09:26:39 From Hamidullah Mansoor To Everyone:

is there any type of lung cancer not staged with TNM staging system?

09:28:20 From Francesca Willson To Everyone:

is it possible to look at the images with the contralateral lymph nodes again as it scrolled through the images really quickly

09:33:17 From Samar Abdelhameed To Everyone:

Replying to "is it possible to lo..."

Apologies for the speed, these images were quoted from the thoracic oncology manual. Also I believe the PPT will be available later.

09:49:52 From Stuart Baugh To Everyone:

how should we stage leipedic adenocarcinoma when it appears multi-focal?

09:52:24 From Sughra Alawi To Everyone:

What minimum size of nodule can be detected by PET

09:53:02 From Samar Abdelhameed To Everyone:

Replying to "how should we stage ..."

We should stage the dominant lesion (is it pure GGO or PSN) and then we can include the number of the synchronous lesions between apprentices. For example, Multiple bilateral synchronous adenocarcinoma

spectrum lesions, Dominant lesion is LUL. Radiological staging is T1a(5) N0 M0.

09:53:56 From Samar Abdelhameed To Everyone:

Replying to "how should we stage ..."

If we for example got only few synch lesion, each should be mentioned and staged separately in the report.

09:55:40 From Rachel Benamore To Everyone:

Replying to "how should we stage ..."

you beat me to it, Samar! I agree. In Oxford, we work on the premise of giving the patient the benefit of the doubt or the staging which offers the best chance of radical treatment. We tend to stage and

treat these patients on the assumption that they have multifocal primary tumours, rather than staging as satellite nodules or lung metastases. This gives us the option of radical treatment - surgery/SABR/ablation for

each as and when they develop sufficient solid component.

09:56:49 From Rachel Benamore To Everyone:

Replying to "What minimum size of..."

generally 8 to 10mm in considered the threshold for assessment with PET-CT but check with your local centre

09:59:10 From Ihsan Ullah To Everyone:

Replying to "What minimum size of..."

What is significant herder score ? 10 % ? and how you calculate it?

10:00:52 From Rachel Benamore To Everyone:

Replying to "What minimum size of..."

I suggest you download the BTS pulmonary nodule app; this will calculate nodule VDT, Brock and Herder scores for you. In my nodule lecture, which is pre-recorded, I talk through Herder scores

10:01:44 From Rachel Benamore To Everyone:

Replying to "What minimum size of..."

https://www.bing.com/search?q=bts+nodule+guidelines&cvid=67545ba1bb744b6b80a484d8a12f01bc&gs_lcrp=EgZjaHJvbWUqBAgAEAAyBAgAEAAyBAgBEAAyBAgCEAAyBAgDEAAyBAgEEAAyBAgFEAAyBAgGEAAyBAgHEAAyBAgIEADSAQg1MDMy

ajBqOagCALACAA&FORM=ANAB01&PC=NMTS

10:01:55 From Rachel Benamore To Everyone:

Replying to "What minimum size of..."

above is the link to the BTS nodule guidelines

10:05:10 From Katie Ferguson To Everyone:

Do recent pleural procedures such as thoracoscopy/pleurodesis/chest drains affect PET interpretation?

10:11:27 From Patrick Haslam To Everyone:

Is the DOTA PET scanning available everywhere or is it research tool/certain centres?

10:13:23 From Gaurav Ahuja To Everyone:

What is your take on difference in the avidity of the primary and nodes, when EBUS confidently excludes nodal involvement? In your MDT, would you stage them as N1/2 etc or N0. Thank you.

10:18:33 From Syeda Jafri To Everyone:

Till how long after RT the avidity remains high?

10:19:14 From Kay Por Yip To Everyone:

Do we still see a role for PETs in pleural malignancy considering surgery will probably not be considered for mesothelioma management from now on (taking into account MARS2 trial)

10:19:52 From George Hulston To Everyone:

If two lesions have very different SUVs would that suggest two different pathologies?

10:20:06 From Syed Hassan To Everyone:

Replying to "If two lesions have ..."

yes

10:20:59 From Manil Subesinghe To Everyone:

Replying to "What minimum size of..."

@Rachel Benamore Agree. With newer scanners on the horizon with improved sensitivity this threshold may reduce

10:21:52 From Manil Subesinghe To Everyone:

Replying to "Do recent pleural pr..."

Definitely. Pleurodesis especially usually demonstrates high-intensity FDG uptake and this persists for many many years as it is essentially a chronic inflammatory response

10:22:13 From Manil Subesinghe To Everyone:

Replying to "Do recent pleural pr..."

Chest drains usually only demonstrate low-grade uptake

10:22:44 From Gaurav Ahuja To Everyone:

Is there value of PET in treating AIS/T1mi spectrum lesions ? We know they are unlikely going to PET avid. Is there any evidence that doing PET in these cases upstages the cancer? Thanks.

10:24:04 From Manil Subesinghe To Everyone:

Replying to "Do recent pleural pr..."

Recent thoracoscopic surgery can demonstrate higher intensity uptake...we usually recommend waiting 6-8 weeks following surgery to allow benign post-surgical changes on FDG PET-CT to resolve. The risk of doing PET-CT

earlier, with higher intensity uptake associated with post-surgical change, is that we potentially call benign post-surgical change, malignant..i.e. false positive observation.

10:24:12 From Syed Hassan To Everyone:

Replying to "Is the DOTA PET scan..."

Had it in all the DGHs I worked

10:25:38 From Manil Subesinghe To Everyone:

Replying to "Is the DOTA PET scan..."

DOTA-peptide PET-CT is available but not at all hospitals. It requires a Gallium generator and radiopharmacy on-site. But the centres that do perform it accept referrals from anywhere, like our institution KCL/GSTT PET

Centre http://www.sthpetcentre.org.uk/ForClinicians_Referrals/referrals.php

10:26:20 From Manil Subesinghe To Everyone:

Replying to "What is your take on..."

For me, if there is differential avidity between the primary tumour and hilar/mediastinal nodes would be

10:26:35 From Manil Subesinghe To Everyone:

Replying to "What is your take on..."

1. Are they different pathologies

10:27:20 From Manil Subesinghe To Everyone:

Replying to "What is your take on..."

2. Are they related, but is it that the nodal disease has only small volume metastatic involvement, hence not generating much PET signal to have comparable avidity to the primary tumour

10:27:39 From Manil Subesinghe To Everyone:

Replying to "What is your take on..."

3. Is it possible that the EBUS-TBNA is a false negative result

10:28:16 From Manil Subesinghe To Everyone:

Replying to "What is your take on..."

If the nodes are small, non-enlarged, and EBUS-TBNA negative...I would trust the results..you have to set your threshold somewhere

10:29:50 From Manil Subesinghe To Everyone:

Replying to "What is your take on..."

If the nodes are enlarged, not much uptake, EBUS-TBNA negative for malignancy...I would ask the pathologist, were there any granulomas/anthracosis etc that could explain the uptake on PET-CT. If not, as

per NICE guideline, consider formal surgical staging of the nodes

10:33:14 From Manil Subesinghe To Everyone:

Replying to "For case 1 is there ..."

Absolutely a case for MRI liver at the outset and I think nowadays given the easier accessibility to diagnostics an MRI is justified. Remember can only say benign or malignant based on avidity. If a solitary

liver lesion, and no definitely a cyst, or any features on the prior CT to suggest a benign haemangioma, I personally would suggest a MRI for better characterisation with MRI, which can non-invasively suggest a diagnosis.

10:34:09 From Patrick Haslam To Everyone:

Replying to "For case 1 is there ..."

Mail - out of interest was that case considered a missed or delayed diagnosis?

10:34:34 From Manil Subesinghe To Everyone:

Replying to "Till how long after ..."

Following radiotherapy, we usually recommend waiting 3 months post-completion to give us much time to allow for any benign post-RT inflammatory changes, which will be FDG avid, to subside. However, they can

still persist beyond this

10:37:11 From Manil Subesinghe To Everyone:

Replying to "Till how long after ..."

But most RT changes should not be particularly FDG avid, i.e. low-grade uptake at most. In the lung, we know that RT changes can become progressive and evolve many months after RT has finished with naturally,

concern raised for recurrence. The use of FDG PET-CT here to confirm low-grade uptake can be reassuring to suggest RT changes only (this is assuming the primary tumour showed significantly increased FDG uptake)

10:39:09 From Manil Subesinghe To Everyone:

Replying to "For case 1 is there ..."

This case was before my time so can't really comment. I think standard of care was followed...the differential for the liver lesion on CT would have been a benign haemangioma and with the FDG PET-CT showing no

increased uptake, that would fit

10:39:58 From Manil Subesinghe To Everyone:

Replying to "If two lesions have ..."

Agree

10:40:09 From Georgia Tunnicliffe To Everyone:

Replying to "Do recent pleural pr..."

How about a recent bronchoscopy?

10:42:20 From Manil Subesinghe To Everyone:

Replying to "Do we still see a ro..."

Hi Kay. I didn't know about the MARS2 trial. I agree, if surgery is no longer indicated in mesothelioma, then the indications for PET-CT in pleural malignancy will reduce.

10:44:09 From Manil Subesinghe To Everyone:

Replying to "Do we still see a ro..."

It will probably settle to utilising PET-CT for cases of uncertainty, e.g. characterisation of indeterminate lesions, or in situations where management will change based on the PET-CT result.

10:45:38 From Manil Subesinghe To Everyone:

Replying to "Is there value of PE..."

No role for PET-CT in ground glass nodules...not avid, so the question is what is the PET adding? The lack of avidity means no additive value of PET-CT, so wasted test.

10:47:11 From Manil Subesinghe To Everyone:

Replying to "Do recent pleural pr..."

@Georgia Tunnicliffe Not sure..I've not knowingly looked at a PET-CT and thought they've had a recent bronchoscopy..so I think unlikely to see uptake related to the bronchoscope per se, but if you've taken

transbronchial biopsies, perhaps we may see the site at which you've taken the biopsies from

10:49:30 From Gaurav Ahuja To Everyone:

Replying to "Is there value of PE..."

Thanks Samar. So, I hope our surgeons would not ask for a PET before considering resection

10:56:38 From Rachel Benamore To Everyone:

Replying to "Is there value of PE..."

I would also ask, though, why are your surgeons resecting ground glass nodules?

11:51:12 From Muhammad Tufail To Everyone:

Which one is the best view to look for endobronchial component? Axial or coronal

11:51:44 From Rachel Benamore To Everyone:

Replying to "Which one is the bes..."

I always start with axial imaging

11:52:03 From Rachel Benamore To Everyone:

Replying to "Which one is the bes..."

coronal and sagittal is good for measuring distance from the cords or the carina

12:04:31 From britney vernon To Everyone:

Sorry, what was the diagnosis for case 5? My internet froze.

12:05:07 From Rachel Benamore To Everyone:

Replying to "Sorry, what was the ..."

diffuse pneumonic type adenoca

12:17:16 From Syeda Jafri To Everyone:

would u biopsy before PET?

12:17:24 From Rachel Benamore To Everyone:

Replying to "would u biopsy befor..."

in parallel

13:27:03 From Ricky Jones To Everyone:

Positive versus negative silhouette sign?

13:45:48 From Lucy Webb To Everyone:

Would recent pleurodesis 'mimic' empyema on imaging - would enhancement of pleura be smooth as in empyema or more irregular?

13:46:47 From Syeda Jafri To Everyone:

Consolidation vs malignancy.

.???

13:48:04 From Rachel Benamore To Everyone:

Replying to "Would recent pleurod..."

it depends. If there was underlying features of pleural malignancy pre-pleurodesis, then nodularity would persist. Talc can incite an inflammatory reaction so can cause extrapleural oedema, as can

other inflammatory non-infectious causes of pleural thiekcneing/ effusions such as rheumatoid. It comes back to the history

13:59:14 From Meera Mehta To Everyone:

what are the radiological features of a fungal vs mycobacterial vs bacterial cavity CT?

13:59:47 From Lucy Webb To Everyone:

How do you differentiate between pneumatocoeles and cysts radiologically?

14:01:28 From Rachel Benamore To Everyone:

Replying to "How do you different..."

they can look the same. History is important e.g. PMH PCP/ staph etc.. If very numerous, then likely cystic lung disease

14:03:06 From Rachel Benamore To Everyone:

Replying to "what are the radiolo..."

air fluid levels--> bacterial. Fungal vs mycobacterial can be difficult but if there is irregular material inside or related to the inner wall of the cavity, this is much more likely to be fungal.

Often the fungal material can be irregular, a bit like the cut surface of a cauliflower or broccoli (radiologists love food analagies!)

14:03:50 From Rachel Benamore To Everyone:

Replying to "what are the radiolo..."

marked apical pleural thickening favours chronic pulm aspergillosis over mycobacterial and I often find serial CXR v helpful to appreciate this

14:06:20 From Ricky Jones To Everyone:

Pneumonia was significant mediastinal lymphadenopathy is Tb until proven otherwise.

14:09:01 From Rachel Benamore To Everyone:

Replying to "Pneumonia was signif..."

Yep

14:18:50 From Abdullah Bin Huda To Everyone:

Replying to "Pneumonia was signif..."

Is there any involvement of left lung?

14:20:43 From Rachel Benamore To Everyone:

Replying to "Pneumonia was signif..."

with respect to what?

14:21:07 From Abdullah Bin Huda To Everyone:

Replying to "Pneumonia was signif..."

the streptococcal pneumonia CT

14:26:12 From Wael Osman To Everyone:

It causes autoimmune anaemia

14:26:24 From Wael Osman To Everyone:

haemolysis and as such coombs positive

14:26:47 From Rachel Benamore To Everyone:

Replying to "haemolysis and as su..."

thank you. Fun fact! I vaguely remember that from MRCP :)

14:30:04 From Emad Abugassa To Everyone:

any

14:30:24 From Rachel Benamore To Everyone:

Replying to "any"

who'd be a radiologist heh?

14:31:24 From Kay Por Yip To Everyone:

Replying to "haemolysis and as su..."

The cold agglutinin bit clinched it for me