CLINICAL STATEMENT: Neck swelling, lump, mass right side for two months. History of carotid surgery in 2007. Marker placed at ROI.

TECHNIQUE: Axial images were obtained through the head following bolus intravenous administration of 50 cc of Optiray-300 reduced GFR of 43.

Axial images were obtained through the neck with reconstructed images in the sagittal and coronal planes.

FINDINGS: There is a complex mass in the right parotid gland. It remains in the superficial lobe, it measures 21 mm AP, 16 mm transverse and 22 mm seen on image 68 sagittally and image 55 series 3 axially. It is heterogeneous in its enhancement pattern, in part this may be related to the reduced volume of contrast. It is mildly lobulated. The left parotid gland is unremarkable. There are no calcifications of the parotid glands. Small calcification is seen posterior to the mandible on the right side related to arterial structures.

No pathologically enlarged adenopathy is seen throughout the neck. There are a few scattered subcentimeter level I, level II and level III nodes.

Normal floor in mouth, base of the tongue, normal epiglottis, glottis and subglottic regions.

Thyroid gland is within normal limits in size without focal abnormality.

There are vascular calcifications seen moderately heavy in the region of the carotid bifurcations bilaterally involving the origins of the vertebral arteries bilaterally. There is heavy atherosclerotic disease.

Normal parapharyngeal soft tissue planes. Normal posterior nasopharyngeal and retropharyngeal soft tissues.

The retrostyloid fat, facial nerve canal are unremarkable. Mastoid air cells, middle ear cavities are clear. IACs, inner ear structures are unremarkable. Skull base foramina are within normal limits.

Paranasal sinuses demonstrate a few mucous retention cysts in the maxillary sinuses, no air-fluid levels are seen.

Normal intraorbital contents including globes, optic nerve sheath complexes, extraocular muscles, intraorbital fat.

Intracranially no evidence of hydrocephalus, hemorrhage or abnormal enhancement.

In the cervical spine mild compromise of the foramina bilaterally at C2-3, moderately at C3-4, C4-5, moderate to severe at C5-6 with a mild to moderate spinal canal stenosis and moderate at C6-7. The lung apices demonstrate diffuse emphysematous changes and there is interstitial scarring in the posterior aspect of the left upper lobe.

IMPRESSION:

1. There is a 22 x 21 x 16 mm lobulated mass, heterogeneous in its appearance contained within the superficial lobe of the right parotid. It does not extend into the stylohyoid canal. It is likely a pleomorphic adenoma which can be heterogeneous as it gets larger. There is no pathologically

enlarged adenopathy seen. Fine needle aspirate would be recommended however. No evidence of perineural spread is seen.

2. There is moderately heavy atherosclerotic disease in the region of the carotid bifurcations and the origins of the vertebral arteries bilaterally.