DIFFUSE MEDIASTINAL ABNORMALITIES BOISELLE pdf

1: Thoracic Radiology The Requisites 2nd Edition | booksmedicos

Mediastinal Lipomatosis. Mediastinal lipomatosis is the diffuse accumulation of excess unencapsulated fat within the mediastinum. This benign condition is usually seen in adult patients and may be associated with Cushing's syndrome, exogenous steroid use, and obesity.

Overall A and progression-free B survival of patients with primary mediastinal large B-cell lymphoma. Favorable outcome of primary mediastinal large B-cell lymphoma in a single institution: This may in part reflect differences between studies in assigning patients as stage IV or stage 2E if multiple but contiguous extranodal sites are involved. Even if the age-adjusted IPI is used, which eliminates the number of extranodal sites as a risk factor, most patients have an elevated lactate dehydrogenase LDH level, thus reducing the usefulness of its discriminatory power [30]. There is emerging evidence that dose-intensified therapy using methotrexate, doxorubicin, cyclophosphamide, vincristine, prednisone, and bleomycin MACOP-B [32] or etoposide, doxorubicin, cyclophosphamide, vincristine, prednisone, and bleomycin VACOP-B [33] may be superior to cyclophosphamide, doxorubicin, vincristine, and prednisone CHOP -type regimens using historical comparisons [11 â€” 13]. More recently, an intensive chemotherapy regimen, NHL using dose-dense sequential induction with doxorubicin followed by cyclophosphamide with G-CSF support , demonstrated superiority to CHOP-like regimens that included some of the familiar second- and third-generation regimens. However, the number of patients receiving specific regimens was too small for individual comparisons. Further, there is an inherent selection bias of patients chosen to be treated with more intensive regimens. However, all but two patients were in a PR or CR prior to transplant with induction therapy consisting of VACOP-B, and because of the high frequency of residual masses in this disease, many of the patients in PR according to imaging may be in pathological CR. This regimen administers the natural product chemotherapy agents by continuous infusion etoposide, doxorubicin, vincristine in addition to bolus cyclophosphamide and oral prednisone with dose adjustments based on the neutrophil nadir [39]. With a median follow-up of 8. However, the utility of more intensive chemotherapy regimens in the treatment of PMBCL can only be evaluated in a well-designed clinical trial that includes the addition of rituximab to each regimen. There is poor correlation between the size of a residual mass on computerized tomography and the risk for relapse [41 , 42]. In many instances, the residual density represents fibrotic tissue rather than active lymphoma, similar to the problem encountered in bulky mediastinal NScHL [41]. Many patients are given mediastinal radiotherapy as consolidative treatment for this reason; however, it is unclear whether this impacts relapse or cure rates. There is an inherent concern of long-term toxicities of mediastinal radiotherapy, including an increased risk for cardiovascular disease and secondary malignancies, particularly given the young population at risk [43], akin to treatment considerations NScHL. Further, several studies have demonstrated that chemotherapy alone is effective in many cases [9 , 13 , 30 , 40], suggesting that radiotherapy is not necessary in all patients. A longer event-free survival time was reported in one study when radiotherapy was given to patients achieving a CR [11]. However, a recent analysis evaluating the impact of a treatment policy change recommending routine consolidative radiotherapy following primary chemotherapy, failed to demonstrate a benefit [13]. The retrospective nature of such analyses, including definitions of response rates, is problematic, and randomized studies addressing this question are lacking. Better identification of patients who may benefit from the addition of radiotherapy is needed. Gallium 67Ga scintigraphy has been used to detect persistent viable tumor in patients with a residual mass after therapy [44]. Future studies are needed to evaluate the utility of 18F-FDG-PET to select patients with PMBCL who may benefit from radiotherapy and to identify those cases in which it can be safely withheld without compromising cure rates, with the goal of reducing secondary long-term complications. Recent studies, including those using a refined molecular signature, suggest that the outcome is more favorable than that of DLBCL. Using historical comparisons, dose-dense and dose-intensive regimens may be more effective than CHOP chemotherapy; however, the impact of adding rituximab to these regimens and effect on outcome comparisons is unknown. Clinical trials exploring these questions in addition to the benefit of consolidative radiotherapy are necessary to definitively answer these questions. Disclosure of

Potential Conflicts of Interest The author indicates no potential conflicts of interest.

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2: The Mediastinum: Anatomy | Radiology Key

2. Introduction "The identification of fat within a focal or diffuse mediastinal lesion significantly narrows the differential diagnosis " and "In many cases, a.

Multinodular lung parenchymal disease can be characterized by lobar distribution and by diffuse versus focal disease. However, in order to develop a useful differential diagnosis, characterizing nodular disease by its relationship to secondary lobar anatomy is the most useful 1. The three most commonly used distributions are: Randomly distributed nodules are by definition diffuse in nature with no obvious pattern. Diseases that are spread via a hematogenous route commonly cause a random distribution of nodules. Although diffuse, these nodules may show a predominance in the lung bases due to the higher perfusion there 2. Metastatic disease, such as carcinomatosis, is the most common cause of random nodules. Miliary infections, such as tuberculosis, Mycobacterium avium complex, or fungal disease can also cause this pattern, but are usually seen in a centrilobular distribution see below. Nodular disease can also be found clustered around the fissures, along the interlobular septae, and along the pleura. These regions are where the lymphatics are extensive, and this pattern is termed a perilymphatic distribution 2. Sarcoidosis is the classic disease that fits this distribution. Sarcoidosis can also occur in the lymphatics of the bronchovascular bundle. Importantly, lymphangitic carcinomatosis occasionally fits a perilymphatic distribution, but it is usually associated with lymphadenopathy, pleural effusions, and septal thickening. The third category involves nodules that do not touch the pleura and are not along the fissures. These nodules are found around the centrilobular bronchioles and their pulmonary artery branches, hence the label centrilobular nodules 3. Tree-in-bud refers to branches that can come off the nodules, giving them this appearance 4. This appearance usually fits with an infection such as Mycobacterium avium complex, Mycobacterium tuberculosis, fungal, or other bacterial infection. Hypersensitivity pneumonitis and respiratory bronchiolitis are the most common diseases that present as ground-glass centrilobular nodules 2. In our case, the nodules were in a perilymphatic pattern. However, no malignant cells were seen in the mediastinoscopy samples or the trans-bronchial biopsy samples. Also, little septal thickening and no effusions were seen. Pathology instead revealed granulomatous lymphadenitis in the lymph node samples and multiple non-necrotizing granulomas in the trans-bronchial samples. While clubbing is rare in sarcoid, given these findings and the perilymphatic distribution, sarcoidosis is the most likely diagnosis. However, the diagnosis of a sarcoid-like reaction to tumor antigens released from a recurrence cannot be completely ruled out see below. Given the large number of biopsies with no evidence of recurrence, this is somewhat less likely. This is especially true in light of her malignancy history, as any treatment has the potential to increase the risk of recurrence or development of a secondary malignancy. Question 2 Which of the following statements concerning sarcoidosis and malignancy is the most accurate? Sarcoid increases the risk of certain types of malignancies Incorrect! The relationship between sarcoid and malignancy is unclear Correct! Sarcoid has no effect on the incidence of malignancy Incorrect! There is a decrease in malignancies in patients with sarcoid Incorrect! Certain malignancies increase the risk of developing sarcoidosis Incorrect! One of the first attempted links between sarcoidosis and malignancy was a paper by Brincker in 5. He compared the incidence of lymphoma in the general population with the incidence in patients with respiratory sarcoidosis and found an fold increase in the occurrence of lymphoma in this population. Others have noted patients with sarcoidosis having a higher incidence of other malignancies, mostly lung and breast, although links have been reported with many others 6. The above evidence citing a relationship between sarcoid and malignancy has been refuted by several authors. Using a large national sarcoid registry of patients, Askling et al 8 compared the incidence ratios of a variety of malignancies in this group to that of the general population. Skin cancer, lung cancer, melanoma, and lymphoma rates were all increased in the sarcoid group. Again, most of the increase was found in the first years after the diagnosis of sarcoid. Additional studies have shown the development of non-caseating granulomas in the organ where the tumor originated, along with the spleen and bone marrow of patients with cancer 9 without having the systemic signs of sarcoidosis. These investigations have led to the theory that patients with malignancies can develop areas of non-caseating granulomas as a

response to their tumors without having overt sarcoidosis. This has been termed the sarcoid reaction. The most common occurrence of this is in lymph nodes which drain the area of the malignancy Further controversy has come from other observations finding no link between sarcoidosis and malignancy It is not currently clear what the relationship between sarcoid and malignancy is at this point. Question 3 Which imaging test best differentiates between sarcoidosis and malignancy when evaluating lymphadenopathy?

3: - NLM Catalog Result

The identification of fat within a focal or diffuse mediastinal lesion significantly narrows the differential diagnosis. In many cases, a specific diagnosis can be suggested on the basis of CT findings. In this article, we illustrate and review the characteristic CT features of common and uncommon.

4: Primary Mediastinal Large B-cell Lymphoma Exhibiting Endobronchial Involvement

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5: Diffuse Mediastinal Abnormalities | Radiology Key

As part of the successful THE REQUISITES series, the second edition of Thoracic Radiology: The Requisites, by Theresa McLoud, MD and Phillip Boiselle, MD, presents the most essential information you need to know about chest radiology, including some of the more recent techniques in chest imaging such as CTA and PET imaging.

6: Mediastinum | Radiology Reference Article | www.enganchecubano.com

Infections of the mediastinum (ie, mediastinitis) are serious, are associated with high morbidity and mortality, and may result from adjacent disease with direct extension, hematogenous spread, or direct introduction into the mediastinal space.

7: Primary Mediastinal Large B-Cell Lymphoma

Phillip M. Boiselle. we illustrate and review the characteristic CT features of common and uncommon fat attenuation lesions of the mediastinum, including focal masses and diffuse abnormalities.

8: RadiologySpirit: Diffuse Mediastinal Abnormalities

The mediastinum is a space in the thorax that contains a group of non-delineated organs and their surrounding connective tissue. It lies in the midline of the chest between the pleura of each lung and extends from the sternum to the vertebral col.

9: Mediastinal lymph node enlargement | Radiology Reference Article | www.enganchecubano.com

The mediastinum is an anatomic region bounded laterally by the two lungs, anteriorly by the sternum, posteriorly by the vertebrae, superiorly by the thoracic inlet, and inferiorly by the diaphragm.

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