

radiological sings of diffuse alveolar process but this is not a specific finding in any of them⁽⁹⁾. In the present case, the patient was healthy, with no comorbidity at the immediate postoperative period following upper airway surgery (tonsillectomy), presenting spontaneous resolution in only three days. Despite the nonspecificity of the radiological pattern, the preoperative history of the patient and the prompt resolution allowed for ruling out other causes, and NPPE was the only remaining possible diagnosis. Thus, the authors considered to be unnecessary to proceed with the diagnostic investigation with other imaging methods and laboratory tests.

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Mammographic artifact leading to false-positive result

Artefato em mamografia causando resultado falso-positivo

Dear Editor,

A female, 75-year-old was referred by another service with previous screening mammogram demonstrating clustered pleomorphic microcalcifications in the superolateral quadrant of her left breast, classified as highly suspicious mammographic findings (BI-RADS category 5), to be submitted to mammography-guided needle localization followed by excisional biopsy of the suspicious lesion.

A new mammography demonstrated an apparently benign nodule already present and stable in relation to the findings of the previous mammogram, besides the presence of clustered pleomorphic microcalcifications, both findings located in the superolateral quadrant of the left breast. The finding of suspicious microcalcifications drew attention for being a round-shaped cluster (Figures 1A and 1B).

A new assessment detected a skin nevus with irregular surface presenting with talc residues in the lesion fissures. Once the lesion was marked with a metal clip, a new mammographic image revealed that the microcalcifications corresponded to artifacts related to the talc residues present on the dermal nevus surface (Figures 1C and 1D). The mammogram was reclassified as benign mammographic findings (BI-RADS category 2) and the patient was referred for follow-up at the public basic health network.

Except for non-melanoma skin tumors, breast cancer is the most frequent neoplasm with high mortality in women in Brazil⁽¹⁾. Mammography is the main imaging method for the early diagnosis of breast cancer; and the analysis of the differences between normal breast tissue and suspicious findings requires high imaging quality for early detection of lesions^(2–9). In addition, the presence of imaging artifacts reduces the sensitivity and specificity of imaging methods, masking or mimicking the diagnosis of initial-stage lesions and leading to the adoption of inappropriate approaches.

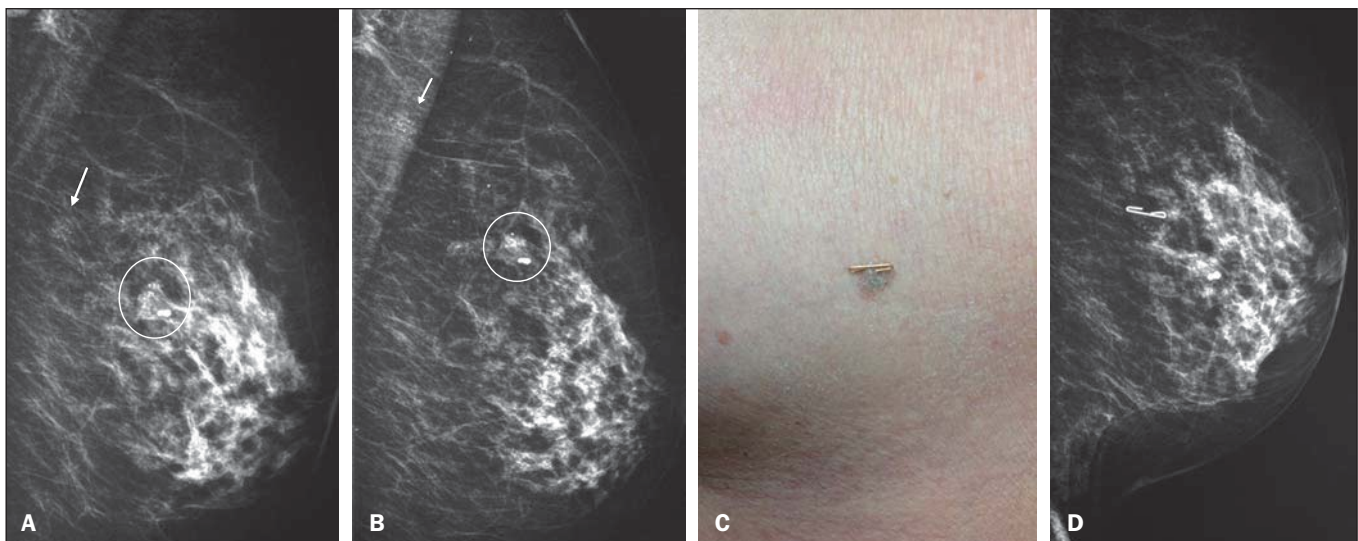


Figure 1. A,B: Mediolateral oblique and craniocaudal views of left breast showing a partially calcified nodule (circle) and a cluster of pleomorphic microcalcifications (arrow) located in the superolateral quadrant of the breast. C,D: Metal clip on the dermal nevus with talc residues in its fissures, and craniocaudal view of the left breast demonstrating that the cluster of microcalcifications corresponded to talc residues.

Most common artifacts are associated with factors related to the patient, to the imaging technique, image processing or problems in the apparatus^(10,11). The main patient-related artifacts are caused by motion during images acquisition and use of substances on the skin.

The present case illustrates the necessity of a strict mammographic image quality control and correlation with clinical findings for greater diagnostic accuracy. As already mentioned, the skin lesion led to simulation of a clustered pleomorphic microcalcifications which would imply the necessity of biopsy. The active quest for prevention and detection of artifacts, in association with a continued quality control of imaging, processing, storage and images analysis, reduces the incidence of misdiagnosis and costs, e should be the objective of any team involved in mammography services.

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Hypertrophic olivary degeneration secondary to central tegmental tract injury

Degeneração olivar hipertrófica secundária a lesão do trato tegmentar central

Dear Editor,

A male, 30-year-old patient presenting with a sudden-onset convergent squint attended the service complaining of diplopia. At physical examination the patient presented compromise of the left VI nerve and palatal myoclonus. Magnetic resonance imaging (Figure 1) demonstrated hypertrophic olivary degeneration (HOD) secondary to central tegmental tract injury.

Recently, the Brazilian radiological literature has been much concerned about the relevant role played by imaging methods in the improvement of the diagnosis of central nervous system diseases^(1–10).

HOD is a rare phenomenon that occurs after an insult to the dentato-rubro-olivary tract (Guillain-Mollaret triangle), constituted by the dentate, rubro and inferior olivary nuclei, which are interconnected via the central tegmental tract and superior and inferior cerebellar peduncles. This is a degenerative disorder that initially develops with hypertrophy⁽¹¹⁾. Injury to any of such components may result in axonal interruption to the inferior olivary nucleus, leading to its degeneration⁽¹²⁾. In cases where the alterations are

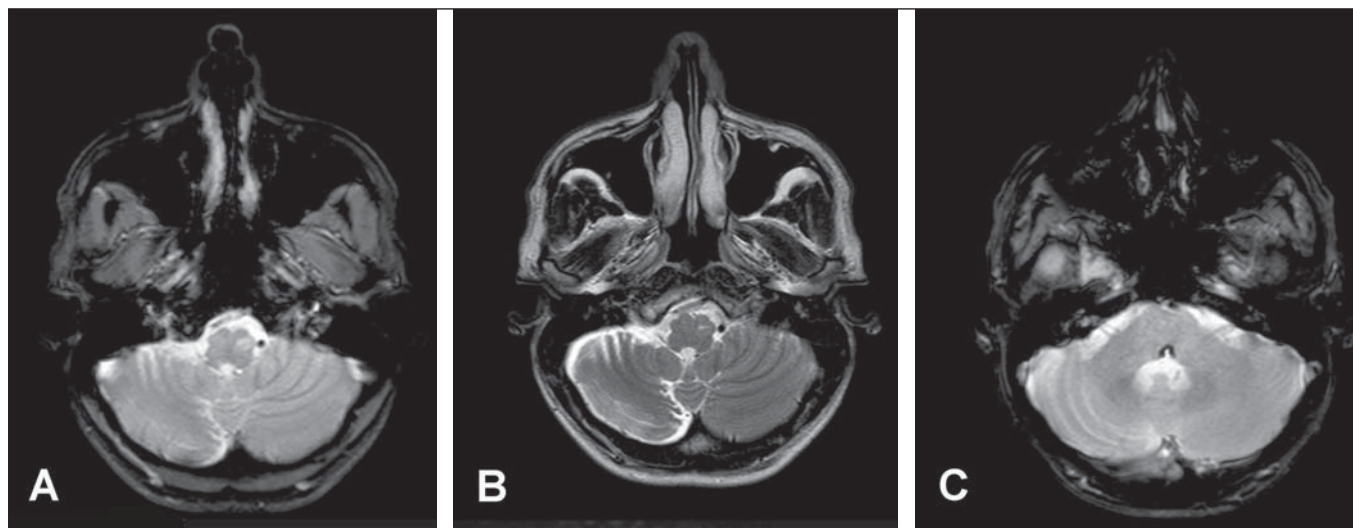


Figure 1. MRI of the brain. Axial, T2-weighted FFE image at the level of the bulb (A) and axial T2-weighted image (B) shows hypersignal in the region of the left inferior olivary nucleus, as well as accentuation of sulci in the right cerebellar hemisphere. Susceptibility-weighted imaging (C) at the level of the pons shows lesion with peripheral hyposignal in the pontine tegmentum (left facial colliculus), compatible with hemorrhagic focus.