteriosclerosis -kidney cyst
6066 Cadaver II Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -COPD -cachexia CT Findings: -calcification of the choroid plexus -emphysema of lung -pleura effusion, atelectasis -fracture of left acetabulum with osteosynthesis -fracture of pelvis girdle -TEP (hip) right side
6067 Cadaver JJ Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -pneumonia (aspiration) -pulmonary embolism -ileus CT Findings: -calcification of the choroid plexus -pneumonia -arteriosclerosis -kidney stone left side -enlarged heart -TEP right shoulder
6068 Cadaver KK Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -sudden cardiac death -dementia -sinusitis CT Findings: -calcification of the choroid plexus -arteriosclerosis -pneumonia -trapped air in liver and gam (potentially postmortal) -TEP on both hips
6069 Cadaver LL Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -cardiac arrest -arteriosclerosis -apoplexy -dementia CT Findings: -Potential infarct in occipital region -arteriosclerosis -large bladder -calcification in uterus wall -marrow nail left femur -calcification of the choroid plexus & falx -pleura effusion -aspiration of stomach content in trachea and bronchi -some device in IVC to right ventricle
6070 Cadaver MM Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -heart failure (mitral valve insufficiency) -acute abdomen -atrial fibrillation CT Findings: -arteriosclerosis -TEP shoulder -cholecystitis -kidney stone left side
6071 Cadaver NN Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -ruptured gi bleeding -ileus ventricali CT Findings: -TEP Left (hip) -TEP right (knee) -pelvic girdle fracture (old) -tibia fracture (old) with plate osteosynthesis -calcified pleura (potential Asbestos) -calcified falx and choroid plexus
6072 Cadaver OO Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -heart failure -acute hypotension -dementia -kidney insufficiency CT Findings: -calcification of the choroid plexus -pneumonia -arteriosclerosis
6073 Cadaver PP Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -oesophagus bleeding -chronic gastritis -hernia (hiatus) -PAD, CHD -dementia -cachexia CT Findings: -stent (coronary) -arteriosclerosis -gallbladder stones -TEP left (hip) -calcification of the choroid plexus
6074 Cadaver QQ Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -cachexia -pelvic fracture -Diabetes mellitus Type II -hypertonia CT Findings: -pleura effusion -calcification of the choroid plexus
6075 Cadaver RR Naturel	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -small-celled neuroendocrine cancer -metastatic liver, pleura, bones, peritoneum, bladder -osteoporosis -hyperkyphosis CT Findings: -TEP left (hip) -TEP right (knee) -hydronephrosis, dilated ureter -apoplexy -calcification of the choroid plexus
6076 Cadaver SS Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -apoplexy CT Findings: -gallstones
6077 Cadaver TT Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -acute kidney failure, chronic insufficiency -urothelium cancer -pneumonia -CHD CT Findings: -calcification of the choroid plexus -bypass -coronarystent left -aneurysm anterior common iliac -serial fractures of the ribs (possible reanimation)
6078 Cadaver UU Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -heart failure -thrombosis -dysphagia CT Findings: -tibia fracture right side -aneurysm left popliteal a -calcification of the choroid plexus -arteriosclerosis -polycystic kidney desease
6079 Cadaver VV Natural	Unknown	Male	Scan contributed by Heidelberg University.

Anatomage Table 9.0 Case Library Descriptions

			Death Certificate: -cardiac failure -heart insufficiency -CHD after heart attack -apoplexy -arteriosclerosis -hypertonia CT Findings: -dilatation of hypertric ventricle -calcification of the choroid plexus & falx -pleurea effusion with atelektasis -trapped air in gain (potentially postmortal)
6080	Cadaver WW Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -sudden cardiac death -c.a. mamma cancer CT Findings: -calcification of the choroid plexus -pneumonia -arteriosclerosis
6081	Cadaver XXNatural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -myocardial infarct -stenosis of vessels -morbus alzheimer CT Findings: -calcification of the choroid plexus -osteosynthesis spine -kidney cyst left side -TEP (hip) both sides
6082	Cadaver VV Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -sepsis -pneumonia -COPD -arterial hypertension CT Findings: -calcification of the choroid plexus -metastasis in liver -arteriosclerosis -external fixator spine -port
6083	Cadaver ZZ Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -cardiac arrest -CHD -bypass CT Findings: -calcification of the choroid plexus & falx -4th Electrode (right (possible maintenance) -metastasis -pleura effusion -arteriosclerosis
6084	Cadaver AAA Natural	Unknown	Male	Scan contributed by Heidelberg University.
				Death Certificate: -heart failure, atrial fibrillation -COPD, arterial hypertension -hyperthyreosis CT Findings: -arteriosclerosis -pneumonia, pleura effusion -calcification of the choroid plexus
6085	Cadaver BBB Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -cachexia -multi organ failure CT Findings: -calcification of the choroid plexus -arteriosclerosis -TEP (hip & knee) right side
6086	Cadaver CCC Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -pneumonia, COPD -kidney failure CT Findings: -arteriosclerosis -enlarged left ventricle (heart) with rounded apex -TEP hip left side -possible kidney cyst left -degenerative alteration on spine
6087	Cadaver DDD Natural	Unknown	Male	Scan contributed by Heidelberg University.
				Death Certificate: -heart failure, atrial fibrillation -COPD, arterial hypertension -hyperthyreosis CT Findings: -arteriosclerosis -pneumonia, pleura effusion -calcification of the choroid plexus
6088	Cadaver EEE Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -apoplexy -hypertonia -dementia -kidney insufficiency CT Findings: -calcification of the choroid plexus -enlarged right lobe of thyroid gland -COPD ratrification of lung vessels with signs of overinflation -kidney cysts on both sides -radius fracture with osteosynthesis right side -TEP (hip) both sides -arteriosclerosis
6089	Cadaver FFF Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -liver failure because of mutastasis -pancreas & oesophagus cancer CT Findings: -port -pneumonia -enlarged gall bladder -pleura effusion
6090	Cadaver GGG Natural	Unknown	Male	Scan contributed by Heidelberg University.
				Death Certificate: -multiorgan failure -COPD CT Findings: -calcification of the choroid plexus -lung: panlobular emphysema -pleura effusion with atelectasis -arteriosclerosis -gallbladder hydrops
6091	Cadaver HHH Natural	Unknown	Male	Scan contributed by Heidelberg University.
				Death Certificate: -lung cancer -multiorgan failure CT Findings: -metastasis in liver and spine -port -calcification of the choroid plexus
6092	Cadaver III Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -bedridden CT Findings: -TEP (hip) -pleura effusion -lung: partly collapsed -arteriosclerosis
6093	Cadaver JJJ Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -heart failure, atrial fibrillation -tachycardia CT Findings: -pleura effusion -arteriosclerosis -osteoporosis
6094	Cadaver KKK Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -hypoxic insufficiency - COPD -mammary cancer CT Findings: -calcification of the choroid plexus -port -septuation of stomach content in trachea and bronchi -arteriosclerosis -right kidney much larger than left one -possible artifact in ileum-colon ascendens -gallbladder hydrops -catheter in bladder -TEP (hip) both sides -pleura effusion, lung atelectasis -coronary stent -myocardium is hypertrophic
6095	Cadaver LLL Natural	Unknown	Female	Scan contributed by Heidelberg University.
				Death Certificate: -teething CT Findings: -jaw cerclage -arteriosclerosis, bypass -silication of abdominal aorta -huge scrotum -right heart hypertrophy
6096	Cadaver MMM Natural	Unknown	Male	Scan contributed by Heidelberg University.

Anatomage Table 9.0 Case Library Descriptions

			Death Certificate: -tuberculosis -cardiovascular collapse -sepsis -ovarian cancer CT Findings: -thickened bony structures (scull) -calcification of the choroid plexus -humerus fracture with osteosynthesis -pleuritis, pneumonia -enterolithiasis -liquid tumor mass in lesser pelvis, possible colon cancer
6097	Cadaver NNN Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -sudden cardiac death, myocardium-damage -hypjaxs, stasis -COPD CT Findings: -cardiomegaly -serial fracture of the ribs (possible reanimation) -radius fracture (old) with plate osteosynthesis -uterine myoma -kidney cyst -TEP (knee) -artificial sphincter (urethra)
6098	Cadaver OOO Natural	Unknown	Female	Scan contributed by Heidelberg University. Death Certificate: -respiratory insufficiency -COPD -hypertonia -CHD CT Findings: -bladder diverticulum -kidney cyst -calcification of the popliteal artery -haviel chest (COPD) -pericardial effusion
6099	Cadaver PPP Natural	Unknown	Male	Scan contributed by Heidelberg University. Death Certificate: -heart failure -CHD CT Findings: -coronary stent -aneurysm, aortic and renal artery stents -kidney cyst -pleura effusion -TEP (hip) -calcification of the choroid plexus
6100	Cadaver QQQ Natural	Unknown	Male	Scan contributed by Heidelberg University.
6101	Cadaver RRR Natural	Unknown	Female	Findings: Whole-body computed tomography without intravenous contrast medium administration is available for review in the transverse, sagittal, and dorsal planes. This study is compared to several research turtles with CT studies performed between 2015-2018. The Hounsfield Unit measurements are variable between research turtles. Overal margin thickness of the outer and inner margins of the shell(carapace and plastron) are similar between patients. However, between the inner and outer layers, the attenuation is reduced with increased definition of trabeculation. The long bones also have subjectively coarse trabecular bone and reduced attenuation of medullary regions; cortical thickness remains similar but accurate measurements are difficult given the small size. Additionally, the attenuation of the liver, gallbladder and fat is variable between patients. The liver is mildly larger in the current patient in comparis Selected data points include: Average Hounsfield unit measurements of the current patient: Carapace (between inner and outer layers) average = 230-390 max = 300-550 Medulla of proximal humerus: average = 520-580, max = 600-640 Medulla of proximal femurs: average = 350-380, max = 420-500 Liver: average = -10to -30, max = -10to 5 Gallbladder: average = 45, max = 60 Coelomic fat: average = -95to -110, max = -50 to -90 Comparison turtle #1 (unknown species): Carapace (average) 730-780 +/- 75 Medulla of proximal humerus (average) 750 +/-45 Medulla of proximal femurs (average) 630 +/-40 Liver (average) 80 +/- 3 Gallbladder (average) 35+/-5 Coelomic fat (average) -34+/- 3 Comparison turtle #2 (unknown species): Carapace (average) 550-700 +/- 80 Medulla of proximal humerus (average) 680 +/-60 Medulla of proximal femurs (average) 575 +/- 35 Liver (average) 68 +/- 5 Gallbladder (average) not identified Coelomic fat (average) -95+/- 8 Comparison turtle #3 (Western Pond Turtle): Carapace (average) 470-650 +/- 60 Medulla of proximal humerus (average) 680-730 +/- 55 Medulla of proximal femurs (average) 590-650 +/- 40 Liver (average) 70-80+/-5 Gallbladder (average)45+/- 5 Coelomic fat (average) -62+/- 4 Impressions: 1. Probable diffuse hepatopathy; the liver is primarily fat attenuating(co-eminent with lipidosis) 2. Suspect diffuse osteopenia Published normal reference values are not available. The comparison between the current patient and research animals is difficult as underlying disease processes are not known for the research animals. Size and species of turtle are likely contributing factors to differences in measurements which were not taken into account during this evaluation although the first two turtles were similar in height to the patient; the Western Pond Turtle is smaller than the current patient.
6300	Turtle	18 years	M	Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident Supervised by: Stacy D. Cooley DVM, DACVR Findings: Computed tomography images of the head and thorax pre- and post-contrast medium administration with1 minute and several minute delays are reviewed in transverse, sagittal, and dorsal planes. HEAD: In the caudomedial and dorsal aspect of the left occipital lobe, adjacent to the falx cerebri, is a medium(0.7 x 1.1 x 0.8 cm; LWH), rounded, well-defined mass that is isoattenuating to the brain parenchyma and moderately, heterogeneously contrast medium enhancing. The mass is broad-based along the caudodorsal aspect of the skull and dorsally has a thin dorsolateral projection along the margins of the calvarium. There is a moderate rightward shift of the falx cerebri. No ventricular enlargement is evident. In the caudal to the right and left tonsils, there are rounded regions of moderate contrast medium enhancement, mildly worse on the left. The region of left arytenoid cartilage is moderately heterogeneously and strongly contrast medium-enhancing; however, no definitive mass or nodule is identified. Caudoventral to the caudal aspect of the left medial retropharyngeal lymph node and adjacent to the lateral aspect of the trachea, the soft tissues are focally moderately heterogeneously contrast medium enhancing. The thyroid glands are not definitively identified. Bilaterally, the nasal cavities are diffusely gas-filled and the turbinates are smooth and well-defined. The left frontal sinus is mildly small but is gas-filled, smooth, and well-defined. Bilaterally, the medial retropharyngeal and mandibular lymph nodes are normal in size, shape, margination, attenuation, and enhancement. The right and left maxillary incisors are absent; the 3rd right maxillary incisor root persists within the alveolar bone. THORAX: The caudoventral aspect of the right middle lung lobe is mildly small and focally increased in attenuation. The remainder of the pulmonary parenchyma is normal in attenuation and no soft tissue nodules are identified. In the caudal neck and throughout the thorax, the esophagus is mildly large and predominantly gas-filled. At the thoracic inlet, there is a mild amount of dependent fluid within the esophagus. In the left lobe of the pancreas, is a focal mediate(1.2 cm) rounded, centrally hypoattenuating(30 HU), hypoenhancing region that also contains several small mineral attenuating structure in the dependent aspect. The pancreas is mildly large and lobular but is otherwise homogeneous in attenuation and enhancement. No nodules or masses are identified and the fat surrounding the pancreas is normal in attenuation. In the one-minute delay images, the spleen is heterogeneously enhancing; however, is homogeneous in the delay images. The spleen is normal in size and margination. The gallbladder is bi-lobed. The common bile duct is moderately tortuous but remains normal in contents and size. There is no evidence of mineralization within the intra or extrahepatic bile ducts. MUSCULOSKELETAL: In the left axillary region, in the superficial soft tissues at the level of the left scapula, and left dorsolateral thorax, are several small gas accumulations and the fat has mild wispy soft tissue Impressions: 1. Left occipital extraxial mass with mild secondary mass effect, for which the primary differential is a meningioma 2. Left perilaryngeal enhancement is unusual, possible etiologies include focally increased vascularize with a poorly-defined nodule/mass, inflammation, or incidental 3. Bilateral tonsillar enhancement is of unknown clinical significance(e.g. normal variation, inflammatory) 4. Absent thyroid glands is attributed to reported previous I-131treatment 5. Bilateral nasal cavity soft tissue attenuation, diffuse pancreatopathy, may be attributed to chronic or previous pancreatitis 6. Incidental bi-lobed gallbladder. Common bile duct otherwise is attributed to age 7. Absent 3rd maxillary incisors, retained 3rd right maxillary tooth root 8. Incidental left frontal sinus hypoplasia 9. Subcutaneous gas, most likely secondary to a subcutaneous administration of medication/ fluids
6301	DMH	17 Years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Sheila Eras DVM, DACVR Findings: Computed tomography images of the whole body are reviewed in transverse, sagittal, and dorsal planes. HEAD: The margins of the horizontal and vertical portions of the left external ear canal are ill-defined and in the region of the vertical canal, there is a medium sized (1.5 x 1.0 x 1.4 cm; LWH), rounded, lobular, heterogeneous, hyperattenuating soft tissue mass. This mass extends to the ventrolateral aspect of the pinna. In the region of the mass, there are several small poorly-defined mineral foci. The walls of the left external ear canal are moderately thick and lobular and indistinctively defined from the mass. The margins of the calvarium remain smooth and well-defined; no lysis is detected. The horizontal and vertical portions of the right external ear ca Bilaterally, the tympanic cavities are gas-filled and the bulla are similar in size, shape, and margination. The tooth roots are normal in margination and attenuation and the surrounding alveolar bone is normal in attenuation and margination. The nasal cavities are gas-filled. In the ventral aspect of the left nasal cavity (Series 11, image 32), is a small, well defined, mineral attenuating structure measuring approximately 3mm in length and 2mm in width. THORAX AND ABDOMEN: No abnormality of the thorax, abdomen, or musculoskeletal structures is identified. Impressions: 1. Bilateral, severe chronic otitis externa with left external ear canal to pinna mass. The mass is most concerning for abscess, granuloma. A neoplastic process cannot be excluded, but is considered less likely considering the hyperattenuation of the mass and the species and improvement with antimicrobial treatment. 2. Focal left nasal mineral, which could be a small aspirated foreign body. As no signs of rhinitis and no osseous changes are noted, this is currently suspected to be an incidental finding.
6302	Rabbit	5 years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Suzanne Steiger-Vanegas, DVM, PhD, DipECVDI Findings: Computed tomography images of the whole body are reviewed in transverse, sagittal, and dorsal planes. HEAD: No osseous or dental abnormalities are noted. THORAX: A patchy unstructured interstitial to alveolar lung pattern is noted bilateral in the cranial, in the right right middle and cranial aspect of the left caudal lung lobes and this is worse in the left cranial lung lobes. ABDOMEN: The gastrointestinal tract is normal with normal luminal filling with fibrous and fluid material. The parenchymatous organs are normal in attenuation, size and location. MUSCULOSKELETAL: At the middle phalanx of the right third digit, the dorsal soft tissues are focally moderately thick with a small (0.5 x 0.4 x 0.2 cm; LWH), broad-based, soft tissue attenuating nodule. Deep to the nodule, the fat is normal in attenuation. The proximal and distal interphalangeal joints are well-aligned and uniform in width. In the fat cranioventral to the left testicle is a small (0.2 cm), rounded, mineral attenuating structure. Craniodorsal to the right testicle, adjacent to the spermatic cord, is a similar mineral attenuating structure. In the peritoneal fat, are at least two attritional mineral attenuating foci. In the right epaxial muscles and the dorsal superficial soft tissues at the level of L1-4, are several small gas accumulations. No fractures are identified. The vertebral bodies are well aligned. Impressions: 1. Diffuse pulmonary parenchymal changes are concerning for pneumonia and less likely pulmonary hemorrhage and in part could also be due to atelectasis. 2. Right third digital swelling, may be a site of bleeding, and may indicate focal soft tissue injury. This study is negative for fractures, luxation, or additional sites of soft tissue swelling 3. Mineralized peritoneal nodules are likely benign (e.g. granuloma, mineralized fat)
6303	Chinchilla	6 years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Suzanne Steiger-Vanegas, DVM, PhD, DipECVDI Findings: CT images of the head pre- and post-intravenous iodinated contrast medium administration are available for review in the transverse, sagittal, and dorsal planes. The paranasal and frontal sinuses are normal. Few of the mandibular and maxillary premolar and molar tooth roots are flattened and normal in attenuation; no evidence of periapical lucency is seen. Bilaterally, the mandibular and maxillary third molars are seen within the alveolar bone and the crowns have not erupted. yet The mandibular and medial retropharyngeal lymph nodes are normal in size, contrast enhancement, and margination. The brain parenchyma is normal in attenuation and margination; no evidence of a midline shift or mass is seen. The cranial cervical spinal cord is also unremarkable. The lobes of the thyroid are normal in size (L- 0.8 cm and R: 0.7 cm), attenuation, and margination. The lumen of the esophagus has a mild amount of soft tissue attenuating and noncontrast enhancing fluid cranially. Along the left lateral and ventral aspect of the C4-C5, the region of the left longus colli muscle is mildly hyperenhancing (mean 88 HU) and asymmetrically thick compared to the right (mean 71 HU). The muscular heterogeneity is not seen within the adjacent vertebral column; no evidence of periosteal proliferation or lysis is seen. The remainder of the cervical soft tissues are unremarkable. The left deep cervical lymph node is mildly larger (1.8 cm thick) and rounded, and mildly heterogeneously contrast medium enhancing with compared to the right (0.8 cm). The superficial cervical lymph nodes are similar in size (L- 1.8 cm and R: 1.6 cm), margination, and contrast enhancement. Impressions: 1. No cause is seen for the reported CNS signs. 2. Questionable left longus colli heterogeneity and swelling (e.g. edema, cellulitis, or hemorrhage) 3. Mild left deep cervical lymphadenopathy, likely reactive 4. Bilateral mandibular and maxillary deciduous molar teeth consistent with the young age of the patient 5. Mild esophageal fluid
6304	Dorper Sheep	1 year	F	Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident Supervised by: Suzanne Steiger-Vanegas, DVM, PhD, DipECVDI

Anatomage Table 9.0 Case Library Descriptions

6305	Labrador Retriever	9 years	M

Findings:

CT images of the abdomen pre- and post-intravenous contrast medium administration and thorax (postintravenous contrast medium administration) are available for review in the transverse, sagittal, and dorsal planes.

REPRODUCTIVE TRACT: In the left inguinal region there is a well-defined, moderately sized(5 cm x 4.8 cm x 7.4 cm; LWH), rounded mass with mildly irregular margination, centrally. This mass is heterogeneously soft tissue attenuating and contrast medium enhancing. The peripheral margin of this mass is smooth and strongly hyperenhancing while the central aspects has several peripheral supral areas that are lobular and strongly contrast medium enhancing forming. Within the left inguinal mass, the mass septations have several cavitary areas of variable fluid attenuation and contrast medium enhancement(mean range 13 HU-58HU).The caudal aspec

The left inguinal lymph node is mildly larger (0.5 cm) and rounded when compared to the right (0.3 cm).

The prostate is normal in size (1.6 cm) and homogeneously contrast medium enhancing.

ABDOMEN: No evidence of sublumbar lymph node enlargement is seen. In the right-ventral aspect of the rectum there is a small (1 cm), ovoid, hypoattenuating nodule that is similar in attenuation to the right anal sac. Both anal sacs are normal in size, shape and attenuation.
The head of the spleen has a poorly defined, rounded, small(1 cm), isoattenuating, and mildly contrast enhancing nodule.

Diffusely, the hepatic parenchyma is mildly heterogenous contrast medium enhancing which is most likely attributed to the medial injection of contrast medium.

THORAX: No evidence of pulmonary soft tissue nodules are seen. Throughout the pulmonary parenchyma there are a few, well-defined, tiny, mineral attenuating foci. The dorsal aspect of the lung lobes are mildly small and mildly increased in attenuation causing reduced distinction of the pulmonary blood vessels.

MUSCULOSKELETAL: At the lumbosacral junction there is mild disc extension dorsally into the ventral vertebral canal. The L7-S1 disc mildly extends laterally into the intervertebral foramina. Several segments of the lumbosacral vertebral column have mild to moderate amounts of bridging spondylosis deformans, worse at L3-L4 and L7-S1. The spondylosis deformans of L7-S1 mildly narrows the intervertebral foramen, worse on the right. The L6-L7 and L7-S1 intervertebral disc spaces have a few well-defined and rounded to curvilinear gas attenuations.

The periarticular margins of the left and right sacroiliac joints have a mild to moderate amounts of bony proliferation, worse on the left.
Impressions:

SUMMARY:
1. Medium, left ventral mass
2. Small rectal nodule, likely benignin.g. adenoma)
3. No evidence of pulmonary soft tissue nodules or metastatic
4. Multifocal, mild intervertebral disc degeneration, worse at L3-L4 and L7-S1 with vacuum phenomenon
5. Mild L7-S1 right foraminal stenosis
6. Nonspecific splenic nodule, likely benignin.g. hyperplasia)
7. Incidental pulmonary osteomas
8. Mild, multifocal pulmonary atelectasis

CONCLUSION: The primary differential diagnosis is a mass arising from remnant testicular tissue(a.g. tunica vaginalis, spermatic cord) but other benign or malignant neoplasms (e.g. hemangioma, hemagiosarcoma) are possible. The duration of growth and lack of clinical signs indicate an abscess is unlikely. The results of this study are negative for pulmonary metastasis.

6306	Pygmy Goat	10 years	F

Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DCM, DACVR
Findings:

CT images of the abdomen pre- and manually injected postintravenous contrast medium administration and precontrast thoracic images are available for review in the transverse, sagittal, and dorsal planes.

PERINEAL REGION: Surrounding the rectum and in the region of the anus, the left anal sac has a mass that is lobular, soft tissue attenuating, and heterogeneously contrast medium enhancing. The dorsomedial aspect of this mass is strongly contrast medium enhancing compared to the adjacent regions. The mass measures approximately (L: 4.3 cm x 3 cm x 3 cm; LWH) and mildly displaces the rectum medially. The soft tissues surrounding the left anal sac masses are moderately thick and strongly contrast medium enhancing. The right anal sac is mildly non-uniform in enhancement with stronger enhancement ventrally than dorsally but without a defined

LYMPH CENTERS: The right medial iliac and internal iliac nodes are moderately enlarged(up to 2 cm thick) with the remaining sublumbar and intrapelvic lymph nodes are poorly differentiated, severely enlarged(up to 4 cm thick) and exhibit a similar contrast enhancement features as the anal sac mass. These enlarged lymph nodes also cause mild right lateral-ventral displacement of the descending colon and right lateral-ventral displacement of the descending aorta and caudal vena cava. No evidence of intrathoracic lymph node enlargement is seen.

MUSCULOSKELETAL: The right lumbosacral intervertebral foramen is moderately narrowed due to bony proliferation which is also seen ventrally as bridging spondylosis deformans. The L7-S1 intervertebral disc mildly extends dorsally into the ventral aspect of the vertebral canal, but the spinal nerve roots remain surrounded by a moderate amount of fat. One of the cranial mesenteric lymph nodes is at the upper limit of normal size, mildly hyperattenuating and poorly-enhancing.

Within the thoracic body wall and thoracic and pelvic limb fascial planes there are a few well-defined, variably sized(at least 7.5 cm x 6.5 cm x 9.7 cm; LWH), smoothly marginal, fat attenuating, and noncontrast enhancing masses, largest along the
caudomedial right thigh.

THORAX: In the ventral periphery of the lung lobes there is a mild unstructured interstitial pulmonary pattern causing mild reduction in the visibility of the margins of the pulmonary blood vessels. The remainder of the pulmonary parenchyma is normal in attenuation.

ABDOMEN: Throughout the liver there are few, poorly defined, round to ovoid, hypo- to isoattenuating nodules that are either noncontrast enhancing or heterogeneously mildly contrast medium enhancing; the parenchyma also contains amorphous regions of enhancement without a defined mass(largest, 3 cm, seen ventromedial to the intrahepatic caudal vena cava).

Within the spleen there is a poorly defined, small(up to 0.6 cm), rounded, isoattenuating, and mildly contrast enhancing nodule.

The cortex of the right kidney is mildly irregularly margined due concave defects. The right kidney corticomedullary distinction is normal and no renal pelvis enlargement is seen. The right adrenal gland is unremarkable.

Within the gallbladder lumen there is a mild amount of unstructured mineral attenuating material and a small mineral attenuation that is hyperenhancing compared to the adjacent soft tissue

Impressions:

SUMMARY:
1. Left anal sac mass
2. Moderate to severe, multifocal metastatic lymphadenopathy of the colic, pelvic and sublumbar lymph nodes
3. Moderate L7-S1 right foraminal stenosis and mild disc protrusion without extradural spinal nerve root compression
4. Few, nonspecific splenic and hepatic nodules, likely benignin.g. cysts, nodular hyperplasia, or extramedullary hematopoiesis)
5. Mild right renal scarring
6. Cystic mesenteric lymph node
7. Few cutaneous and subcutaneous lipomas
8. Incidental, mild gallbladder cholelithiasis with debris

CONCLUSION: Left anal sac mass is consistent apocrine gland anal sac adenocarcinoma with regional lymph node metastasis. The results of this study are negative for pulmonary metastasis.

6307	Labrador Retriever	10.5 years	M

Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR
Findings:

CT images of the abdomen pre- and post-intravenous contrast medium administration are reviewed in transverse, sagittal, and dorsal planes and are compared to CT images performed December7, 2018.

ABDOMEN: In the left cranioventral aspect of the liver, the previously described medium, rounded, irregularly-margined, and poorly-defined mass is moderately larger, (5.3 x 3.6 x 4.7 cm; previously 3.9 x 3.2 x 2.9 cm; LWH).The mass is similarly hypoattenuating and predominantly hyposenhancing but contains strongly opacified, curvilinear structures continuous with blood vessels.

The liver also contains several smaller, rounded, poorly-defined nodules with similar patterns of enhancement as the mass that are also mildly larger and more numerous compared to previous. The right-sided liver resection surgical site is similar rounded to irregular marginations, homogeneous in attenuation and enhancement and small mineral to metal sutures. No nodule or mass is seen in this location.

Not seen previously, in the caudal peritoneal fat, to the left of the urinary bladder and descending colon, are at least two small(0.8 cm), rounded, mildly irregular, and mildly peripherally contrast medium enhancing nodes. In the right ventrolateral peritoneal fat, in the cranial to mid abdomen at the level of the right kidney, the previously described nodule is moderately larger, lobular in margination, and peripherally contrast medium enhancing. Similar to previous, in the periaortic region and in the region of the spleen in the dorsal peritoneal fat are several small(0.6 cm), rounded, predominantly well-defined nodules, dorsal to the region of lymph nodes.No

The caudal aspect of the left lobe of the pancreas is mildly lobular but remains homogeneous in attenuation and enhancement.

Similar to previous, the cranial pole of the right adrenal gland is moderately heterogeneously contrast medium enhancing and mildly large (1.0 cm).
In the ventral aspect of the right caudal lung lobe, not seen previously (although the region was small and poorly-seen), is a small, ovoid, soft tissue attenuating nodule. In the caudal portions of the lungs, there are similar pin-point to small(0.1 cm), rounded, well-defined, soft tissue to mineral attenuating foci.

MUSCULOSKELETAL: The left hip has similar moderate to severe well-defined, irregularly-margined, periarticular bone formation. The subchondral bone of the left hip remains moderately heterogeneous and the left femoral head is mildly irregular in margination. The right hip has mild well-defined periarticular bone formation.

The lumbosacral intervertebral disk is similarly mildly heterogeneous, partially mineralized and dorsally displaced causing reduced left and right intervertebral foraminal fat and ventral epidural fat. At the lumbosacral intervertebral disk space, the vertebral bodies have moderate smooth, well-defined new bone formation that extends dorsally and causes bilateral foraminal narrowing. Several additional caudal thoracic and lumbar intervertebral disks are mildly dorsally displaced causing reduced ventral epidural fat.

Unchanged from previous, the ventral midline of the abdominal body wall is mildly heterogeneous and contains several rounded mineral attenuating structures.

Impressions:

1. Progressive hepatic mass and increased number of hepatic and multifocal peritoneal nodules are attributed to metastasis from previously excised hemangiosarcoma
2. Right caudal pulmonary nodule may be a poorly-mineralized osteoma or due to metastasis; other pulmonary osteomata are present
3. Similar, mild right adrenomegaly is most likely benignin.g. hyperplasia, adenoma)
4. Similar, mild lumbosacral disk spondylosis deformans, joint disease, mild right hip degenerative joint disease
5. Similar mild lumbosacral disk herniation and spondylosis deformans with foraminal stenosis
6. Similar multifocal intervertebral disk herniations
7. Prior splenectomy, right-sided hepatic resection

6308	Hound	12 years	M

Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR
Findings:

CT images of the abdomen pre- and manually injected postintravenous contrast medium administration are available for review in the transverse, sagittal, and dorsal planes. A 3-D reconstruction image is also available for interpretation.

ABDOMEN: The left uterine horn is severely abnormal. The left horn is severely enlarged (6 cm wide), has mildly lobular margins, and has a large amount of heterogeneous soft tissues attenuating and noncontrast enhancing material that has similar attenuation with the uterine wall (intraluminal vs. intramural); however intraluminal content is suspected. The left uterine horn intraluminal mixed material consists of small mineral attenuations and predominantly soft tissue delineated from the wall by the moderately contrast enhancing horn walls. Additionally, the left uterine horn wall is mildly to moderately thick (up to 2.7 cm). The enlarged left uterine hor

As previously described, the right uterine horn is displaced to the right but is normal in size (2.3 cm wide). The intraluminal contents of the right uterine horn are more uniform than the left. The right uterine horn is mildly fluid-filled but normal in margination and size given the recent parturition.

Within the uterine body there is a moderate amount of granular soft tissue attenuating material with mild amount of stippled gas. A small portion of the uterine body has a small volume of non-contrast enhancing fluid. The uterine body measures approximately 3.2 cm wide from serosa to serosa. The uterine body walls are mildly thick (up to 0.7 cm) but are homogenously contrast medium enhancing.
No evidence of intra-abdominal lymph node enlargement is seen.

MUSCULOSKELETAL: The left dorsolateral aspect of the sacrum has a well-defined, rounded, irregularly margined, and concave defect noted in the cranial endplate. The caudal endplate of L7 has smooth and continuous margins. No evidence of sclerosis is seen surrounding the osseous defect.

THORAX: The ventral periphery of the right cranial and middle lung lobes have a mild amount of unstructured interstitial pulmonary pattern causing the margins of the regional pulmonary blood vessels to be less defined. There are also a few small, poorly defined soft tissue attenuating foci in the dorsal periphery of the lungs.

Impressions:

SUMMARY:
1. Left-sided metromegaly (intraluminal> extraluminal)
2. Mild uterine gas is likely secondary to the recent endoscopic procedure
3. Mild pulmonary atelectasis with questionable pulmonary nodules
4. Incidental finding of L7 left end plate subchondral defect. Finding may represent an osteochondral defect. Lack of surrounding sclerosis and circumscribed appearance suggest a non-aggressive lesion

CONCLUSION: The recently history of the patient having aborted fetuses is concerning that the cause of unilateral uteromegaly is due to endometritis, retained placenta, or incomplete involution. Pulmonary nodules are questioned due to motion blurring but previous or current infectious/inflammatory or parasitic granulomas cannot be fully excluded.

6309	Bear Goat	5 years	F

Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident
Supervised by: Sheila Enu, DVM, DACVR
Findings:

Computed tomography images of the thorax pre- and post-contrast medium administration are reviewed in transverse, sagittal, and dorsal planes.

Multifocally throughout the lungs, there are medium sized (approximately 4.2 x 1.0 x 2.6 cm; LWH), rounded to branching, irregularly-margined, variably well-defined, regions of alveolar pulmonary patterns that are predominantly centered on airways and contain air bronchograms. In the non-affected portions of lung, the parenchyma is normal in attenuation and the airways are normal in thickness and margination. Some of the airways contain small amounts of luminal hypoattenuating material. The lungs remain normal in size. Mild pleural thickening is noted in the areas were the lung parenchymal lesions extend to the visceral pleural surface. No stenu

Impressions:

Multifocal alveolar pulmonary pattern with pleuritis is most likely attributed to infectious (e.g. bacterial, fungal, viral or less likely parasitic) or inflammatory etiologies (e.g. eosinophilic pneumopathy)

6310	DSH	5 years	F

Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Suzanne Steiger-Vanegas, DVM, PhD, DipECVDI
Findings:

CT images of the lumbar spine without intravenous contrast medium administration are available for review in the transverse, sagittal, and dorsal planes.

THORAX: Within the left hemithorax there is a large volume of pleural gas causing moderate ventral and medial displacement of the left caudal lung lobe. The diaphragm is mildly irregular and tented in the left hemithorax. The left caudal lung lobe is moderately small and diffusely increased in attenuation with few nodular soft tissue attenuations. The right hemithorax has a mild amount of pleural gas displacing the right caudal lung lobe cranially. Both the right caudal and accessory lung lobe are mildly increased in attenuation.

MUSCULOSKELETAL: The visible rib, thoracic vertebrae, and thoracic articular process joints are intact, well-aligned, and smoothly margined; no evidence of fracture or displacement of the ribs or vertebrae is noted.

Several fractures are seen wiv the right pelvic limb; pelvis, and lumbosacral vertebrae which are sharply demarcated and exhibit variable displacement. A nondisplaced dorsoventral comminuted fracture of the L4 vertebral body is noted which extends into the left dorsal lamina and pedicle at the level of the L3-L4 articular joint. Mild shortening of the vertebral body of L4 is present. The dorsal surface of the L4 vertebral body is mildly dorsally convex. The spinal cord at the dorsal aspect of L4 is mildly heterogeneous in attenuation and left laterally mildly reduced in dorsal ventral height when compared to the right lateral. There is a loss of epidural fat also

The right sacral tubercle has a well-defined and nondisplaced transverse to short oblique fracture with no evidence of the right sacroiliac or lumbosacral malalignment. Additional multiple fractures of the pelvis are noted including a mild caudolaterally displaced long oblique right ilial wing, comminuted articular fracture of the caudal aspect of the right acetabulum with minimal cranial and lateral displacement, a short oblique right pubic bone fracture with caudomedial displacement, incomplete transverse fracture of the left pubic bone, comminuted pubic symphysis fracture with left lateral-ventral displacement, and short oblique left ischial table fracture

The coccygeal vertebrae are abnormally shaped consistent with the braid.

ABDOMEN: The peritoneal and retroperitoneal spaces have a mild to moderate amount of wispy soft tissue attenuation, worse caudally. The borders of the left kidney are mildly irregular and indistinctively defined from the retroperitoneal fluid. The urinary bladder has an indwelling catheter.

Impressions:

1. Moderate to large volume, bilateral pneumothorax, worse on the left with left lung lobe collapse and suspected pulmonary hemorrhage
2. Comminuted L4 vertebral fracture with mild L4/L5 subluxation with suspected focal spinal cord injury, possibly spinal cord hemorrhage
3. Multiple pelvic fractures with right caudal acetabular fracture
4. Right femur fracture
5. Small, non-displaced right sacral wing fracture. 6. Mild to moderate peritoneal and retroperitoneal fluid likely hemorrhage 7. Possible left renal trauma with hemorrhage

6311	Boston Terrier	1 year	M

Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident
Supervised by: Suzanne Steiger-Vanegas, DCM, PhD, DipECVDI

6312 Nubian Goat	4 years	F	Findings: Computed tomography images of the proximal thoracic limbs are reviewed in transverse, sagittal, and dorsal plans. In the mid to distal diaphyseal region of the left humerus, is a proximal caudolaterally-distomedially oriented long oblique fracture with severe caudoproximal and moderate lateral displacement. The fracture margins are angular and well-defined. At the distolateral aspect of the proximal segment, there are a few small (up to 0.5 cm) angular mineral attenuating fragments. The medullary cavity of the humerus in the region of the fractures is moderately heterogeneously hyperattenuating. In the region of the left humeral fracture, the soft tissues are severely heterogeneous, enlarged, and contain several pin-point mineral attenuating foci and the margins of the biceps and triceps muscles are poorly-defined. The fat contains moderate wispy soft tissues. The left elbow and carpus are well-aligned and no fractures are identified. The cranial aspect of the trachea contains a mild amount of fluid. The cranial pulmonary parenchyma is normal. The left dorsolateral neck muscles are diffusely mildly small and from the level of C2-C5, the nuchal ligament is moderately left ventrolaterally displaced. Impressions: 1. Acute, traumatic, left humeral fracture with large hematoma formation 2. Left cervical muscle atrophy and nuchal ligament displacement is of unknown clinical significance and may indicate prior trauma or congenital abnormality 3. Mild tracheal fluid could be secondary to regurgitation and/or aspiration. Reported by: Kristn Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Susanne Steiger-Vanegas, DCM, Phd, DipECVDI
6313 Terrier Mix	13 years	M	Findings: Computed tomography images of the thoracic limbs and abdomen pre- and post-contrast medium administration are reviewed in transverse, sagittal, and dorsal planes. MUSCULOSKELETAL: Circumferentially surrounding the right scapula, is a large, heterogeneous mass with effacement of the margins of the supraspinatus, infraspinatus, and subscapularis muscles. Within the mass, there are many small, irregular-margined, peripherally enhancing, and centrally hypoattenuating and hyposenhancing regions, and amorphous mineral which extend distally to the region of musculotendinous insertions on the proximal humerus. The margins of the mass are poorly-defined, worse craniomedially and the fat contains moderate wispy soft tissue that extends into the right axillary region and right lateral aspect of the thoracic inlet. The cortices of the proximal right humerus are heterogeneously thin and the medullary cavity is heterogeneously reduced in attenuation and heterogeneously contrast-medium enhancing. Incompletely included in the image, the caudodorsal margin of C1 has mild smooth, well-defined periosteal new bone formation. The right axillary lymph node is mildly larger, rounded, and contrast medium enhancing than the left. The L7-S1 intervertebral disk is moderately dorsally displaced causing reduced ventral epidural fat and the vertebral bodies have moderate smooth, well-defined, bridging bone that also extends laterally causing severe narrowing of the left and right intervertebral foramina. Throughout the spine, the vertebral bodies have moderate to severe well-defined bridging bone that incompletely spans the intervertebral disk spaces, and in some locations causes narrowing of the intervertebral foramina. In the cranial thoracic spine, many intervertebral disks are dorsally mineralized and dorsally displaced causing reduced ventral epidural fat and mild ventral flattening of the spinal cord. The left gluteus musculature and muscles dorsal of the left femur neck areas larger than on the right side and moderately heterogeneously contrast-enhancing with an indistinct central hypoechoic enhancing area. Bilaterally, the stifles have mild periarticular bone formation. Along the left ventrolateral caudal thoracic and abdominal body wall are several small to medium rounded, well-defined, non-enhancing fat attenuating masses. In the dorsolateral superficial soft tissues at the level of the left greater trochanter, there is a small(2.3 cm), pedunculated, minimally enhancing soft tissue attenuating nodule. Additional smaller (0.5 cm), rounded, non-enhancing, nodules are identified in the superficial soft tissues. THORAX: The dorsal pulmonary parenchyma is mildly small and has a mild unstructured interstitial pulmonary pattern. In the most medial aspect of the right caudal lung lobe mildly cranial to the diaphragm an indistinct small nodular area of 5-6 mm diameter is noted along the pleural surface. Mild focal pleural thickening is noted in the mid lateral aspect of the left cranial lung lobe. No intrathoracic lymphadenopathy is identified. Focally at the level of the fourth to sixth rib the left thoracic wall musculature is moderately thickened and mildly heterogeneous in contrast enhancement. ABDOMEN: The liver contains several small to medium(2.0 cm), rounded to irregularly-margined, iso- to hypoattenuating and hyposenhancing nodules. The liver is normal in size, shape, and margination and no hepatic lymphadenopathy is identified. The spleen is diffusely mildly heterogeneously contrast medium-enhancing. The spleen remains normal in shape and margination and no splenic lymphadenopathy is identified. The caudal pole of the right adrenal gland is ventrally hyposenhancing. Impressions: 1. Locally extensive, invasive, aggressive right shoulder soft tissue mass (right scapula and proximal humerus) is attributed to malignant neoplasia (e.g. hemangiosarcoma, histiocytic sarcoma) 2. Focal thickening of the left thoracic wall musculature could be positional; however, a small mass lesion cannot fully be excluded. This could be a site of metastatic disease. 3. Focal thickening of the left gluteus musculature could be secondary to myositis and the previous trauma; however, a neoplastic process cannot fully be excluded. 4. Right axillary lymphadenopathy is either neoplastic or reactive. 5. Nonspecific small pulmonary nodules are either granulomas or focal area of pleural thickening; however, a single metastatic nodule cannot fully be excluded. 6. Nonspecific small hepatic nodules are often benignn (e.g. nodular hyperplasia, extramedullary hematopoiesis), but malignant etiologies (e.g. metastatic neoplasia) are possible 7. Mild splenic heterogeneity is most likely benign(e.g. extramedullary hematopoiesis, lymphoid hyperplasia) 8. Lumbosacral intervertebral disk herniation and foraminal stenosis 9. Multifocal spondylosis deformans with foraminal stenosis 10. Multifocal intervertebral disk degeneration and herniation 11. Mild C1 periosteal response is of unknown clinical significance and may indicate previous injury or an additional aggressive bone lesion 12. Multifocal periarticular osteophytosis/joint disease 13. Multiple dermal nodules and body wall lipomas Reported by: Kristn Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Susanne Steiger-Vanegas DCM, PhD, DipECVDI
6314 Miniature Pinscher	4 years	M	Findings: CT images of the head, neck, and thorax pre- and postintravenous contrast medium administration are available for review in the transverse, sagittal, and dorsal planes. THORAX: Along the right lateral of the caudal thoracic esophagus, coursing caudally along the diaphragm and ventrocaudal to the diaphragm and gastric cardia, there is a large mass (6.9 cm x 7.3 cm x 6.3 cm; LWH) that is round and has well-defined margins with heterogenous contrast enhancement pattern. The right aspect of the esophagus silhouettes with the mass but the mucosal enhancement is normal and the dorsal, ventral and left-lateral aspects are well-defined. The mass moderately displaces the esophagus to the left. Peripherally this mass is strongly contrast enhancing and centrally less contrast enhancing. This mass extends between the right The lungs contain a few, tiny, mineral attenuating nodules. No soft tissue nodule is detected. The right lung has a small bulla (best, Se 17, Im 55) MUSCULOSKELETAL: In the neck, ventral to the laryngeal musculature, there is a large mass (7.5 cm x 8.5 cm x 3.1 cm; LWH) that is rounded, smoothly margined, fat attenuating, and noncontrast enhancing. This mass dorsally displaces the ventral cervical muscles, left lateral displacement of the left mandibular lymph nodes, and dorsolateral displacement of the left mandibular salivary gland. Along the caudal mentalbrae and sighted process there is a smaller fat attenuating and noncontrast enhancing mass. LYMPH CENTERS: No evidence of intrathoracic lymph node enlargement is seen. The left mandibular lymph node is mildly larger (up to 0.8cm thick) in comparison to the right (0.6 cm).The right medial retropharyngeal lymph node is mildly larger (0.7 cm) than the left (0.4 cm).Both the mandibular and medial retropharyngeal lymph nodes remain normal in size, margination, and contrast enhancement. The portal lymph nodes are mildly enlarged(range 1.3 cm- 1.6 cm), rounded, and noncontrast enhancing. The pancreatic-duodenal, gastric, splenic, periaortic, and few jejunal lymph nodes have central regions of nonenhancement but remain normal in size. ABDOMEN: Within the stomach, extending from the fundus to the body, there is a soft tissue attenuating and lobular structure with linear internal gas striations that is noncontrast enhancing. Within this material, ventrally, there are two, undulating, linear (approximately 5 cm length) accumulations of mineral to metal attenuations. The caudal esophagus and and cardia of the stomach are normal in size and attenuation and no esophageal enlargement is detected. Both renal cortices have several ill-defined, rounded, and tiny to pinpoint iwartmanning foci that are noncontrast enhancing. In the right liver there is a tiny (0.2 cm), ovoid, hypoattenuating, and noncontrast enhancing nodule. Between the gastric fundus and body of the spleen there is a small(0.7 cm), rounded, smoothly marginal, and soft tissue attenuating structure that has a similar attenuation and contrast enhancement pattern as the spleen. HEAD: The right eye is small, irregularly marginal and the lens is not detected; tiny mineral foci are present, primarily caudally. No other substantial abnormality is detected. Impressions: SUMMARY: 1. Large caudal thoracic mass, likely mediastinal 2. Nonobstructive gastric foreign body, consistent with cloth 3. Multifocal pulmonary atelectasis (worse adjacent to the mass), few pulmonary osteomas and small bulla; no pulmonary metastasis is detected 4. Large cervical lipoma; multifocal additional body wall lipomas 5. Small right globe, likely prior traumas/ degenerative but congenital malformation is possible 6. Numerous, bilateral renal cysts 7. Tiny hepatic cyst; likely incidental 8. Small, peri-splenic nodule, like incidental splenunculus ("daughter spleen") 9. Multifocal, cystic, abdominal lymph nodes, likely reactive CONCLUSION: The primary differential diagnosis for the caudal thoracic mass is a benign, caudal mediastinal mass (e.g. chronic paraesophageal abscess, granuloma).Malignant etiology (e.g. primary pulmonary neoplasm is less likely). Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident Supervised by: Stacy D. Cooley DCM, DACVR
6315 Mix Breed	9 years	M	Findings: CT images of the pelvic limbs are available for review in the transverse, sagittal, and dorsal planes. LEFT PELVIC LIMB: The plantaroproximal aspects of the middle phalanges of the left pelvic third and fourth digits have a few well-defined and sharply margined comminuted articular fractures extending to the proximal interphalangeal joints. The fracture lines coarse from plantarodistolateral-dorsoproximomedial on the both digits and majority of the fracture fragments are dorsoproximally to caudodorsally displaced. The largest fragment is seen in the left third middle phalanx. Additionally, dorsolaterally the proximal aspects of the middle phalanges of the third and fourth digits have small chip fractures with the fragments being mildly dorsolaterally d The proximal phalanges of the third and fourth digits have mildly lacent proximal physes along the plantar aspect. The dorsal aspect of these physes are homogenously mineral attenuating. RIGHT PELVIC LIMB: No abnormality is detected. Impressions: 1. Acute, traumatic, comminuted, articular, palmar fractures of the left pelvic middle phalanges at the proximal interphalangeal joints 2. Suspect nonuniform proximal physeal closure of the left pelvic proximal phalanges; no displacement is detected 3. Unremarkable right pelvic limb Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident Supervised by: Stacy D. Cooley DVM, DACVR
6316 Pygmy Goat	1 year	M	Findings: CT images of the thorax pre- and postintravenous contrast medium administration are available for review in the transverse, sagittal, and dorsal planes. This study is compared to a previous radiographic study performed on February 18th, 2019. MUSCULOSKELETAL: Throughout the paraspinal and body wall muscles there are poorly defined, variably sized and shaped, hypo- to isoattenuating nodules that are centrally nonenhancing and peripherally hyperenhancing and consistent with abscess. The largest abscess is seen in the cranial cervical region surrounding C1-C2 and extending to the atlantoccipital joint. This particular abscess extends dorsomedially into the vertebral canal to cause severe, bilateral narrowing of the intravertebral structures with a strongly enhancing periphery. The intravertebral soft tissue structures cranial and caudal to this site are normal in attenuation and position in the Additional sites of abscess formation is seen centered at the right carpus, left shoulder, T2 spinous process (with small chip fracture), thoracic body wall, and left 6th rib; the distal aspect of the left 6th rib also has a moderate amount of geographic lysis with smoothly marginal periosteal proliferation. The plantar aspect of the proximomedial right third metacarpal bone has distinct thin mineral fragment adjacent to the right carpal abscess. The right third metacarpal bone in this region has an irregularly shaped concavo defect surrounded by a mild amount of lysis and bony proliferation. In the proximal physis of the proximal phalanx of the thoracic right thir Caudal to the left jugular catheter there is a mild amount of intramuscular gas. A single gas focus is seen within the left jugular vein lateral periphery with tiny, poorly-defined but suspected abscesses along the ventrolateral margin. At the level of the left shoulder the dorsal soft tissues adjacent to the left superficial cervical lymph node has a mild amount of stippled gas. Also, the right dorsolateral soft tissues in the scapular region(at the region of soft tissue gas and extending caudally) are thicker, hyperenhancing and heterogeneous compared to the right with a poorly-defined abscesses along the skin margin. ABDOMEN: The liver contains many abscesses. The largest abscess is seen within the craniodorsal liver which extends cranially into a focal mass. This mass cranially is dorsally surrounded by well-defined air bronchograms within the right caudal lung lobe. A few of the liver abscesses have thin mineral attenuating mineral peripheral rims. Similar to previous, some of the small intestinal segments contain a mild to moderate amount of luminal gas. The gravity dependent aspect of the rumen contains a mild to moderate amount of soft tissue attenuating and noncontrast enhancing fluid. THORAX: Adjacent to the liver abscess there is a locally extensive alveolar pattern in the right caudal lung lobe; less likely one of the abscesses is located in the right caudal lung lobe. Multifocally the lungs are small and have unstructured interstitial to alveolar pulmonary pattern, that is primarily curvilinear and worse in the left cranial lung lobe. Impressions: SUMMARY: 1. Disseminated appendicular, axial, body wall and hepatic abscessation, worse at C1-C2 with osteomyelitis and intra-axial extension 2. Focal right third metacarpal bone suppurtuate with associated osteomyelitis and abscess 3. Multifocal alveolar pattern, likely a combination of bronchopneumonia and atelectasis 4. Left neck intramuscular gas, likely iatrogenic, with associated body wall abscessation CONCLUSIONS: Persistent weakness is due to disseminated abscesses, worse at C1-2 causing severe, extradural spinal cord compression and likely secondary meningitis.
6317 Ovine - Unknown	1 month	Unknown	Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident Supervised by: Stacy D. Cooley DVM, DACVR Findings: Computed tomography images of the whole body are reviewed in transverse, sagittal, and dorsal planes. HEAD: The margins of the left alar fold are poorly-defined and no gas is identified rostrally. In the rostral aspect of the left nasal cavity, there is a small(0.2 cm), rounded, well-defined mineral structure and there is moderate fluid causing the nasal turbinates to be poorly-defined. The fluid extends caudally in the ventral portions of the left nasal cavity to the level of the first maxillary cheek tooth. In the region of the mineral attenuating fragment in the left nasal cavity, the rostral aspect of the left nasal bone is mildly short. In the rostral aspect of the left maxillar bone a small bone fragment with minimal left lateral displacement is noted. The left maxillary suture is moderately wide. The bone surrounding the maxillary left incisor tooth root is normal in attenuation and is intact. THORAX/ABDOMEN: In the ventral portion of the urinary bladder and cranial urethra contain a moderate amount of hyperattenuating soft tissue to mineral attenuating sediment (200 HU). Impressions: 1. Traumatic left incisive and maxillary bone fractures with minimal displacement and a small cortical maxillary fragment. 2. The small mineral fragment in the rostral aspect of the left nasal cavity could be a small displaced bone fragment; however, a small left intranasal foreign body cannot fully be excluded. 3. Fluid in the left nasal cavity is likely hemorrhage secondary to trauma or could be a combination of hemorrhage and rhinitis secondary to a small foreign body 4. Urinary bladder sediment, normal in this species Reported by: Kristn Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Susanne Steiger-Vanegas, DCM, PhD, DipECVDI
6318 Rabbit	7 years	F	Findings: Computed tomography images of the thorax are reviewed in transverse, sagittal, and dorsal planes. THORAX: In the cranioventral portion of the right cranial lung lobe, there is a locally extensive alveolar pulmonary pattern with border effacement of the vessels and air bronchograms. The lung remains normal in size in this region. The lungs are also diffusely mildly hyperattenuating due to a mild unstructured interstitial pulmonary pattern. ABDOMEN: In the included portions of the abdomen, there is a large amount of peritoneal fluid (10 HU) and gas. Within the fluid, there are many smaller accumulations of gas. The peritoneal pleura is moderately thick. The stomach is subjectively small and contains heterogeneous soft tissue, granular mineral, and small accumulations of gas. MUSCULOSKELETAL: Bilaterally, in the superficial soft tissues caudal to the triceps muscles, there are several gas accumulations and the soft tissues are heterogeneous and thick in this region. Impressions: 1. Severe pneumoperitoneum and peritoneal fluid, is most concerning for septic peritonitis, likely secondary to gastric rupture or intestinal perforation. The large amount of peritoneal gas is more suggestive of a gastric perforation than intestinal. 2. Bronchopneumonia 3. Subcutaneous gas and heterogeneity is attributed to previous subcutaneous injection Reported by: Kristn Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Susanne Steiger-Vanegas, DVM, PhD, DipECVDI
6319 Hereford Cattle	1 month	M	

			Findings: Computed tomography images of the head pre- and post-contrast medium administration are reviewed in transverse, sagittal, and dorsal planes. Centered in the left maxillary paranasal sinus and the left maxillary bone at the level of the last maxillary cheek tooth, is large (6.8 x 5.2 5.2 cm; LWH), rounded, poorly-defined, expansile mass. In the region of the mass, there is permeative lysis of the maxillary bone and multifocal regions of full thickness cortical lysis and poorly-defined periosteal, irregular new bone formation. The mass within the left maxillary paranasal sinus extends ventrally into the left palatomaxillary sinus, medially into the left nasal cavity, and caudally to the caudal most caudal aspect of the maxillary sinus. Laterally, this mass extends into the soft tissues on the left lateral aspect The left maxillary tooth room remain normal in shape and well-defined; however, the expansile lysis of the maxillary bone extends to the dorsal aspect of the left maxillary molar tooth room. No expansion of the periodontal space is identified. The left nasal cavity and the left frontal sinus contain a mild amount of homogeneous non-enhancing soft tissue and fluid. The left globe is moderately larger than the right and the anterior chamber has mild to moderate wispy contrast medium enhancing soft tissue. The left anterior eye chamber is increased in size and measures at least 8mm in anterior to posterior direction (craniocaudal) compared to the right side, which measures approximately 3mm. No mass is identified within the globe. The region of the left tonsil is mildly heterogeneously contrast medium enhancing. The right ventrolateral aspect of the trachea at the left of the 5th to 6th tracheal ring contains a focal broad-based mildly contrast medium enhancing nodule, which is incompletely included within the image. No medial retropharyngeal or mandibular lymphadenopathy is detected. Impressions: 1. Locally extensive, aggressive left maxillary paranasal sinus mass with left retrobulbar and maxillary extension and frontal sinusitis for which the primary differentials include neoplastic(e.g. squamous cell carcinoma, adenocarcinoma, carcinoma), or infectious (e.g. fungal, bacterial) or inflammatory (sinus cyst) etiologies. 2. Left globe enlargement and ocular orbitocochlear is concerning for anterior uveitis with secondary glaucoma 3. Left orbital nodule could be benign(granuloma, cyst, hematoma, granuloma) or malignant (metastasis, primary neoplasia such as chondrosarcoma, etc.). 4. Questionable left tonsillar enhancement, could be secondary to inflammation, normal variation and less likely due to metastatic disease
6320 Siamen Goat	8 years	F	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Susanne Shuger-Vanagas, DVM, PhD, DipECVDI Findings: Computed tomography images of the thorax, abdomen, and pelvis are reviewed in transverse, sagittal, and dorsal planes. THORAX: The cranial mediastinum contains a mild amount of wispy soft tissue attenuation and in the region of the caudal vena cava are a few small gas accumulations. The cranioventral aspects of the left and right cranial lung lobes and the right middle lung lobe have patchy unstructured to alveolar pulmonary patterns. Mild thickening of the bronchial walls is noted in the central and ventral aspects of all lung lobes. The pleural space contains a mild amount of homogeneous fluid and a few small gas accumulations. ABDOMEN: Throughout the liver, are multifocal linear to curvilinear mineral attenuating foci. The gallbladder contains a mild amount of dependent mineral attenuating material. The spleen is moderately thick and lobular in margination. In the peritoneal fat adjacent to the spleen, is a mild to moderate amount of wispy soft tissue and few small fluid accumulations. Throughout the peritoneum, there is a mild amount of wispy soft tissue attenuation. Adjacent to the cranial portions of the left and right ureters, there is a mild amount of wispy soft tissue causing the ureter margins to be ill-defined. The urinary bladder is moderately enlarged. In the region of the pelvic fractures, the margins of the urethra are ill-defined; however, no periurethral fluid is noted in the pelvic region. MUSCULOSKELETAL: Bilaterally, at the caudomedial aspects of the medial humeral epicondyles are thin linear to rounded well-defined mineral attenuation structures. The soft tissues remain homogeneous in attenuation in this region. A short oblique fracture with minimal medial displacement through the most cranial aspect of the right sacral wing is present. An incomplete fissure line is noted in the most caudoventral aspect of the right sacral wing. The right ilial body has a mildly comminuted, cranioventral-caudodorsally oriented, short oblique fracture with moderate cranioventromedial displacement and of the caudal fragment and lateral overriding of the cranial segment. The fracture line extends to the sacroiliac joint and the lateral cortex of the caudal segment is mildly dorsally displaced and within the right sacroiliac joint. The caudal fragment of the right ilium is positioned ventral to the right sacral wing. The right sacroiliac joint is moderately wide, worse craniodorsally and the right wing of the sacrum is mildly cranially displaced relative to the ilial body. The left sacroiliac joint is normal in s The caudal aspect of the left acetabulum has a mildly comminuted fracture with minimal displacement; the left coxofemoral joint remains uniform in width. A comminuted fracture of the left pubic and ischiatic bones with involvement of the pelvic symphysis is present. The left pubic bones and ischial rami are moderately dorsomedially displaced resulting a narrowed pelvic canal. The left ischial body is moderately to severely ventrally-angled. The cauda equine fibers are incompletely defined. The intervertebral disc at L7-S1 is extending ventral to ventral border of the vertebral bodies. Within the fat caudal to the pelvis and left thigh, is a mild to moderate amount of wispy, soft tissue attenuation. The left caudolateral abdominal wall towards the inguinal area is irregularly thickened. In the left inguinal region, the caudoventral body wall is irregular in margination and variably ill-defined and in this region, there is mild to moderate wispy soft tissue in the peritoneal and inguinal fat. Impressions: 1. Acute traumatic right ilial body fracture and right sacroiliac joint subluxation 2. Acute traumatic articular left caudal acetabular fracture 3. Acute traumatic comminuted right ischial and pubic fractures. 4. Acute small fractures of the right sacral wing 5. Probable splenic contusions, rupture with hematoma formation 6. Mild to moderate peritoneal fluid and mild retroperitoneal fluid is most likely hemorrhage secondary to abdominal trauma; a trauma to the kidneys and ureters cannot fully be excluded 7. Mild pleural and mediastinal fluid and gas. Likely secondary to trauma, the mediastinal gas could also be secondary to an interventional procedure such as jugular venipuncture for blood draw or treatment. 8. Mild multifocal unstructured interstitial to alveolar pulmonary pattern may indicate pulmonary hemorrhage (contusions) 9. Hemobilia(hemorrhage into the gallbladder mineral), likely traumatic and secondary to dystrophic mineralization in the liver and biliary sand 10. Suspect bilateral medial humeral epicondylitis or osteochondrosis; this could be an incidental finding, but could also be associated with pain with front limb ambulation
6321 Bengal	10 years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Susanne Shuger-Vanagas, DVM, PhD, DipECVDI Findings: Computed tomography images of the head pre-and post-IV iodinated contrast medium administration are reviewed in transverse, sagittal, and dorsal planes. Extending along the right side of the skull from the choana to the level of the prosphenoid bone, there is a large, oblong, irregularly shaped, well-defined, predominantly soft tissue mass occluding the choana and rostral nasopharynx. This mass has moderately heterogeneous contrast enhancement and a mild amount of centrally located, multifocal, granular mineralization. Additionally, this mass is causing severe, locally extensive lysis of the choana, caudal aspect of the hard palate, right ventral ethmoid bone and turbinates, adjacent paranasal bones, right hamulus of the pterygoid, and the cribriform plate. The mass invades the neurocranium along the right r Within the right nasal cavity, there is a moderate amount of homogeneous, soft tissue attenuating fluid with numerous gas foci centrally. At the level of the nasal gland, there is a mild to moderate amount of lysis and thinning of the turbinate bones ventrally. The right mandibular lateral mandibular lymph node is mildly larger(1.8 cm x 0.7 cm), hyperechoic,eg yet retains a normal fat hilus and well-defined capsular margins. Bilaterally, both medial retropharyngeal lymph nodes are mildly round, hyperattenuating prescentient with moderate heterogeneous contrast enhancement. The second maxillary molar teeth(110; 210) have wide periodontal ligament spaces, worse in the left which also has sclerotic alveolar bone and blunt, irregular margins. Both maxillary fourth premolar teeth(108; 208) have laterally located, heterogenous mineral attenuating calculus. Additionally, all teeth have poor definition of the lamina dura and mild alveolar bone sclerosis. Impressions: 1. Severely destructive, locally extensive, right-sided skull and nasal mass causing right intracranial, right optic nerve and oral cavity invasion. Differential diagnosis includes a chondrosarcoma, nasal carcinoma (e.g. adenocarcinoma, squamous cell carcinoma), or atypical histiocytic sarcoma. 2. Right lateral mandibular and bilateral, medial retropharyngeal lymphadenopathy, either reactive or neoplastic. 3. Mild to moderate, diffuse periodontal disease with focal tooth root abscess of the left second maxillary molar tooth(208)
6322 Bernese Mountain Dog	11 years	F	Reported by: Lauren Newsom, DVM, DACVR Findings: Computed tomography images of the left carpus are reviewed without IV contrast medium administration in transverse, sagittal, and dorsal planes. This study is compared to the radiographs performed one day prior. On the dorsal aspect of the left intermediate carpal bone, there is a moderate amount of ill-defined, palisading bone formation with severe, dorsal trabecular bone sclerosis. Minimally displaced from the dorsal margin of the intermediate carpal bone there are several, frontal plane, proximally located chip fragments; an oblique, sagittal plane chip fracture along the dorsoproximal and medial margin, and numerous, tiny, ill-defined granular bone fragments located dorsally. Similarly, on the dorsal aspect of the left radial carpal bone, there is a moderate amount of ill-defined, palisading bone formation with severe, dorsolateral trabecular bone sclerosis. Additionally, there are several, frontal plane, mildly dorsally displaced, dorsolateral cortical chip fragments and numerous, tiny, ill-defined granular bone fragments located dorsally. Coursing around the medial aspect of the radiocarpal bone there is a moderate amount of well-defined and irregularly margined bone formation in addition to osteophytes at the middle carpal joint. The dorsal aspects of the distal radius, ulnar carpal bone, the fourth carpal bone, and the second carpal bone have a mild amount of well-defined bone proliferation, osteophytes and sclerosis. The dorsal aspect of the third carpal bone has a moderate amount of predominantly well-defined and mildly irregularly margined new bone formation, creating a double cortical margin. Additionally, there is a moderate amount of trabecular bone sclerosis dorsally, worse in the radial facet. On the palmar aspect of the third carpal bone, there are a few, well-defined, tubular to round concavities with surrounding sclerotic trabecular bone. At the palmar aspect of the ulnar Similar to the radiographs, there are multifocal, small foci of bone within the soft tissues palmar to the lateral aspect of the carpometacarpal joint. There is moderate intra- and extra-capsular thick soft tissues surrounding the carpus. The palmar soft tissues have a couple of tiny gas foci at the dorsal aspect of the flexor tendons. Impressions: 1. Severely comminuted, minimally displaced, chip fractures of the left intermediate (with large fissure) and radial carpal bones secondary to chronic remodeling. There is moderate, secondary intracapsular and extracapsular swelling. 2. Left third carpal bone trabecular bone sclerosis and remodeling without fracture 3. Mild to moderate degenerative joint disease of the left carpus, worse at the middle carpal joint 4. Palmar mineral fragments at the palmarolateral aspect of the carpometacarpal joint. Differential diagnosis includes synovial mineralization, dystrophic soft tissue mineralization, or tiny avulsion fragments
6323 Thoroughbred Horse	5 years	M	Reported by: Lauren Newsom, DVM, DACVR Supervised by: Stacy D. Cooley DVM, DACVR Findings: Computed tomography images of the abdomen pre- and post-contrast medium administration and the thorax pre-contrast medium administration are reviewed in transverse, sagittal, and dorsal planes and are compared to CT images of the thoracic limbs obtained August3, 2015. THORAX: In the dorsal aspect of the right caudal lung lobe, is a small(0.4 cm), rounded, mineral attenuating structure. The remainder of the pulmonary parenchyma is normal in attenuation. No intrathoracic lymphadenopathy is identified. ABDOMEN: The liver contains many small rounded, to curvilinear, well-defined, mineral attenuating structures; in some regions they have a branching pattern. The ventral aspect of the abomasum contains a moderate amount of granular mineral attenuating material. At the left ventrolateral aspect of the reticulum, is a medium, rounded, well-defined fat attenuating mass. The mass contains mild wispy soft tissue and causes focal rightward displacement of the reticular wall. The cecum and spiral colon are predominantly fluid-filled; however, remain normal in size. The small intestines are small and predominantly empty. The uterine horns are severely enlarged and contain homogeneous fluid(ranging from9-20 HU).The uterine horn walls are uniform in thickness and subjectively thin. The uterine horn measures up to 6 cm in diameter. In the region of the uterine body, no luminal fluid is identified and the uterine body to cervix wall is moderately thick; however, uniformly contrast enhancing. The cervix measures approximately 3 cm in diameter. The cranial vagina contains a mild amount of homogeneous fluid. The ovaries are similar in size, shape, attenuation, and enhancement. A contrast sparing round to 7-8 mm in diameter large structures noted in the left ovary. MUSCULOSKELETAL: The central aspect of the C3-4 intervertebral disk is similarly mineralized. Circumferential at the right elbow, there is moderately to severely progressive well-defined periarticular bone formation. The joint margins are less well-defined and the subchondral bone is progressively heterogenous. Moderate periosteal new bone formation is noted at the medial and lateral epicondyle of the right humerus. The left elbow has mildly progressive well-defined periarticular bone formation, worse along the medial and lateral aspects of the elbow. Mild periosteal new bone formation is noted at the medial and lateral epicondyle of the left humerus. Mild periosteal new bone formation is bilaterally noted in the greater trochanter of the femur. A small mineral opacity is noted adjacent to the cranial lateral aspect of the right acetabulum. Mild periarticular osteophyte formation is noted at the right and left acetabulum. The lumbosacral vertebra is transitional and the dorsal aspect of the lumbosacral intervertebral disk space is severely narrow, contains a mild amount of gas, and the endplates are sclerotic. In the superficial soft tissues dorsolateral to the right shoulder, is a small rounded, heterogeneously mineral attenuating nodule. Impressions: 1. Moderately enlarged, fluid-filled uterus is most consistent with hydrometra or mucometra. Considering the low Hounsefield units of the uterine fluid a pyometra is considered less likely. 2. Mild to moderate, diffuse hepatic mineral, likely biliary; possibly secondary to pancreatic migration or endocrinopathy. 3. Mild to moderate hepatic mineral, likely biliary; possibly secondary to pancreatic migration or endocrinopathy 4. Focal pulmonary mineralization is likely an incidental finding and secondary to scarring possibly due to a previous and insult; otherwise unremarkable thorax 5. Progressive, severe right elbow degenerative joint disease, moderate-left elbow degenerative joint disease 6. Peritoneal lipomatous mass 7. C3-4 intervertebral disk degeneration 8. Bilateral, mild to moderate chronic enthesiopathy of the greater trochanter. 9. Mild bilateral posterior groin of the coxofemoral joints. 10. Incidental transitional lumbosacral vertebra 11. Right shoulder subcutaneous nodule, likely benign(e.g. granuloma)
6324 Suffolk Sheep	10 years	F	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Susanne Shuger-Vanagas, DVM, PhD, DipECVDI Findings: Computed tomography images of the thorax, abdomen, and pelvic limbs pre- and post-contrast medium administration with arterial and venous phases are reviewed in transverse, sagittal, and dorsal planes. THORAX: Throughout the lungs, several pulmonary arteries have large soft tissue attenuating filling defects and are poorly-opacified. The right middle, right caudal, accessory, and left caudal lung lobes have multifocal regions of alveolar pulmonary pattern. These regions of the lung are predominantly ventrally located; however, in the caudal lung lobes, the alveolar pulmonary pattern extends dorsally along the right lateral aspect of the right and left caudal lung lobes with a nearly vertical border. In these regions, the lung lobes remain normal in size, there is border effacement of the vasculature structures, and air bronchograms. No nodules or masses are At the craniodorsal aspect of the cardiac silhouette, ventral to the cranial vena cava, is a medium(3.8 cm) rounded, well-defined, non-enhancing fluid to soft tissue attenuating(4-8 HU) nodule. ABDOMEN: The left lateral aspect of the liver, there is an irregular area of mildly diffusely reduced contrast enhancement. No distinct masses are identified. The ventral aspect of the gallbladder contains a mild amount of mineral attenuating material. No portal vein filling defects are identified. Caudal to the renal veins and cranial to the deep circumflex iliac veins, the caudal vena cava bifurcates. Immediately caudal to the bifurcation, within the left branch of the caudal vena cava, is a round, well-defined filling defect that extends caudally into the left internal iliac vein. The filling defect occupies up to 39% of the cross sectional area and tapers caudally. In the right branch of the caudal vena cava, is a smaller filling defect that extends caudally into the right internal and external iliac veins. Distally, the right external iliac vein has a few small poorly-defined filling defects, but is predominantly well-opacified. The left external iliac vein is well-opa The urinary bladder is a small and within the lumen is a mineral attenuating tubular structure that courses to the distal urethra consistent with a urinary bladder catheter. In the right cranioventral aspect of the urinary bladder, is a small, poorly-defined mineral attenuating structure. No mineral attenuating calculi are identified in the urethra. The prostate is mildly to moderately large, lobular, and mildly heterogeneously contrast medium enhancing; however, remains symmetric in size and shape. The medial iliac lymph nodes are moderately enlarged, rounded, and strongly contrast medium enhancing. MUSCULOSKELETAL: Bilaterally the shoulders have moderate to severe well-defined periarticular bone formation. The C6-7 intervertebral disk space is moderately narrow, and the endplates are irregular, heterogeneous and sclerotic. A vertical tubular radiolucent area with adjacent mild irregular new bone formation is noted through the caudal endplate of C6 and the cranial endplate of C7 consistent with a previous ventral slot surgery. Several thoracic and lumbar intervertebral disks are dorsally displaced causing reduced ventral epidural fat. The lumbosacral intervertebral disk is moderately heterogenous, contains gas, and is dorsally displaced causing the ventral margins of the nerve roots to be poorly-defined. The L7-S1 vertebral endplates are irregular and sclerotic and the craniodorsal aspect of S1 is mildly ventral positioned relative to the caudodorsal aspect of L7. Worse at L7-S1, many vertebral bodies have moderate to severe well-defined bridging bone. The left femoral head is moderately dorsally and mildly cranially displaced from the left acetabulum. The left femoral head is irregular in shape and sclerotic. The left hip joint has severe, well-defined periarticular bone formation and subchondral heterogeneity. The intra-articular soft tissues of the left hip joint are severely large, heterogeneous, and contain many small well-defined mineral attenuating structures. The right femoral head remains seated within the acetabulum; however, is irregular in shape and the right hip joint has moderate to severe, well-defined periarticular bone formation and subchondral heterogeneity. Bilaterally the stifles have at least mild well-defined periarticular bone formation. The right popliteal lymph node is moderately enlarged, rounded, and strongly contrast medium enhancing. From the level of the caudal thorax, the superficial soft tissues of the caudal half of the body and the pelvic limbs are moderately thick and the fat contains moderate to severe amounts of wispy to lobular soft tissue. The caudal aspect of the proximal right pelvic limb and ventral to the rectum, there is a large locally extensive region of irregular gas accumulation and soft tissue heterogeneity. The gas extends cranioventrally to the region of the right spermatic cord. Small accumulations of gas are also identified in the bulbus glandis and corpus cavernosum. In the region of the bulbus glandis and corpus cavernosum, are several small, irregularly-shaped to rounded, peripherally enhancing and centrally hyposchanscing soft tissue nodules and the margins of the penile tissues are poorly-defined. The scrotum is severely enlarged and increased in attenuation. The caudoventral aspect of the right testicle has a medium sized(1.8 cm), rounded, peripherally enhancing nodule that extends craniodorsally to the region of the epididymis. The right testicle is mildly hypoenhancing compared to the left; however, the vessels of the spermatic cord are more strongly opacified. The testes are similar in size. Impressions: 1. Locally extensive perineal and right pelvic limb emphysematic cellulitis 2. Multifocal penile abscesses and gas 3. Multifocal pulmonary thromboembolli. Multifocal alveolar pulmonary pattern is likely multifactorial and attributed to bronchopneumonia, or hemorrhage and thromboseed vasculature 4. Right caudal lung lobe pulmonary thromboembolus extending into the left internal iliac vein and right internal and external iliac veins 5. Locally extensive body wall, pelvic limb, and scrotal edema and cellulitis 6. Right testicular nodule, altered blood flow is concerning for additional site of thrombus formation and vascular obstruction. Differential diagnosis include abscess formation and/or granuloma. 7. Medial iliac and right popliteal lymphadenopathy, likely reactive 8. Severe, bilateral shoulder and hip degenerative joint disease and chronic left hip luxation. Mild bilateral stifle degenerative joint disease 9. Multifocal intervertebral disk degeneration and herniation, severe lumbosacral intervertebral disk degeneration and herniation, with suspected lumbosacral instability 10. Probable small cranial mediastinal cyst, incidental 11. Mild gallbladder mineral 12. Focal cystic calculus CONCLUSIONS: Locally extensive perineal and right pelvic limb emphysematic cellulitis and multifocal penile abscesses and gas are a likely cause of systemic inflammation leading multifocal thromboembolis. A previous testicle torsion leading to thrombus formation in the right testicle cannot fully be excluded. The severe subcutaneous edema is likely multifactorial, and attributed to both cellulitis and impaired venous drainage.
6325 Saint Bernard	Unknown	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Susanne Shuger-Vanagas, DVM, Phd, DipECVDI

Anatomage Table 9.0 Case Library Descriptions

			Findings: Computed tomography images of the thorax and abdomen pre- and post- IV contrast medium administration are reviewed in transverse, sagittal and dorsal planes. MUSCULOSKELETAL: Arising from the fascial plane between the right thoracic limb and neck, there is a severely large (14.5cm x 11.2cm x 11.8cm), lobular, variably defined, heterogeneously contrast enhancing mass that is predominantly centrally hypoenhancing. Craniodorsally, near the scapula, there are several, strongly enhancing tortuous vessels. This portion of the mass is ill-defined from the subscapularis muscle where the mass causes mild, multifocal permeative lysis of the dorsal aspect of the scapula and mild, smoothly margined periosteal reaction. This mass peripherally displaces the right thoracic limb, and has a mild amount of wispy fat att Located cranial to the left shoulder joint and caudal to the cleidobrachialis and pectoral muscles, there is a large (3.7cm x 9.3cm x 6.5cm), lobular, well-defined and heterogeneously contrast enhancing mass in the region of the deltoideus muscle. The humerus and shoulder joints are otherwise normal in size, shape, margination and attenuation. Multifocally, subcutaneously, within several muscle bellies, and along the right flank, there are numerous, well-defined, small to medium sized, oval and encapsulated fat attenuating masses. Both of the axillary lymph nodes are normal in size, shape, margination and contrast enhancement. Mild periarticular osteophytes are noted at both elbow joints. There is mild lumbar and lumbosacral spondylosis deformans. At the lumbosacral intervertebral disc space, the disc is protruding mildly into the ventral left the vertebral canal. The cauda equina nerve roots retain normal, surrounding epidural fat. The spondylosis courses dorsally causing marked narrowing of the lumbosacral intervertebral foramina. THORAX: Multifocally, there are a few, small, mineral attenuating pulmonary osteomas. Additionally, there is mild gravity dependent hypoinflation and interstitial pulmonary pattern, consistent with atelectasis. No soft tissue attenuating, round, well-defined pulmonary nodules are noted. The intrathoracic lymph nodes are normal. ABDOMEN: In the right cranial ventral liver, there is a large (7.8 cm x 4cm) , lobular, ill-defined and heterogeneously hypoenhancing mass. Two additional, small, oval hypoenhancing nodules are present in the left liver. No peritoneal fluid is noted. The spleen has multifocal, round and variably defined hyperenhancing nodules. The capsular margins are mildly irregular and the parenchyma is diffusely heterogenous. The ventral half of the bladder has moderate granular material. The gallbladder and common bile duct is normal in size. Impressions: 1. Large right body wall mass between the neck and scapula with locally extensive aggressive bone lesion of the right dorsal scapula and subscapularis muscle. Differential diagnosis includes predominantly malignant neoplasia (e.g. soft tissue sarcoma, fibrosarcoma, liposarcoma, rhabdomyosarcoma). No regional lymphadenopathy or pulmonary metastatic neoplasia detected. 2. Large right ventral liver mass with multifocal hepatic nodules. Differential diagnosis is broad and includes benigne g. hyperplasia, vascular hepatopathy) and malignant (metastatic neoplasia and less likely hepatocellular carcinoma) etiologies. 4. Diffusely heterogeneous spleen is a nonspecific finding. Differential diagnoses includes benigne.g. hyperplasia, extramedullary hematopoiesis) and malignant (e.g. metastatic neoplasia) etiologies. 5. Mild bilateral elbow degenerative joint disease 6. Mild lumbosacral disease with marked bilateral foraminal stenosis 7. Likely incidental, non-obstructive gallbladder mineral sludge 8. Multifocal subcutaneous and intramuscular lipomas
6326 Border Collie Mix	13 years	M	Reported by: Lauren Newsom, DVM, DACVR Findings: Computed tomography images of the thorax and abdomen pre-and post-IV iodinated contrast medium administration are reviewed in transverse, sagittal, and dorsal planes. Arterial and venous phases were performed. ABDOMEN: There is a moderate amount of homogenous, soft tissue attenuating fluid within the peritoneal space, and there is mild, uniform contrast enhancement of the peritoneum. In the body of the spleen, there is a severely large (14 cm x 7 cm x 10 cm), lobular and heterogenously hypoenhancing mass with combined fat and soft tissue attenuation. The head and tail of the spleen are ill-defined from this mass with moderate heterogenous contrast enhancement. Additionally, the splenic lymph nodes are mildly large, round and heterogenously contrast enhancing. The stomach is displaced dorsally and to the left and the liver is displaced dorsally and to th Multifocally in the liver, there are at least ten, round, well-defined, variably sized (up to 3 cm diameter), heterogenously hypoenhancing hepatic nodules. The portal lymph nodes are normal. In the renal pelves, there is a small amount of multifocal mineral. THORAX: The pulmonary parenchyma is normal in opacity. No pulmonary nodules are seen. The sternal lymph nodes are mildly large, round and heterogenously contrast enhancing. The cranial mediastinal and tracheobronchial lymph nodes are normal. The cardiac structures are also normal, and no intracardiac luminal filling defects are seen. MUSCULOSKELETAL: At the insertion of the right iliopsoas on the proximal femur, there is multifocal, irregularly marginated well-defined mineralization. On all periarticular surfaces of the left stifle joint, there are moderate, well-defined osteophytes and enthesophytes. Mild intra-articular swelling is also noted. The left popliteal lymph node is small. The patella is normally located within the trochlear groove; however, the lateral aspect of the femoral patellar joint is wide. Impressions: 1. Severely large, hypoenhancing splenic mass with moderate peritoneal fluid, mild splenic lymphadenopathy, and multifocal hepatic metastasis. The primary differential diagnosis for this finding is rupture of a primary splenic neoplasia (e.g. hemangiosarcoma) resulting in a hemoabdomen. 2. No pulmonary metastatic neoplasia 3. Mild sternal lymphadenopathy, most likely reactive to the abdominal disease; metastasis is also possible. 4. Right iliopsoas insertional enthesopathy, dystrophic mineralization or previous partial avulsion fractures. 5. Moderate left stifle degenerative joint disease 6. Bilateral, multifocal renal pelvic mineral of unknown clinical significance
6327 Pembroke Welsh Corgie	6.5 years	F	Reported by: Lauren Newsom, DVM, DACVR Findings: The study is part of a research project of Dr. Nicole LaBlanc. Pre- and post-intravenous iodinated computed tomography images of the thorax are available for interpretation; included is an ECG gated cardiac study. Images are available in various planes and bone and soft tissue algorithms. No abnormality of the cardiovascular structures is noted. The left circumflex artery and the left paracanal coronary artery originate separately from the left sinus Valsalva and follow a normal branching pattern. A small amount of mineral attenuating material is noted in the ventral (dependent) aspect of the gallbladder with a horizontal interface to the normal, hypoattenuating bile. Impressions: Normal cardiovascular structures. The left coronary artery branches originate both directly from the left sinus Valsalva; likely normal anatomic variant. Mild gallbladder sediment (sand) without biliary obstruction, likely incidental finding.
6328 Mix Breed	4 years	M	Reported by: Susanne Stiger-Vanegas, DVM, PhD, DipECVDI Findings: The study is part of a research project of Dr. Nicole LaBlanc. Pre- and post-intravenous iodinated computed tomography images of the thorax are available for interpretation; included is an ECG gated cardiac study. Images are available in various planes and bone and soft tissue algorithms. No abnormality of the cardiovascular structures is noted. Normal morphometry of the coronary arteries. The pulmonary parenchyma is normal Impressions: Normal cardiovascular structures and lung parenchyma
6329 Mix Breed	5 years	M	Reported By: Susanne Stiegar-Vanegas, DVM, PhD, DipECVDI Findings: Computed tomography images of the neck, thorax, and abdomen pre- and post-contrast medium administration are reviewed in transverse, sagittal, and dorsal planes. NECK: In the region of the right lobe of the thyroid gland, there is a medium(6.9 x 3.3 x 4.0 cm; LWH), well-defined, mildly heterogeneous, soft tissue attenuating and markedly contrast medium enhancing mass. In the region of the mass, trachea is moderately displaced to the left. The esophagus remains normal in position, and the adventitial esophageal margin remains well-defined. The carotid artery and internal and external jugular veins are well-opacified and normal in margination. The left lobe of the thyroid gland is normal in size, shape, margination, attenuation, and contrast medium enhancement. Along the cranial periphery and medial aspect of t Within the fascial plane cranial to the mass, there is a small(0.8 cm), rounded, well-defined, moderately contrast medium enhancing nodule. The caudal aspect of the right medial retropharyngeal lymph node is mildly rounded and strongly contrast medium enhancing compared to the left; the cranial portions of the right medial retropharyngeal lymph node are normal in size and are similar in size and enhancement to left. The mandibular lymph nodes are normal in size, shape, margination, attenuation, and enhancement. The lateral ventricles are mildly asymmetric; the septum pellucidum is not definitively identified. No midline shift is noted in the brain. THORAX: At the heart base, caudoventral to the aortic arch and craniodorsal to the main pulmonary arteries, there is a small(1.2 cm), rounded, predominantly well-defined soft tissue attenuating and heterogeneously contrast medium enhancing nodule. There is a well-defined fat margin between the nodules and the adjacent cardiovascular structures. No pericardial fluid is noted. Throughout the lungs, there are several pin-point to small soft tissue to mineral attenuating foci. The ventral portions of the right middle lung lobe is mildly small and increased in attenuation; in the well-aerated portions of the lungs, no soft tissue nodules are identified. No intrathoracic lymphadenopathy is detected. ABDOMEN: The spleen is diffusely mildly heterogeneously contrast medium enhancing and contains several (roentmarating and mildly hyperenhancing nodules. The stomach is normal in size and contains a mild amount of homogeneous soft tissue and gas. The gastric walls are uniform in thickness and enhancement; no masses or thickening is identified. The small intestinal walls are also uniform in thickness and no masses are identified. The pancreas is homogeneous and normal in size and margination. The fat surrounding the pancreas is normal in attenuation. MUSCULOSKELETAL: The C6-7 vertebral bodies and several thoracolumbar vertebral bodies have mild well-defined bridging bone. The L7-S1 intervertebral disk is mildly dorsally displaced causing reduced ventral epidural fat. The L7-S1 vertebral bodies have mild to moderate well-defined bridging bone, which mildly extends dorsally into the left and right intervertebral foramina causing mild narrowing. Impressions: 1. Right-sided neck mass with mild, tortuous vascularization arising from the right thyroid lobe is consistent with clinically suspected thyroid carcinoma 2. Small pervisceral nodal and mild right medial retropharyngeal lymphadenopathy are concerning for metastasis; reactive lymphadenopathy is less likely 3. Heart-base mass is attributed either to chemodectoma or less likely ectopic thyroid carcinoma 4. The multifocal hyperattenuating pulmonary nodules are most consistent with pulmonary osteomas; hyperattenuating pulmonary metastatic neoplasia from thyroid carcinoma is possible, yet less likely. 5. Splenic heterogeneity and nodules are likely benignic g. extramedullary hematopoiesis, hyperplasia), otherwise unremarkable abdomen and a cause for vomiting is not identified; this study is negative for foreign material, pyloric outflow obstruction, gastrointestinal masses, or signs of pancreatitis. 6. Mild lumbosacral disease with mild foraminal stenosis
6330 Boxer	8.5 years	F	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Lauren Newsom, DVM, DACVR Findings: Computed tomography images of the thoracic and lumbar back without contrast medium administration are reviewed in transverse, sagittal, and dorsal planes. Several of the thoracic vertebral bodies are severely variable in size and shape with a moderate rightward deviation of the vertebral column in the mid-thoracic spine; this has resulted in an overall left dorsally convex shape. In this region, the vertebral canal has moderately irregular and undulating course being triangular in shape. At several locations in the mid to caudal thoracic spine (T5-T11), the dorsolateral aspects of the spinal cord/subarachnoid space has multifocal flattening with loss of epidural fat. The left aspect of the T11 vertebral body is severely small and there is a large, vertically oriented, well-defined, soft tissue, linear region of incomplete vertebral body fusion to the left of midline. The left aspect of the vertebral body and the left pedicle also have discontinuous cortices, yet are smooth and well defined. Alone midline of the T11 spinous process and lamina, there is a well-defined, vertically oriented, soft-tissue line indicative of incomplete midline fusion. The region of the T10–12 intervertebral disc has moderate, multifocal mineral and extends mildly into the left ventrolateral aspect of the spinal canal causing focally reduced ventral epidural Throughout the caudal cervical and thoracolumbar spine, many intervertebral disks contain mild to moderate mineral, and several of the vertebral bodies have moderate well-defined bridging bone. The L7-S1 intervertebral disk is moderately heterogeneous, contains foci of mineral, and is moderately dorsally displaced causing reduced epidural fat, extends into the left and right intervertebral foramina; the margins of the nerve roots are poorly-defined if there remains mild epidural fat dorsal to the cauda equina nerve roots. At the L7-S1 intervertebral disk space, the vertebral endplates are moderately irregular, sclerotic, with well-defined, round concave Schmorl's nodes. The L7 S1 articular joints are irregular in shape with nonuniform increased in joint space width. The left wing of the sacrum is moderately large, elongated, and extends craniolateral Bilaterally, the hips have moderate well-defined periarticular bone formation and the hip joints are subjectively moderately wide. Impressions: 1. Multifocal congenital thoracic vertebral malformations (wedge, butterfly, and hemivertebrae; T11spina bifida) resulting in scoliosis, kyphosis, irregular course of the spinal canal, and deviation of the spinal cord. Given the history of neurologic deficits, a thoracic myelopathy is suspected. 2. Mild left-sided T11-12intervertebral disk degeneration and protrusion may be contributing to the reported neurologic symptoms. Definitive spinal cord compression is not seen. 3. Moderate lumbosacral disease with disc herniation and bilateral foraminal stenosis, and 4. Multifocal intervertebral disk degeneration and spondylosis deformans in the thoracolumbar spine 5. Moderate bilateral hip degenerative joint disease
6331 French Bulldog	7 years	F	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Lauren Newsom, DVM, DACVR Findings: Computed tomography images of the abdomen are reviewed in transverse, sagittal, and dorsal planes. The urinary bladder is moderately enlarged and in the ventral aspect of the urinary bladder are several small well-defined mineral attenuating foci. The cranial urethra is also moderately enlarged and within the penile urethral lumen cranial to the sigmoid flexure, there is a medium (0.6 cm), rounded, well-defined mineral calculus. The fat surrounding the penile urethra and perineal region contains has a moderate to severe amount of wispy soft tissue. Worse surround the urinary bladder, there is a medium to large amount of homogenous caudal peritoneal fluid. Bilaterally, the retroperitoneal space contains a large volume of homogeneous fluid pockets and wispy fluid. The renal pelves and diverticulea are mildly to moderately enlarged (1.2 cm) with homogeneous urine; the kidneys remain subjectively normal in size and are normal in margination and attenuation. No mineral attenuating material is identified within the kidneys or ureters. The ventral and ventrolateral superficial soft tissues of the right caudal thoracic body wall, right lateral and ventral abdominal body wall, inguinal region, and proximal right pelvic limb contain large accumulations of homogeneous soft tissue and wispy soft tissue attenuating fat. Along the right caudolateral body wall, the soft tissue extends dorsally to the level of the transverse processes. The pre-femoral and inguinal lymph nodes are moderately enlarged and rounded. At the cranial extent of the scan, bilaterally, the pleural space contains a mild to moderate amount of homogeneous fluid. The caudal pulmonary parenchyma is normal in attenuation. The gastrointestinal tract is predominantly empty and the rumen is subjectively small containing a mild amount of granular mineral. Impressions: 1. Obstructive penile urethral calculus with severe fluid accumulation in the retroperitoneal, peritoneal, subcutaneous and pleural spaces. There is secondary bilateral hydronephrosis supportive of lower urinary tract obstruction. There are also several non-obstructive cystic calculi. The fluid accumulation is most likely secondary to a systemic inflammatory response (e.g. urosepsis, uremic crisis) in addition to actual urine accumulation. 2. Moderate pre-femoral and inguinal lymphadenopathy, likely reactive
6332 Nigerian Dwarf Goat	5 years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Lauren Newsom,DVM, DACVR Findings: Computed tomography images of the head pre- and post-right positive contrast dacrocystography are reviewed in transverse, sagittal, and dorsal planes. The right nasolacrimal canal is diffusely moderately expanded from the medial canthus to the level of the nasal cavity (e.g. series 10, image 50/R: 1.0 cm; L: 0.4 cm). The contents of the canal are predominantly homogeneously soft tissue attenuating and contain a couple small gas accumulations rostrally. The rostroventral and ventrolateral mucosa of the right nasal cavity is mildly thick and there is a mild amount of fluid. The right nasolacrimal gland is moderately enlarged and lobular compared to the left. The maxillary and nasal bones are otherwise smoothly margined and well-defined. Surrounding the rostral root of the most rostral erupted right maxillary cheek tooth, there is moderate lysis of the alveolar bone in this region. This tooth root is moderately reduced in attenuation, heterogeneous, and less well-defined. The lysis extends dorsally and the margin between the nasolacrimal canal at the level of the rostral root of the right maxillary 1st premolar is lysed. The periodontal space surrounding the caudal roots of the 1st cheek tooth and the rostral root of the second cheek tooth is moderately wide with focal alveolar lysis; however does not communicate with the nasolacrimal canal. Following antegrade administration of positive contrast into the right nasolacrimal duct at the medial canthus, the duct is diffusely well-opacified and severely large. At the level of the rostral root of the first erupted right maxillary cheek tooth, contrast coarses ventrally into the alveolus and along the margin to the tooth root. Rostral to this, the duct is well-opacified and positive contrast is identified within the ventral portions of the right nasal cavity and nare. No contrast medium is noted within the oral cavity. The remainder of the maxillary and mandibular teeth are normal in shape, well-defined, and surrounded by normal alveolar bone. Bilaterally, the external ear canals contain mild tubular soft tissue material. The tympanic cavities are gas-filled and the bullae are normal in shape, margination, attenuation, and size. The left and right mandibular and medial retropharyngeal lymph nodes are normal in size, shape, attenuation, and enhancement. Impressions: 1. The results of this study confirm right dacrocystitis and communication with a tooth root abscess of the right maxillary rostral cheek tooth. The right nasolacrimal duct remains patent. 2. Mild right non-destructive rhinitis is likely secondary to chronic dacrocystitis 3. Bilateral mild external ear canal debris
6333 Llama	3 years	F	Reported By: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Lauren Newsom, DVM, DACVR Findings: CT images of the pelvic limbs are reviewed in transverse, sagittal, and dorsal planes. RIGHT PELVIC LIMB: Centered at the right stifle joint, there is severe mesh-motion to permeative lysis of the distal femoral metaphysis, femoral condyles, and proximal tibia with long zones of transition, and concave lysis of the articular surfaces. The subchondral margins of the right stifle joint are severely irregular, poorly-defined and heterogeneous; the joint space is severely narrow. No medial fabella is present. The subchondral bone margin of the patella is ill-defined and the femoropatellar joint space is narrow. The intracapsular soft tissues of the right stifle are moderately increased in size and heterogeneously soft tissue attenuating with loss of the s The left and right inguinal lymph nodes are moderately enlarged, lobular, and rounded. The right medial iliac lymph node is also moderately enlarged (0.9 cm height) and rounded. The left medial iliac lymph node is poorly-defined. The right popliteal lymph node is also mildly enlarged and rounded but is similar in size to the contralateral limb. At the distal plantaromedial and plantarolateral aspects of the right calcaneus, there are several, predominantly well-defined regions of new bone formation. The calcaneal tuberosity has moderate predominantly smooth and well-defined periosteal new bone formation. The tarsocrural, intertarsal, and tarsometatarsal joints are well-aligned and well-defined. No soft tissue swelling is noted. The muscles of the right pelvic limb are moderately small compared to the left. The caudal 13th vertebrae of the tail is curvilinear shape with ill-defined cortical margins and moderate, smoothly margined bridging callus formation. Both testes are present. In the region of the caudal urethra, is a thin linear mineral attenuation, likely the os penis. No urethral enlargement is identified. The urinary bladder is moderately enlarged. LEFT PELVIC LIMB: No substantial abnormality is detected. The medial fabella is small when compared to the lateral fabella. Impressions: 1. The right hind limb lameness, dense muscle atrophy, and resistance to leg extension is attributed to the polyostotic aggressive bone lesion of the right stifle joint, for which the primary differential is septic arthritis and osteomyelitis. Joint associated neoplasia is less likely. 2. Multifocal, reactive lymphadenopathy (popliteal, inguinal, medial iliac) 3. Chronic remodeling of the right calcaneus, suspect previous trauma 4. Healed malunion fracture of the 13th caudal vertebra
6334 DLH	2 years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Lauren Newsom, DVM, DACVR

Anatomage Table 9.0 Case Library Descriptions

6335	Dachshund	3.5 years	F

Findings:

Computed tomography images of the neck are reviewed in transverse, sagittal, and dorsal planes without IV contrast medium administration.

All cervical intervertebral disks and several cranial thoracic intervertebral disks have small to medium regions of well-defined mineral attenuation of the nucleus pulposus. In the right ventral and ventrolateral aspect of the vertebral canal at the level of the C6-7 intervertebral disk space, there is a medium amount of lobular, well-defined, mildly heterogeneous mineral attenuating material that is continuous with mineralized portions of disk within the disk space. In this region, the mineralized disk material occupies up to 50% the cross-sectional area of the vertebral canal. The spinal cord is displaced to the left dorsolateral aspect of the vertebral canal and is

Impressions:
1. Cervical pain and neurologic deficits are attributed to a C6-7 intervertebral disk herniation (Hansen Type
1) resulting in spinal cord compression and right foraminal stenosis
2. Multifocal cervicothoracic intervertebral disk degeneration without herniation

Reported by: Kristin Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Lauren Newsom, DVM, DACVR

6336	German Shepherd	5 years	M

Findings:

Computed tomography images of the abdomen pre- and post-IV contrast medium administration are reviewed in transverse, sagittal, and dorsal planes.

MUSCULOSKELETAL: In the right lumbar hypaxial muscles and ventrolateral epaxial muscles from the level of L2 to L6-7, there are medium to large, poorly-defined, coalescing masses that are peripherally enhancing and centrally hypoattenuating and hyposhancing. In the ventral aspect of one of the masses, there is a thin linear hyperattenuating and non-enhancing structure (series 3, images 101 and 102). The muscle margins surrounding the masses are poorly-defined, heterogeneous, and the muscles are enlarged. Caudal and dorsal to the right kidney, the retroperitoneal space contains moderate, wispy, soft tissue soft tissue accumulations. At the leve

The caudal endplate of L2 has a large, irregularly-margined, poorly-defined region of lysis surrounded by mildly sclerotic bone and a few small, poorly-defined concave defects. The L2-3 intervertebral disk is mildly heterogeneous and contains mineral and gas. At the left ventrolateral aspect of the L2-3 intervertebral disk space and left L2-3 intervertebral foramen, there is a small amount of soft tissue and mineral attenuating material that is continuous with the intervertebral disk. The vertebral bodies have moderate, predominantly well-defined periosteal response. The spinal cord/ subarachnoid space remains well-defined with normal lateral and dorsal epi

The L2-S1 intervertebral disk is moderately heterogeneous, partially mineralized and is mildly dorsally displaced causing reduced ventral epidural fat. The central aspects of several lumbar intervertebral disks contain small foci of mineral.

ABDOMEN: Bilaterally, the medial iliac and internal iliac lymph nodes are mildly to moderately enlarged, rounded, and heterogeneously contrast medium enhancing. The lumbar (peri-aortic) are mildly enlarged and rounded, worse on the right.

The prostate is moderately enlarged, heterogeneous, and lobular; in the left aspect of the prostate, is a small (1.3 cm), rounded, peripherally enhancing and centrally hypoattenuating and hyposenhancing nodule. Both testes are present and unremarkable.

The spleen contains several small rounded, swattenuating and mildly hyperenhancing nodules.

Impressions:
1. Lumbar swelling, chronic fever, anemia, thrombocytopenia, and back pain are attributed to the locally extensive right paraspinal muscle and subcutaneous abscesses with L2-3 diskospondylitis, likely secondary to foreign material; no spinal cord compression is detected
2. Moderate lumbar and sublumbar lymphadenopathy is likely reactive
4. Benign prostatic hyperplasia; focal, small, cystic nodule may be an additional abscess or a benign cyst
5. Splenic nodules are commonly benignic (e.g. extramedullary hematopoiesis, lymphoid hyperplasia)
6. Multifocal intervertebral disk degeneration and mild L7-S1 disk herniation

Reported by: Kristin Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR

6337	Persian Mix	11 years	F

Findings:

Computed tomography images of the head and thorax pre- and post-contrast medium administration are reviewed in transverse, sagittal, and dorsal planes. The thoracic images were repeated in dorsal recumbancy (initially sternal).

HEAD: The lumen of the caudal nasopharynx, at the level of the caudal half of the soft palate, is subjectively narrow and the mucosa is subjectively thick and irregular in margination with rounded gas opacities. The caudal aspect of the right nasal cavity contains a mild amount of homogeneous soft tissue. No lysis of the maxillary and ethmoidal conchae is seen.

The left maxillary first premolar and right mandibular first premolar are absent. No tooth root-associated lysis is identified. The alveolar bone surrounding the maxillary tooth roots is intact and no intraoseal extension is identified.

The right medial retropharyngeal lymph node is mildly larger than the left but normal in size. The mandibular lymph nodes are bilaterally normal in size, shape, margination, and enhancement. The right superficial cervical lymph node is mildly larger, rounded, and hyperenhancing compared to the left.

In the right ventrolateral soft tissues of the neck, dorsal and medial to the jugular vein, there is a moderate amount of non-enhancing soft tissue that causes moderate lateral displacement of the jugular vein and the muscle margins to be ill-defined.

THORAX: In the cranioventral portion of the left cranial lung lobe, the lung is small and there is a locally extensive region of soft tissue attenuation with border effacement of the vessels and small air bronchograms which is markedly reduced with changed recumbancy. The right cranial, right middle, and accessory lung lobes, and ventral portions of the caudal lung lobes have multifocal, patchy, wispy to nodular regions of soft tissue attenuation that are also reduced in attenuation to resolved with altered recumbancy.

The spleen is heterogeneously contrast medium enhancing in the initial scans but is homogeneous in the repeat

Impressions:
1. Mild non-dermactive right-sided rhinitis, likely normal variation(i.e. nasal cycle) and, less likely, inflammatory (e.g. lymphoplasmacytic rhinitis)
2. Subjective nasopharyngeal narrowing may indicate inflammation and stenosis secondary to procedure (e.g. aspiration) or normal variation
3. Multifocal absent teeth; this study is negative for teeth root-associated abscess
4. Mild right superficial cervical lymphadenopathy is likely reactive
5. Nearly resolved ventral alveolar pattern with altered recumbancy consistent with atelectasis; this study is negative for bronchopneumonia

Reported by: Kristin Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR

6338	Nigerian Dwarf Goat	2 years	M

Findings:

Computed tomography images of the neck and cranial back are reviewed in transverse, sagittal, and dorsal planes.

In the left caudodorsal aspect of C1, there is a medium (1.5 x 1.6 x 0.8 cm; LWH), rounded, expansile, predominantly well-defined, region of geographic medullary lysis. In the region of lysis, the soft tissue are heterogeneous and centrally, there is a small, irregularly-margined mineral attenuating structure. At the caudoventral aspect of this region, there is lysis of the cortex and partially mineralized, heterogeneous, soft tissue mass extends into the vertebral canal. This mass occupies up to 90% of the cross sectional area, extends approximately 2.8 cm in height, and causes severe right ventrolateral displacement and flattening of the spinal cord / subarachno

At the atlanto-occipital joint, C1 is mildly angled to the right and right dorsolaterally rotated. At the articulation, the medial aspects atlanto-occipital joint are mildly wide and there is loss of the right ventrolateral epidural fat.

At the C6-7 intervertebral disk space, the cranial aspect of C7 is mildly dorsal to the caudal aspect of C6 with reduced dorsal and ventral epidural fat. The T8-9 intervertebral disk space is severely narrow to absent and there is a focal ventral convexity of the vertebral bodies. The ventral and mid cortices of T8 and 9 spinous processes are continuous.

In the included portions of the lungs, there are several small, rounded, poorly-defined soft tissue attenuating regions and the airways are moderately, diffusely thick.

Impressions:
1. Neurologic deficits are attributed to a C1 sequestrum and chronic abscess with extension into the vertebral canal causing severe extradural spinal cord compression
2. Questionable occipito-atlanto instability / subluxation
3. Moderate C6-7 step-defect, likely traumatic
5. Pulmonary nodules and airway thickening are most likely secondary to infectious etiology (e.g. lungworm)
5. Incidental small abscess foci, bronchitis and focal lordosis

Reported by: Kristin Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR

6339	American Paint Horse	6 years	F

Findings:

Computed tomography images of the left tarsus are reviewed in transverse, sagittal, and dorsal planes and are compared to radiographs performed March 19, 2019.

In the parasagittal aspect of the central tarsal bone, is a well-defined dorsomedially-palmarolaterally oriented fracture with minimal displacement. The fracture extends from the proximal intertarsal joint to the distal intertarsal joint and at the plantarolateral aspect, the fracture extends to the articulation with the 4th tarsal bone. The fracture is predominantly uniform in width. The tarsal bones remains well-aligned and the joints are uniform in width.

The central tarsal bone is diffusely increased in attenuation with decreased cortic-omedullary definition, worse dorsally. At the distomedial, dorsomedial, and plantar aspects of the central tarsal bone the cortical margins are mildly irregular and have mild well-defined periarticular bone formation. The dorsal margins and plantaroproximal aspect of the third tarsal bone also have mild periarticular bone formation.

The dorsal aspect of the third tarsal bone is also moderately sclerotic with reduced amount of trabecular bone.

The intracapsular soft tissues of the proximal intertarsal joint are normal in size and attenuation. The margins of the flexor and extensor tendons are well-defined and normal in margination and attenuation.
Impressions:
1. This study confirms a chronic, left central tarsal bone slab fracture with mild proximal and distal intertarsal degenerative joint disease
2. Mild, chronic remodeling of the left pelvic third tarsal bone

Reported by: Kristin Bruckner, DVM, Diagnostic Imaging Resident
Stacy D. Cooley DVM, DACVR

6340	Pygmy Goat	1.5 years	M

Findings:

CT images of the pelvic limbs are available for review in the transverse, sagittal, and dorsal planes.

LEFT PELVIC LIMB: The plantaroproximal aspects of the middle phalanges of the left pelvic third and fourth digits have a few well-defined and sharply margined comminuted articular fractures extending to the proximal interphalangeal joints. The fracture lines coarse from plantarodistolateral-dorsoproximomedial on the both digits and majority of the fracture fragments are dorsoproximally to caudodorsally displaced. The largest fragment is seen in the left third middle phalanx. Additionally, dorsolaterally the proximal aspects of the middle phalanges of the third and fourth digits have small chip fractures with the fragments being mildly dorsolaterally d

The proximal phalanges of the third and fourth digits have mildly lucent proximal physes along the plantar aspect. The dorsal aspect of these physes are homogenously mineral attenuating.

RIGHT PELVIC LIMB: No abnormality is detected.

Impressions:
1. Acute, transtate, comminuted, articular, palmar fractures of the left pelvic middle phalanges at the proximal interphalangeal joints
2. Suspect nonuniform proximal physeal closure of the left pelvic proximal phalanges; no displacement is detected
3. Unremarkable right pelvic limb

Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR

6341	Healer	10 years	M

Findings:

Computed tomography images of the thoracic pre- and post-contrast medium administration are reviewed in transverse, sagittal, and dorsal planes and compared to a CT performed August 15, 2018 and abdominal sonograms obtained December 18, 2018.

MUSCULOSKELETAL: In the mid to caudal aspect of the sacrum, worse on the left, there is a locally extensive region of cortical and medullary lysis. In this region, there is a large strongly contrast medium enhancing mass, which extends mildly superficial to the sacral margins and into the vertebral canal, occupying up to 100% of the vertebral canal and effacing the nerve roots; the mass also extends into the left dorsolateral aspect of the pelvic canal. Adjacent to the mass, the dorsomedial aspect of the left ilial body has focal region of cortical thinning and heterogeneity. The sacroiliac joints remain well-aligned.

The left medial iliac lymph node is mildly enlarged, rounded, and heterogeneously contrast medium enhancing. In the region of the right subiumbar lymph nodes, the small, metal attenuating surgical clips are unchanged.

In the region of the right anal sac, no nodule or mass is detected; the left anal sac is unremarkable.

Unchanged, there is no right 13th rib and in this region is a transverse process. The left 13th rib is mildly small and the costovertebral joint is narrow and sclerotic. Seven lumbar vertebrae are present. Several intervertebral disks are centrally mineralized.

ABDOMEN: In the right aspect of the liver is a large (5.5 cm), rounded to lobular, poorly-defined, mildly hypoattenuating, and heterogeneously contrast medium enhancing mass. Throughout the liver, are several additional nodules with similar attenuation and enhancement as the mass. The hepatic lymph nodes are moderately enlarged (up to 2.7 cm height), rounded, and heterogeneously contrast medium enhancing. The gallbladder similarly contains a mild amount of dependent soft tissue to mineral attenuating material. The gallbladder remains normal in size.

In the body of the spleen, the previously described mass is similar in size (3.2 cm), shape, margination, and is heterogeneously iso to hypoattenuating and centrally hyposenhancing. Similar to previous, the spleen also contains a few small (0.9 cm), rounded, variably well-defined hyposenhancing nodules.

The urinary bladder is moderately enlarged; the trigone region is normal without a mass and the prostate is normal in size, shape and margin. No abnormality is seen in the urethra or penis.

THORAX: A cranial mediastinal lymph node is moderately enlarged (1.8 cm height) and rounded. The ventral portion of the right middle lung lobe is mildly small and increased in attenuation; the remainder of the pulmonary parenchyma is otherwise normal in attenuation and no soft tissue nodules are identified.

Impressions:
1. Locally extensive aggressive sacral mass with vertebral canal extension and effacement of the nerve roots is most likely attributed to metastasis from previously excised right anal sac adenocarcinoma and likely a cause of hypercalcemia, lethargy, and hyporexia
2. New liver mass, hepatic nodules and multifocal lymphadenopathy (hepatic, cranial mediastinal, and left medial iliac) are also attributed to metastasis and likely contribute to reported clinical signs
3. Unremarkable lungs; this study is negative for pulmonary metastasis
4. Mild cystitis; urinalysis and culture are recommended for confirmation
5. Similar splenic mass consistent with reported lymphoid hyperplasia and extramedullary hematopoiesis. Splenic nodules are most likely benignca (e. extramedullary hematopoiesis)
6. Similar, mildly mineralized biliary sediment
7. Incidental, T13transitional vertebra and multifocal intervertebral disk degeneration

Reported by: Kristin Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR

6342	Golden Retriever	2 years	F

Findings:

Computed tomography images of the thorax pre and post-contrast medium administration are reviewed in transverse, sagittal, and dorsal planes.

The right middle lung lobe is severely small and homogeneously soft tissue attenuating with air bronchograms and border effacement of the blood vessels. The ventral aspect of the left cranial lung lobe (caudoventral portion of the cranial part, entirety of the caudal part) are also severely small and soft tissue attenuating. Within these lung lobes, the airways are lobular and remain wide peripherally. The other lung lobes are moderately enlarged and hyperinflated; adjacent to the hyperinflated lung lobes, the caudal vena cava is small and angular but normal in opacification. The cranial aspect of the right cranial lung extends to the left hemithorax cranial and

At T13-L2 intervertebral disk space, there is moderate well-defined bridging bone. Several additional thoracolumbar vertebral bodies have mild well-defined bridging bone.

Impressions:
Chronic cough is attributed to right middle and left cranial lung lobe collapse with bronchiectasis for which the primary differential diagnosis is scarring from previous bronchopneumonia; additional, current bronchopneumonia is possible.

Reported by: Kristin Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR

6343	Nigerian Dwarf Goat	1 year	M

Findings:

Computed tomography images of the abdomen pre- and post-IV contrast medium administration are reviewed in transverse, sagittal, and dorsal planes and are compared to previous studies, most recently performed July 24, 2018.

The urinary bladder is severely enlarged, occupying the caudal third of the abdomen. The cranial urethra is also severely enlarged (3.3 cm); however, at the level of the caudal pelvic symphysis, approximately 3 cm cranial to perineal urethrostomy site, the urethral lumen abruptly narrows (0.2 cm) and is irregular in margination. Caudal to the narrowing, the urethra is mildly widened (0.9 cm) to the region of the perineum. Ventral and cranial to the perineum, the urethra is not definitively identified. Within the urinary bladder and urethra, no mineral attenuating material is identified.

Bilaterally, the renal pelves and diverticuli are moderately enlarged (R: 1.1 cm; L: 1.3 cm) and contain homogeneous fluid; the renal papillae are also moderately flattened. The previously identified renal mineral is not identified in today's study. The ureters are diffusely mildly enlarged (0.5 cm) and contain homogeneous fluid but are poorly-defined caudally. Bilaterally, the retroperitoneal space contains a moderate amount of wispy soft tissue. In the caudal peritoneum and the fat surrounding the urethra also contains moderate wispy soft tissue.

Adjacent to the proximal urethra in the pelvic canal, there are a few small (1.1. cm), rounded, well-defined soft tissue attenuating and contrast medium enhancing nodules. The inguinal lymph nodes are moderately reduced in size compared to previous.

Impressions:
1. Urinary obstruction is attributed to a focal urethral stricture with secondary, severe urinary bladder enlargement, bilateral hydroureter, bilateral hydronephrosis and peritoneal and retroperitoneal fluid; this study is negative for urinary mineral
2. Mild inguinal and subiumbar lymphadenopathy; likely reactive

Reported by: Kristin Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR

6344	Miniature Schnauzer	11 years	M

Findings:

Computed tomography images of the thorax and abdomen pre and post-IV contrast medium administration are reviewed in transverse, sagittal, and dorsal planes.

ABDOMEN: In the mid-abdomen, there is a large (16.0 x 17. 4 x 9.2 cm; LWH), rounded, heterogeneously soft tissue attenuating and contract medium enhancing mass; the left caudal dorsolateral aspect of the mass is continuous with the caudal aspect of the spleen. That mass contains medium to large rounded regions that are peripherally hyperattenuating and enhancing and centrally hyperattenuating (17 HU) and non-enhancing. The margins of the mass are variably well-defined and surrounding the mass, there is a mild amount of peritoneal fluid. The mass causes severe caudal and lateral displacement of the intestinal tract and left lateral displacement a

In the cranial liver, craniodorsal and to the left of the gallbladder, the right dorsolateral, and left caudolateral aspects of the liver there are small (1.9 cm), rounded, poorly-defined, swattenuating and mildly heterogeneously contrast medium enhancing nodules. The ventral aspect of the gallbladder contains a small amount of mineral attenuating material. The hepatic lymph nodes are moderately enlarged, rounded, and heterogeneously contrast medium enhancing.

Bilaterally, the kidneys contain mild pin-point mineral attenuation. The kidneys are normal in margination and enhancement.

THORAX: The ventral aspect of the right middle lung lobe and the accessory lung lobe are mildly small and increased in attenuation. The remainder of the pulmonary parenchyma is normal in attenuation and no soft tissue nodules are identified. No intrathoracic lymphadenopathy is detected.

MUSCULOSKELETAL: The L5-S1 intervertebral disc extends moderately dorsally into the ventral aspect of the vertebral canal causing reduced ventral epidural fat; however, surrounding the the lateral and dorsal aspect of the nerve room, normal epidural fat remains.

Impressions:
1. This study confirms the presence of a large splenic mass, which may be due to malignant neoplasia (e.g. hemangiosarcoma) or benign etiologies (e.g. hematoma); mild peritoneal fluid is likely hemorrhage
2. Moderate splenic and hepatic lymphadenopathy is either metastatic or reactive
3. Hepatic nodules are most likely attributed to benign etiologies (e.g. nodular hyperplasia, extramedullary hematopoiesis)
4. Unremarkable lungs; this study is negative for pulmonary metastases from splenic mass
5. Incidental gallbladder mineral sediment
6. Bilateral renal mineral
7. Intervertebral disc protrusion without extradural nerve root compression, L7-S1

Reported by: Kristin Bruckner, DVM, Diagnostic Imaging Resident
Supervised by: Stacy D. Cooley DVM, DACVR

			Findings: Computed tomography images of the thorax pre-contrast and the abdomen pre- and post-contrast medium administration with arterial, portal, and venous phases are reviewed in transverse, sagittal, and dorsal planes. ABDOMEN: The liver is moderately enlarged and lobular. Multifocally throughout the liver, there are medium to large (15.2 x 9.1 x 9.3 cm; LWH), lobular to coalescing, variably well-defined masses. The masses are heterogeneously hypo to isoattenuating and heterogeneously hyperenhancing in all phases. The masses are predominantly in the left aspect of the liver (left lateral and left medial) and the largest mass extends caudal, causing a severe caudal convexity of the liver. In the right portions of the liver, are additional smaller masses that are isoattenuating with variable enhancement; some nodules are heterogeneously hypoenhancing and others are hyperenhancing. There are also several small, rounded, well-defined, hypoattenuating and non to hypoenhancing nodules. The hepatic lymph nodes are mildly enlarged (up to 0.9 cm) and lobular. The spleen contains many small (0.8 cm), rounded, iso to hypoattenuating and hyperenhancing nodules. The spleen remains normal in size and margination and no splenic lymphadenopathy is identified. Throughout the abdomen, there are small accumulation of homogeneous fluid in the peritoneal cavity, worse surrounding the liver and the caudally located hepatic mass. THORAX: Throughout the lungs, there are many pin-point mineral attenuating foci. The remainder of the pulmonary parenchyma is normal in attenuation and no soft tissue attenuating nodules are identified. No intrathoracic lymphadenopathy is identified. MUSCULOSKELETAL: Incompletely included in the images, the femoral epicondyles and trochlea have moderate well-defined periarticular bone formation and subchondral heterogeneity. The lumbosacral intervertebral disk is mildly dorsally displaced causing mildly reduced ventral epidural fat. Many vertebral bodies have moderate to severe well-defined bridging bone and at the lumbosacral intervertebral disk space, the bone extends dorsolaterally into the left and right intervertebral foramina. In the skin at the level of the caudoproximal right thigh and the left scapula, there are small (0.7 cm), rounded, soft tissue and fat attenuating and non-enhancing nodules. Impressions: 1. Lethargy is attributed to the multifocal hepatic masses, for which the primary differential is malignant neoplasia (hepatocellular carcinoma).Multifocal hepatic nodules may be metastatic or benign. Mild hepatic lymphadenopathy is metastatic or reactive. 2. Mild peritoneal fluid is likely hemorrhage 3. Splenic nodules are commonly benignca (e.g. extramedullary hematopoiesis, lymphoid hyperplasia) 4. Pulmonary osteomata, otherwise unremarkable thorax without pulmonary metastasis from hepatic masses 5. Moderate bilateral stifle degenerative joint disease 6. Lumbosacral intervertebral disk herniation and spondylosis deformans with foraminal stenosis 7. Non-specific cutaneous nodules
6345	Cattle Dog Mix	14 years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Stacy D. Cooley DVM, DACVR Findings: Computed tomography images of the abdomen are reviewed in transverse, sagittal, and dorsal planes and are compared to CT images performed May 26, 2017. Within the urethral lumen in the perineal region, approximately 1-2 cm distal to the ischiatic arch and proximal to the sigmoid flexure, are two small (0.4 cm), rounded, well-defined, mineral calculi, resulting in the pelvic urethra being moderately enlarged (2.5 cm) and contains homogeneous fluid. Within the penile urethra, the previously identified mineral focus is no longer identified. The penile urethra has a normal luminal size and is not enlarged. In the mid to caudoventral portion of the urinary bladder, there is a moderate amount of wispy to lobular soft tissue that spans from the left to right urinary bladder walls and is ventrally convex. The urinary bladder is moderately enlarged, rounded, and contains several (5-10) well-defined mineral attenuating foci, which are larger than the previously identified mineral attenuating sediment. The mineral attenuating foci are predominantly located along the ventral margin of the urinary bladder lumen; however, several are dorsal to the dependent portion of bladder and are located within the previously described intraluminal curvilinear soft tissue material. Th Bilaterally, the renal pelves are mildly enlarged (0.8 cm) and contain hyperattenuating fluid; questionable enlargement of the left diverticula is noted. The ureters are also mildly enlarged cranially. Bilaterally, the retroperitoneal fat had mild wispy soft tissue, worse caudally and surrounding the ureters. In the right retroperitoneal space, caudomedial to the kidney, is a small (0.8 cm), rounded, soft tissue and mineral attenuating nodule, which was previously non-mineralized. The inguinal lymph nodes are mildly rounded and larger than previous, with the left inguinal lymph nodes being larger than the right. The ventral portion of the L6-7 intervertebral disk contains mildly progressive mineral; this intervertebral disc space is wedge-shaped, being wide ventrally and the cranial endplate is subjectively cranioventrally angled. The intervertebral disc material is seen within the vertebral canal at this location. The lumbosacral region is transitional. Impressions: 1. Suspected urethral urolithiasis resulting in urethral obstruction. There is secondary bilateral hydroureter, pyelectasia, and retroperitoneal and peritoneal fluid. No evidence of bladder or urethral rupture is seen. 2. Urinary bladder intraluminal soft tissue may be attributed an accumulation of non-structured debris (e.g. hemorrhage, mucus) or indicate mucosal strauds (e.g. membranous cystitis) or less likely scar tissue from previous cystotomy. 3. Mild, asymmetric inguinal lymphadenopathy, likely reactive 4. L6-7 intervertebral disk degeneration without protrusion 5. Focal right retroperitoneal mineralizing granuloma
6346	Barbado Sheep	5 years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Lauren Newsom, DVM, DACVR Findings: Computed tomography images of the thorax and abdomen pre- and post-IV contrast medium administration are reviewed in transverse, sagittal, and dorsal planes. THORAX: Centered at the right 4th rib, there is a large (8.3 x 10.5 x 9.6 cm; LWH), locally extensive, lobular, variably-defined mass. The mass is heterogeneously soft tissue attenuating with multifocal wispy mineral and is heterogeneously contrast medium enhancing. The mass causes severe, locally extensive and expansive lysis of the ventral half of the right 4th rib and the costal cartilage with mild extension into the superficial extrathoracic tissues and effacement of the intercostal musculature. The right 3rd rib remains predominantly well-defined, but is moderately thin, reduced in attenuation, and craniolaterally convex due to lysis of the caudal cortex Bilaterally, there is mild left and moderate right pleural fluid that is homogeneous and non-contrast enhancing. The right pleural space also has a mild amount of homogeneous soft tissue with wispy to nodular regions of enhancement that is continuous with the costal pleura ventrally. In the region of the mass, the right cranial and middle lung lobes are caudally and dorsally displaced, moderately small and soft tissue attenuating causing border effacement of the vessels and air bronchograms. In the well-aerated portions of the lungs, no soft tissue nodules are identified. The sternal lymph nodes and a cranial mediastinal lymph node are moderately enlarged (2.4 cm), rounded, and heterogeneously contrast medium enhancing. The left tracheobronchial lymph nodes are mildly enlarged (1.2 cm), rounded, and peripherally contrast medium enhancing. The subcutaneous fat surrounding the sternum, axillary region and cranial mediastinum has moderately wispy soft tissue reducing margin definition of the soft tissue structures. ABDOMEN: No substantial abnormality is detected. MUSCULOSKELETAL: Bilaterally, the hips and shoulders have mild to moderate well-defined periarticular bone formation. On the proximal aspect of the right greater tubercle and at the insertion of the left iliopsoas muscle, there is mild, well-defined enthesophytosis. Impressions: 1. Locally extensive right thoracic body wall mass centered at the rightebth rib, for which the primary differential diagnosis is primary bone neoplasia (e.g. chondrosarcoma, osteosarcoma).This study is negative for nodular pulmonary metastasis. 2. Bilateral pleural fluid, neoplastic or hemorrhagic 3. Sternal, cranial mediastinal, and tracheobronchial lymphadenopathy, metastatic or reactive 4. Cranial mediastinal and ventral body wall edema is likely secondary to cranial vena cava occlusion 5. Pulmonary atelectasis 6. Bilateral moderate shoulder degenerative joint disease 7. Mild bilateral hip degenerative joint disease, right gluteal insertional enthesopathy, and left lesser trochanter insertional enthesopathy
6347	West Highland White Terrier	9 years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Lauren Newsom, DVM, DACVR Findings: CT images of the thorax and abdomen pre-and post-intravenous iodinated contrast medium administration are reviewed in transverse, sagittal, and dorsal planes. This study is compared to a previous CT performed on February 12, 2019. ABDOMEN: A mild motion artifact is noted within the cranial aspect of the abdomen. Seen previously, the spleen remains absent. The previously described ill-defined soft tissue nodules within the peritoneal fat which correspond with the peripheral splenic vasculature are similar in contrast enhancement and size. However, the soft tissue attenuating nodules along and adjacent to the mid to caudoventral abdominal body wall are mildly larger (up to 1.9 cm x 1.5 cm) and increased in number (i.e. right cranial abdomen).The splenic vein and portal vein thrombus is persistent with similar luminal filling defects; approximately 1/6-1 /3 of the extrahepatic porti During the recheck interval, the nodular heterogeneity of the hepatic parenchyma is mildly increased such that the hyperattenuating and hypoenhancing nodules are mildly larger and new nodules are identified within both the left and right aspects of the liver. The left kidney has similar, multifocal, concave cortical defects adjacent to regions of reduced enhancement. The intra-abdominal lymph nodes remain normal in size, margination, and contrast e enhancement. THORAX: When compared to previous, the numerous soft tissue attenuating pulmonary nodules have increased in size (up to 1 cm and previously reported up to 0.7 cm) and number while remaining predominantly within the ventral periphery and being mildly contrast medium enhancing. The mediastinum and pleural spaces are unremarkable as there is no evidence of intrathoracic lymph node enlargement. Seen previously, the small myocardial hypoattenuating and hyperenhancing nodules are present and similar in size. MUSCULOSKELETAL: The previously reported oval and heterogeneously mineralized C7-T1 and L3-4 intervertebral discs are similar to previous. Seen previously, at L1-L2 the spinal cord is mildly right dorsally displaced due to dorsal displacement of the associated mineralized disc. The L2-L3 intervertebral disc space remains to have a small volume of gas ventrally. Throughout the cervical spine, centered at the articular joints, there is moderate, well-defined, angular to curvilinear new bone formation projecting axially, resulting in the vertebral canal being mildly square-shaped. The articular joint surfaces are mildly curvilinear, yet remain well-defined. The cervical spinal cord remains centrally located and surrounded by epidural fat. Bilaterally, at the insertion of the supraspinatus tendon, there is moderate, multifocal well-defined mineralization. A new subcutaneous soft tissue nodule is present to the right of the anus. Additionally, within the muscle cranial to the left hip, there is a similar, heterogeneously enhancing region. Impressions: 1. Mildly progressive, multifocal, and new metastatic pulmonary and peritoneal nodules 2. Progressive, multifocal nodular hepatopathy (e.g. cyst or metastatic hemangiosarcoma) 3. Previous splenectomy with similar thrombus formation in the splenic and portal veins. The results of this study remain negative for portal hypertension. 4. Subcutaneous and intramuscular enhancing nodules of unknown clinical significance; hemangiosarcoma metastasis is possible 5. Similar, mild, left renal scarring 6. Similar, multifocal cervical and thoracolumbar intervertebral disc degeneration with L1-L2 disc protrusion 7. Moderate cervical spondylomyelopathy 8. Similar, multifocal, myocardial nodules (i.e. fatty degeneration) 9. Moderate bilateral supraspinatus insertional enthesopathy
6348	German Shepherd	8.5 years	M	Reported by: Kristen Fleming, DVM, Diagnostic Imaging Resident Supervised by: Lauren Newsom, DVM, DACVR Findings: Computed tomography images of the right thoracic distal limb pre- and post-IV contrast medium administration with arterial and venous phases are reviewed in transverse, sagittal, and dorsal planes. In the dorsal aspect of the lateral lobe of the deep digital flexor tendon, extending approximately 2.0 cm proximally from the level the proximal third of the navicular bone, there is a medium (series 28, image 50), poorly-defined, hypoattenuating region that is peripherally enhancing in the arterial phase. In this region, the cranial margins of the lateral lobe of the deep digital flexor tendon are ill-defined and the fat dorsal to the tendon has wispy soft tissue. The lateral lobe of the deep digital flexor tendon is mildly enlarged compared to the medial lobe. Proximal to the proximal interphalangeal joint, the deep digital flexor tendon is normal in size, marginatio In the distal axial aspect of the navicular bone, there is a medium (9.5 cm) lobular lucent region surrounding by a thin rim of sclerosis. The remainder of the medullary cavity is normal in attenuation. Distal to the mid to lateral aspect of the navicular bone, is a small (0.2 cm), rounded, well-defined, mineral attenuating fragment. Adjacent to the fragment, the distal margin of the navicular bone is mildly irregular with subchondral sclerosis. The flexor margin of the navicular bone is smooth, well-defined, and normal in attenuation. The lateral extremity of the navicular bone has a tiny enthesophyte. The distal margins of the proximal interphalangeal joint have mild well-defined periarticular bone formation. The dorsodistal aspect of the sagittal ridge of the 3rd metacarpal bone is a focal region of reduced attenuation surrounded by mild sclerosis. The metacarpophalangeal joint remains smooth and well-defined and the intracapsular soft tissues are normal in size. At the dorsomedial aspect of the hoof wall, extending from the deep margin of the insensitive lamina into the sensitive lamina, there are two, linear regions of hyperattenuation, parallel with the dorsal hoof wall and dorsomedial margin of the distal phalanx. The adjacent distal phalanx has a tiny, well-defined and smooth concavity. The medial and lateral branches of the suspensory ligaments are similar in size, margination, attenuation, and enhancement. The entheses of the suspensory ligament origin and insertion are smooth and well-defined. Proximal to the metacarpophalangeal joint and proximal sesamoid bones, well-opacified blood vessels are seen along the lateral margins of the flexor tendons and extending into the central aspect of the deep digital flexor tendon; both flexor tends remain normal in shape, uniform and subjectively normal in size with well-defined margins and a subjectively normal amount of fluid in the tendon sheath. Impressions: 1. Recurrent lameness is likely multifactorial but is predominantly attributed to the locally extensive core lesion of the lateral lobe of the right deep digital flexor tendon 2. Mild right navicular degenerative soft tissue injury and minimal lateral collateral enthesopathy, may also contribute to lameness. The small fragment may be a small avulsion of the impar ligament or dystrophic mineralization 3. Subchondral cystic-like lesion or remodeling/lysis of the sagittal ridge of the right3rd metacarpal bone without intracapsular swelling or degenerative joint disease is unlikely a cause of clinical signs 4. Suspect hoof wall hypoplasia; no mass is seen but an early keratoma is possible 5. Minimal proximal interphalangeal degenerative joint disease
6349	Appaloosa Horse	10 years	M	Reported by: Krista Bruckner, DVM, Diagnostic Imaging Resident Supervised by: Stacy D. Cooley DVM, DACVR This full body CT scan includes 464 DICOM files of a male Brachaelurus waddi specimen housed in the spirit collection of the British Natural History Museum, London with registration number BMNH 1890.9.23.233. The specimen is scanned in a medical CT scanner (Siemens Sensation 64) at the Royal Brompton Hospital, London at 100 kV and 210 mAs with a slice thickness of 1.00 mm.
6414	Blind Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Brachaelurus waddi (BMNH 1890.9.23.233). figshare. Dataset. This full body CT scan includes 1300 DICOM files of a male Echinorhinus brucus specimen housed in the spirit collection of the British Natural History Museum, London with registration number BMNH 1900.11.6.7. The specimen is scanned in a medical CT scanner (Siemens Sensation 64) at the Royal Brompton Hospital, London at 100 kV and 210 mAs with a slice thickness of 1.00 mm.
6415	Bramble Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of an Echinorhinus brucus (BMNH 1900.11.6.7). figshare. Dataset. This full body CT scan includes 1275 DICOM files of a female Chlamydoselachus anguineus specimen housed in the spirit collection of the British Natural History Museum, London with registration number BMNH 1935.2.26.1. The specimen is scanned in a medical CT scanner (Siemens Sensation 64) at the Royal Brompton Hospital, London at 100 kV and 210 mAs with a slice thickness of 1.00 mm.
6416	Frilled Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Chlamydoselachus anguineus (BMNH 1935.2.26.1). figshare. Dataset. This full body CT scan includes 1373 DICOM files of a female Centrophorus seychellorum specimen housed in the spirit collection of the British Natural History Museum, London with registration number BMNH 1973.7.9.12. The specimen is scanned in a medical CT scanner (Siemens Sensation 64) at the Royal Brompton Hospital, London at 100 kV and 210 mAs with a slice thickness of 1.00 mm.
6417	Seychelles Gulper Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Centrophorus seychellorum (BMNH 1973.7.9.12). figshare. Dataset. This CT scan of the head includes 1228 DICOM files of a Cetorhinus maximus specimen housed in the spirit collection of the British Natural History Museum, London with registration number BMNH 1978.6.22.1. The specimen is scanned in a medical CT scanner (Siemens Sensation 64) at the Royal Brompton Hospital, London at 100 kV and 210 mAs with a slice thickness of 1.00 mm.
6418	Basking Shark	Unknown	Unknown	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): CT scan of the head of a Cetorhinus maximus (BMNH 1978.6.22.1). figshare. Dataset. This full body CT scan includes 773 DICOM files of a female Oxynotidae japonicus specimen housed in the spirit collection of the British Natural History Museum, London with registration number BMNH 1982.11.1.90. The specimen is scanned in a medical CT scanner (Siemens Sensation 64) at the Royal Brompton Hospital, London at 100 kV and 210 mAs with a slice thickness of 1.00 mm.
6419	Japanese Wobbegong Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of an Oxynotidae japonicus (BMNH 1982.11.1.90). figshare. Dataset. This full body CT scan includes 468 DICOM files of a male Apristurus laurussonii specimen housed in the spirit collection of the British Natural History Museum, London with registration number BMNH 1987.1.21.3. The specimen is scanned in a medical CT scanner (Siemens Sensation 64) at the Royal Brompton Hospital, London at 100 kV and 210 mAs with a slice thickness of 1.00 mm.
6420	Atlantic Ghost Catshark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of an Apristurus laurussonii (BMNH 1987.1.21.3). figshare. Dataset. This full body CT scan includes 840 DICOM files of a female Centroscymnus cryptacanthus specimen housed in the spirit collection of the British Natural History Museum, London with registration number BMNH 2000.2.24.4. The specimen is scanned in a medical CT scanner (Siemens Sensation 64) at the Royal Brompton Hospital, London at 100 kV and 210 mAs with a slice thickness of 1.00 mm.
6421	Longnose Velvet Dogfish	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Centroscymnus cryptacanthus (BMNH 2000.2.24.4). figshare. Dataset. This full body CT scan includes 911 DICOM files of a male Heterodontus japonicus specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.4202. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6422	Japanese Bullhead Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Heterodontus japonicus (RMNH.PISC.4202). figshare. Dataset. This full body CT scan includes 803 DICOM files of a female Pristiophorus japonicus specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.4158. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6423	Japanese Sawshark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Pristiophorus japonicus (RMNH.PISC.4158). figshare. Dataset. This full body CT scan includes 840 DICOM files of a female Chaenogaleus macrostoma specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.7389.a. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6424	Hooktooth Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Chaenogaleus macrostoma (RMNH.PISC.7389.a). figshare. Dataset. This full body CT scan includes 1442 DICOM files of a female Hemigaleus microstoma specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.7390. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6425	Sicklefin Weasel Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Hemigaleus microstoma (RMNH.PISC.7390). figshare. Dataset. This full body CT scan includes 905 DICOM files of a male Sphyrna lewini specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.7393.d. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6426	Scalloped Hammerhead Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Sphyrna lewini (RMNH.PISC.7393.d). figshare. Dataset. This full body CT scan includes 1789 DICOM files of a female Stegostoma fasciatum specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.7401.b. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6427	Zebra Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Stegostoma fasciatum (RMNH.PISC.7401.b). figshare. Dataset. This full body CT scan includes 896 DICOM files of a female and male Chiloscyllium indicum specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.7406.a and RMNH.PISC.7406.b respectively. The specimens are scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6428	Slender Bamboo Sharks	Unknown	Female and Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of 2 Chiloscyllium indicum specimens (RMNH.PISC.7406.a+b). figshare. Dataset. This full body CT scan includes 1226 DICOM files of a female Eucrossorhinus dasypogon specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.7411. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6429	Tasselled Wobbegong Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of an Eucrossorhinus dasypogon (RMNH.PISC.7411). figshare. Dataset. This full body CT scan includes 748 DICOM files of a male Eupromicrus bispinatus specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.17804. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6430	Pygmy Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of an Eupromicrus bispinatus (RMNH.PISC.17804). figshare. Dataset. This full body CT scan includes 1310 DICOM files of a female Galeus mullerrostan specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.23617. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6431	Blackmouth Catshark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Galeus mullerrostan (RMNH.PISC.23617). figshare. Dataset. This full body CT scan includes 2336 DICOM files of a male Galeorhinus galeus specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.23690. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6432	School Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Galeorhinus galeus (RMNH.PISC.23690). figshare. Dataset. This full body CT scan includes 591 DICOM files of a male Etmopterus spinax specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.24057.b. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6433	Velvet Belly Lanternshark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of an Etmopterus spinax (RMNH.PISC.24057.b). figshare. Dataset. This full body CT scan includes 777 DICOM files of a female Haliutaeus boucomani specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.33989. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6434	Speckled Catshark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of a Haliutaeus boucomani (RMNH.PISC.33989). figshare. Dataset. This full body CT scan includes 1155 DICOM files of a female Atelomycterus marmoratus specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.34027. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6435	Coral Catshark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelslejus, Jacob (2017): Full body CT scan of an Atelomycterus marmoratus (RMNH.PISC.34027). figshare. Dataset.

Anatomage Table 9.0 Case Library Descriptions

				This CT scan of the head includes 516 DICOM files of a Primaeae glauca specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.34044. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6436	Blue Shark	Unknown	Unknown	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): CT scan of the head of a Primaeae glauca (RMNH.PISC.34044). figshare. Dataset. This full body CT scan includes 925 DICOM files of a female Anthonycetus machaeyi specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.34078.b. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6437	Australian Marbled Catshark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of an Anthonycetus machaeyi (RMNH.PISC.34078.b). figshare. Dataset. This full body CT scan includes 642 DICOM files of a male Carcharhinus hemiodon specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.34102. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6438	Pondicherry Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Carcharhinus hemiodon (RMNH.PISC.34102). figshare. Dataset. This full body CT scan includes 594 DICOM files of 2 specimens. The left specimen is a female Scyliorhinus canicula housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.34107. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6439	Small-Spotted Catsharks	Unknown	Female and Unknown	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Scyliorhinus canicula (RMNH.PISC.34107). figshare. Dataset. This full body CT scan includes 932 DICOM files of a male and female Hemiscyllium trispeculare specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.35295.a and RMNH.PISC.35295.b respectively. The specimens are scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6440	Speckled Carpetsharks	Unknown	Male and Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of 2 specimens of Hemiscyllium trispeculare (RMNH.PISC.35295.a & RMNH.PISC.35295.b). figshare. Dataset. This full body CT scan includes 869 DICOM files of a male Sphyrna tiburo specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.37209. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6441	Bonnethead Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Sphyrna tiburo (RMNH.PISC.37209). figshare. Dataset. This full body CT scan includes 873 DICOM files of a male Sphyrna corona specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.37210. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6442	Scalloped Bonnethead Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Sphyrna corona (RMNH.PISC.37210). figshare. Dataset. This full body CT scan includes 755 DICOM files of a female Isistius brasiliensis specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.37689. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6443	Cookiecutter Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of an Isistius brasiliensis (RMNH.PISC.37689). figshare. Dataset. This full body CT scan includes 1867 DICOM files of a female Scymnodalatia albicauda specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.37980. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6444	Whitetail Dogfish	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Scymnodalatia albicauda (RMNH.PISC.37980). figshare. Dataset. This full body CT scan includes 1544 DICOM files of a female Deania calcea specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.37981. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6445	Birdbeak Dogfish	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Deania calcea (RMNH.PISC.37981). figshare. Dataset. This full body CT scan includes 868 DICOM files of a female Sphyrna tudes specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands without a registration number. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6446	Smalleye Hammerhead Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Sphyrna tudes. figshare. Dataset. This full body CT scan includes 1193 DICOM files of a male Euaphyra blochii specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.108685. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6447	Winghead Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of an Euaphyra blochii (ZMA.PISC.108685). figshare. Dataset. This full body CT scan includes 2916 DICOM files of a female Squatina africana specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.108696. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6448	African Angelshark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Squatina africana (ZMA.PISC.108696). figshare. Dataset. This full body CT scan le includes 604 DICOM files of a female Ginglymostoma cirratum specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.108710. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6449	Nurse Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Gingliymostoma cirratum (ZMA.PISC.108710). figshare. Dataset. This full body CT scan includes 1051 DICOM files of a female Mustelus mustelus specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.109497. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6450	Common Smooth-Hound Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Mustelus mustelus (ZMA.PISC.109497). figshare. Dataset. This full body CT scan includes 1272 DICOM files of a female Oxynotus centrina specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.110745. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6451	Angular Roughshark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of an Oxynotus centrina (ZMA.PISC.110745). figshare. Dataset. This CT of the head and fins includes 872 DICOM files of a Carcharhinus melanopterus specimen and comprises the head, pectoral fins and caudal fin. The specimen is housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.111010. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6452	Blacktip Reef Shark	Unknown	Unknown	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): CT scan of head & fins of a Carcharhinus melanopterus (ZMA.PISC.111010). figshare. Dataset. This full body CT scan includes 653 DICOM files of a female Squalus cubensis specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.111207. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6453	Cuban Dogfish	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Squalus cubensis (ZMA.PISC.111207). figshare. Dataset. This full body CT scan includes 889 DICOM files of a male Isogomphodon oxyrhynchus specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.111240. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6454	Daggernose Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of an Isogomphodon oxyrhynchus (ZMA.PISC.111240). figshare. Dataset. This full body CT scan includes 1973 DICOM files of a female Hypnos monopterygius specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.111361. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6455	Sharpnose Sevengill Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Heptranchias perlo (ZMA.PISC.111361). figshare. Dataset. This full body CT scan includes 1006 DICOM files of a female Rhinoprionodon terraenovae specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.111362. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6456	Atlantic Sharpnose Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Rhinoprionodon terraenovae (ZMA.PISC.111362). figshare. Dataset. This full body CT scan includes 2239 DICOM files of a male Dalatias licha specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.112272. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6457	Kitefin Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Dalatias licha (ZMA.PISC.112272). figshare. Dataset. This full body CT scan includes 2394 DICOM files of a female Triakis semifasciata specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.114250. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6458	Leopard Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Triakis semifasciata (ZMA.PISC.114250). figshare. Dataset. This full body CT scan includes 742 DICOM files of a female Nebrius ferrugineus specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.114675. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6459	Tawny Nurse Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Nebrius ferrugineus (ZMA.PISC.114675). figshare. Dataset. This full body CT scan includes 500 DICOM files of a female Chiloscyllium indicum specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.114781. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6460	Slender Bamboo Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Chiloscyllium indicum (ZMA.PISC.114781). figshare. Dataset. This full body CT scan includes 1310 DICOM files of a male Lamna nasus specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.116165. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6461	Porbeagle Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Lamna nasus (ZMA.PISC.116165). figshare. Dataset. This full body CT scan includes 1873 DICOM files of a female Primaeae glauca specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.116203. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6462	Blue Shark	Unknown	Female	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Primaeae glauca (ZMA.PISC.116203). figshare. Dataset. This full body CT scan includes 1124 DICOM files of a male Chiloscyllium arabicum specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number ZMA.PISC.140443. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6463	Arabian Carpetshark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Chiloscyllium arabicum (ZMA.PISC.140443). figshare. Dataset. This full body CT scan includes 2170 DICOM files of a male Carcharhinus leucas specimen housed in the spirit collection of Naturalis Biodiversity Center, Leiden, the Netherlands with registration number RMNH.PISC.24271. The specimen is scanned in a medical CT scanner (Toshiba Aquilion 64) at the Leiden University Medical Center, the Netherlands at 100 kV and 150 mAs with a slice thickness of 0.5 mm.
6464	Bull Shark	Unknown	Male	Brazeau, Martin; Kamminga, Pepijn; De Bruin, Paul W.; Gelsjins, Jacob (2017): Full body CT scan of a Carcharhinus leucas (RMNH.PISC.24271). figshare. Dataset.]
7000	Brain - Case 0001 (With Segmentation)	unknown	unknown	Interval placement of an aorto-bi-iliac metallic stent graft into an inflammat abdominal aortic aneurysm. The stent graft originates just below the right renal artery and a stent is seen extending laterally into the left renal artery. The celiac, SMA, and bilateral renal arteries are patent. A large endoleak is noted at the junction of the aortic and iliac portions of the stent graft. We cannot ascertain the continuity between these two components namely the aortic and iliac components. The graft ends in the bilateral common iliac arteries. The approximate maximal diameter measured on Series 3, Image 174 of the aortic aneurysm measured at Series 3, Image 174 is 4.8 x 3.6 cm (please note that 3-D orthogonal measurements will be provided) and these are grossly within range of the previous measurements provided. A soft tissue density measuring 2.8 x 1.8 cm seen on Series 3, Image 369 over the right groin soft tissues likely represents a soft tissue hematoma perhaps from the puncture site. Within the thorax there is interval development of small bilateral pleural effusions. The visualized portions of the lung bases are otherwise unremarkable, respiratory motion does degrade the images. The liver is unremarkable. There is vicarious secretion of contrast into the gallbladder. The pancreas appears atrophic. There are multiple punctate calcifications noted within the spleen consistent with splenic granulomata. The visualized portions of the small and large bowel appear grossly unremarkable. The bilateral kidneys enhance symmetrically. 1. Interval placement of aortbi-iliac stent graft for infrarenal abdominal aortic aneurysm with a large endoleak noted at the junction of the aortic and iliac components of the stent graft. We cannot ascertain continuity between these aortic and iliac components. The graft ends at the bilateral common iliac arteries. 2. There are small bilateral new pleural effusions. 3. Small 1.8 x 2.8 cm right groin soft tissue hematoma possibly from puncture site noted. 4. Left proximal renal artery stent with bilateral single renal arteries patent. Report: Volume rendered, curved planar reformations, minimum intensity projections were acquired. The orthogonal dimension of the aorta at the maximum diameter at the level of L3 measures 43 x 38 mm. Total aneurysm volume is 87 cc. These are likely unchanged from the prior exam. Attention on follow-up.
7001	Aneurysm with Endoleak - Case 0053 (With Segmentation)		73 Male	35 year old female with history of subglottic and left main stem bronchus narrowing status post- stent placement. Mediastinum: Few small lymph nodes, none pathologic by size criteria. Normal heart size. No pericardial effusion. Chest wall: No axillary lymphadenopathy. No pleural effusion. Ribs and bony structures are unremarkable. Lungs: Interval stent placement in the left main stem bronchus with improved caliber of the prior high-grade stenosis. 17 mm of the proximal left main stem bronchus not covered by this stent has approximately 50% stenosis. Left upper lobe with slightly worse bronchial wall thickening and airway narrowing. Superior and inferior lingular bronchi again with mucous impaction. New small parenchymal opacity in the inferior lingular segment probably represents inflammatory process. Right lung with bronchial wall thickening similar to the left bronchi, with the right upper lobe bronchus slightly worse in wall thickening. Question polypoid lesion in the right main stem bronchus producing mild stenosis.
7002	Bronchial Stent - Case 0131 (With Segmentation)		35 Female	Visualized abdomen: Nonocontrast examination unremarkable. 1. Interval left main stem bronchus stent placement with improved caliber at the stent site. Proximal left main stem bronchus not covered by stenct has approximately 50% stenosis. 2. New small parenchymal opacity visualized in the inferior segment of the lingula probably represents inflammatory change. 3. Right upper lobe bronchus with question of polypoid wall thickening producing mild stenosis. 4. Bronchial thickening seen throughout the bilateral bronchi with the right upper lobe component slightly worse.
7003	Tetralogy of Fallot - Case 0165 (With Segmentation)		3 Female	A three-year-old female with tetralogy of Fallot, MAPCAs, Alagille syndrome, juvenile rheumatoid arthritis, status post bilateral unifocalization revision with Blalock-Taussig shunt, status post shunt dehiscence and re-operation 2011, now with septic shock and evidence of splenic infarction on ultrasound. Evaluate for vascular abnormality, thromboembolic disease, vasculitis, abscess. Instrumentation: Stemal wires, endotracheal tube in appropriate position, right-sided power PICC with tip at SVC/atrial junction, gastrostomy tube, left femoral venous catheter ending at the left common iliac, mediastinal surgical clips, and right-sided chest tube are in place. Situs: There is a left upper quadrant spleen, diffusely infarcted, only a very small region of normally-enhancing tissue remaining approximate to the hilum. There is situs solitus by atrial appendage morphology. Cavae: There are patent and normal-caliber right-sided SVC and IVC terminating in the right atrium, unobstructed. Pulmonary veins: There are 2 right and 1 left pulmonary veins draining unobstructed into a normal-appearing left atrium. Atria: There is mild right atrial enlargement. The left atrium is normal in caliber. Based on technique, cannot exclude interatrial communication. Atrioventricular connection: AV relationship is concordant. Two separate and normally-positioned inlet valves are identified. Ventricles: There is evidence for right ventricular hypertrophy. There is a malalignment VSD. The left ventricle is otherwise unremarkable in appearance. The ventricles are D-loop, levocardia. Ventriculoarterial connection: There is an overriding aorta, consistent with tetralogy of Fallot. There is pulmonary atresia. Coronary arteries: Two sets of coronary arteries are present emanating from the facing cusps. There is mild clockwise rotation orientation of the aortic root with consequent clockwise-appearing rotation of the coronary artery origins, which nevertheless originate from the appropriate cusps. There is a normal-appearing LAD branching from the left main coronary artery. Coronary arteries are right-sided dominant. Aorta: There is a left-sided aortic arch. What appears to be surgical materials lie immediately adjacent to the left-sided contour of the ascending aorta. The appearance is consistent with recent surgical repair. There is an abrupt caliber change at the ascending aorta/proximal arch junction, the ascending aorta measuring 8 mm, the proximal-to-mid arch 13 mm, likely related to the surgical repair. There is three-vessel supra-arch cervical branching. A Blalock-Taussig shunt is present from the innominate artery to the right pulmonary artery. There is no evidence for coarctation or patent ductus arteriosus. The descending aorta to the hiatus is normal in caliber an Pulmonary arteries: A widely-patent 5-mm diameter graft is present from the innominate to the right pulmonary artery. There are surgically-created, centrally-confluent pulmonary arteries, widely patent, the narrowest point at the central confluence measuring approximately 6 mm. The right and left pulmonary arteries and branch pulmonary arteries appear to be patent. Airways: The central airways and peripheral airways appear widely patent with normal architecture. Lungs: There is a localized pleural effusion within the major fissure measuring approximately 4 cm anterior-posterior x 5.1 cm transverse x 2.7 cm anterior-posterior, accounting for the right lower lung opacity seen on chest x-ray. There is localized complex/thickened material layering along the right pleural margin, with multiple gas bubbles contained it, possibly tracking from the chest tube insertion site. The chest tube pigtail lies deep within the right lower lung sulcus medially, remote from either the effusion or the pneumothorax. There is a localized pneumothorax measuring 4.9 cm anterior-posterior x 3.6 cm transverse x 2 cm craniocaudal, accountin Mediastinum: There is a 6-mm pericardial lymph node. No paricardial effusion is present. There are mildly prominent soft tissues surrounding the ascending aorta and proximal arch, with no evidence for mediastinal fluid collection to suggest abscess. Thoracic wall: There are multiple enlarged bilateral axillary lymph nodes. A right-sided chest tube is in place. There is no evidence for subcutaneous emphysema. Supraclavicular soft tissues are unremarkable. Chest wall osseous structures are unremarkable. Abdomen and pelvis vasculature: The abdominal aorta is of somewhat narrow caliber, but normal in course and patent to the iliac bifurcation. Branching vessels of the abdominal aorta are markedly narrowed, likely due to vasoconstriction, most notably the origin of the celiac trunk which is severely narrowed to approximately 1 mm, widening to approximately 1.8 mm proximal to the normal-appearing bifurcation into the splenic and common hepatic arteries. There is conventional branching of the hepatic arteries. The splenic artery is patent to the splenic hilum. The superior mesenteric artery is also narrowed, vasoconstricted, normal in distribution. The c The IMV, SMV, portal and splenic veins, and renal veins appear widely patent, best seen on delayed-phase imaging. Abdomen and pelvis soft tissue: The liver, gallbladder, pancreas, kidneys, stomach, retroperitoneum, colon, urinary bladder, and pelvic floor are unremarkable. Oral contrast is present throughout the small bowel. There is minimal small bowel distension, possibly suggesting mild ileus. There is no evidence for ascites nor for any other abnormal intraabdominal or pelvic fluid collections to suggest abscess. Chest wall soft tissues are unremarkable. Note is made of gastrostomy tube with balb inflated in the stomach body. Osseous structures are unremarkable. 1. Native anatomy consistent with tetralogy of fallot, pulmonary atresia, and aortopulmonary collaterals. 2. Status post unifocalization, and Taussig-Blalock shunt from innominate artery to right pulmonary artery. Central pulmonary arterial reconstruction. 3. Widely-patent shunt and pulmonary arterial arborization. 4. Right lung localized effusion and loculated pneumothorax as described. 5. Bilateral pulmonary nodules, largest in the right middle lobe 6. Infarction of the majority of the spleen. 7. Diffuse vasoconstriction. None available
7004	Takayasu Arteritis - Case 0198 (With Segmentation)	unknown	Female	Vasculature: Demonstrated circumferential soft tissue thickening surrounding the cervical branch vessels including the right subclavian, left common carotid, and left subclavian arteries. A common origin of the right brachiocephalic and left common carotid artery is again identified. There is persistent high grade at least 95% stenosis of the right common carotid artery, left common carotid artery, left subclavian artery which is difficult to quantify but appears worse on the current exam. The right brachiocephalic artery is narrowed but appears patent. There is persistent mild soft tissue thickening of the proximal descending thoracic aorta, unchanged from 57-year-old female with history of congenital hypertrophic cardiomyopathy -Ascending aortic arch repair with Dacron graft and PDA ligation -Subaortic membrane resection -Degenerative changes of spine -St. Jude prosthetic mechanical aortic valve
7005	Hypertrophic Cardiomyopathy - Case 0204 (With Segmentation)		57 Female	Scan resolution (mm): 0.59 X 0.59 X 0.63 Scan size (mm): 300.0 X 300.0 X 563.1 The abdominal aorta, celiac artery, superior mesenteric artery, and inferior mesenteric artery are patent. The left gastric artery again arises from the descending aorta. Conventional hepatic arterial anatomy is present. There are single bilateral renal arteries, patent. 1. Diffuse cystic and cylindrical bronchiectasis, peripheral mucous plugging and centrilobular nodularity within the right lung, most prominent in the right upper and middle lobes with associated air trapping. These findings are all consistent with patient's history of cystic fibrosis. 2. No focal consolidation or pneumothorax.
7006	Cystic Fibrosis - Inspiration - Case 0235 (With Segmentation)	unknown	Female	Right lung: There has been interval moderate increase in bronchial wall thickening and mucoid impaction in the right upper lobe. The degree of bronchiectasis in the right upper lobe is grossly unchanged and appears moderate to severe. There is new inferior RUL consolidation. There has been interval significant increase in bronchial wall thickening, mucoid impaction, and airspace consolidation in the right middle lobe. The appearance is compatible with a significant acute exacerbation of disease. There is mild bronchiectasis and mucoid impaction in the superior right lower lobe. The inferior portions of the right lower lobe appear slightly improved compared to prior study and appear relatively normal. Left lung: There is very mild bronchiectasis and mucoid impaction in the left upper lobe and lingula. There is very minimal bronchial wall thickening in the left lower lobe. Overall, the degree of involvement in the left lung is markedly less than in the right lung. No pleural effusions are seen. On expiratory images, there is patchy air trapping in the lungs, most pronounced in the right middle lobe and posterior left lower lobe. The heart size is normal. Several lymph nodes are seen posterior to the superior vena cava. The right hilum appears slightly full, possibly representing lymphadenopathy, thought full evaluation is limited by lack of intravenous contrast. Limited visualized of the upper abdomen, including portions of the liver, pancreas, spleen, and stomach, is grossly unremarkable. The pancreatic gland does not appear significantly atrophied.
7007	Cystic Fibrosis - Expiration Case 0236 (With Segmentation)	unknown	Female	The visualized osseous structures demonstrate no suspicious lytic or sclerotic lesions. 1. Diffuse cystic bronchiectasis with mucous plugging and air trapping in the right middle lobe and right upper lobe. This is characterized by increased bronchial wall thickening, bronchiectasis, mucoid impaction as well as airspace consolidation. 2. Interval slight decrease in disease in the inferior portions of the right lower lobe. 3. The degree of involvement of the left lung is markedly less compared to the right lung, as before. Deep vein thrombosis: Filter in IVC to block emboli going to heart and lungs. Analysis: - Presence of an inferior vena cava filtrum suggestive of risk of pulmonary embolism. - Superficial femoral artery occlusion at its origin. - Calcification of abdominal aorta. - The others scanned structures appear normal within the limits of the technique.
7008	Pelvic Runoff - Case 0249 (With Segmentation)		19 Male	Analysis provided by Universit degli Studi de L'Aquila (Prof. Maccharielli, Prof. Bianchi and Dr.Bernardi)

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			There has been interval placement of an aorto-bi-iliac stent graft which commences immediately below the level of the celiac axis and extends to the distal portion of the common iliac arteries bilaterally. Bilateral renal artery snorkel stent grafts have been placed. The renal arteries appear patent bilaterally. The superior pole of the left kidney demonstrates patchy inhomogeneous contrast enhancement. A wedge-shaped area of decreased attenuation is identified in the interpolar region of both kidneys. A trace amount of left perinephric fluid is present. Innumerable small peripheral cortical hypodensities are present in both kidneys, suspicious for microemboli
			Significant calcified and noncalcified mural thrombus is noted in the distal descending thoracic aorta and supra-celiac abdominal aorta. The native abdominal aortic aneurysm sac measures 5.3 x 5.3 cm and contains a small amount of air. No obvious endoleak is identified. The origin of the SMA is adjacent to the superior metal marker of the aortic stent graft and resultant metal artifact, obscuring the SMA ostium. There is abrupt caliber change in the distal SMA noted immediately distal to the duodenum. A Foley catheter is noted in the urinary bladder.
			Mild subcutaneous emphysema and post operative changes are noted anterior to the visualized femoral vessels, compatible with recent bilateral catheterization.
			There is a filling defect involving the proximal portion of the IMA.
			There is mild bowel wall thickening of the descending and sigmoid colon. There is no obvious pericolonic fat permeation. The superior hemorrhoidal artery and left colic artery are patent.
			There is redemonstration of the 2.9-cm hypoattenuating lesion in the right hepatic lobe which demonstrates discontinuous and peripheral nodular enhancement on this arterial phase study. This most likely represents a hemangioma. Note is again made of nodularity of the left adrenal gland.
			Note is made of vicarious excretion of contrast material into the gallbladder and extrahepatic biliary system, which can be traced into the duodenum. A Foley catheter is noted in the urinary bladder.
			There is no free fluid in the abdomen or pelvis.
			Limited images of the lung bases redemonstrates mild peripheral bronchiolectasis. Bilateral lower lobe dependent areas of subsegmental atelectasis are noted. Negative for pleural effusions. The visualized heart chambers are unremarkable. Negative for pericardial effusion.
7009	Gallbladder with Contrast - Case 0254 (With Segmentation)	unknown	The visualized osseous structures are unremarkable. 1. Status post placement of an abdominal aortobiiliac stent graft with bilateral renal artery snorkel stent grafts. 2. Innumerable bilateral renal cortical hypodensities are suspicious for microembolic phenomenon from shedvering of cholesterol emboli potentially from thetracsabdominal atherosclerotic disease. Larger areas of inhomogeneous parenchymal enhancement in the upper pole of the left kidney and interpolar regions of both kidneys likely reflect sequela of ischemia/infarction. Persistent nephrographic phase of both kidneys on the initial noncontrast images can be seen in ATN [acute tubular necrosis], which may be superimposed on the aforementioned findings. 3. Focal dissection of the distal SMA just distal to the ileo-colic artery origin. Metal artifact from the metal marker of the superior aortic stent obscures the SMA ostium. 4. Mild bowel wall thickening of the descending and sigmoid colon with proximal IMA occlusion. The radiographic findings are concerning for watershed bowel ischemia.
		Female	Severe Pulmonary HTN patient with chest pain, c/o coronary artery compression by enlarged pulmonary artery. Cardiac and great vessels: Since the prior exam, no significant interval change in seen in the caliber and contour of the aorta or the main pulmonary artery, which is markedly dilated (35 mm). Please note, orthonormal measurements will be added by 3D-laboratory. There is minimal enlargement of the right ventricle with hypertrophy, which is essentially unchanged compared to the prior exam. Right atrial enlargement is also noted.
			The greatest is seen subcentimeter atrium septum defect is again noted. The left ventricle is within normal limits for size and morphology. No pericardial effusion is seen; trace pericardial fluid is noted.
			Coronaries: There is right dominant coronary circulation. The right and left coronary arteries arise from their respective ostpe. No coronary stenotic lesion seen. During dynamic cine views of the LMCA withe respect to the main pulmonary artery, stable to slightly increased contact of the LMCA by the MPA is appreciated.
			Extracardiac findings: There is significant breathing motion artifact, which limits evaluation of the lung parenchyma. Within these limitations, no nodule or mass is seen. The previously noted centrilobular groundglass nodules are not well seen in this exam. No pneumothorax.
			No pleural effusion.
			Limited evaluation of the upper abdomen in pulmonary arterial contrast phase demonstrates no gross abnormalities.
			Evaluation of the osseous structures demonstrates no suspicious appearing lesions. 1. Essentially unchanged enlargement of the main pulmonary arteries consistent with patient's history of severe pulmonary hypertension. 2. No pulmonary embolism evident. 3. Stable to slightly increased main pulmonary artery contact with left main coronary artery (LMCA) with minimal downward deviation of the LMCA during diastole. 4. Right dominant coronary circulation without significant stenosis. 5. Essentially unchanged right ventricular hypertrophy and prominence with enlargement of the right atrium. Unchanged small ASD. Report: Preliminary measurements were made during primary interpretation. The following protocol measurements were obtained:
			Diameters in mm Ascending aorta - 70% phase (major 23.60, minor 23.10
			Percentages Left ventricle ejection fraction 74.90%
7010	Coronary Angiogram - Case 0286 (With Segmentation)	unknown	Volumes: Left ventricle volume - Systolic 15.6Hz Left ventricle volume - Diastolic 62.2Hz Coronaries: There is right dominant coronary circulation. The right and left coronary arteries arise from their respective ostpe. No coronary stenotic lesion seen. During dynamic cine views of the LMCA withe respect to the main pulmonary artery, stable to slightly increased contact of the LMCA by the MPA is appreciated.
			Extracardiac findings: There is significant breathing motion artifact, which limits evaluation of the lung parenchyma. Within these limitations, no nodule or mass is seen. The previously noted centrilobular groundglass nodules are not well seen in this exam. No pneumothorax. No pleural effusion. Limited evaluation of the upper abdomen in pulmonary arterial contrast phase demonstrates no gross abnormalities. Evaluation of the osseous structures demonstrates no suspicious appearing lesions. 1. Essentially unchanged enlargement of the main pulmonary arteries consistent with patient's history of severe pulmonary hypertension.
			2. No pulmonary embolism evident.
			3. Stable to slightly increased main pulmonary artery contact with left main coronary artery (LMCA) with minimal downward deviation of the LMCA during diastole.
			4. Right dominant coronary circulation without significant stenosis.
7011	Pulmonary Artery - Case 0290 (With Segmentation)	41 Female	5. Essentially unchanged right ventricular hypertrophy and prominence with enlargement of the right atrium. Unchanged small ASD.
			Vascular: Extensive thrombus is identified extending from the IVC at the level of the renal veins to the bilateral common iliac veins, external and internal iliac veins, common femoral veins, superficial femoral veins, profunda veins, popliteal vein, and peroneal veins and posterior tibial veins. The entrance of the greater saphenous vein into the superficial femoral vein is clotted bilaterally, however, the remaining greater saphenous and lesser saphenous vein are patent.
			The right renal vein is patent and empties into the IVC. The left renal vein appears diminutive and is mostly drained by collaterals into the paravertebral plexus. The bilateral perirenal veins are occluded.
			Beginning at L1, paravertebral plexus collateralization is identified which empties into prominent hemiazygos and azygos veins.
			The splenic vein, SMV, and portal system are patent. The hepatic veins are unremarkable.
			The arterial vasculature appears patent and unremarkable.
			Lungs: The lung bases are clear.
			Abdomen and pelvis: Evaluation of the abdominal solid organs is limited due to the venous phase of imaging. The liver and gallbladder, pancreas, spleen, adrenal glands, and kidneys are normal in appearance. No nephrolithiasis or hydronephrosis. The bowel is normal in course and caliber. No ascites or pneumoperitoneum.
			Prominent bilateral ovarian with multiple follicles are seen.
7012	Venogram ABD, PEL, LL - Case 0296 (With Segmentation)	24 Female	Bones and soft tissue: No acute osseous abnormality. The soft tissues demonstrate swelling in the bilateral lower extremities. Complete occlusion of the deep venous system of the bilateral lower extremities, extending proximally to the infrarenal IVC. There is enhancement of the venous walls. Enlarged hemiazygos and azygos veins are noted. Only mild soft tissue edema is noted throughout the bilateral lower extremities. Technique:CT venogram of the abdomen and pelvis with run- offs to knee was performed with IV contrast. Multiplanar reformatted, maximal intensity projection, and 3-D volume-rendered reconstructions were reviewed on an independ
			Four-year-old male with reported history Williams' syndrome who has immigrated from China. Prior history of supravalvular aortic stenosis as well as branch pulmonary artery stenosis. Prior surgical history includes patch augmentation of the aortic arch and aortic isthmus as well as autologous pericardial patch across the right and left pulmonary arteries distal to the main pulmonary artery. Procedures were performed at Shanghai Children's Heart Center. CT angiogram requested for evaluation of aortic arch hypoplasia. Situs: Solitus of the chest and abdomen by normal bronchial arterial relationships and a normal shaped spleen in the left upper quadrant.
			Cavae: A single right-sided superior vena cava and single right-sided inferior vena cava drain unobstructed into the right atrium.
			Pulmonary veins: Three right-sided and two left-sided pulmonary veins drain unobstructed into the left atrium.
			Atria: Atria are morphologically unremarkable bilaterally. No evidence for interatrial communication.
			Atrioventricular connection: There is atrioventricular concordance with two inlet valves and an endocardial cushion present.
			Ventricles: Ventricles are morphologically unremarkable although ventricular function is not evaluated. No evidence for interventricular communication.
			Ventriculoarterial connection: Concordant. The right and left ventricular outflow tracts are patent without stenosis. The aortic and pulmonary valves are trileaflet without evidence for valvular stenosis.
			Coronaries: There is codominance with the right coronary supplying the PDA and the left circumflex supplying the PLV arteries. The RCA arises from the far leftward aspect of the right coronary cusp with a short segment of proximal narrowing of approximately 50-60%. The left main coronary arises from a superior position upon the left coronary cusp without stenosis.
			Aorta: Left-sided aortic arch with normal cervical branching, no evidence of patent ductus arteriosus or aortopulmonary collateral. No evidence of coarctation distal to the transverse arch. There is irregular narrowing of the ascending aorta with a minimum cross-sectional diameter of 7.5 x 7.5 mm. This may reflect prior surgical intervention or underlying supravalvular stenosis of Williams' syndrome. The aorta proximal to the brachiocephalic artery measures 9-10 mm in diameter with this diameter maintained through the transverse arch tapering to 8 mm at the level of the isthmus. The descending thoracic aorta proximal to the hiatus measures approximat
			Pulmonary arteries: The main pulmonary artery measrue 16.5 mm in diameter without evidence of stenosis. There is mild dilation of the proximal left pulmonary artery which measures 12 mm in diameter tapering to 9 mm proximal to the origin of the left upper lobe artery. The right pulmonary artery measures 10 mm in diameter.
			Airways: The trachea and central bronchi are patent without stenosis or endoluminal filling defect.
			Lungs: Patchy areas of mosaic attenuation are seen in the superior segment of the right lower lobe suggesting mild degree of air trapping. Minor atelectatic changes are present in the upper lobes bilaterally. The lungs are otherwise unremarkable.
			Extracardiac thoracic anterior: Overlying chest wall musculoskeletal structures are noteconcerning in appearance.
7013	Gated Heart - Case 0324 (With Segmentation)	4 Male	Aorta: There is a long-segment irregular narrowing of the ascending aorta in keeping with mild supravalvular stenosis. Minimal luminal diameter of approximately 7.5 mm. Patch augmented region of the transverse and proximal descending thoracic aorta shows no evidence for recurrent stenosis with a mean diameter of approximately 9 mm. 2. Central pulmonary arteries of normal caliber without stenosis. Minor focal dilation of the proximal left pulmonary artery in keeping with prior patchy augmentation. 3. Right coronary artery arises from the far left aspect of the right coronary cusp with mild proximal narrowing of approximately 50-60% as it passes between the aortic sinus and the pulmonary artery.
7014	Pancreas-Gallbladder - Case 0326 (With Segmentation)		
7015	MRI Head - Case 0385 (With Segmentation)		
7016	Livsar MRI - Case 0387 (With Segmentation)		
7017	Normal Heart Angio - Case 0634 (With Segmentation)		
7018	Normal Foramen - Case 0641 (With Segmentation)		
7019	Calcification of Coronary Arteries - Case 0643 (With Segmentation)		
7020	Interstitial Fibrosis - Case 0648 (With Segmentation)		
7021	Diffuse Parenchymal Lung Disease - Case 0649 (With Segmentation)		
7022	Enlarged Common Bile Duct - Case 0658 (With Segmentation)		
7023	Partial Small Bowel Obstruction - Case 0676 (With Segmentation)		
7024	Hepatosplenomegaly - Case 0680 (With Segmentation)		
7025	Hepatoblastoma - Case 0703 (With Segmentation)		
7026	Choledochal Cyst - Case 0705 (With Segmentation)		
7027	Page Kidney - Case 0710 (With Segmentation)		
7028	Endometrioma 2 - Case 0720 (With Segmentation)		
7029	Crohn's Disease - Case 0733 (With Segmentation)		
7030	Aortic Aneurysm - Case 0747 (With Segmentation)		
7031	Focal Nodular Hyperplasia - Case 0753 (With Segmentation)		
7032	Hemangioma - Case 0755 (With Segmentation)		
7033	Cholangitis - Case 0759 (With Segmentation)		
7034	Gallbladder Cancer - Case 0760 (With Segmentation)		
7035	Medullary Sponge Kidney - Case 0761 (With Segmentation)		
7036	Paramedianinal Mass - Case 0785 (With Segmentation)		
7037	Mediastinal Mass - Case 0799 (With Segmentation)		
7038	High-Grade Narrowing of SMA - Case 0802 (With Segmentation)		
7039	Liver Metastasis - Case 0812 (With Segmentation)		
7040	Multiple Sclerosis Brain - Case 0853 (With Segmentation)		
7041	IVC Thrombosis - Case 0858 (With Segmentation)		
			Lungs: Near complete collapse of the right upper lobe with cavitary confluent consolidations. Cavitary lesions and consolidations are also present within the superior segment of the right lower lobe. Additional scattered nodular opacities are noted within the left upper and lower lobes Pleura: No pleural effusions Mediastinum and Hila: Enlarged mediastinal lymph nodes Heart: Normal in size Vessels: Normal course and caliber Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen demonstrate ventral abdominal wall hernia
7043	Cavitary Pulmonary Lesions - Case 1062 (With Segmentation)	72 Female	No clinical history or reported symptom available for this patient. Possible differential diagnoses for cavitary pulmonary lesions with bilateral consolidations include malignancy such as squamous cell carcinoma or infectious disease such as necrotizing pneumonia or tuberculosis, if the patient is immunocompromised Lungs: There is subpleural reticulation, fibrotic change, and traction bronchiectasis in an apical basilar gradient. There is mild honeycombing at the lung bases. Pleura: No pleural effusions Mediastinum and Hila: There are prominent mediastinal lymph nodes not meeting criteria for size enlargement Heart: Unremarkable Vessels: Unremarkable Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen reveal no significant abnormality
7044	Idiopathic Pulmonary Fibrosis - Case 1073 (With Segmentation)	72 Male	No clinical history or reported symptoms available for this patient Chest: There are bilateral subcentimeter lung nodules within all lobes of both lungs Liver: There are multiple low density lesions within the both lobes of the liver, measuring up to 8.9 cm. Gallbladder: There are gallstones Bile ducts: Normal Pancreas: Normal Spleen: Unremarkable Kidneys: 2.1 cm left renal cyst in the lower pole, 1.3 cm right renal cyst in the lower pole Adrenals: Unremarkable Bowel: Normal caliber Mesentery & Peritoneum: Unremarkable Lymph Nodes: No enlarged lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: There is a destructive/lytic lesion in the left iliac bone
7045	Widespread Metastatic Disease - Case 1086 (With Segmentation)	75 Male	No clinical history or reported symptom available for this patient Lungs: There is a 5.6 cm mass in the right upper lobe with adjacent satellite nodules/ masses. There is moderate emphysema. Pleura: No pleural effusions Mediastinum and Hila: There is right hilar and mediastinal lymphadenopathy Heart: Unremarkable Vessels: Mild atherosclerotic disease. Chest wall: Normal Bones and Soft Tissue: Normal Lower Neck: Normal Abdomen: Limited images through the upper abdomen demonstrate a 2.1cm left renal cyst
7046	Lung Adenocarcinoma - Case 1096 (With Segmentation)	75 Male	No clinical history or reported symptom available for this patient
7047	Aortic Dissection - Case 1153 (With Segmentation)	24 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
7048	Aortic Aneurysm - Case 1157 (With Segmentation)	79 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
7049	Aortic Dissection - Case 1160 (With Segmentation)	59 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
7050	Ehlers-Danlos Syndrome - Case 1176 (With Segmentation)	43 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
7051	Coronary Artery Abnormalities - Case 1186 (With Segmentation)	69 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"

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			Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Temporal Lobe Tumor Grade: G3 Histologic Diagnosis: Oligodendroglioma Supratentorial Localization: Cerebral Cortex Clinical History: - History of other malignancy - No history of seizures - History of headaches No family history of cancer or brain tumors. First Presenting Symptom: Headaches Symptom Changes: - No reported mental status changes - No sensory changes - No motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
7052 Low Grade Glioma - Case 1243 (With Segmentation)	40s	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Patient Race: White Diagnosis Information: Tumor Location: Supratentorial, Temporal Lobe Tumor Grade: G3 Histologic Diagnosis: Astrocytoma Supratentorial Localization: Not listed in medical record Clinical History: - No history of other malignancy - No history of seizures - No history of headaches Family history of cancer; no family history of brain tumors. First Presenting Symptom: Seizures Symptom Changes: - No reported mental status changes - No sensory changes - No motor movement changes TCGA Attribution: The data shown here generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Pedano, N., Flanders, A. E., Scarpace, L., Mikkelsen, T., Eschbacher, J. M., Hermes, B., ... Ostrom, Q. (2016). Radiology Data from The Cancer Genome Atlas Low Grade Glioma [TCGA-LGG] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.L4LTD3TK
7053 Low Grade Glioma - Case 1247 (With Segmentation)	60s	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSUI5L Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
7054 Benign Lung Nodule - Case 1248 (With Segmentation)	70	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSUI5L Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
7055 Benign Lung Nodule - Case 1250 (With Segmentation)	84	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSUI5L Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
7056 Malignant Lung Nodule - Case 1251 (With Segmentation)	50	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) Data Citation: Armato III, Samuel G., Hadjiiski, Lubomir, Tourassi, Georgia D., Drukker, Karen, Giger, Maryellen L., Li, Feng, Redmond, George, Farahani, Keyvan, Kirby, Justin S., Clarke, Laurence P. (2015). SPIE-AAPM-NCI Lung Nodule Classification Challenge Dataset. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.UZLSUI5L Publication Citation: Armato, S. G., III, Hadjiiski, L., Tourassi, G. D., Drukker, K., Giger, M. L., Li, F., ... Clarke, L. P. (2015, June 25). Guest Editorial: LUNGx Challenge for computerized lung nodule classification: reflections and lessons learned. Journal of Medical Imaging. SPIE-Intl Soc Optical Eng. http://doi.org/10.1117/1.jmi.2.2.020103 (paper) Publication Citation: Samuel G Armato, Karen Drukker, Feng Li, Lubomir Hadjiiski, Georgia D. Tourassi, Roger M. Engelmann, Maryellen L. Giger, George Redmond, Keyvan Farahani, Justin S. Kirby, Laurence P. Clarke, "LUNGx Challenge for computerized lung nodule classification," J. Med. Imag. 3(4), 044506 (2016), doi: 10.1117/1.JMI.3.4.044506.
7057 Malignant Lung Nodule - Case 1254 (With Segmentation)	73	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. (paper) A 48-year-old male status post bilateral lung transplant with bronchial stenosis. The patient is status post placement of a right bronchial stent. Impression: 1. Status post placement of metallic stent within the bronchus intermedius as described. When compared to the prior examination, the stenosis immediately proximal to this stent as well as within the right upper lobe bronchus and left main stem bronchus has increased in severity. Additionally, there has been collapse of the proximal aspect of the right middle lobe bronchi as described. 2. Interval resolution of ground-glass opacifications with nodularity identified throughout the upper lungs. This is suggestive of interval resolution of a prior infection. 3. Gallbladder sludge. Findings: The heart and pericardium are unremarkable. A right peripherally inserted central catheter is present with its tip at the cavoatrial junction. There is no definite evidence of mediastinal, hilar, or axillary lymphadenopathy. Prominent soft tissue is present within the right hilum, however, this is likely post-surgical in nature and is not significantly changed when compared to the prior examination. There has been interval placement of a metallic stent within the bronchus intermedius. When compared to the prior examination, there has been interval improved aeration of the right lower lobe. Patchy areas of consolidation with air bronchograms remain present, however, are noted to a lesser extent when compared to the prior study. Immediately proximal to the stent within the bronchus intermedius, there is a focal stenosis present with a luminal diameter of 3 mm. The bronchi to the right middle lobe are collapsed proximally and are patent distally. The right middle lobe however is well aerated and not collapsed. The right upper lobe bronchus is also fo The stenosis proximal to the bronchus intermedius stent also demonstrates increased narrowing. Lastly, the right middle lobe bronchi were patent on the prior examination. There is also focal stenosis involving the left main stem bronchus. This has a maximal luminal diameter of 4 mm. When compared to the prior examination, this stenosis has also increased in severity. There has been interval improved aeration of the left lower lobe. Patchy areas of nonspecific opacification are present within the left lower lobe. There is a trace right pleural effusion. Additionally, when compared to the prior examination, the diffuse areas of centrilobular nodularity with peripheral ground glass opacification have resolved. Sternotomy wires are present compatible with the patient's prior bilateral lung transplant.
7058 Bronchial Stent - Case 2533 (With Segmentation)	48	Male	The visualized upper abdomen demonstrates a percutaneous jejunostomy tube via the stomach is in standard position. Sludge is also present within the gallbladder. The remainder of the visualized upper abdominal organs is unremarkable. 74 year-old man two days status post aortobiliac stent grafting with a left distal iliac extender and ligation of a right internal iliac aneurysm. Impression: 1. Status post aortobiliac stent grafting with no endoleak identified. 2. Slight kinking of the proximal right common iliac artery limb, with narrowing of the flow lumen at this point to approximately 25%, and with normal diameter more distally. This likely results in decreased flow to the left leg, accounting for the decreased RLE ABI. 3. A possible focal dissection of the RT external iliac artery. Findings: Mild diffuse atheromatous disease is seen in the aorta and its branches. Scattered shallow ulcerations are seen, without evidence of penetration. The celiac artery is patent. Minimal scattered areas of narrowing are seen in the superior mesenteric artery, which is otherwise unremarkable. An aortobiliac endograft extends from the juxtarenal region to both common iliac arteries. No endoleak is identified. The left common iliac graft limb arises anteriorly and courses anteriorly relative to the right limb. The right limb terminates in the proximal right external iliac artery, and the left limb terminates at the distal common iliac bifurcation. At the gate for the poster The inferior mesenteric artery is occluded at its very origin but reconstitutes. The single right renal artery is patent. The main left renal artery is patent. A smaller caliber accessory left renal artery supplying the inferior pole demonstrates mild wall thickening but is patent, with relative cortical thinning of the left renal inferior pole as well as small, peripheral areas of decreased enhancement; this could represent chronic changes, with possible superimposed acute small cortical infarcts. Small, scattered areas of scarring are also seen elsewhere in the left kidney. Multiple tiny low density lesions in the right kidney are too small to further characterize are likely Postoperative changes are seen including a small retroperitoneal hematoma at the right external and internal iliac artery levels, with mixed foci of gas. Small amounts of gas are also seen in the anterior abdominal wall and at the right iliacus muscle.
7059 Aortobiliac Stent - Case 2534 (With Segmentation)	74	Male	The thorax at the base shows trace bilateral pleural effusions and areas of subsegmental atelectasis posteriorly with a suggestion of bronchial wall thickening more centrally. The liver, spleen and pancreas are unremarkable. There is vicarious excretion of contrast by the gallbladder. Both adrenal glands were diffusely enlarged, possibly hypoplastic. A small umbilical hernia is seen, containing only fat. The prostate is enlarged. The urinary bladder contains contrast, likely from a recent stent grafting. Evaluate tracheal stenosis for stent planning, with 3D reconstructions focusing on trachea. Impression: 1. The tracheal narrowing is seen within the proximal portion of the trachea within the thoracic inlet over approximately a 4-CM distance. The minimum AP dimension is 1.0 CM. Comparison of this study to the prior study demonstrates improvement in this region of narrowing, perhaps suggesting a component of tracheomalacia. The right bronchus intermedius is also mildly attenuated. 2. Bilateral pleural effusions with associated atelectasis. 3. Debris within the esophagus. Findings: Within the proximal portion of the trachea in the region of the thoracic inlet there is narrowing of the trachea with mild wall thickening over approximately a 4-cm distance. This measures a minimum of approximately 1.0 cm in the AP dimension. When compared to the prior study, this region does not appear as narrowed suggesting there may be an element of tracheomalacia in this patient. The right bronchus intermedius is also slightly narrowed. There is debris present within the esophagus. Evaluation of the mediastinal structures demonstrate a normal sized cardiac silhouette. There is extensive mitral annular calcification, as well as calcification of the aortic valve. The main pulmonary artery and ascending aorta are normal in size. No significant mediastinal, hilar or axillary adenopathy. No significant pericardial effusion. Evaluation of the lung parenchyma demonstrates bronchial wall thickening. There are bilateral pleural effusions with associated atelectasis. No other significant parenchymal abnormalities are identified.
7060 Tracheal Stenosis - Case 2535 (With Segmentation)	60	Female	Limited views of the upper abdomen demonstrate interval increase in the degree of ascites. Degenerative changes an R. noted within the bony structures, but no other significant bony pathology is seen. Male who is 24 years old with history of right temporoparietal parietal parenchymal signal abnormalities and Chiari type I malformation, and intractable epilepsy, now presenting for presurgical planning. Impression: 1. Internal right frontoparietal craniotomy with placement of an electrode grid over the right hemisphere and 4 electrode strips underlying the brain parenchyma. Limited evaluation of the brain parenchyma. Findings: There is redemonstration of the patient's previously seen Chiari type I malformation, with cerebellar tonsils again seen extending approximately 9 mm below the level of the foramen magnum without a definite separating CSF cleft around the brainstem or upper cervical cord. There is redemonstration of patchy parenchymal signal intensity abnormality within the right frontal lobe periventricular white matter and the right temporal parietal white matter with no associated diffusion abnormality. The overlying frontal lobe and temporal lobes again do not demonstrate any cortical thinning, and the Gray-white does appear intact in the overlying adjacent frontal lobe. The ventricles and sulcal size are normal for patient's age. There is no acute intracranial hemorrhage, mass effect , midline shift, or acute infarction. Abnormal intra-axial or extra-axial fluid collections are not present. Bilateral hippocampal formations and mastoidlary bodies are preserved in architecture and signal. There is mild bilateral paranasal sinus mucosal thickening.
7061 Epilepsy - Case 2572 (With Segmentation)	24	Male	The orbits, mastoid air cells, and flow-voids at the skull base are preserved. The calvarium demonstrates no abnormalities. There is redemonstration of the patient's previously seen Chiari type I malformation, with cerebellar tonsils again seen extending approximately 9 mm below the level of the foramen magnum without a definite separating CSF cleft around the brainstem or upper cervical cord.
7062 MRI Heart - Case 2587 (With Segmentation)	35	Female	
7063 Aortic Coarctation - Case 5207 (With Segmentation)	19	Male	
7064 Aortic Aneurysm with Endoprosthesis - Case 5210 (With Segmentat	64	Male	
7065 Lung Cancer - Case 5219 (With Segmentation)	54	Female	
7066 Normal Coronary Arteries - Case 5223 (With Segmentation)	49	Male	
7067 Coronary Artery Aneurysm - Case 5232 (With Segmentation)	73	Female	
7068 PostOp-Aortic Aneurysm - Case 5246 (With Segmentation)	71	Male	
7069 Ascending Aortic Aneurysm - Case 5247 (With Segmentation)	79	Male	
7070 Thrombosis of Fem-Fem Bypass - Case 8084 (With Segmentation)			
			67 year old male with metastatic neuroendocrine tumor with bone and liver metastases. Restaging examination. Chest: There is a right PICC line tip within the superior vena cava. The thyroid is normal. There is normal arch anatomy. The aorta and the pulmonary artery are normal in course and caliber. The heart is normal in size with no pericardial effusion. There is no mediastinal, axillary, or hilaradenopathy. The lungs are clear. There is bibasilar atelectasis. There is small amount ground glass opacification in the medial segment of the right upper lobe near the apex which may be related to prior radiation if patient had radiation therapy within this region otherwise, could be secondary to atelectasis. There is no suspicious lung nodule. There are no pleural effusions. Abdomen: There is a hepatic abscess drainage catheter with tip within segment 8 of the liver. There is minimal residual fluid around the drainage catheter with near complete resolution of the previously identified collection medial to the tip of the drainage catheter which measured 2.0 cm x 1.0 cm in size. There is resolution of the previously identified mild stable intrahepatic and biliary dilatation. There are stable low attenuation lesions in the liver, most compatible with simple cysts, unchanged from prior study. The previously identified hypervascular foci throughout the liver were not seen on this examination. The portal vein and hepatic veins enhance n There has been a prior Whipple's resection. Other than postsurgical change, the pancreas is unremarkable. The adrenal glands are normal. There are bilateral cortical and parapelvic cysts that are stable as compared to the previous exam. There is no hydronephrosis or hydroureter. The urinary bladder is normal in appearance. Incidental mode is made of two right-sided renal arteries and one left sided renal artery.
7071 Pancreas and Liver Cancer - Case 0295 (With Segmentation)	67	Male	There is a 10-mm short axis enhancing lymph node in the fissure for the ligamentumvenosum that has increased in size as compared to 12 mm. There is enhancing soft tissue nodules in the small bowel mesentery and in the periaortic region. 07 axial slices taken from C5 thru the pelvis during bolus infusion of IV contrast. Minimal pleural thickening posteriorly in both lungs. Coronary arteries are normal. Lungs are clear. The pancreatic duct is dilated measuring about 7 mm thru the head and 3-4 mm in the body and tail. No pancreatic mass is seen. The common bile duct is also prominent in size, measuring about 9 mm. No intrahepatic bile ducts are dilated and no stones are seen. The gallbladder is normal in size. The liver shows a 7 mm cyst in the periphery of the right lobe. The spleen, adrenals, and kidneys are normal. The appendix is normal. Calcifications are noted in the distal abdominal aorta.
7072 Mild Dilatation of Common Bile Duct - Case 0665 (With Segmentationknown		Male	Tho-L2-3 and L3-4 disc spaces are narrowed, show air in the disc, and antero-lateral osteophytes are seen. 1. Mild dilatation of common bile duct and pancreatic duct without mass or stone being seen. Obstruction at the ampulla of Vater should be excluded by enzymes, ultrasound, and endoscopy. 2. Tiny cyst in the right lobe of the liver 3. Degenerative changes at L2-3 and L3-4 4. Calcification in the abdominal aorta 5. Normal appendix Coronalview slices 1. axial 102-232; coronal 292-303; sagittal 190-287 2. axial 172 3. axial 235-268; coronal 331-363; sagittal 244-267 4. axial 200-231; coronal 350-317 5. axial 280-310
7073 Gallbladder Carcinoma - Case 0706 (With Segmentation)	95	Female	Patient with a history of adenocarcinoma of the colon and a partial colectomy presented with hematuria. An ultrasound was performed showing a gallbladder mass. An MRCP was subsequently performed showing a 2.5x1.5 cm mass in the gallbladder invading segment V of the liver with periportal lymphadenopathy. AST 59(15-41 U/L) and ALT 129(14-54 U/L) Bilirubin: 1.2(0.3-1.2mg/dL) Alkaline Phosphatase: 160(32-91 U/L). 1.Small bowel loop thickening with stranding, suggestive of infectious versus inflammation. No obstruction, fluid collection, or free air 2. Known gallbladder mass, with increased hepatic invasion 3. Cholelithiasis 4. Distal aortic stenosis A woman presented with a history of episodic epigastric pain, which was gradually worsening. The patient noted dark urine for 2-3 weeks at the time of the visit. An abdominal ultrasound showed a mass on the pancreatic head with bile duct dilation. A follow up abdominal/pelvis CT showed a 3.3x4.0cm mass in the pancreatic head. The mass didn't appear to encase the celiac axis, SMA, or portal vein. There was no obvious evidence of metastasis. An ERCP was performed with stent placement. A pancreatic neck biopsy showed malignant cells, consistent with adenocarcinoma. Approximately 5 months later, the patient underwent a diagnostic laparoscopy LABS Hemoglobin: 10.4 (11.0-15.5 g/dL) Hematocrit: 31.4 (31.1-44.5 %) WBC: 5.2 (4.0-11.0 x 10E3/UL) Glucose: 149 (70-125mg/dL).
7074 Pancreatic Cancer - Case 0713 (With Segmentation)	62	Female	1. Multiple bilateral noncalcified pulmonary nodules. 2. Small bilateral pleural effusions. 3. Multiple hepatic lesions. 4. Mass within the pancreatic head and neck with displacement of the surrounding vessels. 5. Postsurgical changes of Roux-en_Y hepatic jejunostomy. 6. Nodularity along the peritoneal lining and omentum with increased fluid. 7. Small splenic lesions, unchanged. Radiology Report Scan #2 (earliest scan) 1. Mass in the head of the pancreas with biliary and pancreatic ductal obstruction. Appearance consistent with pancreatic carcinoma.

Anatomage Table 9.0 Case Library Descriptions

				A female in her early 60's presented with complaints of bloating. She also complained of that her abdomen had become larger and hard compared to several months prior. An ultrasound noted a massive multiloculated cystic and solid left retroperitoneal mass. A CT was ordered to further evaluate the mass and an ultrasound guided biopsy later concluded the mass to be a well-differentiated liposarcoma. 1. Large retroperitoneal mass containing fat suspicious for liposarcoma. 2. Ascites. 3. Diverticulosis.
7075	Liposarcoma - Case 0765 (With Segmentation)		62 Female	A male in his mid-50's initially presented with intermittent abdominal pain which progressed to severe abdominal pain that could not be controlled by pain medication. The patient was diagnosed with a pancreatic body and tail mass (adenocarcinoma stage IV ; cT3 , cN1 , pM1). Labs: Hemoglobin: 13.6 (13.3-17.3 g/dL) Hematocrit: 40.8 (39.0-52.0%) WBC: 5.4 (4.0-11.0 x 10E3/UL) Glucose: 87 (70-125 mg/dL) Cancer Antigen 19-9: 2024 (0-35U/mL)
7076	Pancreatic Mass - Case 0767 (With Segmentation)		55 Male	1. Large pancreatic body mass obstructing the pancreatic duct in the tail. 2. Several peripancreatic lymph nodes. 3. Encasement of the splenic artery and in the splenic vein with large collateral formation. 4. Mild fatty infiltration of the liver 5. Cholecystectomy. 6. Granulomatous disease of the lungs. 7. Status post lumbar fixation causing artifact in the pelvis.
7077	Giant Hemangioma - Case 0811 (With Segmentation)	Early 50s	Female	A female in her early 50's presented with a 6 year history of a giant hemangioma of her liver. She had been experiencing increased abdominal pain on the right side. A CT scan of her abdomen showed an increase in size of the hemangioma compared to previous scans. A liver resection was recommended. Labs: Platelet: 92 (150-400 x103/uL), Hemoglobin: 8.3 (11.5-15.5 g/dL), Hematocrit: 25.8 (33.1-44.5%), AST: 195 (15-41 U/L), ALT: 137 (14-54 U/L), Alkaline Phosphatase: 26 (32-91 U/L), Bilirubin: 1.4 (0.3-1.2 mg/dL) 1. Giant hemangioma predominantly in the right hepatic lobe. 2. Other hepatic, splenic and pancreatic hemangiomas are not significantly changed. 3. Numerous small bilateral renal cysts.
7078	Gallbladder Cancer - Case 0815 (With Segmentation)	Early-70s	Female	A female in her early 70's with a medical history of aortic insufficiency and hypertension presented with severe abdominal pain starting in the upper part of her abdomen and radiating throughout the abdomen. The patient's hemoglobin was found to be dramatically low compared to prior labs. A CT scan showed probable gallbladder cancer with numerous nodes and probable mets. The patient was diagnosed with adenocarcinoma of the gallbladder via an endoscopic needle biopsy. WBC: 13.9 (4.8-11.0) X10E3/UL RBC: 3.11 (3.70-5.10) X10E6/UL Hemoglobin: 8.8 (11.0-15.5) G/DL Hematocrit: 27.2 (33.1-44.5) % 1. Findings concerning for gallbladder carcinoma with nodal metastasis. A large heterogeneous mass is noted within the gallbladder. Necrotic adenopathy in the gastrohepatic ligament measuring 3.6 cm. 2. Ill-defined 1.3 cm hepatic hypodensity, uncertain if this represents metastatic lesion vs. Artifact. 3. Hepatic cysts & renal cysts.
7079	Pancreatic Metastases - Case 0822 (With Segmentation)	Mid-20's	Male	A male in his mid-20's presented with a seven-month history of metastatic desmoplastic small round cell tumor of the liver with liver and mediastinal nodal metastases. A restaging ultrasound and CT were performed which noted known metastatic disease in both the liver and the pancreas along with a soft tissue mass in the left upper quadrant. LABS: WBC: 2.5 (4.0-11.0 x103/uL), Platelet: 61 (150-400 x103/uL), Hemoglobin: 13.1 (11.5-15.5 g/dL), Hematocrit: 39.6 (33.1-44.5%), AST: 26 (15-41 U/L), Alkaline Phosphatase: 57 (32-91 U/L), ALT: 28 (17-63 U/L) 1. No evidence of new or worsening metastatic disease in the chest, abdomen, or pelvis. 2. Slightly decreased size of spiculated pulmonary nodules within the left upper lobe. 3. Extensive liver metastatic disease is present. 4. Splenomegaly and splenic vein thrombosis with extensive venous collateral formation in the upper abdomen. 5. Left upper quadrant soft tissue mass in between the pancreatic tail and spleen is minimally decreased in size. 6. Hypodense metastases within the pancreas. 7. Mildly enlarged mesenteric lymph nodes. 8. Stable sclerotic lesion within the posterior elements of L4, indeterminate.
7080	T-Spine Injury - Case 0832 (With Segmentation)	Mid-40's	Male	A male in his mid-40's presented to the emergency department with a history of acute-onset abdominal pain with multiple episodes of vomiting. She has a history of a kidney transplant secondary to polycystic kidney disease. A CT scan showed evidence of her polycystic kidney and liver disease as well as a large ventral hernia in the lower abdomen with obstructed small bowel loops. LABS: WBC: 16.0 (4.0-11.0 x103/uL) RBC: 3.71 (3.7-5.1 x106/uL) Hemoglobin: 10.2 (11.0-15.1 g/dL) Hematocrit: 32.6 (33.1-44.5 %) Potassium: 3.1 (3.6-5.1 mmol/L) Albumin: 2.5 (3.4-4.7 g/dL) 1. Polycystic kidney and liver disease. 2. Large ventral hernia in the lower abdomen with obstructed small bowel loops as described. 3. Right lower quadrant kidney transplant, grossly normal. 4. Hysterectomy.
7081	Ventral Hernia - Case 0840 (With Segmentation)	Mid-50's	Female	
7082	Abdomen (52-year-old male) - Case 0866 (With Segmentation)		52 Male	CT scan
7083	Abdomen (40 year old female) - Case 0870 (With Segmentation)		40 Female	CT scan
7084	Abdomen (60 year old female) - Case 0871 (With Segmentation)		60 Female	CT scan
7085	Abdomen (64 year old female) - Case 0876 (With Segmentation)		64 Male	CT scan
7086	Abdomen (77 year old female) - Case 0877 (With Segmentation)		77 Female	CT scan
7087	Thorax and Abdomen (75 year old female) - Case 0906 (With Segm		75 Female	CT Scan Chest: Bronchiectasis and emphysematous changes within the right lower lobe Liver: Normal morphology and size. Minimal perihepatic ascites Gallbladder: Gallbladder wall thickening and mild peri-portal edema. No calcified gallstone Bile ducts: Mild periportal edema Pancreas: There is a 5cm mass within the head of the pancreas with associated dilation of the pancreatic duct distal to the mass. There is surrounding stranding Spleen: Upper limits of normal measuring 14cm in craniocaudal dimension Kidneys: Normal Adrenal Glands: Normal Bowel: Normal caliber. Mesentery & Peritoneum: Small amount of perihepatic ascites and small amount of free fluid in the pelvis. No free air Lymph Nodes: Enlarged peripancreatic lymph nodes Pelvic Organs: Normal Vasculature: Minimal atherosclerotic calcifications of the abdominal aorta Bones: Minimal degenerative changes of the thoracolumbar spine
7088	Adenocarcinoma - Case 1068 (With Segmentation)		63 Male	No clinical history or reported symptoms available for this patient Chest: There are trace bilateral pleural effusions and atelectasis at the lung bases Liver: Unremarkable Gallbladder: Unremarkable Bile ducts: Normal Pancreas: There is significant fat stranding and fluid surrounding the pancreas, particularly around the body of the pancreas. There is hypoattenuation of the body of the pancreas seen on arterial phase imaging. Spleen: Unremarkable Kidneys: Unremarkable Adrenal Glands: Normal Bowel: Normal caliber Mesentery & Peritoneum: Small volume ascites, inactive Lymph Nodes: Scattered prominent lymph nodes Pelvic Organs: Unremarkable Vasculature: Normal Bones: Unremarkable
7089	Acute Necrotizing Pancreatitis - Case 1072 (With Segmentation)		29 Male	No clinical history or reported symptoms available for this patient
7090	Inflammal Enlargement Aneurysm - Case 1167 (With Segmentation)		63 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
7091	Gallstone in the Cecum - Case 1169 (With Segmentation)		80 Female	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni" Right Kidney: - Cortical cyst at superior pole - In the lower third of the anterior face an exophytic, "ball-shaped" mass is present (33x33x30 mm)
7092	Expansive Right Kidney Process - Case 1177 (With Segmentation)		48 Male	Analysis provided by Università degli Studi di L'Aquila (Prof. Muscitiarelli, Prof. Bianchi and Dr.Bernardi) Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni"
7093	Expansive Process of the Superior Lobe of Left Kidney - Case 1178		65 Male	Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni" - Lesion in medial part of right hepatic lobe, with an irregular profile (40x33x35 mm) - Note the renal fossa on each side of the midline with a central isthmus that passes anteriorly to the aorta and inferior vena cava. This configuration represents the fusion of the kidneys at their lower pole.
7094	Horseshoe Kidney - Case 1180 (With Segmentation)		53 Male	Analysis provided by Università degli Studi di L'Aquila (Prof. Muscitiarelli, Prof. Bianchi and Dr.Bernardi) Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni" - Stenotic lesion in the left colic flexure region, which may be due to carcinoma of left colic flexure. The lesion causes a displacement of the left kidney that appears moved down. - Diffuse calcification of aorta.
7095	Colon Tumor - Case 1183 (With Segmentation)		85 Female	Analysis provided by Università degli Studi di L'Aquila (Prof. Muscitiarelli, Prof. Bianchi and Dr.Bernardi) Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni" - Fusiform enlargement of the wall of abdominal aorta below the renal arteries (55x50x105 mm). - Inside the lesion a dense rim is visible suggesting the presence of a mural thrombus. - Diffuse calcification of aorta and iliac arteries.
7096	Aortic Aneurysm - Case 1185 (With Segmentation)		67 Male	Analysis provided by Università degli Studi di L'Aquila (Prof. Muscitiarelli, Prof. Bianchi and Dr.Bernardi) Images provided by Università degli Studi di Catania and Fondazione Mediterranea "G.B. Morgagni" Patient Race: White, not Hispanic
7097	Chromophobe Renal Cell Carcinoma - Case 1262 (With Segmentati		31 Male	History of synchronous/bilateral malignancy Stage II T2 tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Linehan, M. W., Gautam, R., Sadow, C. A., & Levine, S. (2016). Radiology Data from The Cancer Genome Atlas Kidney Chromophobe [TCGA-KICH] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YUSRBCZN TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
7098	Chromophobe Renal Cell Carcinoma - Case 1264 (With Segmentati		39 Male	History of synchronous/bilateral malignancy Stage II T2 tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Linehan, M. W., Gautam, R., Sadow, C. A., & Levine, S. (2016). Radiology Data from The Cancer Genome Atlas Kidney Chromophobe [TCGA-KICH] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.YUSRBCZN TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
7099	Colon Adenocarcinoma - Case 1298 (With Segmentation)	unknown	Male	Race: White, not Hispanic or Latino No history of other malignancy. Stage III tumor TCGA Attribution: The data shown here are in whole or part based upon data generated by the TCGA Research Network: http://cancergenome.nih.gov/. Data Citation: Kirk, S., Lee, Y., Sadow, C. A., Levine, S., Roche, C., Bonaccio, E., & Filippini, J. (2016). Radiology Data from The Cancer Genome Atlas Colon Adenocarcinoma [TCGA-COAD] collection. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2016.HJBHBOXZ TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
7100	Virtual Colonography - Case 1302 (With Segmentation)	unknown	Female	Colonography - no polyp found. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1
7101	Virtual Colonography - Case 1303 (With Segmentation)	unknown	Male	Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996 TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Colonography - no polyp found. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
7102	Virtual Colonography - Case 1305 (With Segmentation)	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
7103	Virtual Colonography - Case 1307 (With Segmentation)	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Colonography - no polyp found. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
7104	Virtual Colonography - Case 1309 (With Segmentation)	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
7105	Virtual Colonography - Case 1311 (With Segmentation)	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 16mm polyp present in ascending colon Lesion histology: tubular adenoma 6mm polyp present in transverse colon 3mm polyp in rectum Lesion histology: hyperplastic Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J. (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
7106	Virtual Colonography - Case 1313 (With Segmentation)	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.

Anatomage Table 9.0 Case Library Descriptions

				2mm polyp present in ascending colon. Lesion histology: tubular adenoma 4mm polyp present in transverse colon. Lesion histology: tubular adenoma 15mm polyp present in ascending colon Lesion histology: tubular adenoma Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., … Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
7107	Virtual Colonography - Case 1315 (With Segmentation)	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 36mm polyp present in rectum. Lesion histology: tubulovillous adenoma 5mm polyp present in transverse colon. Lesion histology: tubular adenoma Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., … Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
7108	Virtual Colonography - Case 1316 (With Segmentation)	unknown	Male	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057. 18mm polyp present in sigmoid colon. Lesion histology: tubulovillous Data Citation: Smith K, Clark K, Bennett W, Nolan T, Kirby J, Wolfsberger M, Moulton J, Vendt B, Freymann J (2015). Data From CT_COLONOGRAPHY. The Cancer Imaging Archive. http://doi.org/10.7937/K9/TCIA.2015.NWTESAY1 Publication Citation: Johnson, C. D., Chen, M.-H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., … Limburg, P. J. (2008, September 18). Accuracy of CT Colonography for Detection of Large Adenomas and Cancers. New England Journal of Medicine. New England Journal of Medicine (NEJM/MMS). http://doi.org/10.1056/nejmoa0800996
7109	Virtual Colonography - Case 1317 (With Segmentation)	unknown	Female	TCIA Citation: Clark K, Vendt B, Smith K, Freymann J, Kirby J, Koppel P, Moore S, Phillips S, Maffitt D, Pringle M, Tarbox L, Prior F. The Cancer Imaging Archive (TCIA): Maintaining and Operating a Public Information Repository, Journal of Digital Imaging, Volume 26, Number 6, December, 2013, pp 1045-1057.
7110	Abdominal Aortic Stent - Case 2512 (With Segmentation)		65 Female	86-year-old male with Type-I-A endoleak of infrarenal abdominal aortic aneurysm repair. Patient had an open replacement of the stent graft body portion with a tube graft. Impression: 1. Interval replacement of the body of the abdominal stent-graft with a tube graft with anastomosis of the common iliac limbs to the prior stent graft. 2. Redemonstration of celiac stenosis but remainder of other aortic branches are patent. 3. Evidence of prior granulomatous disease with multiple splenic and hepatic calcified granulomas. 4. Splenic hemangioma stable in appearance. 5. Enlarged prostate with heterogeneous enhancement in arterial phase. Findings: There is redemonstration of pericardial calcifications and coronary artery calcifications. There is no significant pericardial effusions. Evaluation of the non-contrast portion of the study demonstrates small bilateral pleural effusions. A stable left lower lobe pulmonary nodule is seen on series 3, image 12, unchanged from the prior study. There is a small amount of bibasilar atelectasis or consolidation with adjacent small pleural effusions. The aorta shows interval replacement of the stent graft with a tube graft extending from the level of the infrarenal aneurysm and is anastomosed with the common iliac artery stent graft. The aorta is patent throughout its course and the limbs of the tube graft as well as the stent graft are patent. The common, external, and internal iliac arteries are patent. There is again seen an approximately 50% stenosis of the celiac artery. The superior mesenteric artery and the renal arteries are patent with an accessory right renal artery again noted. Calcifications are noted at the renal origin but there is no significant stenosis and kidneys are of normal size.
7111	Stent to Tube Graft - Case 2520 (With Segmentation)		86 Male	Around the aortic stent graft, there is soft tissue, hematoma, and multiple surgical clips as well as a small amount of adjacent fluid inferior to the pancreas, all consistent with post-operative change. Contrast images and delays demonstrate no leak at either the proximal or distal anastomosis. A stable left internal iliac artery aneurysm is noted. Impression: 1. Aortobi-iliac stent graft is stable. Aneurysm is stable. Unchanged type II endoleak via a lumbar collateral. 2. Stable aneurysm in the mid left main renal artery at the segmental branch point. 3. Overall no significant interval change. Findings: Infrarenal abdominal aortobi-iliac stent-graft is stable in position. The abdominal aortic aneurysm is stable in size measuring 5.9 x 5.3 cm in maximum diameter, unchanged compared to previous study. There is redemonstration of a type II endoleak from a lumbar artery, unchanged. No other endoleak identified. Throughout the aorta, there is mild atherosclerosis. Celiac and superior mesenteric artery are patent without significant stenoses. There are bilateral single renal arteries without stenosis. However, at the mid right renal artery at the segmental branch point, there is a stable 1.3 cm aneurysm. No other aneurysm is identified. Inferior mesenteric artery is not opacified. Bilateral common iliac, internal iliac and external iliac are patent without significant stenoses. Postoperative changes are seen in the groins bilaterally. Limited images of the abdominal viscera during this arterial phase study demonstrates an incidental replaced left hepatic artery. Otherwise, the liver is unremarkable. The patient is status post cholecystectomy. The spleen and pancreas are unremarkable. The kidneys demonstrate normal enhancement. There is an incidental minor peripancreatic stranding of unclear clinical significance. No evidence of obstruction. Postoperative clips are seen in the cecum. Sigmoid diverticulosis without evidence of diverticulitis. Otherwise, the bowel is unremarkable. The patient is status post-prostatectomy. Surgical clips and right total hip prosthesis obscure evaluation of the pelvis secondary to metallic artifact.
7112	Abdominal Aortic Aneurysm Stent - Case 2549 (With Segmentation		73 Male	Degenerative changes are seen in the lower lumbar spine. Otherwise, remaining osseous structures are unremarkable. Impression: 1. Patent superior mesenteric artery with normal arterial supply to small bowel. 2. Marked narrowing of the celiac axis just inferior to the hiatus with post-stenotic dilation, finding is nonspecific though can be seen in median arcuate ligament syndrome. 3. Nonspecific intra-and extrahepatic biliary dilation in the setting of prior cholecystectomy. Cause of ductal dilatation is unclear. Findings: The visualized abdominal aorta is normal in caliber and appears unremarkable. The celiac axis is patent with severe narrowing of its proximal portion at the level of the diaphragmatic hiatus. The celiac axis is displaced inferiorly under the diaphragmatic hiatus with significant narrowing at this region. There is mild post-stenotic dilatation of the celiac artery to 8 mm. The branches of the celiac axis appear unremarkable, including the splenic artery, common hepatic vein, and left gastric artery. The SMA, bilateral single renal arteries, and IMA appear patent and within normal limits. The infrarenal abdominal aorta is normal in caliber. The bilateral common i There is minimal atelectasis at the right lung base. There is a nonspecific 2-mm lung nodule acute in the right lower lobe (2,5). The small nonspecific focus of peripheral ground glass opacity seen in the inferior right upper lobe (2,10). There is no pericardial or pleural effusion. The liver is normal in size and contour with evidence of moderate intrahepatic biliary dilatation. The common bile duct is dilated to 11 mm. There are surgical clips in the right upper quadrant consistent with a prior cholecystectomy. The pancreas, spleen, and adrenal glands appear remarkable. The bilateral kidneys are symmetric in size with no evidence of stones, hydronephrosis, or
7113	Possible Mesenteric Ischemia - Case 2550 (With Segmentation)		53 Female	The visualized osseous structures demonstrate mild degenerative changes of the lumbar spine. Moderate subcutaneous edema is noted. 85-year-old man with a history of abdominal aortic aneurysm. Impression: 1. Fusiform aneurysm from renal arteries to the aortic bifurcation, eccentric mural thrombus. 2. Celiac axonic stenosis. 3. Pericardial calcification, evidence of prior hemorrhage. 4. Multiple pulmonary nodules in the visualized lung bases. 5. Rim-enhancing lesion in the medial aspect of the spleen, the differential diagnosis includes infection or lymphoma. 6. Low density focus at the superior pole of the right kidney. Findings: VASCULAR: On noncontrast images, atherosclerotic calcifications are seen throughout the aorta and bilateral iliac vessels. There is an infrarenal abdominal aortic aneurysm with eccentric mural thrombus arising immediately below the take off of the renal arteries, with maximum axial dimension of 7.3 x 7.0 cm. On non-contrast images,subtle increased crescentic density within the mural thrombus (series 4, image 34) may represent acute clot. The abdominal aortic aneurysm extends to the level of the aortic bifurcation. No evidence of aortic dissection or contrast extravasation. There is extensive calcification in the bilateral iliac arteries. The right common iliac artery is 1.4 cm in maximum dimension, the left common iliac artery is 1.5 cm in maximum dimension. There is a focal dissection extending over a length of approximately 1 cm in the left internal iliac artery (series 5, image 404). Calcification at the origin of the celiac axis causes an approximately 50-70% stenosis. The superior mesenteric artery and single right and left renal arteries are patent. The inferior mesenteric artery in reconstituted distally (series 5, image 321). ABDOMEN AND PELVIS: Pericardial calcification is demonstrated at the visualized inferior aspect of the heart (series 4, image 1). Multiple small pulmonary nodules are seen in the visualized lung bases: 4- mm in the left lower lobe (series 5, image 4), 5-mm in the left lower lobe (series 5, image 23), and 3-mm in the right lower lobe (series 5, image 58). No consolidation. There is mild bronchial wall thickening in the visualized bilateral lower lobes, bronchitis versus aspiration. No pleural effusion. There is a small hiatal hernia. Punctate calcifications are seen in the liver and spleen, sequela of old granulomatous disease. A 1.4 cm rim-enhancing lesion in the medial spleen (series 6, image 14) may be a small hemangioma, although infection or lymphoma is not excluded. A 3-mm low density focus at the superior pole of the right kidney may be a small renal cyst, but is too small to characterize (series 6, image 21). There is bilateral perinephric stranding. The kidneys enhance symmetrically. No hydronephrosis. Bowel is nondilated. Multiple colonic diverticula are seen. The prostate is markedly enlarged.
7114	Aortic Aneurysm - Case 2551 (With Segmentation)		85 Male	On bone window images, there are multilevel degenerative changes in the spine. An 8-mm sclerotic lesion is located in the right ilium, adjacent to the right sacroiliac joint (series 6, image 55).
7115	Polycystic Kidneys Parenchymal Phase - Case 2552 (With Segment		31 Female	Autosomal kidney disease. Intrahepatic biliary dilatation and pancreatic ductal dilatation noted. This may be due to biliary/ampullary compression, though biliary stones or pancreatic cancer should be considered. Renal Cryoblation - post cryoaxia parenchymal phase Findings: A small cyst is seen in the posterior aspect of the spleen. A stable 1 cm nodule is seen in the lateral limb of the left adrenal gland.
7116	Renal Cryoablation - Case 2553 (With Segmentation)		75 unknown	On follow-up CT there is no definite evidence of residual or recurrent cancer. Impression: 1. Multiple bilateral renal septated cysts, some contain thin calcifications, classified as bosniak IIF cysts. Follow up examination within 6 months is recommended to ensure stability. Follow-up examination may be performed as a noncontrast and contrast enhanced CT examination of the abdomen only. Findings: Limited evaluation of the lung bases appears within normal limits. Large cysts are identified in both kidneys. Several of these cysts demonstrate internal septations. For instance, a cyst in the superior pole of the left kidney measures 5.8 x 7.3 cm in greatest axial dimension (5; 27). The cyst demonstrates a thin septation with increased attenuation that likely represents minimal linear calcification. A similar complex cyst is noted about the inferior pole of the right kidney that measures 6.2 x 6.7 cm in greatest axial dimension (5; 76). This also demonstrates thin septations and a region of increased attenuation within one of the septations that likely represents calcification. No nodular enhancing components are identified. The c The kidneys otherwise appear normal. Both kidneys enhance symmetrically and demonstrate normal excretion of contrast without evidence of hydronephrosis. The collecting systems in both kidneys appear normal. No urothelial lesions are identified. No renal masses are identified. The visualized portions of the ureters appear normal. The patient was placed prone to better evaluate the distal left ureter. Portions of the distal right ureter are not opacified with contrast, and are not well evaluated on this examination. However, no obvious abnormality is noted along both ureters. The bladder appears normal. No urothelial lesions or masses are identified within the bladder. Other portions of the abdomen are not well evaluated on this phase of contrast enhancement. However, the visualized portions of the liver, spleen, pancreas, and adrenal glands appear within normal limits. The gallbladder is normal. No evidence of biliary ductal dilatation. All visualized bowel appears normal. Incidental note of a high attenuation 16-mm linear structure within the right colon. This may represent a foreign body ingestion. No surrounding inflammatory process is noted. No evidence of obstruction. Calcified plaque is noted about the distal abdominal aorta consistent with atherosclerotic disease. No aneurysm is present.
7117	Renal Cysts - Case 2575 (With Segmentation)		73 Male	Visualized bones appear within normal limits.
7118	Double Left Renal Duplex with Ureter - Case 5228 (With Segmenta		51 Male	
7119	Cancer of the Right Colon - Case 5242 (With Segmentation)		68 Female	
7200	Coronavirus Patient - COVID-19	unknown	unknown	
7201	Abdominal Aortic Aneurysm		82 Male	Examination performed during the injection of contrast medium (unspecified 370) Ectasia of the ascending aorta in its distal (about 45 mm of maximum diameter) with preserved caliber of the descending thoracic aorta presenting a slightly scoliotic course. At about 6 cm caudally to the origin of the left renal artery there is a saccular aneurysm of the abdominal aorta which presents diameters about 47 x 41 mm, extension CC of 55 mm. In continuity with the described aneurysm, proximal to the iliac bifurcation, there is an aneurysmal blister with right posterolateral extension with maximum CC extension of about 3 cm and with maximum axial diameter of about 32 mm. There is slight stenosis due to the emergence of the celiac tripod. Patent the superior mesenteric artery and renal arteries (the left one with minimal atheromas calcified at its origin). Some calcific wall apposition without significant stenosis of
7202	Cryoablation of Kidney		75 Male	Examination in prone position. We proceed to preliminary execution of CT with contrast medium (100 ml of isoniopril) aimed at treatment by cryoablation of solid lesion to the upper pole of the right kidney, (26 mm of maximum diameter), evaluating the transit more suitable to reach the lesion. At the chosen site, a biopsy Guided CT is performed after local anesthesia (10 ml of Lidocaine) with a 18 G cutting needle and then positioning of two Cryoablation needles Ice Red Plus of 17 G. The procedure is performed under TC guidance we appreciate the formation of the "ice-ball" during the cryoablation concerns the entire expansive process with a appropriate safety margin. Once the suc
7203	Complete Aortic Dissection		63 Female	She arrives in the emergency room for headache, vomiting and hemiplegia of the left lower limb. Angio-CT of the neck vessels revealed important dissection of the thoracic aorta, subsequently the examination was extended from the carotid bifurcation to the femoral bifurcation. Angio-CT supra-aortic trunks, thoracic and abdominal district Examination performed during injection of 80 CC of contrast medium, with Angio-CT technique and cardiac synchronization. Angio-CT highlights the presence of complex aortic dissection, involving the ascending aorta, with probable almost circumferential rupture of the intima at the level of the middle III of the ascendant; the dissection flaps involve caudally the emergencies of the right coronary artery and the common trunk, with partial involvement of the aortic valve and the annulus; the coronary arteries downstream from the dissection are still regularly opaque. All the trunks are also involved; the carotid arteries in particular have a true lumen reduced to the middle III, beyond which the dissection does not appear to extend, with regular opacification of the distal tract of bot The dissection involves the entire arch and the entire abdominal aorta with a true lumen of caliber reduced to the isthmus; At the level of the splanic vessels the celiac tripod is involved in the dissection and is born in part of the false lumen, the superior mesenteric originates from the true lumen, like the right renal, while the left renal is born from the false lumen, as well as most of the arteries Lumbar. The dissection also extensively involves the iliac axes even beyond the iliof bifurcation; To the right, the dissection flap is recognized until the passage into a common femoral; On the left the dissection determines occlusion of the external iliac with a rehabitation of the femoral common artery in the middle third, poorly marked. Emergency surgery for replacement of the ascending aorta with Vascutek prosthesis No. 28. Clinical question: NSTEMI suspected dissection of anterior descending and common trunk. Examination performed during the injection of 65 ml of organoiodine contrast medium with a flow of 5 ml / sec followed by 40 ml of saline solution with the same flow. The study was performed with a retrospective cardiac gating system with a time window at 75% of the cardiac phase and evaluated with soft tissue kernels. 0.9 mg of sublingual nitroglycerin is administered. Dominance: left Left circle: Common trunk: eccentric intimal thickening is appreciated compatible with the clinical suspicion of coronary dissection, which determines stenosis of about 25-50% and extention to the anterior descendant. Anterior descending artery: eccentric intimal thickening extended for about 4 cm, due to likely intimal dissection determines maximum proximal stenosis> 75%, patent and disease-free the downstream vessel that becomes slender distally. Collateral findings: Anterior and basal wall thinning in the apical site. Angio-CT neck vessels and circle of Willis Angio-CT performed during injection of 100 CC of contrast medium. Right: The internal carotid artery at the middle-distal third presents multiple parietal irregularities with focal ectasia alternating with stenosis; dilatation at the distal third with a caliber of about 7 mm; the intrapetrous tract has a reduced caliber estimated at around 2.5 mm. Left At the level of the middle-distal third, multiple wall irregularities can be observed, similar to that observed at the level of the contralateral carotid artery. Also on this side ectasia of the distal sectors of the extracranial internal carotid artery with a reduction of caliber at intrapetrous level. Angio-CT thoracic and abdominal district On the right renal artery, multiple wall irregularities are appreciated with multiple areas of stenosis (40% NASCET criteria) at the middle-distal level. Independent origin of the superior mesenteric artery and common trunk for the hepatic and gastric artery; at the origin of both it is appreciated a short, tight stenosis. Multiple calcifications of the aortic wall and common iliac arteries with the presence of fibro-dysplasia. Multiple calcifications of branch for the lower lobe of the right pulmonary artery, suggestive of the presence of chronic embolic facts.
7204	Coronary Artery Dissection		52 Female	Asymptomatic patient, incidental diagnosis of congenital heart disease. Anomalous pulmonary venous return detected by cardiac RM. Angio-CT confirms the presence of anomalous venous pulmonary drainage that goes from the upper right pulmonary venous branch and middle/lower branch and converge in the superior vena cava, that in correspondence of fenestration it goes through the left atrium with feature of IAD in venous sinus. It also indicates persistence of superior vena cava on the left draining the Hemiazigos hemiolateral system and it has confluation in the enlarged coronary venous sinus. Dilatation of the cardiac right chambers, the common pulmonary trunk (35 mm) and the proximal branches of the pulmonary arteries. Non-Pulmonary pleuroparenchymal alterations takin Conclusione: Anomalous venous pulmonary drainage of upper and middle-inferior pulmonary branch in VCs and type venous sinus. Persistance of SVC left draining also the hemiazigos hemiatarial system and confluent in dilated coronary venous sinus. Dilatation of the right cardiac section and proximal pulmonary arterial branches.
7206	Anomalous Pulmonary Venous Return		45 Male	Short Intratracheatic course of ATV in the middle-thirds Clinical question: patient with injury of left motor area. Paresis of right upper limb and occasional phasic disorders. Brainstem MRI with contrast medium (including related vascular system). The examination was performed with axial, coronal and sagittal scan planes using 3D FLAIR sequence, T2-weighted TSE sequence, diffusion-weighted sequence, DTI sequence, SWI and TSE sequence, and T1-weighted TSE IR performed both before and after contrast medium intravenous paramagnetic (0 CC of Gadobutrol) administration (in SeriesDescription labeled "Neuroangiatore"). It is recognized in the left frontal area with involvement of the motor cortex and premotor area, a roughly oval morphology formation, well delimited, of dimensions equal to 4 x 4 x 3.5 cm with internal hyperintense signal in T2, unevenly hyperintense in the 3DFlair, with diffusion signal restriction and peripheral labium enhancement (T1 volumetric / gradient after contrast agent), in a picture compatible with abscess lesion. The lesion is surrounded by abundant perilesional edema with flattening of the neighboring perisencephalic sulci and imprint on the left lateral ventricle. The lesion dislocates the cortical spinal bundle. Bilaterally, at the level of the predominantly subcortical white matter, some minute areas of completely nonspecific gliosis are evident.
7207	Brain Abscess		63 Female	The midline appears to be deflected to the right by approximately 7 mm. Clinical news: left testicular neoplasm, left renal neoplasm. CT abdomen Investigation performed with basic scans and after IV contrast injection (Iopromide 370). In relation to the clinical question, the presence of voluminous expansive lesion, with rich contrast enhancement, inhomogeneous ap presence of necrotic areas in the central site, of 10x12 x12 cm in diameter LLx AP xCC, is confirmed for the left kidney. The renal structure is partially preserved only at the middle-upper pole, where part of the parenchymal and the markedly extended calico-pyelic cavities are still recognizable. Certain cleavage plans of the lesion with the psoas muscle and the posterior paramural fascia is not visible in some places. Ectasia of the left renal vein which also presents regular opacification. Left adrenal gland and liver regularly opacified. There are peritoneal venous varicose circles. Ectatic the gonadal vein, which affects the vascular structure, ectatic, even at the level of the ipsilateral funiculus. From this side dolymax increased in size, inhomogeneous (for its evaluation it is sent to a targeted ultrasound survey). Some lymph nodes increased in size in the left para-aortic. The loops of the ileum appear anteriorly cleaved by the described formation. No focal hepatic, splenic, pancreatic, adrenal and renal focal tomodensitometric changes on the right. No space-occupying lesions in the pelvic cavity or free liquid in the peritoneal cavity.
7208	Renal and Testicular Tumors		52 Male	No focal osteo-structural alterations affecting the skeletal structures under examination at this level.
7500	Cell	N/A	N/A	
9001	Abdominal Aneurysm	Please refer to cases 0053, 0206, and 0296	Please refer to cases 0053, 0206, and 0296	
9002	Ankle Fracture	Please refer to cases 0269, 0216, and 0247	Please refer to cases 0269, 0216, and 0247	
9003	Aortic Arch Anomaly	Please refer to cases 0163, 0347, and 0010	Please refer to cases 0163, 0347, and 0010	
9004	Axilla Tumor	Please refer to cases 0186, 0240, and 0082	Please refer to cases 0186, 0240, and 0082	
9005	Basilar Aneurysm	Please refer to cases 0183, 0368, and 0369	Please refer to cases 0183, 0368, and 0369	
9006	Common Carotid Aneurysm	Please refer to cases 0139, 0197, and 0369	Please refer to cases 0139, 0197, and 0369	
9007	Common Facial Birth Defect	Please refer to cases 0300, 0303, and 0299	Please refer to cases 0300, 0303, and 0299	
9008	Congenital Heart Abnormality	Please refer to cases 0165, 0324, and 0010	Please refer to cases 0165, 0324, and 0010	
9009	Craniosynostosis	Please refer to cases 0255, 0192, and 0299	Please refer to cases 0255, 0192, and 0299	
9010	Cystic Fibrosis	Please refer to cases 0235, 0236, and 0010	Please refer to cases 0236 and 0010	
9011	Enlarged Heart	Please refer to cases 0204, 0294, and 0010	Please refer to cases 0204, 0294, and 0010	

Anatomage Table 9.0 Case Library Descriptions

9012	Face Fracture	Please refer to cases 0325, 0305, and 0369	Please refer to cases 0325, 0305, and 0369
9013	Femoral Bypass	Please refer to cases 0004, 0011, and 0296	Please refer to cases 0004, 0011, and 0296
9014	Foot Fracture	Please refer to cases 0120, 0113, and 0247	Please refer to cases 0120, 0113, and 0247
9015	Fractured Clavicle	Please refer to cases 0076, 0256, and 0288	Please refer to cases 0076, 0256, and 0288
9016	Hand Fracture	Please refer to cases 0110, 0321, and 0245	Please refer to cases 0110, 0321, and 0245
9017	Hand Vascular	Please refer to cases 0155, 0186, and 0245	Please refer to cases 0155, 0186, and 0245
9018	Heart Valve	Please refer to cases 0204, 0154, and 0010	Please refer to cases 0204, 0154, and 0010
9019	Kidney	Please refer to cases 0276, 0218, and 0296	Please refer to cases 0276, 0218, and 0296
9020	Knee Joint	Please refer to cases 0073, 0069, and 0362	Please refer to cases 0073, 0069, and 0362
9021	Knee Tibia Fracture	Please refer to cases 0073, 0079, and 0362	Please refer to cases 0073, 0079, and 0362
9022	Pelvic Bone	Please refer to cases 0173, 0013, and 0296	Please refer to cases 0173, 0013, and 0296
9023	Shoulder Joint	Please refer to cases 0239, 0288, and 0240	Please refer to cases 0239, 0288, and 0240
9024	Stents	Please refer to cases 0131, 0132, and 0010	Please refer to cases 0131, 0132, and 0010
9025	Trachea	Please refer to cases 0133, 0132, and 0010	Please refer to cases 0133, 0132, and 0010
9026	Vertebra Abnormality	Please refer to cases 0118 and 0051	Please refer to cases 0118 and 0051
9027	Brain Data Comparison	None available	None available
9028	Mouse with Contrast	unknown	unknown
9029	Equine Foot Knee	unknown	unknown
9030	Pig Heart Attack	unknown	unknown This area of necrosis was created in a laboratory as a CT scanning project.
9031	Horse Hoof	Please refer to cases 447, 448, and 449	Please refer to cases 447,448, and 449
9032	Lungs	Please refer to cases 10, 302, and 635	Please refer to cases 10, 302, and 635
9033	Bowel Obstruction	Please refer to cases 678, 679, and 688	Please refer to cases 678, 679, and 688
9034	Bile Duct Abnormalities	Please refer to cases 658, 659, and 665	Please refer to cases 658, 659, and 665
9035	Wrists	Please refer to cases 92, 110, and 245	Please refer to cases 92, 110, and 245
9036	Male Skulls	Please refer to cases 3019, 3029, and 3034	Please refer to cases 3019, 3029, and 3034
9037	Female Skulls	Please refer to cases 3024, 3039, and 3047	Please refer to cases 3024, 3039, and 3047
9038	Rodent Skulls	Please refer to cases 371, 372, and 374	Please refer to cases 371, 372, and 374
9039	Head Gunshot Wounds	Please refer to cases 242, 3024, and 3041	Please refer to cases 242, 3024, and 3041
9040	Breast Cancer	Please refer to cases 131, 740, and 741	Please refer to cases 131, 740, and 741
9041	Breast Implants	Please refer to cases 131, 640, and 666	Please refer to cases 131, 640, and 666
9042	Kidney Disorders	Please refer to cases 659, 709, and 763	Please refer to cases 659, 709, and 763
9043	Aortic Aneurysms	Please refer to cases 650, 747, and 748	Please refer to cases 650, 747, and 748
9044	Embryo Stages	Please refer to cases 2013, 2020, and 2023	Please refer to cases 2013, 2020, and 2023
9045	Hand Vasculature	Please refer to cases 0245, 0155, and 1028	Please refer to cases 0245, 0155, and 1028
9046	Arm Vasculature	Please refer to cases 0015, 0155, and 1027	Please refer to cases 0015, 0155, and 1027
9047	Gorilla Foot and Human Limbs	Please refer to cases 0477, 247, and 1028	Please refer to cases 0477, 247, and 1028
9048	Coronary Vasculature with Contrast	Please refer to cases 5233, 5232, and 0634	Please refer to cases 5233, 5232, and 0634
9049	Fetus	Please refer to cases 2031, 2028, and 2033	Please refer to cases 2031, 2028, and 2033
9050	Breast Cancer 2	Please refer to cases 1275, 1277, and 1274	Please refer to cases 1275, 1277, and 1274
9051	Pancreatic Cancer	Please refer to cases 0713, 1143, and 0659	Please refer to cases 0713, 1143, and 0659
9052	Prostate Cancer	Please refer to cases 1320, 1321, and 0681	Please refer to cases 1320, 1321, and 0681
9053	Farm Animals	Please refer to cases 0471, 0466, and 0417	Please refer to cases 0471, 0466, and 0417
9054	Chimp vs. Human	Please refer to cases 0469, 0617, and 0886	Please refer to cases 0469, 0617, and 0886
9055	Cat vs. Tiger Skull	Please refer to cases 5190, 0481, and 5201	Please refer to cases 5190, 0481, and 5201
9056	Glioblastoma	Please refer to cases 1212, 1214, and 0385	Please refer to cases 1212, 1214, and 0385
9057	Hip Replacements	Please refer to cases 0686, 0687, and 0688	Please refer to cases 0686, 0687, and 0688
9058	COVID-19	Please refer to cases 0138, 5213, and 7200	Please refer to cases 0138, 5213, and 7200
9059	Similar Shark Species	Please refer to cases 6446, 6426, and 6442	Please refer to cases 6446, 6426, and 6442
9060	Different Shark Species	Please refer to cases 6464, 6449, and 6447	Please refer to cases 6464, 6449, and 6447