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**Case Presentation:** The infant presented with progressive respiratory distress immediately after birth. The prenatal ultrasound (US) examinations had been without any pathological findings. The postpartal chest X-ray showed a large homogenous opacity in the left hemithorax with gross mediastinal shifting to the right side. Chest US revealed an intrathoracic mass without any pleural effusion, the complementing CT scan showed a well-circumscribed solid mass with a uniform density, without apparent cysts, and a partial fibrous interface based in the left lower lobe. A left lower lobectomy was done without any complications. The pathological result disclosed the diagnosis of a FLIT.

**Unique Teaching Points:** The diagnostic approach considering the radiographic features of this rare entity of a solid lung tumour in a neonate and the distinction from other congenital lung lesions, which predominantly have a cystic appearance, are discussed.

## CP 10

### Predisposing factors for the migration of endobronchial foreign bodies

*H. Moodley, A. Ranchod, A. Ranchod, Johannesburg/ZA*

**Objective:** To assess predisposing factors for the migration of endobronchial foreign bodies (FB).

**Case Presentation:** Two paediatric and one adult case of migrant endobronchial FB with varying characteristics (pebble, teeth and a pencil) are presented. The changing radiological presentation due to migration of these FB is discussed. The physical properties of the FB were analysed and compared to the literature—with regards to predisposing factors for migration within the tracheobronchial tree.

**Unique Teaching Points:** Any endobronchial FB may migrate irrespective of its shape, size or chemical composition. As the number of reported migratory FB cases is small, too little data is available to conclusively predict predisposing factors for endobronchial FB migration. Until such information becomes available it is prudent for the radiologist to meticulously search for endobronchial FB throughout the airways regardless of the aspirated material's chemical composition, size and shape. Furthermore it is imperative that the endoscopist endeavours to search the rest of the tracheobronchial tree, if the FB is not found where imaging has suggested.

## Education/Healthcare & Global Perspectives - Scientific Poster Presentations

### SP 15

#### Provisional reporting of Emergency Department radiographs and correlation with the final radiological report

*M. Paddock, A. Martin, I. Lang, A. Smith, Sheffield/UK*

**Objective:** To audit provisional reporting of Emergency Department radiographs, and to compare results of this cycle (4th) with previous audits (initial=2009).

**Materials:** Data collected from PACS (2-weeks, November 2014) were audited against local the standard: 100% of radiographs seen by ED clinicians should have a comment. The retrospective analysis included: Presence of comment (provisional report) and correlation with final radiological report; Categorisation of missed findings; Body part imaged; Differences between in-hours (IH)

and out-of-hours (OOH); Attitudes towards commenting (anonymous questionnaire).

**Results:** Three hundred fifty-eight radiographs were included: 241 (67%) had a comment with 85% agreement. In those without agreement, three definite misses and ten possible misses required patient recall. Among those without comment (33%) there were 29 obvious, and six possible missed findings; Chest (38, of which 14 had obvious finding) and wrist (14) were the most common body parts. More radiographs were performed and commented in the IH group. Common themes for not commenting included lack of time and missing confidence in describing fractures.

**Conclusion:** Comments give Radiologists information on patient management, providing a 'safety net' to prevent misses. There is a static commenting since the inception of the audit ( $\chi^2=68\%$ ) despite changes implemented from previous audits. Further learning points are identified: Inclusion of guideline in ED induction; Emphasising management versus fracture description; Review of ED standard to better reflect working practice; and streamline reporting of missed findings.

### SP 16

#### Key-points to evaluate correctly the placement of umbilical venous catheters in infants on frontal radiographs

*S. Salerno, E. Murmura, D. Naresse, C. Geraci, G. La Tona, A. Lo Casto, M. Midiri, Palermo/IT*

**Objective:** Provide basic key-points to evaluate placement of umbilical venous catheters (UVC) using a simplified flow-chart in resident radiologist.

**Materials:** UVC are routinely used in the neonates in intensive care unit and malposition may arise in severe complications. On frontal radiograph, UVC is placed from umbilical vein (center of the abdomen) on the right of lumbar spinous processes (L3-L4), through the liver (D10-D12) to the left portal vein and then to ductus venosus and inferior vena cava (IVC) (D9); the tip is ideally placed in the atrio-caval junction or in the proximal portion of the IVC (D8-D9); these key-points were summarized in a simplified flow-chart. Twenty residents were asked to evaluate the placement of ten UVC before and after they familiarized themselves with the flow-chart and the anatomical findings.

**Results:** Before studying the flow-chart and circulation of the diagram, residents were able to assess properly only 53% of UVC position. Common errors were judging UVC in the intrahepatic region and in the right atrium as being placed properly. After the reading flow-chart with the respective anatomical findings, the 98% of UVC were correctly evaluated. The difference was statistically significant ( $p=0,0033$ ).

**Conclusion:** The used flow-chart improved significantly the ability of residents to determine the correct placement of UVC.

### SP 17

#### Posters to Publications in Paediatric Radiology – Worthy of a Paper?

*S. Shelmerdine, J. Lynch, London/UK*

**Objective:** To determine the proportion, time taken and eventual journal location for poster abstracts converted to published papers presented at the Society of Pediatric Radiology (SPR), European Society of Pediatric Radiology (ESPR) and the British Society for Paediatric Radiology (BSPR) in 2012.