Interesting Cases
Pulmonary
54M with prior history of COPD, hep B/C, and possible history of TB presented with acute on chronic dyspnea, and productive cough
• Hazy opacity overlying the left hemithorax
• Increased opacity in the left lung hilum
• Tenting of the left hemidiaphragm

• Overall, left upper lobe collapse raising suspicion of obstructing mass in the bronchus or hilar mass
• Bronchoscopy revealed post obstructive pneumonia
Presented with shortness of breath

Right middle lobe pneumonia with bulging of the fissure
Presented with hypoxemia

- Stable sclerotic focus within the right lateral third rib
- Surgical clips overlying the right axillary region
63F bone marrow transplant with progressive Rhizopus pneumonia

Near complete opacification of right lower lobe with increased confluence at ground glass opacities involving the right upper lobe with associated bronchograms and septal
Diffuse interlobular septal thickening with minimal areas of consolidation.
Collapse of left upper lobe with possible obstruction of the left upper lobe anterior segmental bronchus

Scattered ground glass opacities in the right lung apex suggestive of post-infectious or post-inflammatory change
• Subcm mediastinal and hilar/peribronchial lymph nodes
• Multiple bilateral subcm nodules and nodular opacities predominating in the mid to upper lung zones, probably in a perilymphatic distribution, with bilateral mass-like consolidation
• Extensive bilateral lung findings above, suggestive of stage III sarcoidosis versus occupational exposure (including berylliosis)
Upper-to-mid lung zone scarring with some volume loss consistent with history of sarcoidosis
• Diffuse groundglass opacity in a crazy paving pattern predominately of the right lung
• No architectural distortion or bronchiectasis
• Scattered centrilobular lucencies suggesting early emphysema
• Bibasal intralobular thickening likely representing fibrotic changes
Hx of metastatic osteosarcoma

- Left upper lobe, left apical component of peripherally calcified, centrally necrotic and centrally partially enhancing mass corresponding to osteosarcoma
- Right lower lobe partially calcified centrally hypodense, mildly enhancing mass
- Mass affect on cardiovascular structures with shift of the mediastinum to the right
S/P Lung transplant

- Lung parenchymal abnormalities with multiple air cysts, bronchial thickening, bronchiectasis and nodular opacities
- Right apical pleural thickening and air cyst demonstrates a central nodular focus
- Query superimposed infection such as aspergillosis
- Left apical thickening and left apical consolidation; may relate to cryptogenic organizing pneumonia
• Left lower lobe and right lung fibrosis
• LINX device at the GE junction
H/o metastatic prostate cancer, now with shortness of breath.

- Sclerotic regions throughout the spine and visualized skeletal system
- Bibasilar small pleural effusion and basilar atelectasis
- Pathological fracture in the left scapula
History of lymphoma

- Multiple lymph nodes are identified bilaterally in the bilateral axillary regions.
- A tented appearance to the RVOT may represent post treatment changes or median sternotomy.
- Some ill-defined ground-glass opacities are noted in the posterior segment of right upper lobe most likely post inflammatory in nature.
History of esophageal cancer, s/p esophagectomy

- Interval progression of presumed post radiation changes of pneumonitis with subtle areas of centrilobular and lobular ground-glass opacities and worsening scarring in the medial aspect of basilar segment of left lower lobe
History of lung cancer, shortness of breath

- Worsening metastatic disease burden in the lung parenchyma with worsening nodular opacities in the left lung
- Small left-sided pleural effusion and more confluent opacities in the right lung, predominantly basilar segment right lower lobe.
55M smoker presented with shortness of breath

- Hazy opacity overlying the left hemithorax with increased opacity in the left lung hilum
- Tenting of the left hemidiaphragm
- Overall, left upper lobe collapse raising suspicion of obstructing mass in the bronchus or hilar mass
• Collapse of left upper lobe with possible obstruction of the left upper lobe anterior segmental bronchus
• LUL collapse due to mucus plugging
• Pt improved s/p removal of plug by bronchoscopy
61F with lung cancer.

1. Infiltrative mass at the left hilum which surrounds the left main bronchus, left descending pulmonary, and descending aorta and exhibits mass effect on the ventral wall of the descending aorta.
2. Spiculated nodule within the left lower lobe which has increased in size and is more solid compared to 5/10/13
67M with diabetic ketoacidosis

Right upper lobe opacity which may represent consolidation concerning for pneumonia versus mass

- Enlarged right axillary/hilar lymph node with mild mass effect on right upper lobe bronchus, concerning for metastasis.
- Spiculated mass within the posterior segment of right upper lobe along the major concerning for metastasis
78F with Kidney cancer, status post right lung resection

Right loculated pleural effusion, most likely malignant pleural effusion
Increase in size of right upper lobe pleural nodules, consistent with metastatic progression of the pleura
78 M with edema and low lung volumes s/p endovascular aortic repair removal 1 month ago

- Low lung volumes with diffuse traction bronchiectasis and a multifocal heterogeneous groundglass opacities with coarse reticulation.
- Compatible with expected evolution of diffuse alveolar damage and fibrotic phase.
- Possible etiologies of diffuse alveolar damage in this patient include idiopathic etiology (acute interstitial pneumonia), infection, or sepsis.
68 yo female with stage IV NSCLC s/p bilateral upper lobectomy

- Stable scarring in the right lower lobe
- Stable right apical subpleural nodule
Nodular scarring in the right middle and lower lobes
Bilateral scatter subcentimeter nodules
Biapical and right lower lobe scarring
Mosaic attenuation of the bilateral lower lobes which is accentuated on expiratory images
Subpleural reticulation predominantly involving the lower lobes

H/o Restrictive lung disease
Pt with hx of Mantle Cell Lymphoma, s/p allogeneic SCT, now with SOB

- Perihilar opacities with central segmental distribution
- May represent edema or infectious process
Same pt, Status post allogenic stem cell transplant. Immunosuppressed. Hypoxia, infiltrate on chest radiograph.

- New scattered ground glass opacities and worsened groundglass opacities
- The differential diagnosis includes atypical infection or pulmonary edema, among others
- Atypical infection is favored given the history of CMV reactivation
43M for pre-PTE eval

- Mildly dilated pulmonary arteries suggesting pulmonary arterial hypertension
- Blunting of right costophrenic sulcus
56-year-old female with newly diagnosed pulmonary hypertension and right ventricle dysfunction

Enlarged main pulmonary artery and flattening of interventricular septum during systole suggestive of pulmonary arterial hypertension
78F with CAD s/p CABG with acute hypoxia and chest pain

Saddle embolism extending to all segments predominantly the basilar segment with suggestion of right heart strain
H/o thymoma

- Right upper lobe segmental two subsegmental pulmonary emboli as well as right lower lobe subsegmental pulmonary emboli

- Anterior mediastinal mass which abuts the ascending aorta, SVC and right subclavian vein in which it may also compress the right subclavian vein
65M with history of HIV; invasive squamous cell carcinoma of the rectum, presenting with cough

- Subcarinal mass. Differential includes a lymphoproliferative process, a mesenchymal tumor, bronchogenic carcinoma, and metastatic lesion
- Reticular opacities are increased emanating from the hila with bronchial wall thickening. Compatible with atypical infection with or without a acute or chronic bronchitis.
36F with Neck and face swelling with no mediastinal mass, rule out SVC syndrome

Large heterogeneously enhancing 15-cm anterior mediastinal mass with invasion of the right chest wall and marked compression of the superior vena cava compatible with SVC syndrome