

# Daniel Powers, M.D., Inc.

R A D I O L O G Y

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B Reader

Board Certified Diagnostic and Nuclear Radiologist  
Certified by the American Board of Radiology

PATIENT NAME: LONG, MYLES (69 years old)  
FILE NO.: 38206  
DATE OF TESTING: NOVEMBER 16, 2002  
REFERRING PHYSICIAN: STEVE PULMANO, M.D.

## **OVERALL CONCLUSIONS:**

The four plain radiographic views of the chest, the supine computerized tomographic scan of the chest without iodinated contrast (spiral CT scan) and the prone high resolution, thin slice computerized tomographic scan of the lungs (HRCT) revealed:

1. **LOW PROFUSION PARENCHYMAL CHANGES AND SCATTERED LIMITED BUT DEFINITE NON-CALCIFIED PLEURAL PLAQUE FORMATION, CONSISTENT WITH THE IMAGING DIAGNOSIS OF ASBESTOSIS.**
2. **SEVERAL SMALL SCATTERED NON-CALCIFIED, LESS THAN 5 MM DIAMETER NODULES – ANY ONE OF WHICH MAY REPRESENT AN EARLY PRIMARY CARCINOMA OR, IN TOTAL, COULD REPRESENT VISUALLY EARLY METASTATIC DISEASE. CLINICAL CORRELATION AND, IF INDICATED, SEQUENTIAL IMAGING FOLLOW-UP IS RECOMMENDED.**
3. **OTHER FINDINGS:**
  - A) **LIMITED BULLOUS EMPHYSEMA INVOLVING THE UPPER AND MID-LUNG ZONES.**
  - B) **SUGGESTED SUBTLE NODULARITY AND FULLNESS IN SIZE TO THE RIGHT ADRENAL GLAND, NEEDING FURTHER WORK-UP. AN EARLY VISUAL MANIFESTATION OF METASTATIC DISEASE COULD NOT BE EXCLUDED.**

***Providing Statewide Diagnostic Imaging Services and Second Opinions***

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**OVERALL CONCLUSIONS:** - (continued)

- C) A MID-THORACIC VERTEBRAL BODY COMPRESSION FRACTURE – SECONDARY TO SOFT BONES – SENILE OSTEOPOROSIS, A HISTORY OF PRIOR TRAUMA AND/OR METASTATIC DISEASE. CORRELATE WITH PRIOR PLAIN RADIOGRAPHS AND HISTORICALLY, AND/OR IF NECESSARY WITH TOTAL BODY BONE SCANNING TO DETERMINE THE ACTIVITY OF THIS SITE AND TO EXCLUDE MULTI-SITE INVOLVEMENT AS MIGHT BE SEEN WITH METASTATIC DISEASE.**

**ADDITIONAL COMMENTS:**

There is a difference of opinion relative to the need to follow-up small non-calcified nodules within the lungs. By far and away, the most common etiology is non-calcified granulomas. Other etiologies can include scarring or lymph nodes. However, early carcinoma(s) can occasionally occur. Given that this was an asbestos-exposed individual, and especially given that this patient smoked, then there is a substantial increased risk of carcinoma of the lung. On that basis, sequential three-months spiral CT or focal HRCT over the nodule may be desired.

In this patient, although the non-calcified nodules may represent small non-calcified granulomas, there was not other visual evidence for prior granulomatous disease in this person's chest, and the right adrenal gland was abnormal in appearance in addition to the mid-thoracic vertebral body compression fracture. Therefore, given both asbestos exposure and smoking history, with findings of both on chest imaging, follow-up sequential CT imaging is highly recommended with the initial scan performed at three months from the date of this examination (and/or less, if so indicated by the treating physician).

**DISCUSSION:**

The PA upright chest x-ray (CXR) gives an overview of the thorax for plaquing, interstitial/parenchymal changes, nodules and/or other masses, effusions and diffuse pleural changes. However the chest wall, pleura, hila, mediastinum and lung parenchyma are superimposed and thus, findings may be missed, underestimated or overlapping and difficult to separate out from one another. Oblique views of the chest allow for additional analysis of the chest walls.

The supine computerized tomographic scan of the chest without iodinated contrast (spiral CT scan) is designed to screen for pleural plaquing and differentiate extra-pleural fat from pleural plaques. It also looks for pulmonary nodules suggestive for carcinoma, rounded atelectasis, mesotheliomas and pleural effusions. Compared with plain radiographs, it is better able to separate out the chest wall, pleura, hila, mediastinum and lung parenchyma for improved delineation of individual findings. It is superior to plain radiographs for the detection of calcification within plaques. Should interstitial fibrosis be a concern, then prone HRCT would be necessary because the spiral CT scan is

**DISCUSSION:** - (continued)

performed with relatively thick slices (7 mm thick, 7 mm apart) and in the supine position, leading to dependent density where the blood pools in the posterior aspects of the lungs causing increased density, the areas most often the location of interstitial fibrosis caused by asbestosis.

The prone high resolution, thin slice computerized tomographic scan of the lungs (HRCT) is designed to evaluate the chest for interstitial fibrosis, given its thin slices (1.0 mm thick). Improved resolution, but lesser screening for pleural plaque formation and improved pulmonary nodule characterization, if specifically scanned, is afforded by this technique.

**PROCEDURE:**

All three studies - the plain radiographs, supine spiral CT and prone HRCT, were obtained at **HIGH-TECH IMAGING (LOS ANGELES)** by Richard Kraneum, CRT, ARRT (CT). The supine spiral CT and prone HRCT studies were performed on a General Electric, Hi-Speed spiral system.

Statement Regarding Section 139.3 of the Labor Code and Truth in Reporting:

Under penalty of perjury, the above diagnostic imaging studies and report have not been obtained in knowing violation of Labor Code Section 139.3 and the contents of the report are true and correct to the best knowledge of the signing physician below.

Mailing Notice and Lien Settlement Request - Please add Daniel Powers, M.D., Inc. (DP) to the address list for service of all notices of conferences, MSC's and hearings before the WCAB. DP is advising the WCAB that it may not appear at hearings or MSC's for the case in chief; however, in accordance with Procedures set forth in the Policy and Procedural Manual Index No. 6.610 effective 2/1/95, DP requests defendants to have full authority to resolve DP's lien by contacting DP's office and asking to speak with a DP "lien negotiator".

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