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BRUCE W MOSKOWITZ, M.D.
1411 NORTH FLAGLER DRIVE
SUITE 7100
WEST PALM BEACH, FL 33401

Patient: EPSTEIN, JEFFREY
Exam Date: 1/30/18 **Acc No:** 7103073 **MRN:** 0315192

Dear Dr. Moskowitz,

CT NECK

Clinical History:

65 y/o male with elevated PTH, concern for parathyroid adenoma.

Technique:

Multidetector helical CT scans of the neck were performed utilizing 4D parathyroid technique, from the superior orbital rim to the thoracic inlet using 2.5 mm slices, prior to and during the constant infusion of nonionic intravenous contrast. Multiphase postcontrast dynamic imaging was employed. Images were reconstructed at 1.25mm slice thicknesses at 1.25mm slice intervals with coronal and sagittal reformats.

Comparison:

Neck MRI performed 11/30/2016

Findings:

The visualized brain parenchyma is normal.

The orbital contents are partially excluded from the field of view but are grossly normal in appearance.

The masticator spaces are normal.

The mastoid air cells and tympanic cavities are clear.

Mild scattered paranasal sinus mucosal thickening is seen with areas appearing polypoid in nature. Findings are worse along the left frontal drainage pathway which is occluded.

A few of the maxillary and mandibular teeth have been endodontically treated. There is a left 2nd mandibular molar dental implant. Small bilateral mandibular tori are present.

The nasopharynx is normal. Prominence of the bilateral palatine tonsils are seen without deep extension, likely reactive in nature. Punctate calcifications involve both palatine tonsils, likely reflecting remote inflammation. Minimal prominence of the bilateral lingual tonsils is seen without deep extension, likely reactive in nature. There is a tiny air-filled right internal laryngocele. The hypopharynx and larynx are otherwise normal. The true cords are adducted.

The major salivary glands including the parotid, submandibular and sublingual glands are normal.

The thyroid is mildly heterogeneous. There is a 0.5 cm enhancing nodule within the posterior right midpole of the thyroid.

There are no early enhancing parathyroid nodules. No discrete parathyroid mass is present. There is no evidence for a parathyroid adenoma.

There is no suspicious or pathologically enlarged cervical chain lymphadenopathy.

There is a partially imaged lipoma within the left supraclavicular fossa measuring 4.7 cm in greatest craniocaudad dimension and 2.5 cm in greatest AP dimension. This is unchanged.

There is a bovine configuration of the great vessels arising from the aortic arch, a normal anatomic variant. There is patency of the major vessels of the neck.

The pericervical musculature, scalene musculature and sternocleidomastoid muscles are normal asymmetric atrophy.

The lung apices are clear. There is no suspicious mediastinal mass or evidence of ectopic parathyroid adenoma within the mediastinum on the images provided.

Multilevel cervical spondylosis is seen with disc herniations and superimposed disc osteophyte complexes resulting in multilevel ventral cord impingement as well as foraminal narrowing with suspected cervical nerve root impingement.

IMPRESSION

No evidence for parathyroid adenoma.

Mild scattered polypoid paranasal sinus mucosal thickening with an occluded left frontal drainage pathway.

A 0.5 cm right midpole thyroid nodule.

Left supraclavicular lipoma, unchanged.

Multilevel cervical spondylosis.

Very truly yours,

ADAM WILNER, M.D.

Electronically Signed By ADAM WILNER, M.D.
Date/Time Transcribed: 1/30/18 9:02 am

Contrast: Omnipaque Contrast 350mg 100cc
Creatinine 1.2mg/dl

REPORT

CC: CC PATIENT

EAST RIVER MEDICAL IMAGING, PC [redacted]

PET/CT • HIGH FIELD MRI • OPEN MRI • MULTIDETECTOR VOLUME CT (VCT) • BONE DENSITY • NUCLEAR MEDICINE
ULTRASOUND • DIGITAL X-RAY • CORONARY CT ANGIOGRAPHY • VIRTUAL COLONOSCOPY • CT/MR ANGIOGRAPHY

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