

**Clinical: Head and neck****P-017 A pictorial review of sclerotic lesions of the skull base**

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**Aims/Objectives:** To provide a pictorial review of common and uncommon sclerotic bone lesions found in the skull base.

**Content:** This pictorial review aims to demonstrate our local experience of sclerotic bone lesions referred to our tertiary centre skull base MDT. There is a wide variety of pathology that causes sclerosis in the skull base. This review will cover both common and uncommon pathologies.

**Relevance/Impact:** The skull base is an important review area in head imaging. Sclerotic lesions are commonly found and referred to our skull base MDT. During a patients work up they undergo numerous radiological investigations which are reviewed by specialist radiologists. Firstly it is important to establish that the sclerosis is pathological and not related to anatomical variance. Secondly the radiologist needs to discriminate between benign and malignant causes of sclerosis.

**Outcomes:** The cases were acquired over a five year period. The skull base MDT occurs on a fortnightly basis. Cases were selected to encompass the wide spectrum of benign and malignant sclerotic bones lesions. We present more than 10 cases of pathology, which include ivory osteoma, fibrous dysplasia, chondrosarcoma and metastases. These pathologies will be presented in a variety of imaging modalities including plain film, isotope bone scans and CT.

**Discussion:** This pictorial review aims to be an aid memoir to all radiologists and clinicians dealing with sclerotic skull base lesions. It demonstrates the huge variability in pathology and emphasises that the skull base can be an uncommon site for common sclerotic bone lesions.

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**P-018 Imaging of salivary gland tumours**

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**Aim:** We aim to review the normal anatomy of salivary glands with illustrations of US, CT and MR images. Discuss the role of imaging and imaging findings of salivary gland tumours.

**Background:** Salivary gland tumors consist of a group of heterogeneous lesions with complex clinico-pathological characteristics. We aim to illustrate the spectrum of the ultrasound (US), computed tomography (CT) and magnetic resonance (MR) in evaluating the major and minor salivary glands. Ultrasound is often the first step in imaging salivary gland pathologies and has proved to be the imaging of choice for obtaining diagnosis by fine needle aspiration and biopsy. CT continues being a useful for staging malignant disease and also as a complementary tool to MR. MRI imaging in most of the cases is superior in assessing a better lesion's characterization, local involvement and demonstrating perineural spread and infiltration of the skull base.

**Conclusion:** Imaging of salivary gland tumors is a challenge for radiologists due to the great variety of differential diagnoses. Tissue diagnosis is essential along with some clinical aspects and imaging features to decide the management and for surgical planning of the lesions.

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**P-019 Tumoral calcinosis: what the general radiologist should know**

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Tumoral calcinosis is a rare hereditary condition characterised by painless calcific peri-articular masses. The prevalence of the condition is unknown, but is extremely uncommonly encountered by clinicians and radiologists alike.

The radiologist is usually the first person to elude to the diagnosis and a basic understanding of the imaging characteristics and the definitions is invaluable to the general radiologist who may incidentally find a case in their reporting pile. Recognition would save unnecessary referrals and unneeded imaging.

Here we present a literature review and case study of idiopathic of tumoral calcinosis. We describe the imaging findings, the clinical diagnostic criteria and the aetiological definitions. We make special reference to the more uncommon manifestation of tumoral calcinosis of the head and neck.

We will also present a case of our own who presented to both the oral and maxillofacial surgeons and the neurosurgeons. The patient presented with multifocal and painful masses over her hips, sacrum, cervical spine and mandible. The masses displayed rapid growth. The patient provoked such diagnostic dilemma that she was passed through a head and neck and a neuro-radiology MDT at regional tertiary centres before the correct diagnosis was reached by a general radiologist at a district general hospital.

## Clinical: Neuroradiology

### P-020 Management of sudden onset severe headache

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The traditional teaching on diagnosis of subarachnoid haemorrhage(SAH) is based on previous reports that computed tomography(CT) would be expected to miss approximately 1 in 20 SAH. In patients with high clinical suspicion and negative CT, lumbar puncture(LP) is performed. More recent data, however, suggests that the sensitivity of CT can be up to 100% when performed within six hours of symptom onset.

We carried out a retrospective observational case-note study of 227 patients who had a CT for suspected diagnosis of SAH over a one year period. 129 female and 98 male patients were identified with mean age of 47.6 years. Collected data included the timing of onset of symptoms, delay to presentation, symptoms and examination findings, vital observations, timing of subsequent investigations, and eventual diagnosis. Of the 227 patients identified, 30 had diagnosis of SAH on CT. Mortality rate among these patients were high(46.7%). 4 patients(1.8%) had another type of intracranial haemorrhage. Another abnormality was identified in 23(10.1%). 170(74.9%) had a normal CT. Of these 170 patients with a normal CT, 96 patients(56.5%) had a LP. 2 of these patients had positive xanthochromia, but neither had final diagnosis of SAH. Follow up of the remaining 74 patients to date revealed no mortalities – making diagnosis of SAH unlikely.

In combination with the reported data, this throws into question the added value of LPs in ruling out SAH. Can we use the timing of presentation and initial findings to avoid LPs in a select group?

### P-021 An a la carte menu of neuroradiology signs

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**Introduction:** Certain pathological conditions have classic radiological appearances that are associated with food. These food signs are often quite specific and sometimes pathognomonic of these conditions. They can also be easily recognisable and memorable, helping a radiologist to make confident diagnoses, sometimes based on radiological findings alone. We therefore decided to host a neuroradiology banquet, presenting some of these signs in a delightful three course menu.

**Content:** We present a mouth watering á la carte menu which will include appetisers (cottage loaf, sandwiches and onion skin), mains (hamburgers, scallops and linguini) and desert (ice cream cone and berries). Each delicious dish will be accompanied with radiological examples giving a flavour of each sign and the condition it represents.

**Discussion:** This poster will provide a taste of some of the signs related to neuroradiological conditions. A review of these signs will remind radiologists about the appearances of conditions encountered in neuroradiology.

### P-022 Cerebral microhaemorrhages – are they all the same?

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**Aims:** To describe the pathophysiology behind cerebral microhaemorrhage