

ÖDÜLLÜ
VAKA
SUNUMU



ANAMNEZ

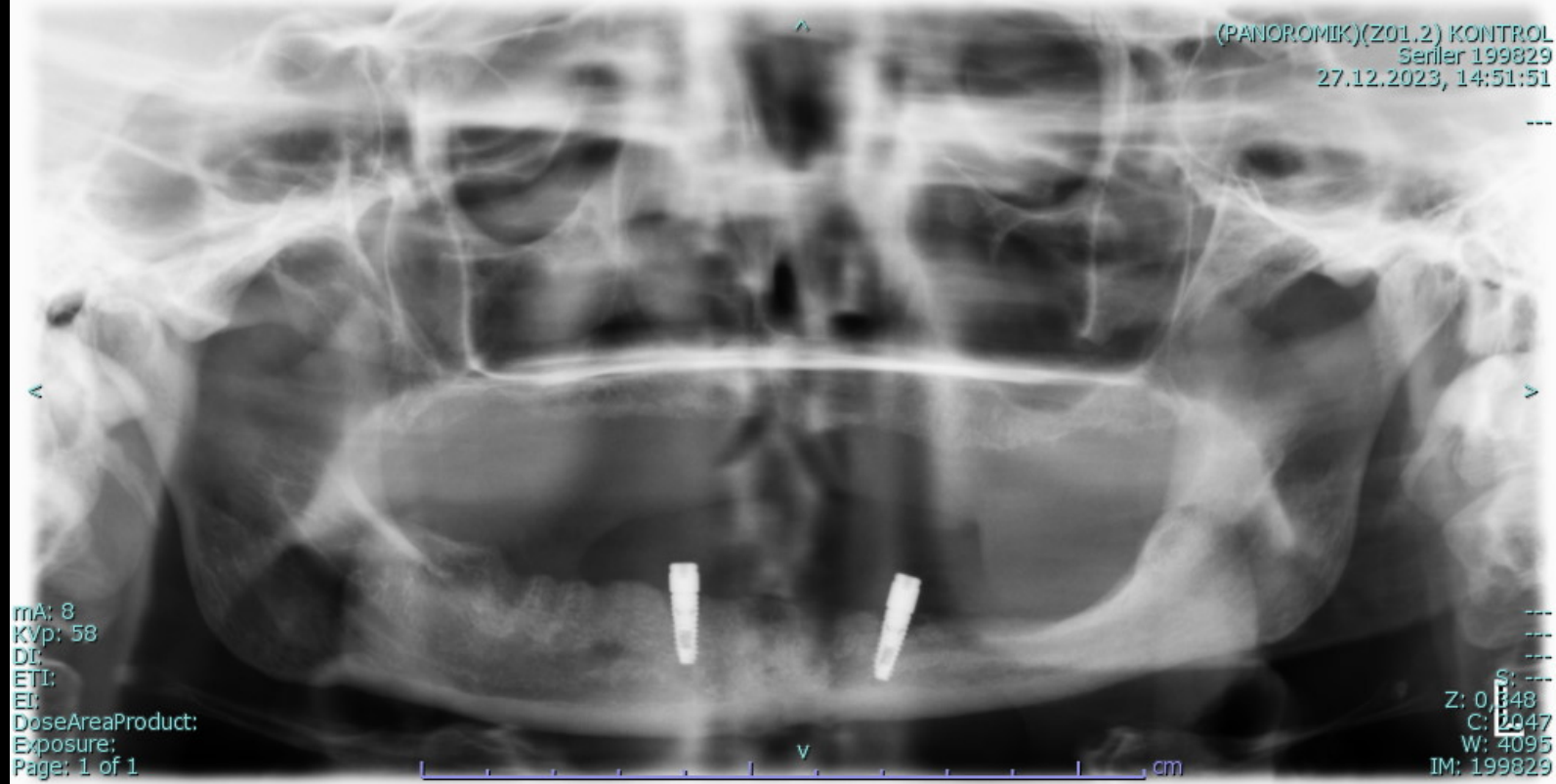
- Yaş/Cinsiyet: 51/ Kadın
- Şikayet: Sol yanak bölgesinde 2 aydır bulunan sertlik
- Sistemik Anamnez: Sistemik bir hastalığı yok

KLINIK BULGULAR

- Sol mandibula posterior bölgede bukkal ve masseter spacede palpasyonda ağrısız sert bir doku saptanmıştır.
- İnspeksiyonda gözle görülür bir fasiyal asimetri ve doku değişikliği izlenmemiştir.

RADYOLOJİK BULGULAR

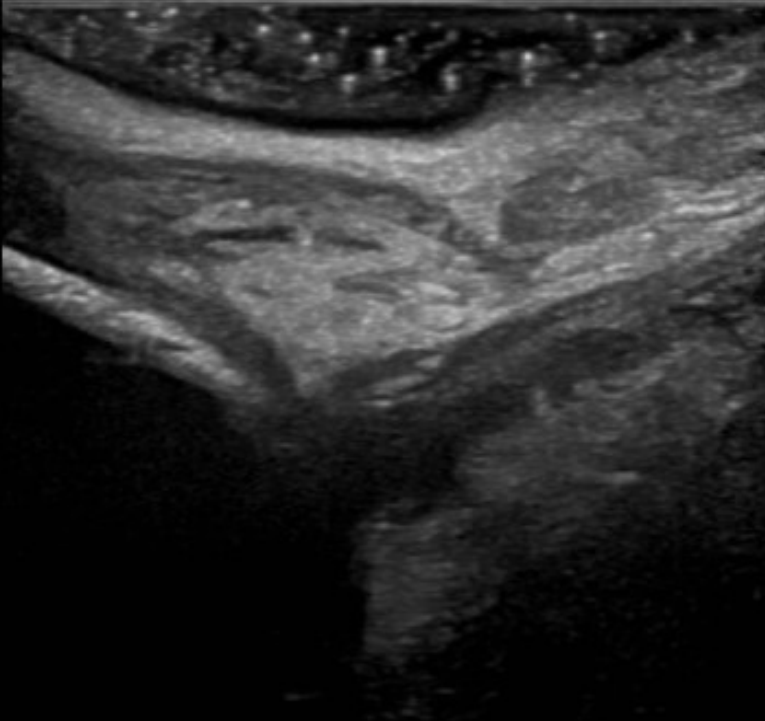
Panoramik radyografıta sol mandibula posterior bölgede sağa göre daha fazla kemik kaybı izlenmiş olup lezyon ile ilgili net bir bilgiye ulaşılamamıştır.



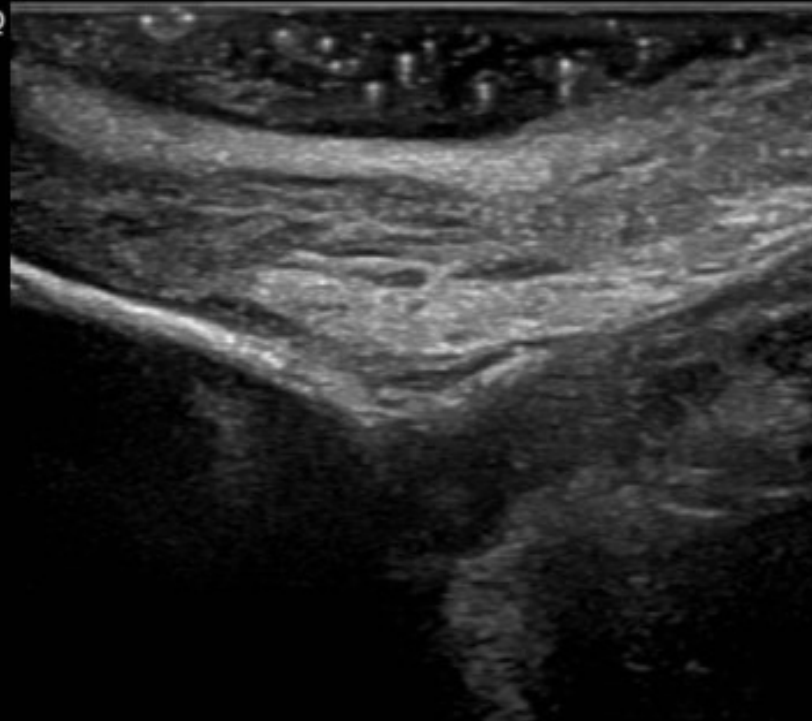
ULTRASONOGRAFI

L8-18i Neo Abd MI 0.9 T1s

LOGIQ



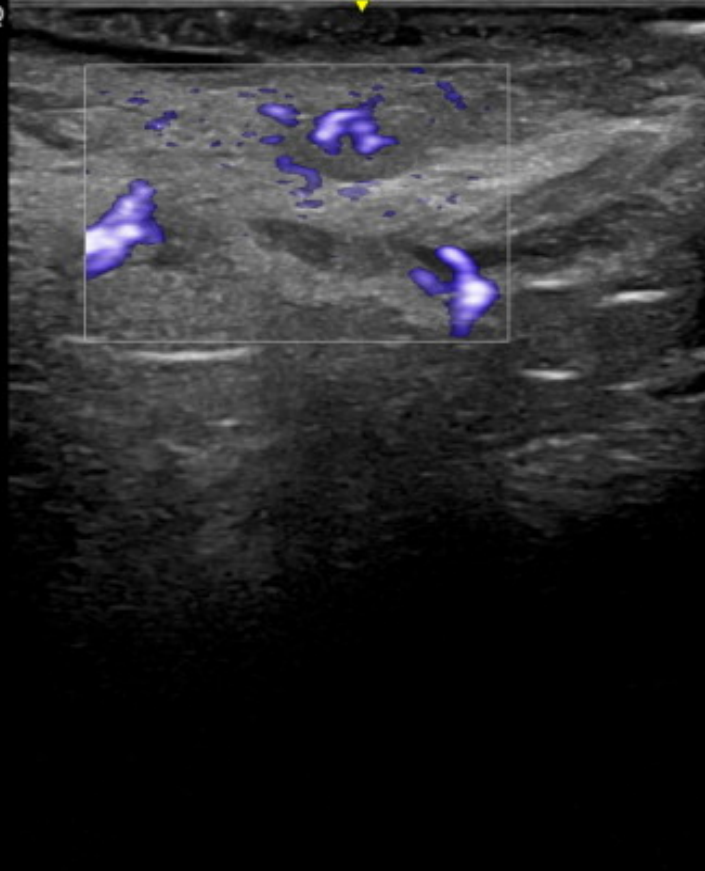
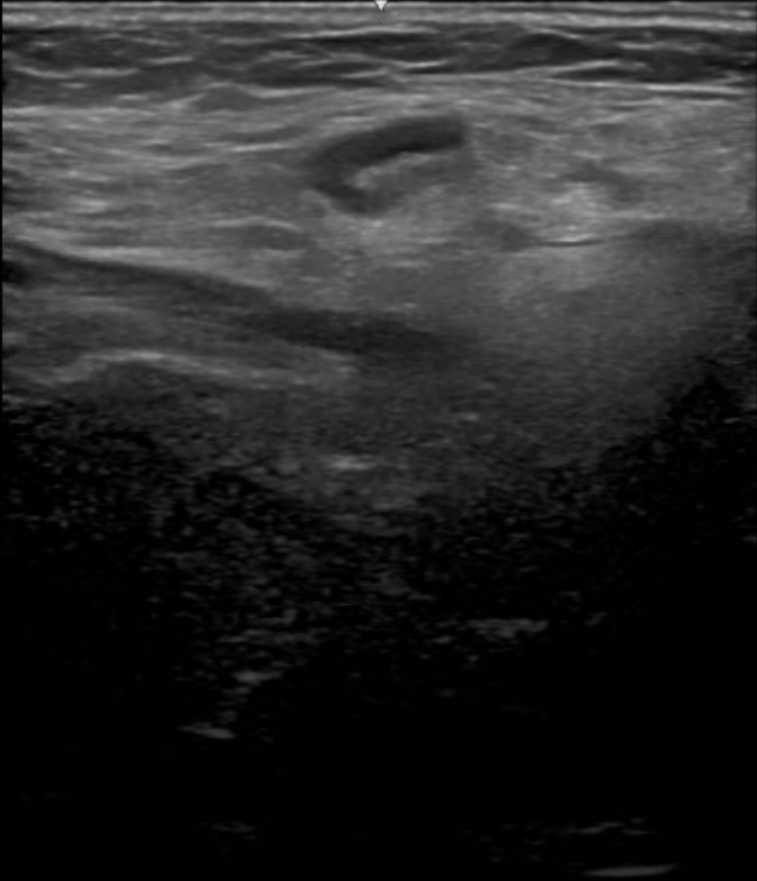
LOGIQ



- Lezyona yapılan intraoral ultrason incelemesinde ilgili bölgede fibrotik deęişiklikler ve çevre kas dokusuna göre hiperekoik lezyon görüntülenmiştir.

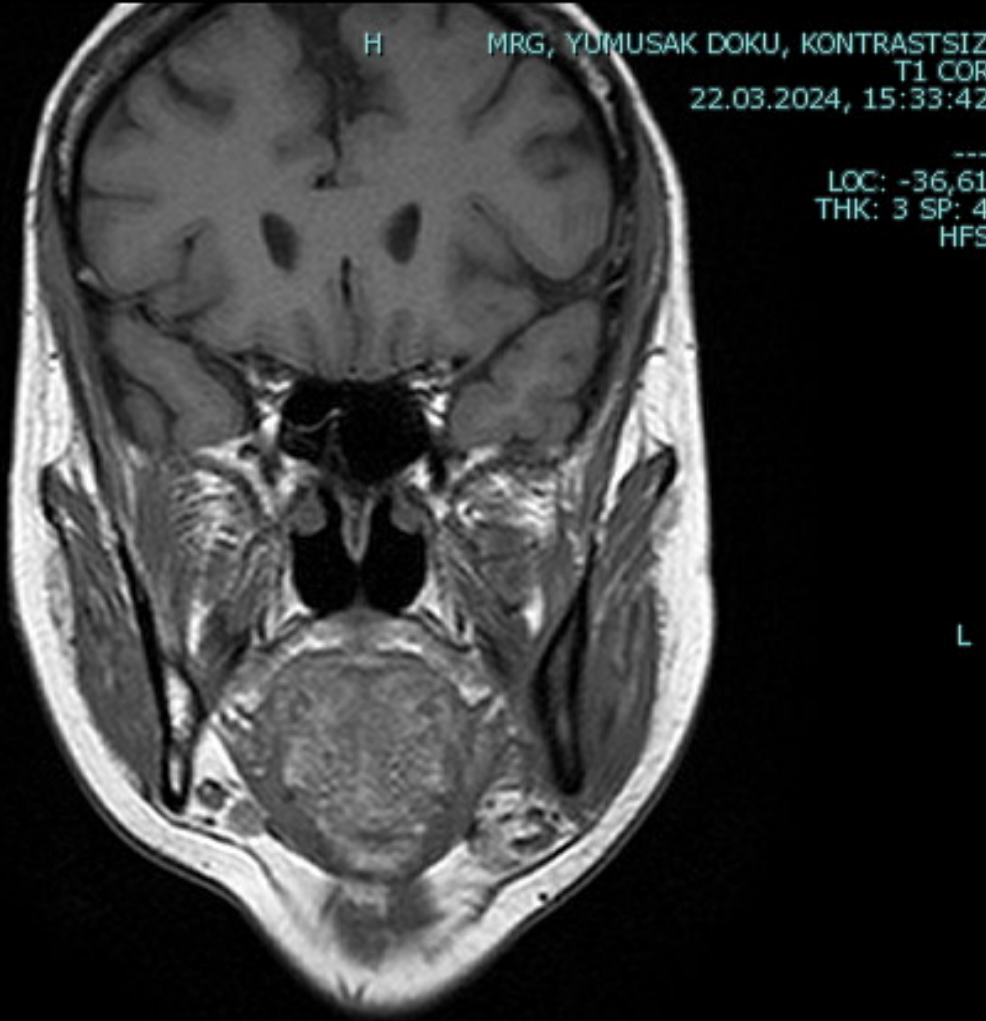
LOGIQ

LOGIQ



- Sol submandibular bölgede lenfadenopati varlığı izlenmiş olup ilgili bölgenin color doppler görüntüsü bu şekildedir.

MR



T1 ağırlıklı koronal kontrastsız görüntülerde sol tarafta mandibula posteriora doğru submandibular ve sublingual loja da geçmiş kasa göre hafif izointensten hipointense doğru giden fibrotik değişiklik içeren bir lezyon izlenmektedir.

Space koronal görüntülerde de yüksek sinyal intensite içerisinde düşük sinyal void alanları izlenmektedir.

MRG, YUMUSAK DOKU, KONTRASTSIZ
CORR-DWI b=800
22.03.2024, 15:42:18

LOC: -50,13
THK: 3 SP: 4
HFS



R

L

Head and Neck

• B=800 difüzyon ağırlıklı görüntülerde difüzyon kısıtlamasıyla kendini gösteren sol tarafta masseter kası içerisinde patolojik lezyon izlenmektedir.

H

MRG, YUMUSAK DOKU, KONTRASTSIZ
T1 COR+C_Echo#1
28.03.2024, 10:24:33

Unknown
LOC: -49,04
THK: 3 SP: 4
HFS



R

L

Head and Neck

• Koronal kontrastlı serilerde homojen bir kontrast tutulumu ile dikkati çekmektedir. Kas ayrımında signal void alanları söz konusudur. Kontrastlanma submandibular ve sublingual loja doğru gitmektedir.

NEKROTIZAN FASIITIS

CT

CT is the most commonly used imaging modality for evaluation of suspected necrotizing fasciitis¹² owing to its speed and sensitivity for gas in the soft tissues, which is present in <50% of cases²⁰. The sensitivity of CT is 80%, but the specificity is low given overlapping features with non-necrotizing fasciitis¹². Gas within fluid collections tracking along fascial planes is the most specific finding but is not always present¹².

Other, non-specific findings include:

- asymmetrical fascial thickening associated with fat stranding
- edema extending into the intermuscular septa and the muscle
- thickening of one or both of the superficial and deep fascial layers

Although fascial fluid collections are typically non-focal, abscesses may be seen.

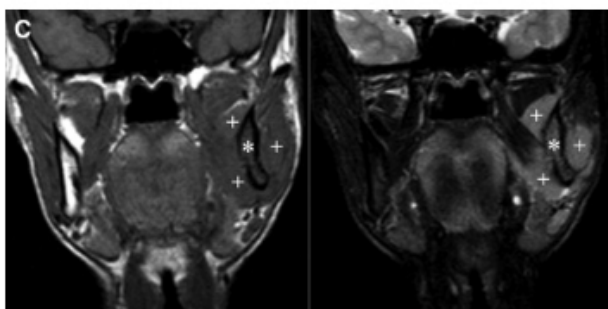
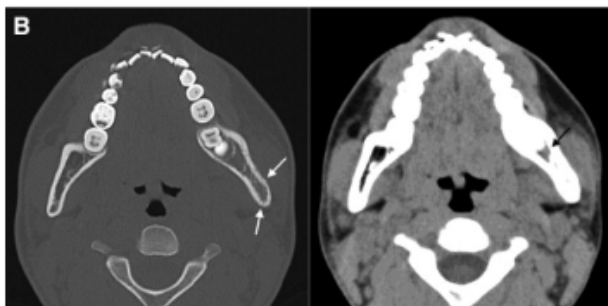
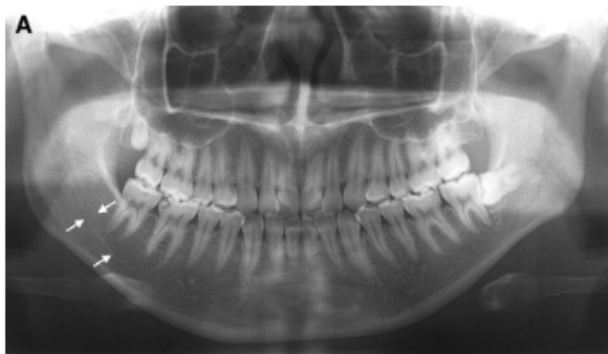
On contrast-enhanced CT, diffuse enhancement of fascia and/or underlying muscle can be seen but is present in both necrotizing or non-necrotizing fasciitis^{8,10}. On the other hand, absent enhancement of the thickened fascia suggests necrosis⁷.

MRI

MRI is the gold standard imaging modality for the investigation of necrotizing fasciitis with high sensitivity (93%)¹² but low specificity²⁰. MRI has a high negative predictive value²⁰. Findings include^{10,12,20}:

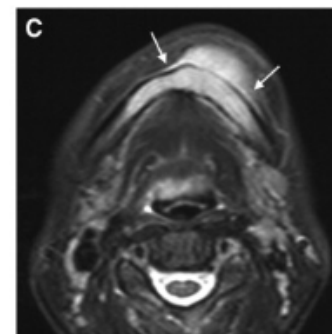
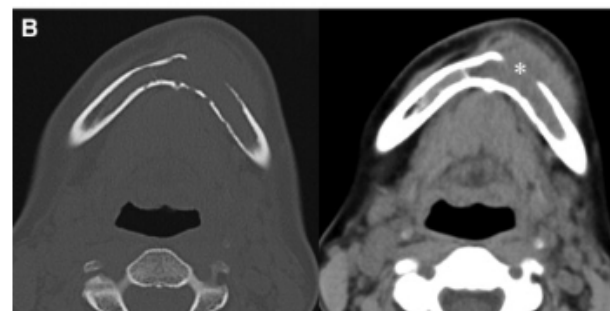
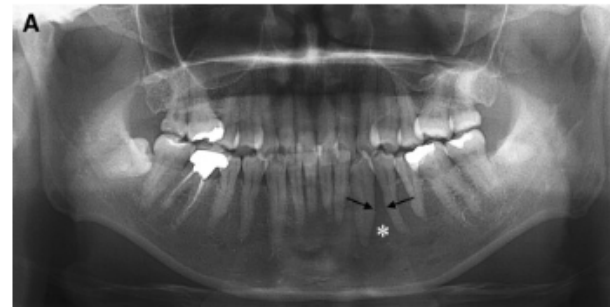
- **T2 FS or STIR**
 - fascial thickening ≥ 3 mm and hyperintensity, starting in the superficial fascia and often involving deep intramuscular fascia in multiple compartments
 - subfascial and interfascial fluid collections
 - low signal foci of gas
 - subcutaneous edema, although commonly seen with cellulitis as well
- **T1**
 - subtle loss of muscle texture and possible high signal intensity compatible with intramuscular hemorrhage
 - low signal foci of gas
- **T1 C+ (Gd)**
 - variable fascial contrast enhancement: increased early due to capillary permeability but absent later due to necrosis





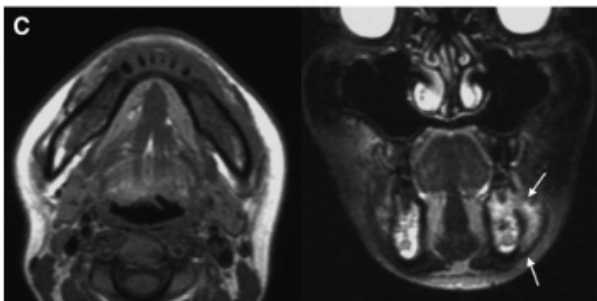
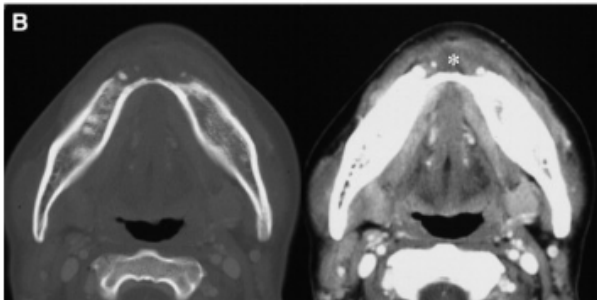
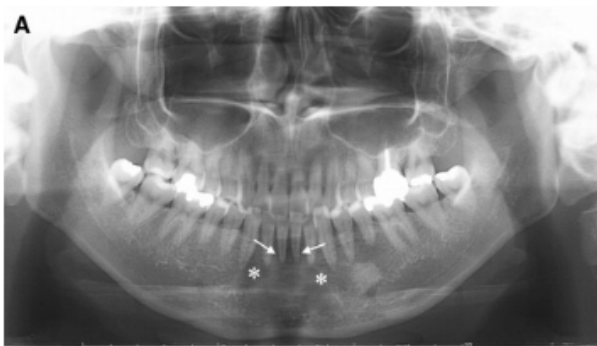
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Fig. 2. Case 2: a 19-year-old man with non-Hodgkin lymphoma involving the left posterior mandible. **A**, Panoramic radiograph. **B**, Axial CT images (left: bone algorithm; right: soft tissue algorithm). **C**, Coronal MR images (left: T1-weighted image; right: T2-weighted image with fat saturation). Although there is no apparent radiolucent lesion on the panoramic radiograph, it demonstrates loss of the left mandibular canal wall (*arrows*; the opposite side). CT demonstrates bone marrow replacement by tumor mass (*black arrow*) with slight cortical erosion of the left mandible (*white arrows*). MRI demonstrates marked bone marrow replacement by tumor mass in the left mandible (*). Although the mass has extensively spread to the masticator and submandibular spaces (+), the cortex of the mandible remains almost completely intact.



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Fig. 3. Case 3: a 43-year-old woman with non-Hodgkin lymphoma involving the left anterior mandible. **A**, Panoramic radiograph. **B**, Axial CT images (left: bone algorithm; right: soft tissue algorithm). **C**, Axial T2-weighted MR image with fat saturation. An ill-defined radiolucent lesion is perceptible on panoramic radiograph (*asterisk*). It also demonstrates widening of the periodontal ligament space (*arrows*). CT demonstrates a tumor mass (*asterisk*) extending from the bone marrow to the surrounding soft tissue. The cortical destruction is relatively mild for the extent of tumor mass. MRI demonstrates involvement of the bone marrow and surrounding soft tissue by a tumor mass more clearly than CT. It appears that the tumor in the surrounding soft tissue has spread along the surface of the mandible in the mesiodistal direction (*arrows*).



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Fig. 4. Case 4: a 40-year-old woman with non-Hodgkin lymphoma involving the anterior mandible. **A**, Panoramic radiograph. **B**, Contrast-enhanced axial CT images (left: bone algorithm; right: soft tissue algorithm). **C**, MR images (left: axial T1-weighted image; right: coronal T2-weighted image with fat saturation). An ill-defined radiolucent lesion is perceptible on the panoramic radiograph (*asterisks*). It also demonstrates widening of the periodontal ligament space (*arrows*). CT demonstrates a tumor mass (*asterisk*) extending from the bone marrow to the surrounding soft tissue. The cortical destruction is relatively mild for the extent of tumor mass. MRI demonstrates the involvement of the bone marrow and surrounding soft tissue by a tumor mass more clearly than CT. It appears that the tumor in the surrounding soft tissue has spread along the surface of the mandible in the superoinferior direction (*arrows*).

MRI depicted the tumor extent more clearly than CT. DCE-MRI and DW-MRI were performed in case 2. In the former, signal intensity of the tumor rapidly increased, followed by gradual decrease. In the latter, the tumor showed a low apparent diffusion coefficient (ADC) value ($0.48 \times 10^{-3} \text{ mm}^2/\text{s}$).

Akiko Imaizumi, Ami Kuribayashi, Hiroshi Watanabe, Naoto Ohbayashi, Shin Nakamura, Yasunori Sumi, Tsukasa Sano, Tohru Kurabayashi, Non-Hodgkin lymphoma involving the mandible: imaging findings, Oral Surgery, Oral Medicine, Oral Pathology and Oral Radiology, Volume 113, Issue 5, 2012, Pages e33-e39,



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