Missing clues for a radiologist

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DESCRIPTION

A 48-year-old man presented with predominant nocturnal cough with minimal sputum, since 2 years. He had frequent retrosternal pain with occasional lower dysphagia since 6 months. He had no weight loss, fever or wheeze. He was a hypertensive for 9 years. He had left leg fracture at the age of 11 and developed permanent limb shortening in spite of multiple surgeries. He had mild cognitive defect since 1 year.

His chest x-ray (figure 1) showed a large retrocardiac globular shadow without a fluid level, unclear borders of left hemi diaphragm and multiple pulmonary nodules. The radiological diagnosis given by the radiologist was a posterior mediastinal mass with multiple lung metastases, most likely a lower oesophageal malignancy.

The reported large mediastinal mass and metastases were actually the tumours on his chest wall (figures 2 and 3). The patient is suffering from Neurofibromatosis type I (NF1), also known as Von Recklinghausen disease.[1] The chest radiogram was reported by a radiologist, who neither saw the patient personally nor enquired into the patient's history. Note the multiple café au lait spots on the patient's skin, another characteristic of this disease.[2] Cognitive defects, peudoarthrosis of tibia and long bone dyplasia are also known to occur in NF1.[3] Pheochromocytoma was not present in him but is known in NF1.

The patient underwent oesophago-gastroscopy which confirmed the presence of GERD (Gastro-oesophageal reflux disease). Oesophageal malignancy or hiatus hernia was ruled out. The cough responded to antireflux treatment within 1 month.

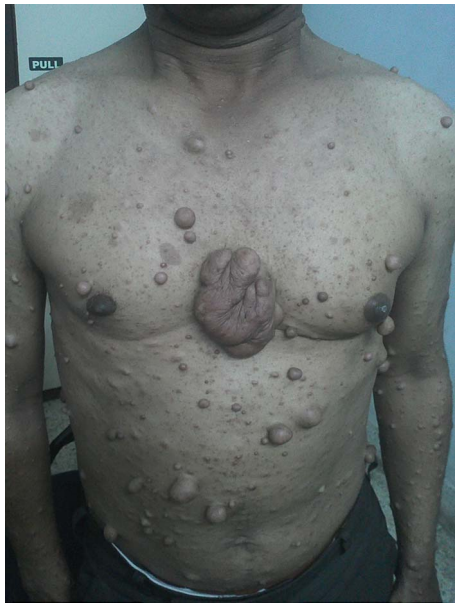

Figure 2 Large chest wall tumour on the lower end of sternum.

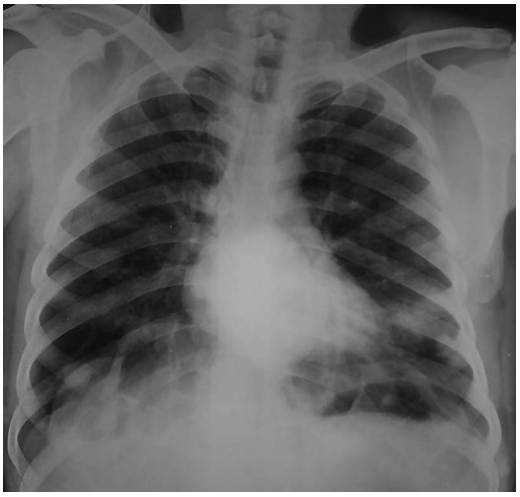

Figure 1 Chest x-ray posteroanterior view.

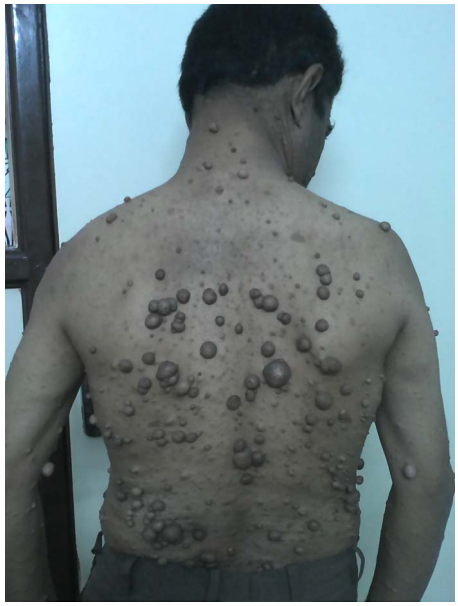

Figure 3 Posterior chest wall tumours.

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Learning points

- Soft tissue lesions on the anterior or posterior chest wall can be easily mistaken as intrapulmonary lesions on a chest radiogram posteroanterior (PA) view.
- A standard chest radiogram PA view should always cover the lateral chest wall. Had this been done, the skin nodules would have been easily picked up.
- A clinician should always clinically correlate an x-ray and its report, before making a diagnosis.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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