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PATIENT: JOHN SMITH
DOB: 5/5/1955
FILE #: 12345
PHYSICIAN: REFERRING
EXAM: MRI NECK WITH AND WITHOUT CONTRAST
DATE: 1/1/2011

CLINICAL INFORMATION

Right parotid mass.

COMPARISON

Comparison CT head/upper neck dated 1/6/2015.

CONTRAST

6 cc of Gadavist administered without complication.

TECHNIQUE

Axial, sagittal and coronal T1-weighted, sagittal, axial and coronal fat saturated T2-weighted images were obtained. Following contrast administration, sagittal, axial and coronal T1-weighted sequences were also obtained.

FINDINGS

Evaluation of the neck reveals a somewhat heterogeneous but well defined lobulated mass within the superficial lobe of the anterior right parotid gland. The mass demonstrates a rounded focus of signal prolongation with enhancement. The mass measures approximately 0.8 x 0.9 x 0.7 CM (anterior-posterior by transverse by superior-inferior). This appears similar to that noted on the prior CT. The mass just abuts the retromandibular vein, patent

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and medial to the right parotid duct. The mass is most consistent with a benign pleomorphic adenoma. No left-sided parotid mass is seen. Right and left submandibular glands are unremarkable.

The mucosal surfaces of the upper aerodigestive tract appear symmetric and unremarkable. The larynx is intact.

The nasopharynx is symmetric without distinct lesion.

The tongue and tongue base appear symmetric and unremarkable. The median raphe is midline.

The thyroid gland appears symmetric without distinct nodule.

No pathologically enlarged lymph nodes are found. The visualized lymph nodes demonstrate no central necrosis or extranodal extension.

The right and left faucial tonsil is symmetric and unremarkable. The lingual tonsillar tissue appears symmetric and of normal volume. The posterior nasopharyngeal lymphoid tissue does not appear enlarged.

Evaluation of the paranasal sinuses reveals no significant sinus inflammatory disease. No air-fluid levels are noted.

The central skull base is intact. The central petrous temporal bones and mastoids remain clear. The visualized base of brain appears unremarkable.

Cervical spondylosis is noted, most notable for a broad-based disc bulge and dorsal osteophytic ridge at the C5/6 level with a C6/7 level focal 2 mm central disc protrusion and dorsal osteophytic ridging, resulting in mild central spinal stenosis. Mild foraminal narrowing also evident bilaterally.

The lung apices are clear.

IMPRESSION

1. Heterogeneous enhancing well-defined right parotid mass located in the superficial lobe anteriorly, likely benign mixed tumor although other parotid tumors may have a similar appearance. No left-sided parotid lesion seen. No pathologic lymphadenopathy.
2. No pharyngeal mucosal lesion.
3. Mild cervical spondylosis.

[NationalRad Neuroradiologist]
Board Certified Radiologist

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