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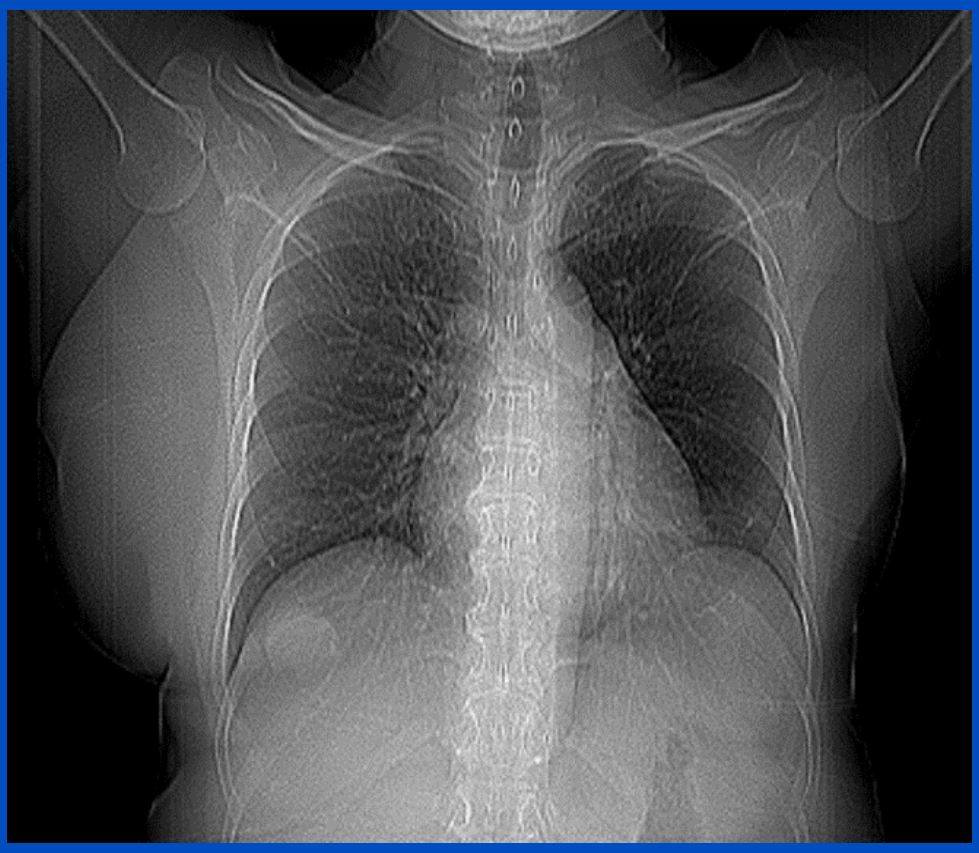

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The BIMJ publishes articles ranging from original research papers, review articles, medical practice papers, special reports, audits, case reports, images of interest, education and technical/innovation papers, editorials, commentaries and letters to the Editor. Topics of interest include all subjects that relate to clinical practice and research in all branches of medicine, basic and clinical including topics related to allied health care fields. The BIMJ welcomes manuscripts from contributors, but usually solicits reviews articles and special reports. Proposals for review papers can be sent to the Managing Editor directly. Please refer to the contact information of the Editorial Office.

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These include controlled trials, interventional studies, studies of screening and diagnostic tests, outcome studies, cost-effectiveness analyses, and large-scale epidemiological studies. Manuscript should include the following; introduction, materials and methods, results and conclusion. The objective should be stated clearly in the introduction. The text should not exceed 2500 words and references not more than 30.

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Case reports should highlight interesting rare cases or provide good learning points. The text should not exceed 1000 words; the number of tables, figures, or both should not be more than two, and references should not be more than 15.

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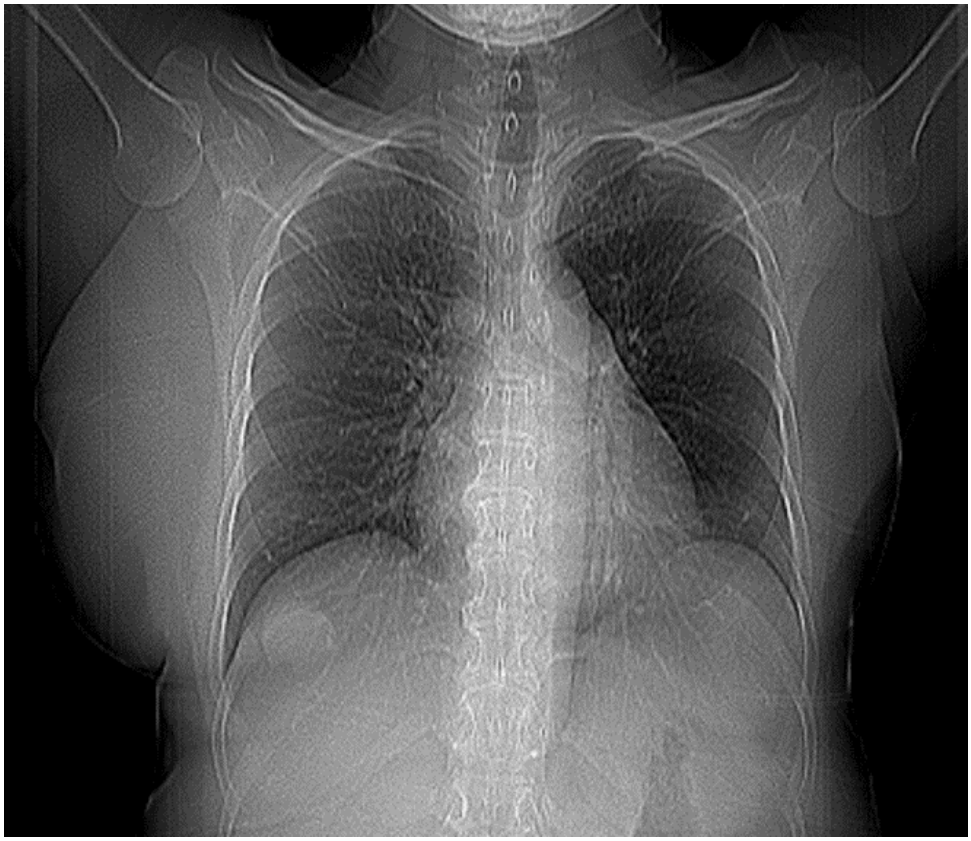

Figure 1

A 63 years old Indian lady with an underlying left breast infiltrating ductal carcinoma diagnosed in early 2012, had left mastectomy and axillary clearance. She was disease free for 6 years, but a recent surveillance chest radiograph (Figure 1) showed a solitary right poster basal lung nodule which was increasing in size on surveillance CT Thorax abdomen and pelvis (CT TAP). She was referred for lung biopsy and a repeat CT thorax for pre-biopsy assessment was performed (Refer to page 103, Figure 2a&b).

What is the likely diagnosis of the lesion?

Answer*: refer to page 103*

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DISCLOSURE: There is no conflict of interest and consent has been obtained from parents for use of these images.

(Refer to page 102)

ANSWER: SUMMATION SHADOW OF A SUPRADIAPHRAGMATIC LIVER.

The aim of this image of interest is to highlight – the mimickers of lower zones lung nodule.

Supradiaphragmatic liver (SDL) is a rare normal variant of the liver. The liver protruded through a defect in the right hemidiaphragm. A non-trauma related incidental finding of "mushroom" pedunculated appearance best seen on coronal plane of CT scan favorable of SDL. Care must be taken to rule out herniated liver secondary trauma.[1]

Chest AP scout image (topogram) above showing mass like opacity projected to the right lower zone. AP scout image (also known as topogram) is useful to aid planning of the CT scan. In this case a CT thorax was obtained.[2]

After a thorough scrutinization of the multiplanar CT thorax reconstruction images, the referred lung lesion is eventually raised from segment VII of the liver, in keeping with SDL with focal diaphragmatic defect (Figure 2a&b).

"Radiographs are the summation of shadowgrams". This statement is the main concept to understand X-ray image. Chest X-ray is an oversimplified image in 2-dimension projected from overlapping 3-dimensional tissue. The SDL is located parallel to the X-ray photon beam.[3] In the AP scout image, the summation shadowgrams was amplified mimicking right lower zone lung mass. This particular predicament also leads to unnecessary "overkill" laboratory and imaging investigations, further giving mental stress to an already stressful patient. In our case, the biopsy is almost being performed to the patient.

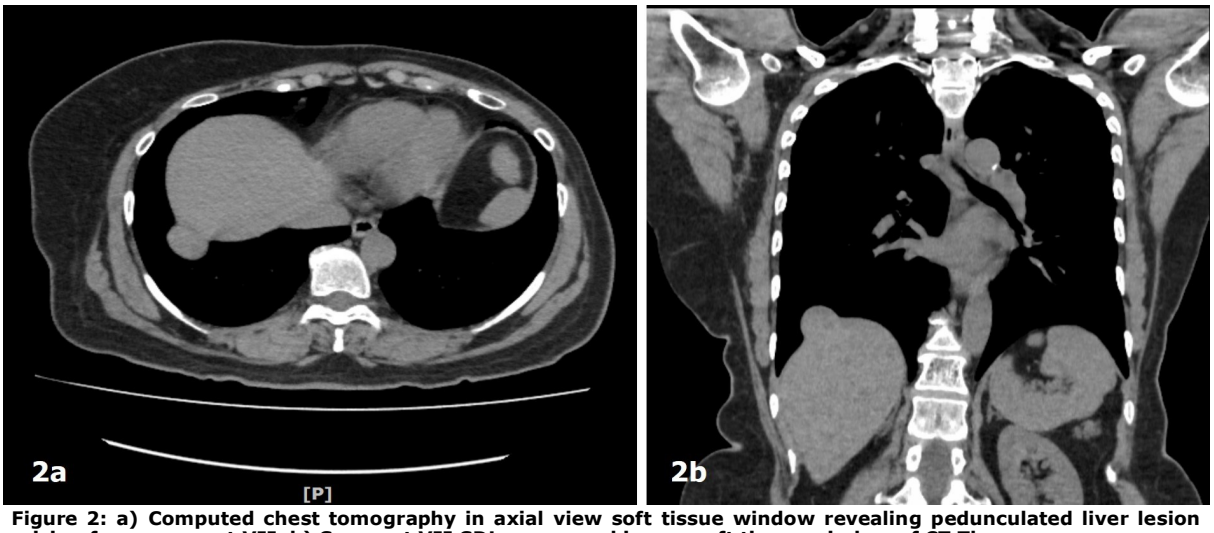

Figure 2: a) Computed chest tomography in axial view soft tissue window revealing pedunculated liver lesion arising from segment VII, b) Segment VII SDL on coronal image soft tissue window of CT Thorax.

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