IRAP case list from Northwestern University

Case – 1

The patient is a 26 year old female with a history of persistent headaches and "light headedness". Imaging of the head was obtained five years prior to presentation and showed no cranial abnormality. Physical examination revealed no external abnormalities and no neurological deficits. Magnetic resonance imaging of the brain was obtained and revealed an expansile lesion of the right temporal bone with subtle thickening of the overlying dura. There was moderate mass effect on the right temporal lobe. Given the interval appearance and increase in size of this lesion, surgical excision was recommended.

Case – 2

The patient was a 38 year old male with history of T-cell lymphoblastic leukemia/lymphoma (T-ALL) with extensive bone marrow involvement and lymphadenopathy. He had refractory disease and achieved complete remission after four cycles of hyper CVAD chemotherapy, Nelarabine x2, cytarabine x12, and a HLA-matched sibling allogeneic HSCT. His post transplant course was complicated by GVHD involving liver and GI tract, treated with steroids, rituximab and cyclosporine.

Nine months post-transplant, he presented with vomiting, diarrhea, and fatigue. CT showed significant bowel thickening, ascites, and peritoneal nodularity [two peripheral hepatic lesions measuring 11 and 9 mm in diameter, multiple hypodense lesions scattered within the spleen, (largest measuring 12 mm x 10 mm), sub-centimeter lymph nodes in the upper abdomen, marked mass-like thickening of the wall of the distal duodenum and proximal jejunum, with submucosal enhancement, prominent mesenteric and omental nodularity, thickening of the peritoneal lining, rectal wall thickening/edema, and increasing upper abdominal and pelvic ascites.]

Cytology and flow evaluation of peritoneal fluid consistent with abnormal mast cell population. The patient then underwent diagnostic laparoscopy, omental and liver nodule biopsy for definitive tissue diagnosis.

Case – 3

The patient was a 64-year-old female with a history of bilateral hip replacements who experienced chest pain, nausea and tingling of the extremities while shoveling snow. Out of concern for aortic dissection, an abdominal CT was performed which demonstrated an incidental 5.8 x 6.0 mass within the lower pole of the right kidney. The patient was referred to Northwestern urology for further management. Workup revealed no additional findings. The patent was taken for right radical nephrectomy, which was uncomplicated.

A 510.4 gram, 18.5 x 8.5 x 4.5 cm nephrectomy was received, with a 7.5 x 6.5 x 6.0 cm circumscribed, bulging mass involving the lower pole. The cut surface of the mass was gelatinous to yellow-orange.

Case – 4

Patient is a 65 year old woman with no significant past medical history. Sigmoid colon polyp was found on routine colonoscopy.

Case – 5

The patient is a 49 year-old male with a history of glioblastoma, IDH wild type and MGMT promoter unmethylated, status-post resection, chemotherapy, and radiation. Serial brain imaging showed no signs of tumor recurrence. Two years post completion of therapy, he presented to the emergency department with acutely worsening right sided back pain and shoulder pain. Imaging revealed multiple bony spinal lesions, including T1, T2, T9, and T12, along with a right chest wall mass involving the 2nd and 3rd ribs, and the pleura. Biopsy was performed.

Case – 6

The patient is a 22-year-old woman with a history of diabetes insipidus and hypothyroidism who presents with pruritic labial ulcers that have waxed and waned over the past year.