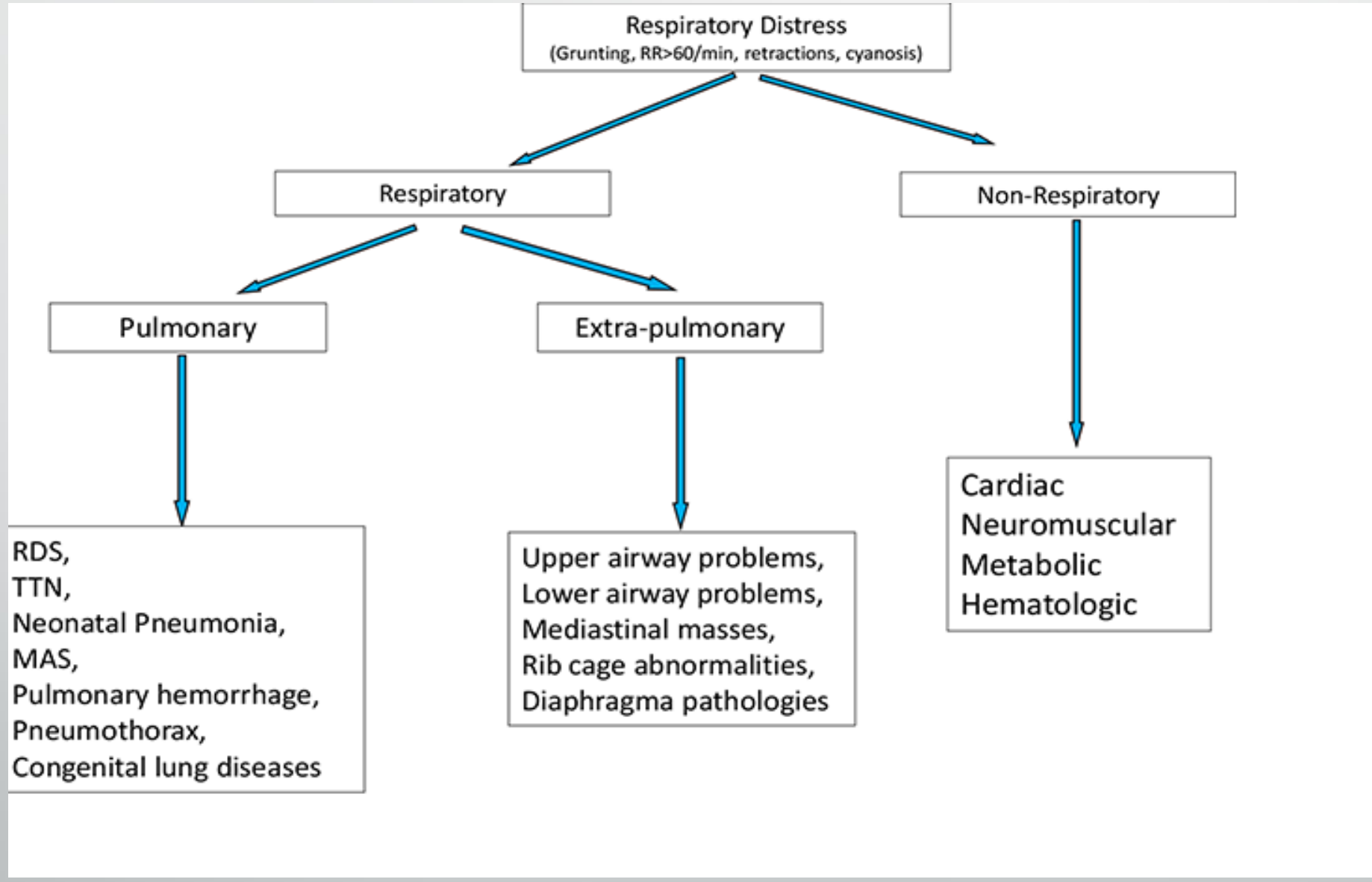
# Case I

- 6o day old term infant with wheezing and respiratory distress from birth especially during breast feeding ,so NG tube was inserted for nutrition .
- What is your diagnosis?? Pulmonary origine? Air way ? Infection? CHD? Neuromuscular and metabolic?
- All biochemistry,CBC,CRP and blood culture are uremarkable.

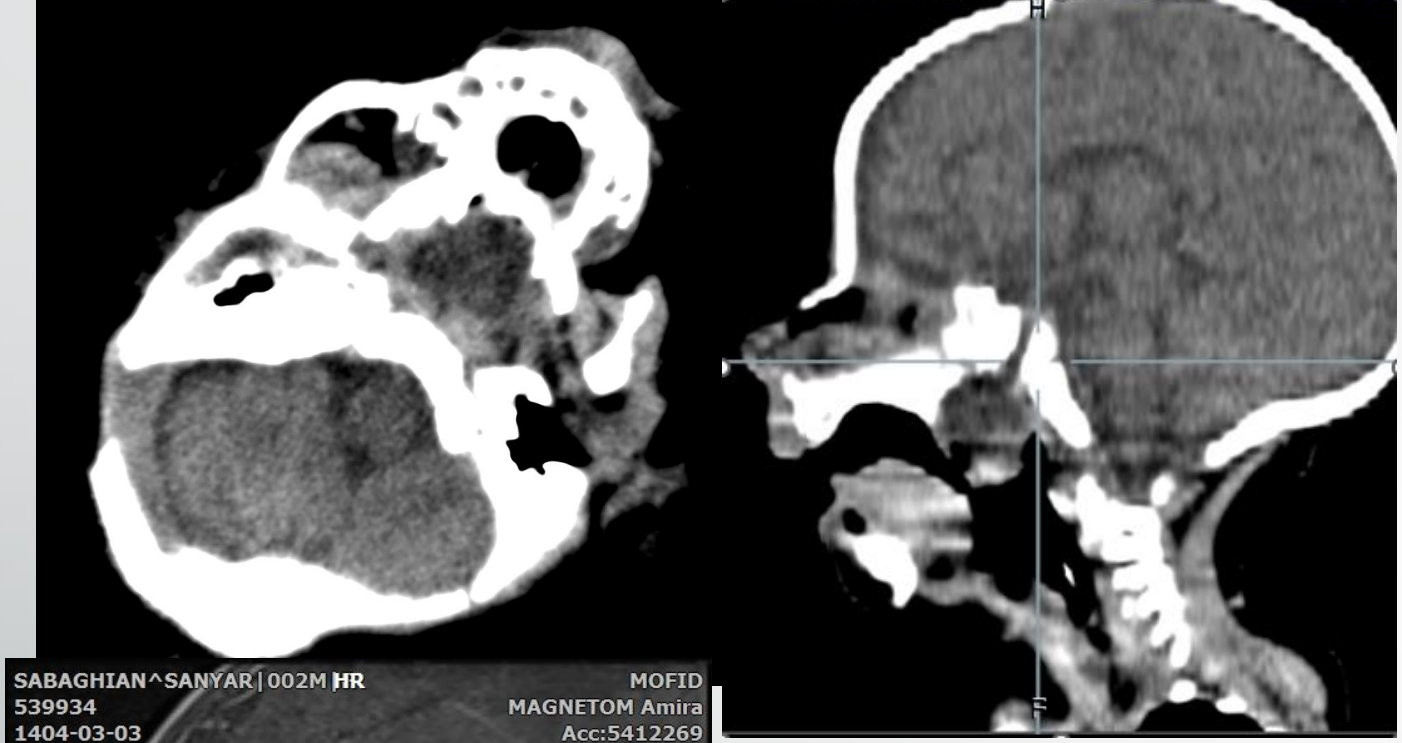
- What is the first imaging modality ? **CXR**

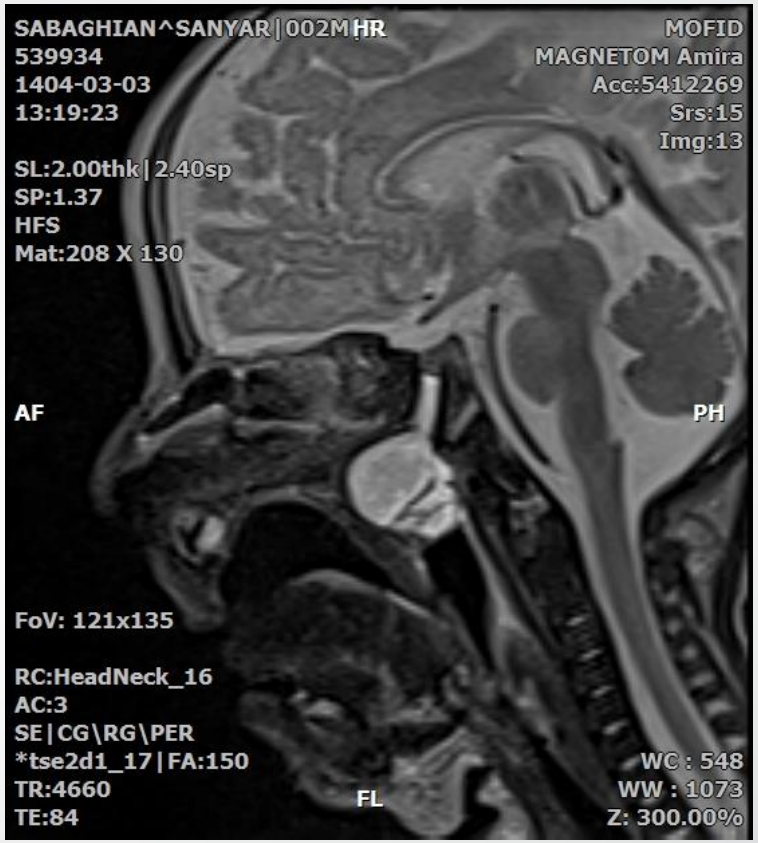

Respiratory Distress
(Grunting, RR>60/min, retractions, cyanosis)
Respiratory
Non-Respiratory
Pulmonary
Extra-pulmonary
RDS,
TTN,
Neonatal Pneumonia,
MAS,
Pulmonary hemorrhage,
Pneumothorax,
Congenital lung diseases
Upper airway problems,
Lower airway problems,
Mediastinal masses,
Rib cage abnormalities,
Diaphragma pathologies
Cardiac
Neuromuscular
Metabolic
Hematologic

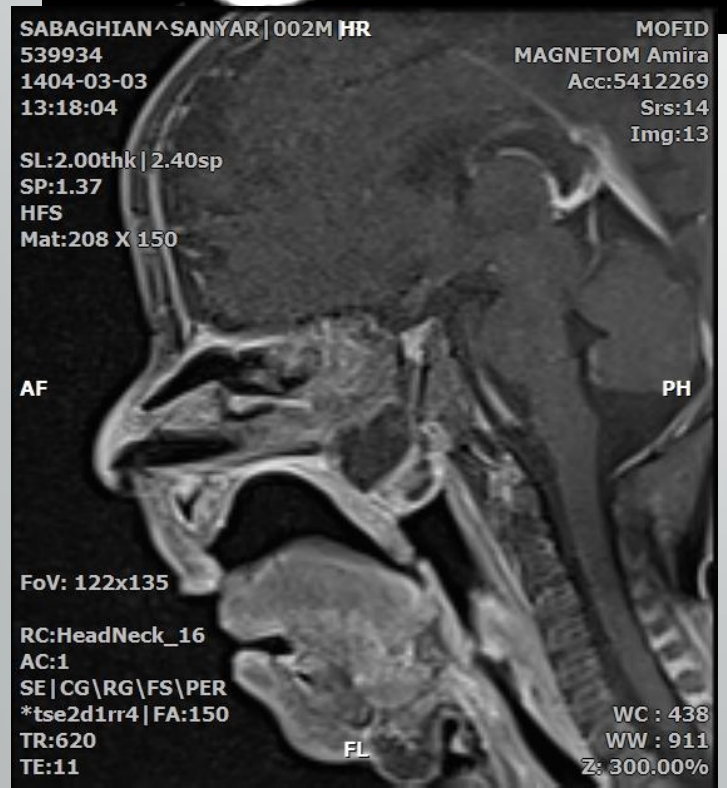
- CXR was normal.
- He referred to our center with diagnosis of laryngeal web or laryngomalacia

- Detailed history is important ; he had nasal discharge 3 days after birth and exaggeration of respiratory distress during feeding
- On close examination there was inferior bulging on soft palate from above during crying

- Masses in the anterior nasal cavity or involving the nasal ala can be readily apparent at clinical examination, those in the posterior nasal cavity and nasopharynx are often difficult to visualize at physical examination.
- Computed tomography (CT) and magnetic resonance (MR) imaging examinations are key to evaluating the location and extension of these masses, characterizing the tissue, and assessing osseous remodeling and/or erosion and determine intracranial connection or extension.






Medial perisellar sphenoidal cephalocel

- MR imaging is the imaging modality of choice for evaluating cephaloceles. MR images show the extension of the malformation, the cephalocele contents, and the associated intracranial congenital anomalies.
- venography and MR arteriography help to identify arteries, veins, and dural venous sinuses in the cephalocele.
- CT is helpful in demonstrating the osseous anatomy and defects for preoperative planning

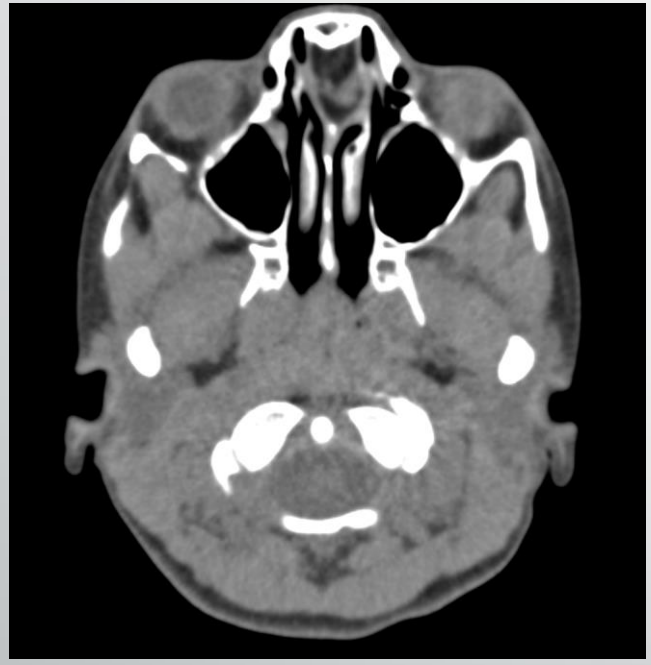
# DDx for nasal obstruction

1. Without mass :neonatal rhinitis, choanal atresia
2. Mass lesions: developmental and congenital, inflammatory and neoplastic

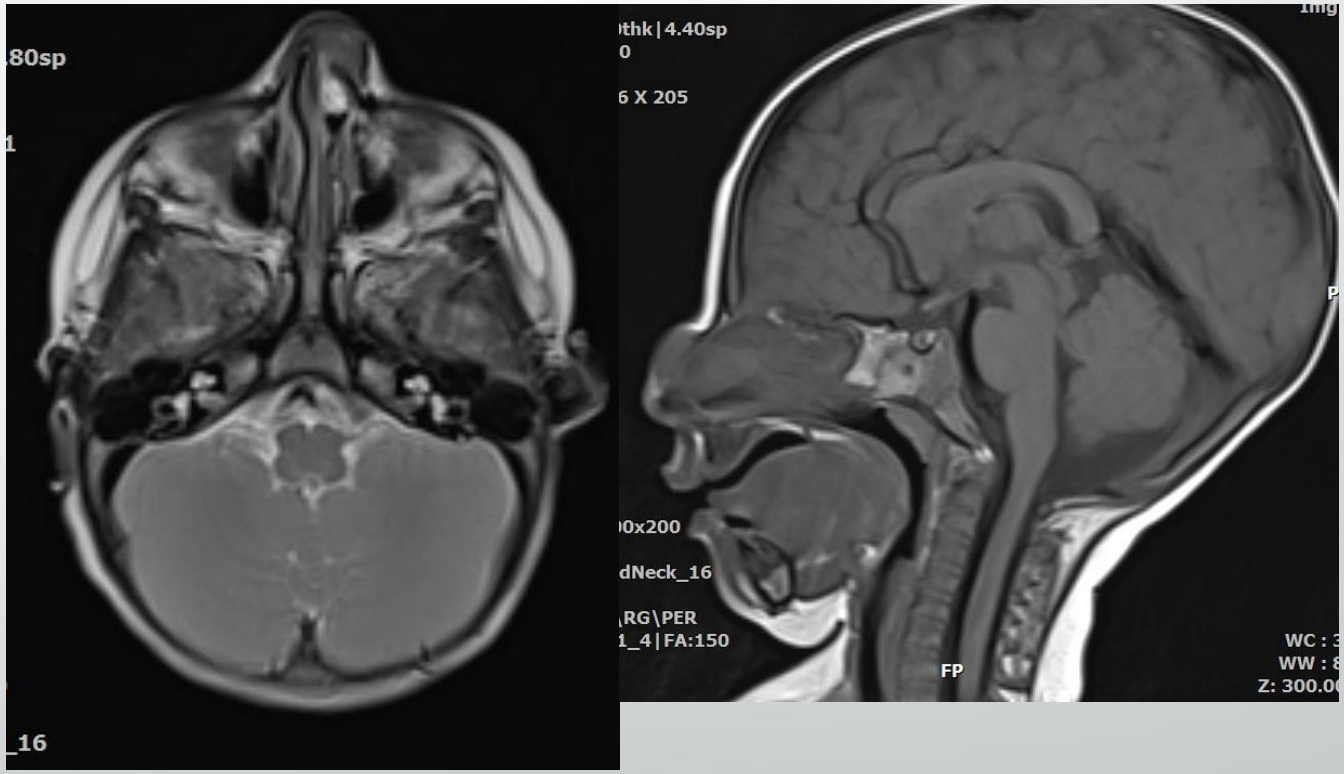
Choanal atresia

Piriformis aperture stenosis

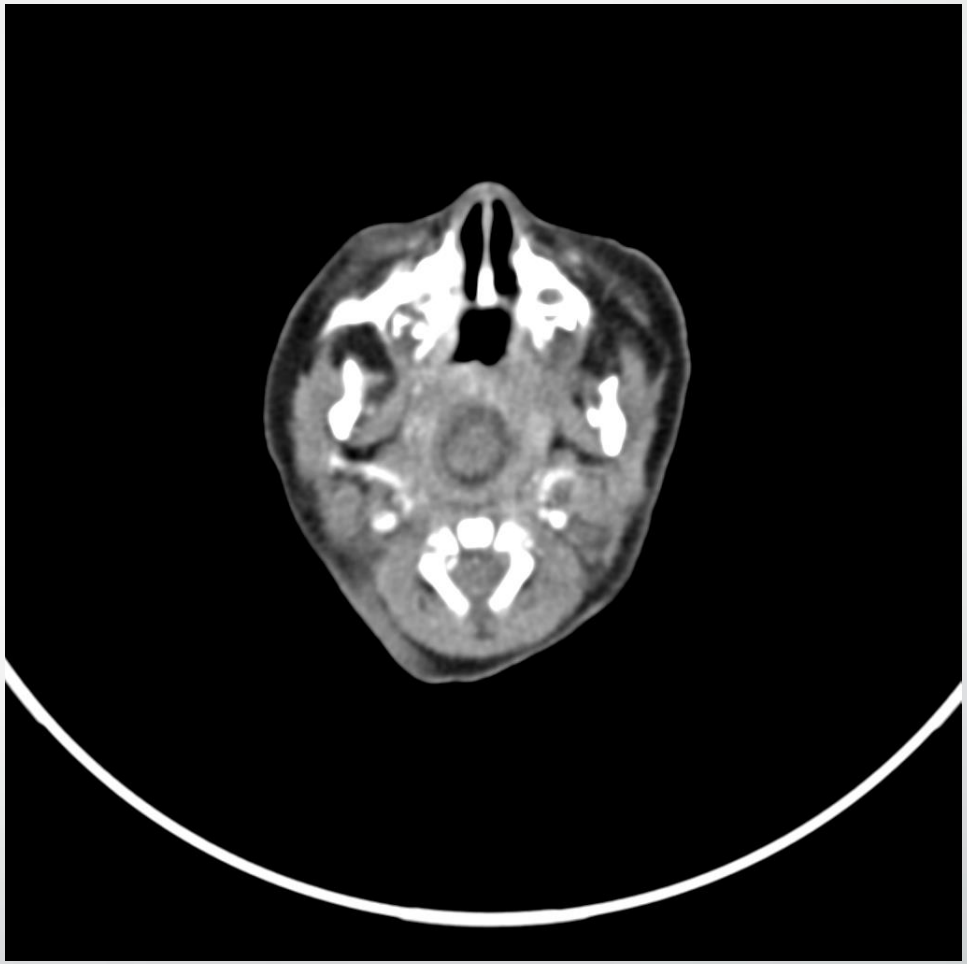
# Nasal and nasopharynx mass in infants



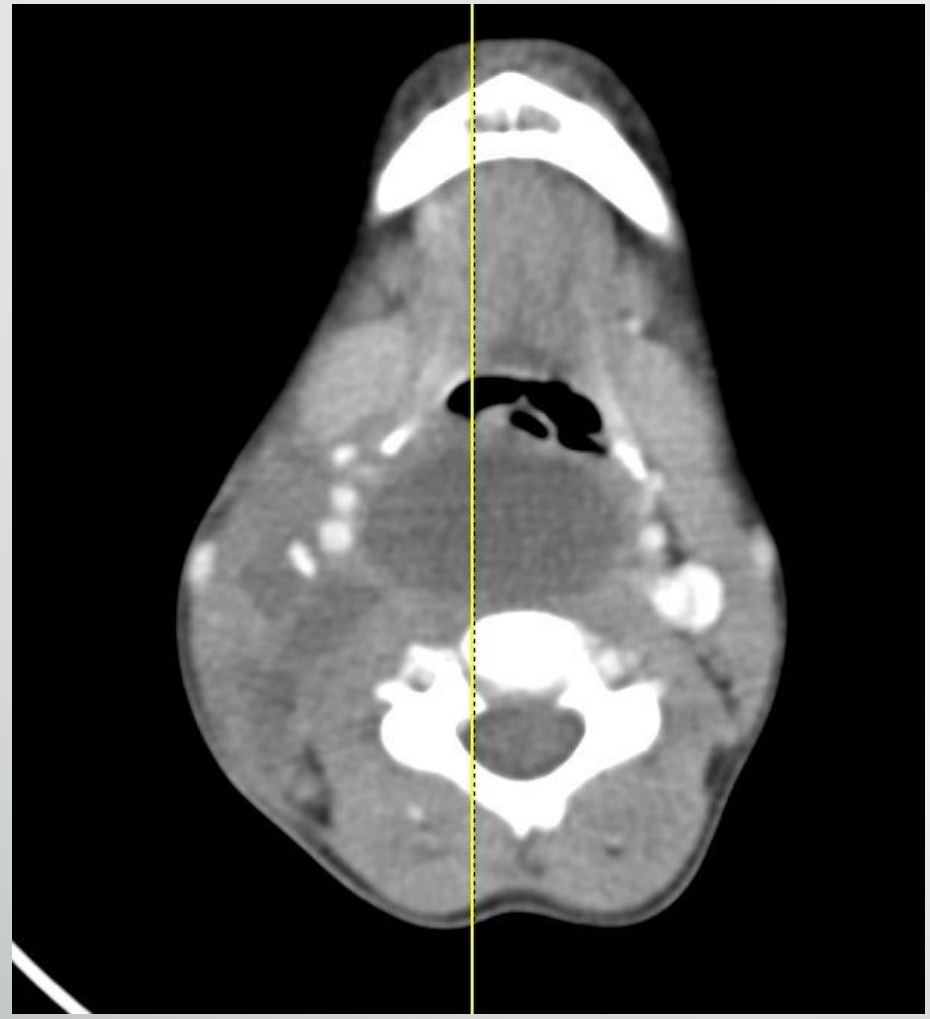
Nasal dermoid



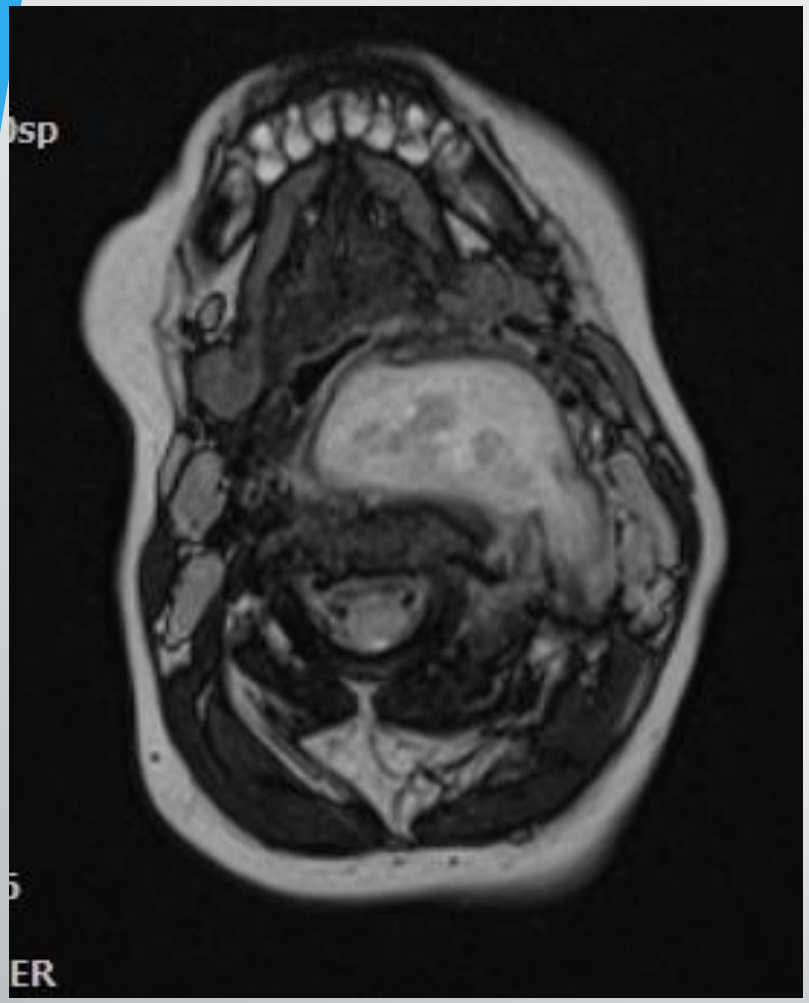

Nasal glioma



Nasopharyngeal Teratoma

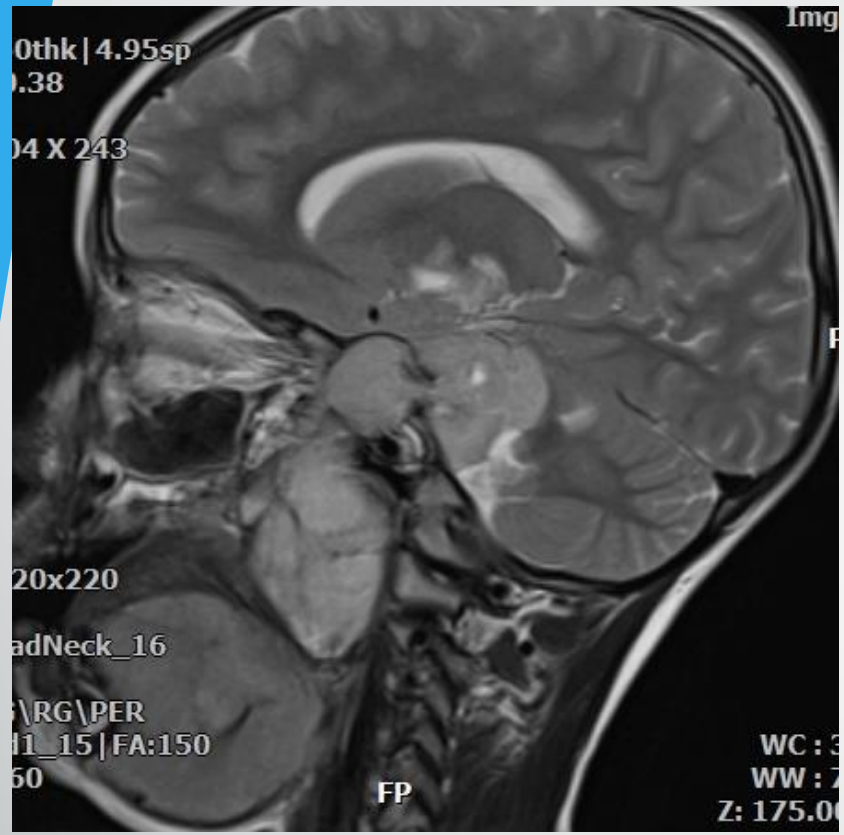


Lymphangioma





Retropharyngeal abcess

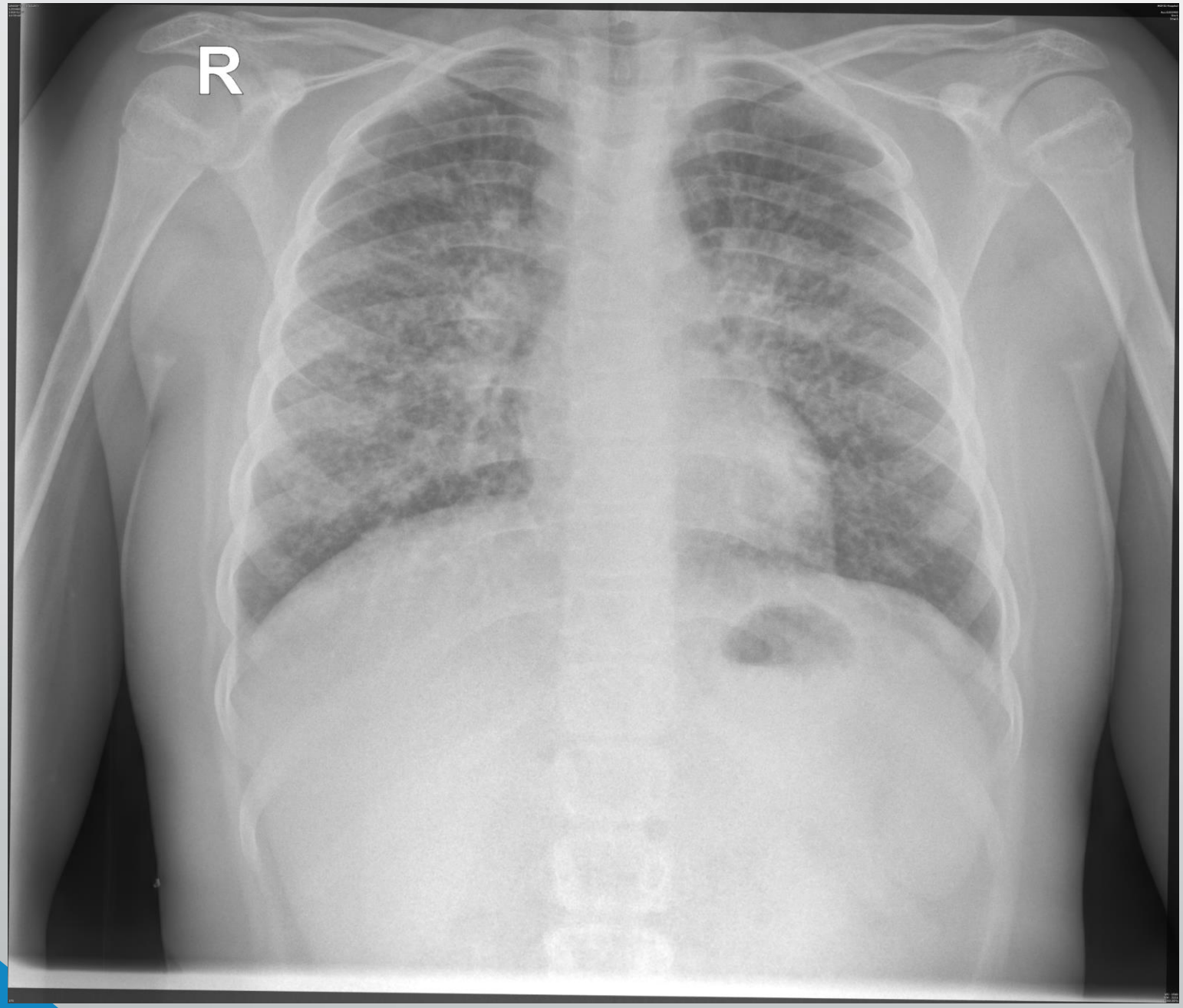




Rhabdomyosarcoma

# Case II

- 13 y/o girl with history of uveitis and sacroileits? from 2 years ago was under treatment with prednisolone , cinnora and MTX . She has cough,weight loss and fever since 2 months ago
- First step? CXR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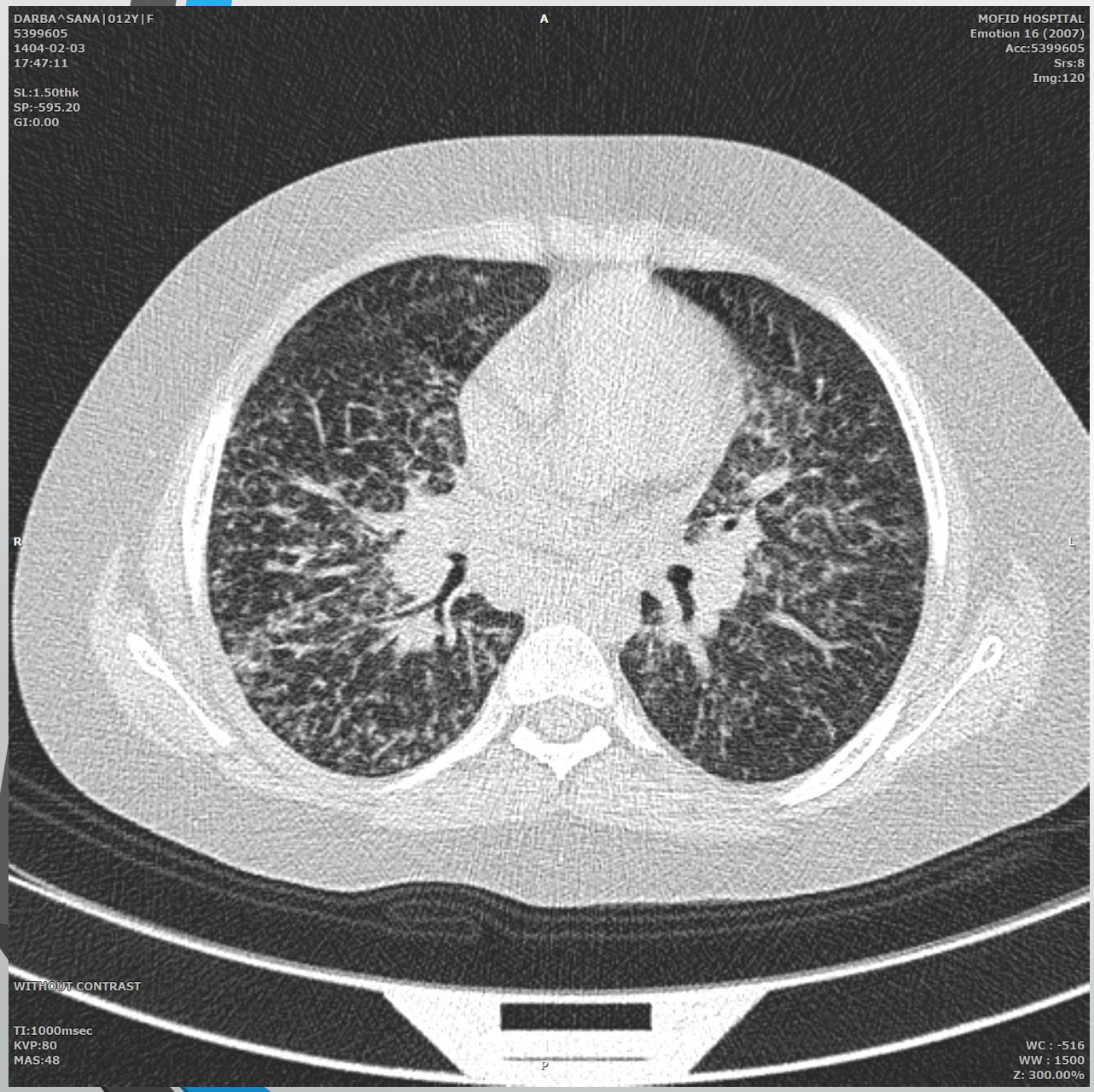
- She was admitted in hospital with suspicion of  sarcoidosis??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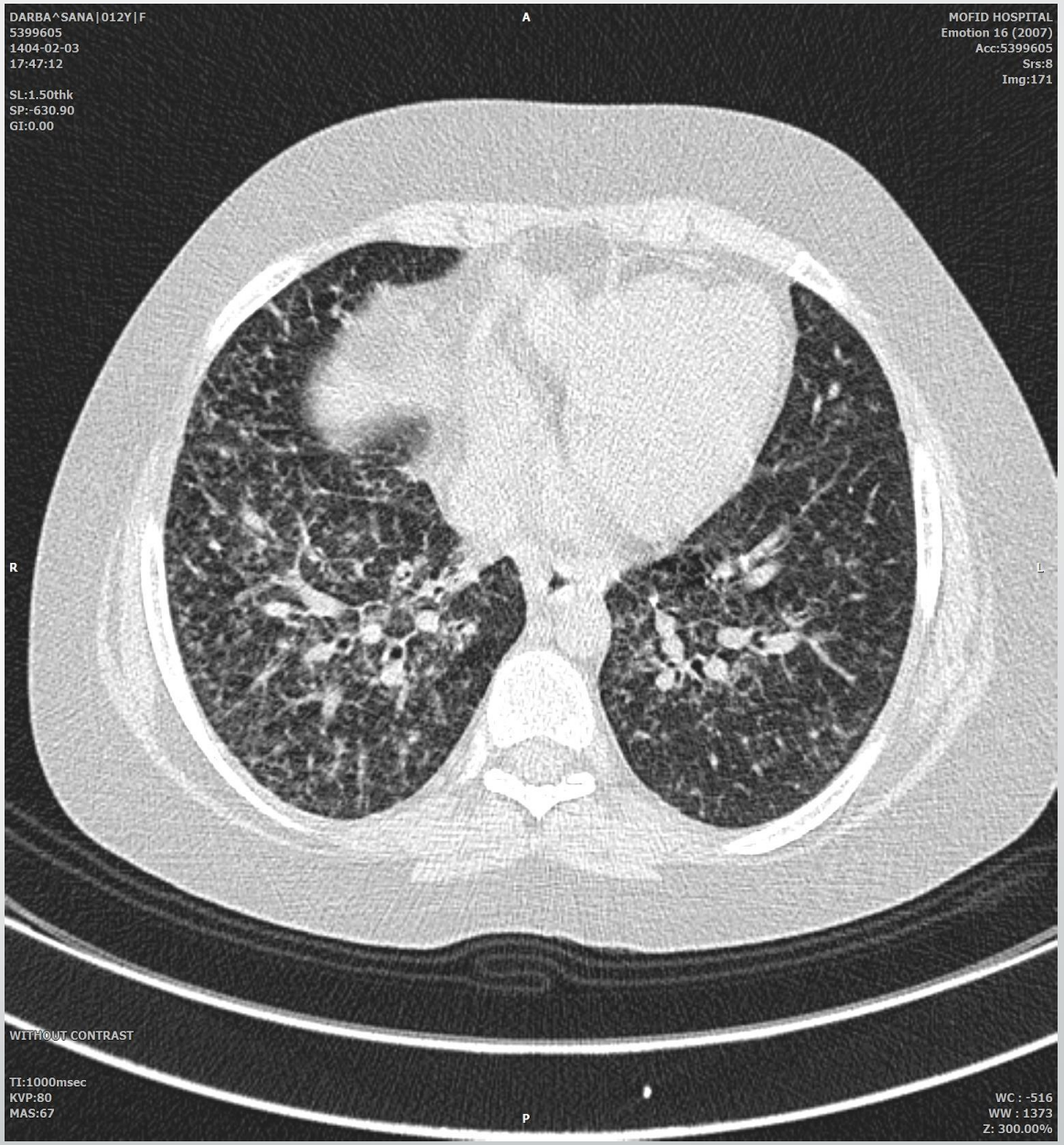
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- **DDx for miliary pattern:**

The causes can be broadly subgrouped depending on whether or not the patient is febrile.

1) Infections: TB, Fungal, Viral, healed varicella
2) Miliary metastasis: Thyroid, RCC, osteosarcoma
3) Others: Miliary sarcoidosis, pneumoconiosis, pulmonary hemosiderosis, LCH, Hypersensitivity pneumonitis

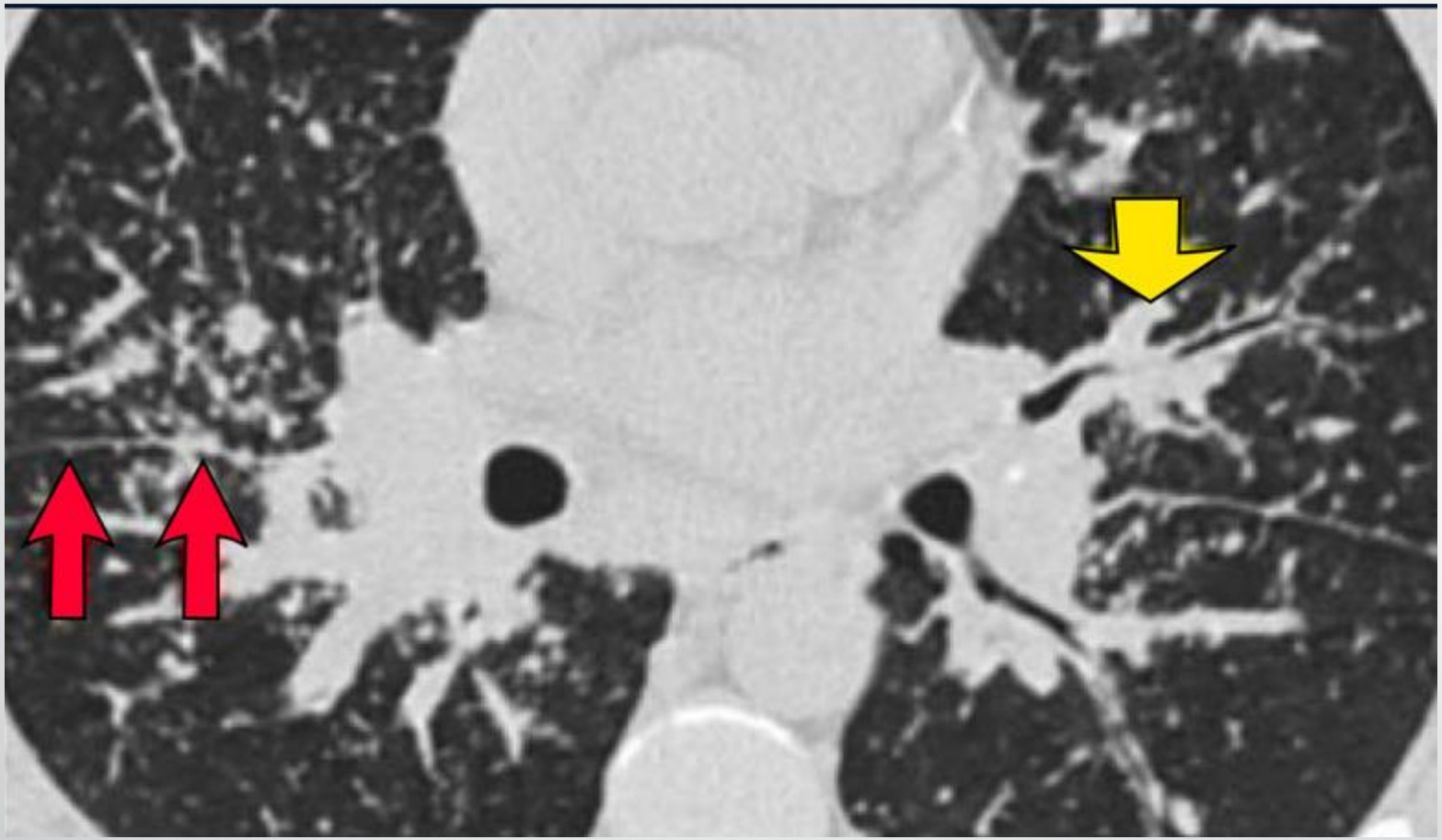
- Miliary sarcoidosis is a rare thoracic manifesation of sarcoidosis
- Miliary form may occur in a slightly older age group (e.g. fifth decade )
- hilar lymphadenopathy to help distinguish it from miliary tuberculosis and miliary metastases however they can be identical

***Key Findings in Sarcoid***

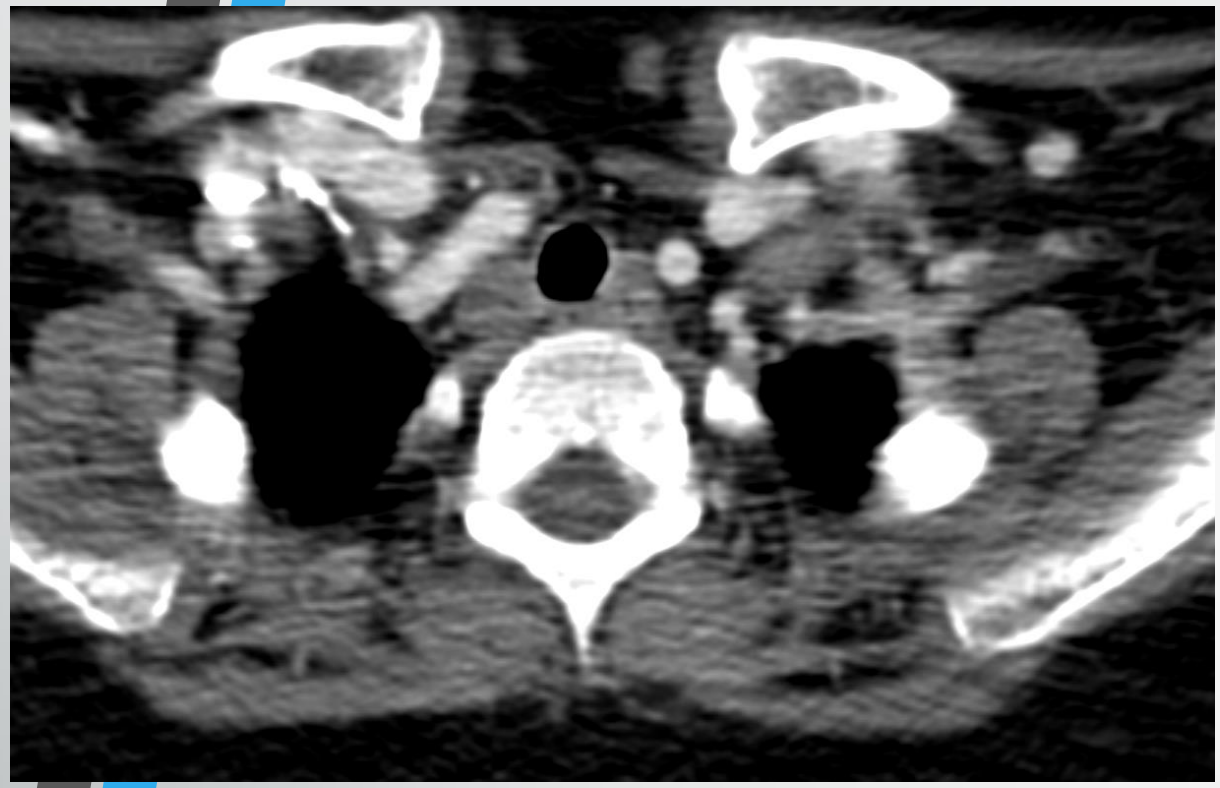
*Hilar and mediastinal lymphadenopathy*

*Small nodules along bronchovascular bundle and fissures*

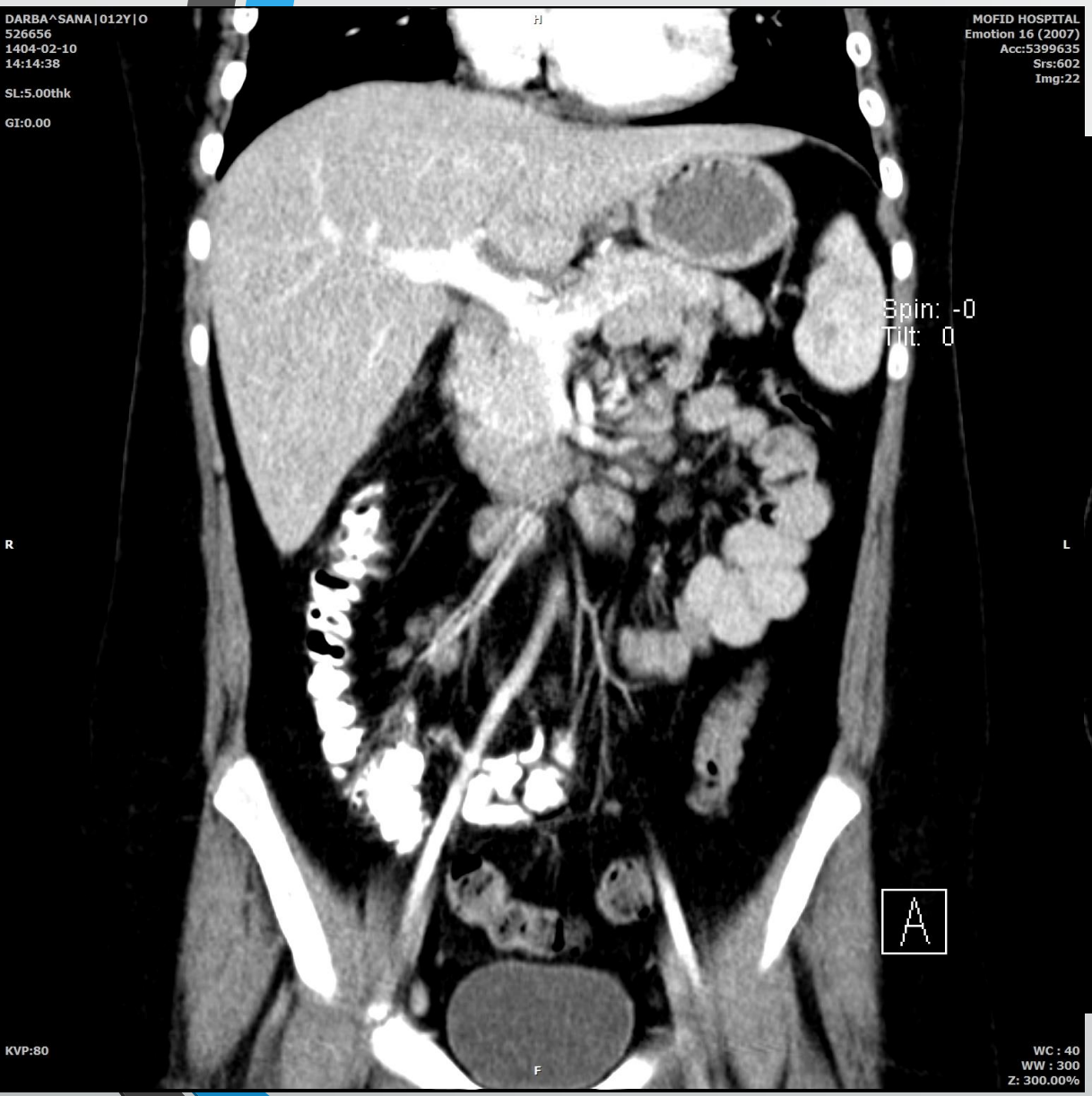
*Patients with fever, weight loss, fatigue and erythema nodosus*



A typical presentation of sarcoidosis with hilar lymphadenopathy and small nodules along bronchovascular bundles (yellow arrow) and along fissures (red arrows).



- **In abdominal US** exam several hypoechoic nodules were seen in spleen in addition to several mesenteric LAPS
- In neck US exam several servical LAPS were seen.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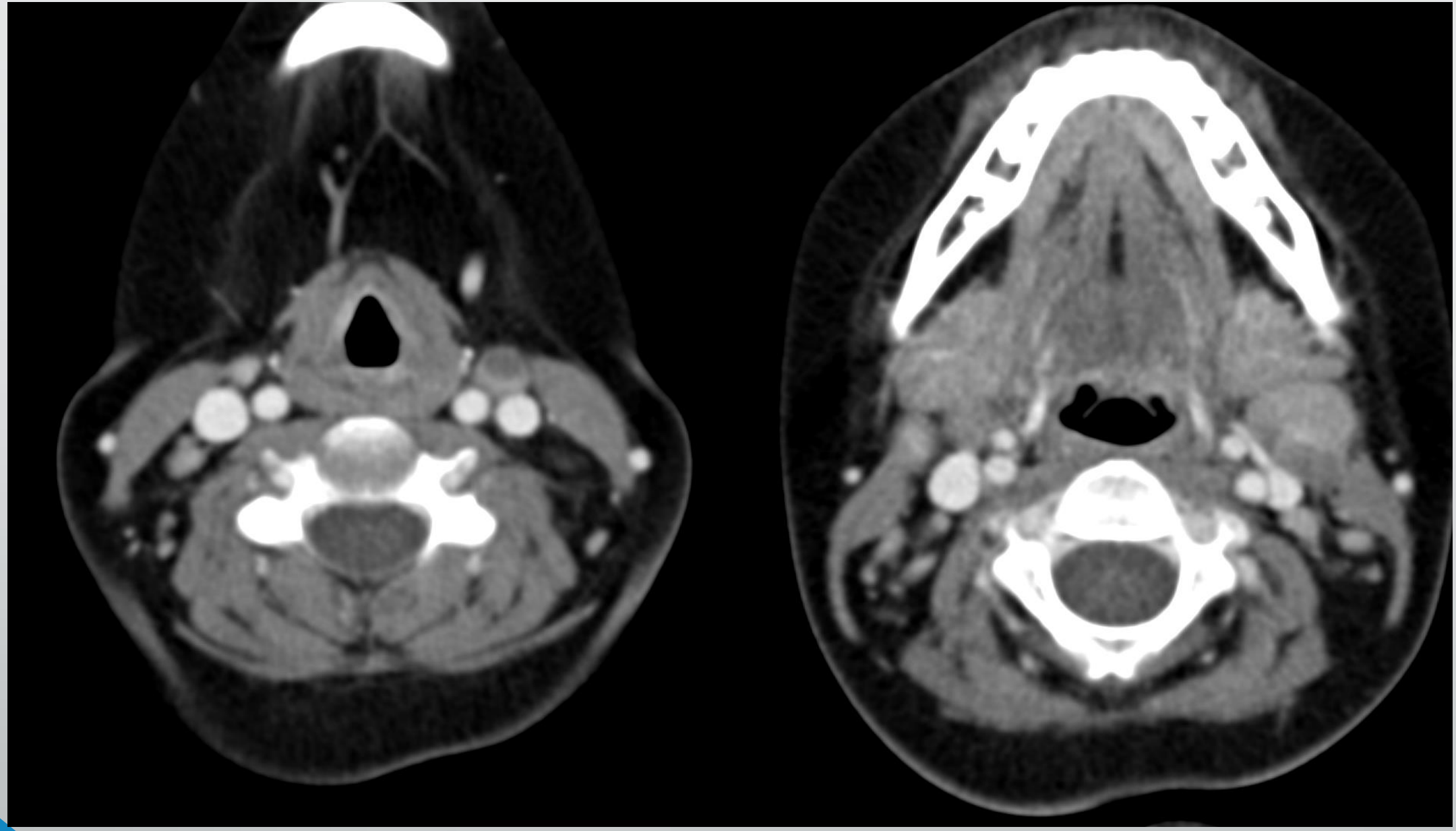


- **cystic (necrotic) lymph nodes:**
- metastatic carcinoma (SCC)
- infection (tuberculous or fungal)
- inflammatory necrotic disorders (e.g. Kikuchi-Fujimoto disease) in neck
- cavitating mesenteric lymph node syndrome related to celiac disease (may contain fluid or fat)

- Findings : disseminated LAPs with internal necrosis

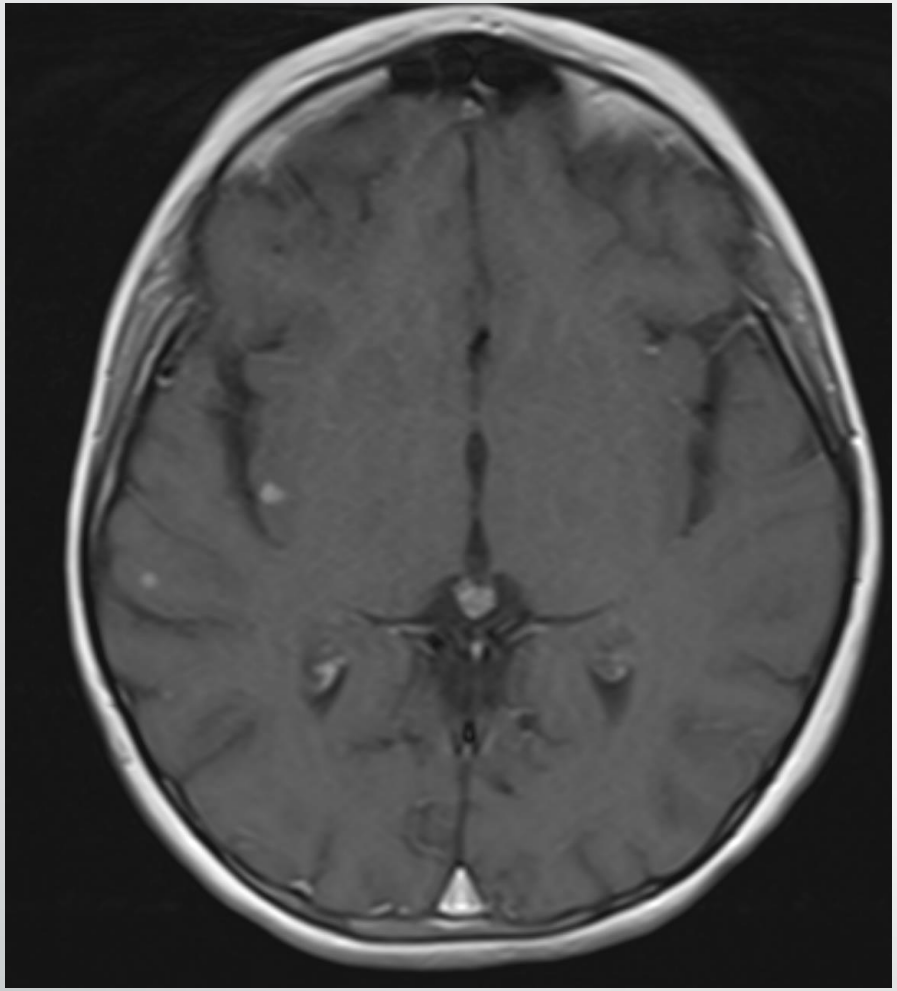
  miliary pattern in lungs

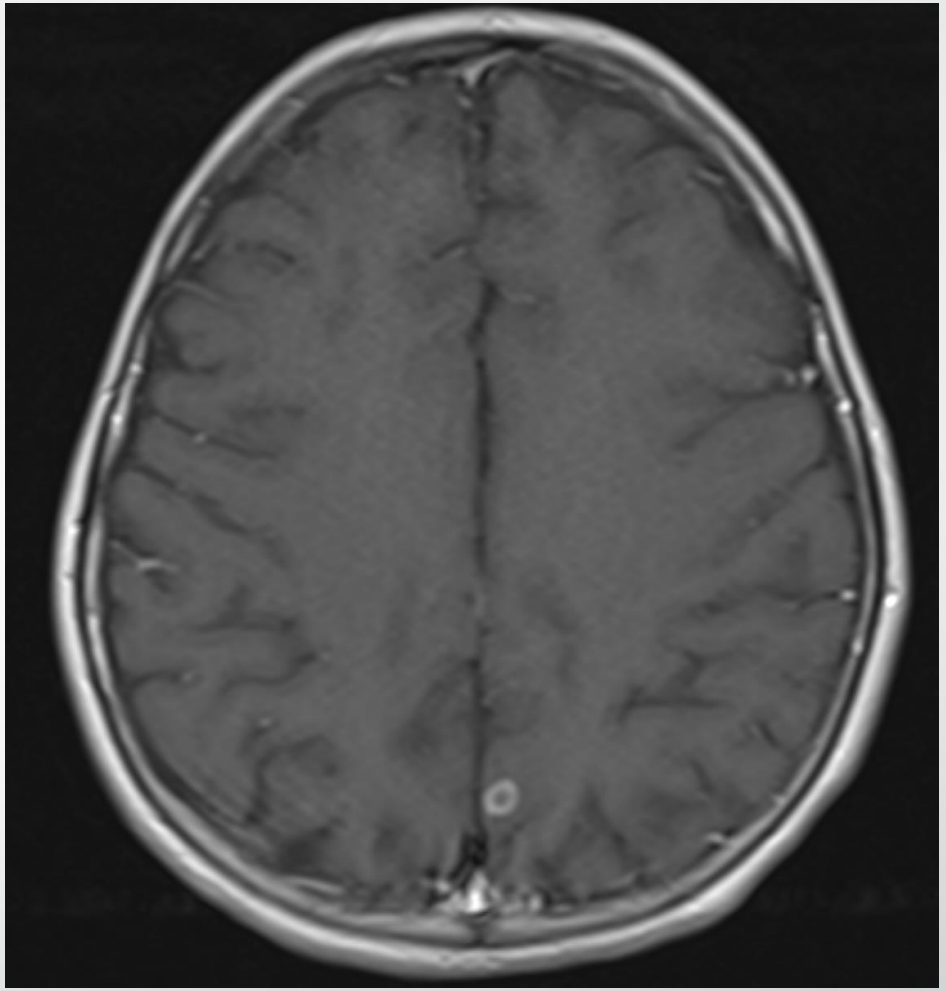
  several small nodules in spleen

  Immunocompromised child

In PMH her father had history of pulmonary TB when she was 2 years old and she was under treatment with INH at that time. 2 years ago when she was admitted for uveitis and low back pain with occasional fever and cough , PPD was positive=14mm.but IGRA , sputum smear and culture for TB was negative.

- Gasteric washing PCR for TB was positive 2 times
- IGRA was positive





**Disseminated TB is the final diagnosis**

DTB is defined by the presence of M. tuberculosis in two or more non-contiguous organs, or involvement of the blood, bone marrow, or liver.

**TAKE HOME MESSAGE:**

- Always think to common diseases rather than rare diseases even presenting with strange manifestations.

- It is important that we think of TB as a differential diagnosis when encountering patients with uveitis in endemic areas especially those with atypical features or poor response to conventional therapy , even when these patients do not present with the classical respiratory symptoms of TB, as TB is an entirely treatable and reversible cause of uveitis.


He who only does what he can will always remain what he is.
Henry Ford