

Sep 18, 2025

Question	Answer	Answer Name
Do fat pad change and if so how quickly?	Fat pads can change over time and tend to mirror then general fat content of the patient. They can change more rapidly if the patient receives treatments such as steroids, that can predispose to central fat deposition. As chest physicians, you have the benefit of having the patient in front of you as well!	Rachel Benamore
can Dr Wing quickly run-through the last CXR before Pleural please? if time is ok, thanks	This was a lateral view of the chest, just to highlight the presence of the fissures. We don't commonly use lateral CXR but if there is density adjacent to the fissure and movement of the fissure, we can use this to delineate whether there is collapse/consolidation within a particular lobe.	Louise Wing
I may have missed it but what was the significant of visible vessels in lateral 2cm of lungs?	Generally, the peripheral lung is generally featureless. If you see structures in the peripheral cm or so of the lung, it usually denotes pathology such as interstitial lung disease, interstitial pulmonary oedema etc...	Rachel Benamore
L heart border on CXR if hazy is that pointing towards a fibrotic picture?	A hazy L heart border simply means that there is something in the in L upper lobe that has increased its density and therefore the sharp silhouette is lost. This may be consolidation, collapse or ILD	Louise Wing
How can trapped lung distinguished from pneumothorax?	Trapped lung is considered on CXR or CT where an effusion or pneumothorax has been drained but the lung has failed to expand fully (assuming no ongoing air leak in the case of pneumothorax). On imaging, look for features of visceral pleural thickening - you may see thickened visceral pleura if the pleural line is thick in the presence of a pneumothorax. Ancillary features of diffuse visceral pleural thickening are pleuroparenchymal bands (crow's feet) and covered in more detail in the pleural lecture.	Rachel Benamore

<p>what is ground glass actually? is that always infection</p>	<p>Ground glass is a description for faint increased density which is less dense than the surrounding vessels. It represents pathology within the alveoli and therefore it is not always infection and can be seen in many other pathologies including pulmonary oedema and ILD.</p>	<p>Louise Wing</p>
<p>If the IV contrast is causing attenuation is that always so diffuse or can it be local too?</p>	<p>It should be diffuse as the IV contrast would in normal patients be distributed throughout the capillary bed</p>	<p>Louise Wing</p>
<p>in practice we generally say do a ctpa (even if we have a low suspicion of PE) thinking that will give us answer for a PE , Malignancy , ILD or any other lung pathology. first qx is this the right thing to do? second qx what is the diff between a ct thorax with contrast and a ctpa</p>	<p>A CTPA is designed to answer the question of whether there is a PE or not. Modern scanners are of such high quality now that often we can make a diagnosis of malignancy, infection or ILD, but it will not always be possible to categorise the ILD. Furthermore, pleural abnormalities will also likely be missed on CTPA. Whether or not it's the right thing to do depends hugely on the clinical picture and what your differential diagnosis is - I don't think it's a simple yes/no answer.</p> <p>A CT is a type of CT thorax with contrast, it is just timed so that the images are obtained while contrast sits in the pulmonary arteries. The standard 'CT thorax with contrast' is obtained at 70s, when the pulmonary veins will also be opacified, making it easier to identify lymphadenopathy.</p>	<p>Louise Wing</p>
<p>in practice we generally say do a ctpa (even if we have a low suspicion of PE) thinking that will give us answer for a PE , Malignancy , ILD or any other lung pathology. first qx is this the right thing to do? second qx what is the diff between a ct thorax with contrast and a ctpa</p>	<p>One work around we sometimes use is an interspaced HRCT followed by CTPA in the same sitting. So we have the opportunity to look at the lungs in greater detail without the confounder of contrast medium, as well as being able to rule out PE.</p>	<p>Louise Wing</p>

why pleural abnormalities are missed on CTPA? is there a technique difference to perform a CTPA vs a CT thorax with contrast	The pleura enhance optimally at 120 seconds. So if we do a CTPA we can miss pleural enhancement although you would see an effusion.	Louise Wing
why pleural abnormalities are missed on CTPA? is there a technique difference to perform a CTPA vs a CT thorax with contrast	all will be revealed in tomorrow's pleural lecture!	Rachel Benamore
homogenous vs heterogenous emphysema pls comment	heterogeneous refers to the distribution - usually upper lobe predominant >lower zone. Homogeneous just means it's equally distributed throughout the lungs. This will be covered in the COPD talk.	Louise Wing
is traction bronchiectasis and traction bronchiolectasis the same ?	essentially the same process but bronchiectasis refers to bronchi and bronchiolectasis refers to bronchioles. They are often used interchangeably.	Louise Wing
What was the diagnosis in the young pt with ILD but not fibrosis who got better with steroids?	sarcoidosis	Louise Wing
could this not be AIP	It could - the appearances are non-specific and therefore history, examination and serology are important here	Louise Wing
are the bronchial wall always thickened? in bronchiectasis or could be just dilated	yes typically the bronchial walls should be dilated in bronchiectasis	Louise Wing
are the bronchial wall always thickened? in bronchiectasis or could be just dilated	bronchiectasis is defined pathologically as irreversible dilation of the airways so they need to be dilated on CT, in order to make the diagnosis	Rachel Benamore
Is the ratio 1 or 1.5 as mentioned earlier? Does it just depend on general age or clinical signs?	1.5 + is abnormal 1-1.5 can be normal in some cases but should be considered in the context of other signs (bronchial wall thickening, mucus plugging) and symptomatology	Louise Wing

would be sensible to classify Emphysema as "interstitial" disease? rather than airway disease?	In emphysema the interstitium is not affected.	Louise Wing
will these aggressive features apply when differentiating thymoma and thymic carcinoma? Or any other features? Thanks	Thymoma is on a spectrum - some are very indolent, some are aggressive. Thymic carcinomas often display aggressive features. PET-CT can be helpful with thymic carcinoma more FDG-avid.	Louise Wing
why is it advised that neurogenic tumours should not be biopsied?	Biopsy is extremely painful because of the dense innervation!	Louise Wing
hilar vs mediastinal LN. can you explain pls. 4R is hilar . so where is mediastinal?	4R is mediastinal, Hilar are 2 figures (10,11..etc)	Tarig Abdelrahim
hilar vs mediastinal LN. can you explain pls. 4R is hilar . so where is mediastinal?	4R is not hilar - it's in the paratracheal region. Differentiating 10R from 4R is a common source of error by radiologists. the inferior border of the azygos vein separates the right inferior paratracheal lymph nodes (#4R) from the right hilar lymph nodes (#10R)	Rachel Benamore
hilar vs mediastinal LN. can you explain pls. 4R is hilar . so where is mediastinal?	so 10R can look like it's a mediastinal node but it's not!	Rachel Benamore
so ebus accesible (hilar) node is only 10R and 10L then. yes?	EBUS can access station 11 nodes as well-they sit at a bronchial bifurcation with no intervening vessels	Rachel Benamore
Can mets from extra thoracic primary / contralateral lung manifest as GG nodules? Thanks	this would be very atypical but I have seen both melanoma and breast mets appear as partially ground glass nodules. The other differential to bear in mind with multiple part solid lesions is lymphoma, but all of these are far lower down the differential list than multifocal adenocarcinoma	Louise Wing

for the upcoming SCE exam in December. Should we be following the 8th or 9th edition?

I'm afraid you will need to confirm with your training committees on that one but we in oxford are now using TNM9 for our lung MDTs

Rachel Benamore

for the upcoming SCE exam in December. Should we be following the 8th or 9th edition?

You will be able to tell as the changes involve additional notation and it's mcq (eg M1c2)

Louise Wing

Carcinoids tend to bleed during endobronchial biopsy. Do they do same during CTGB?

yes!

Rachel Benamore