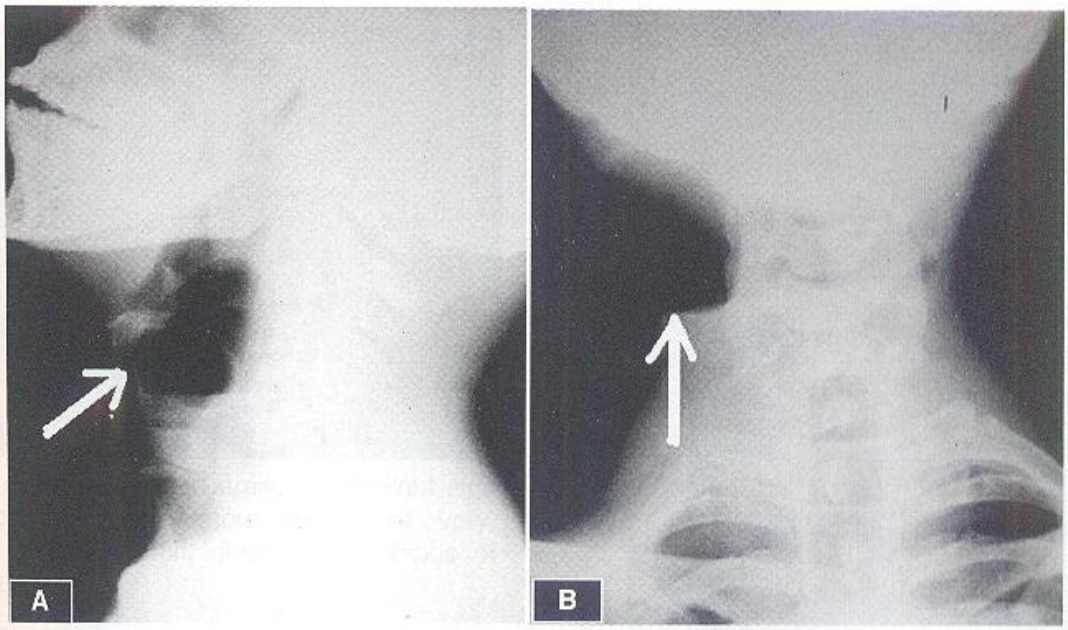
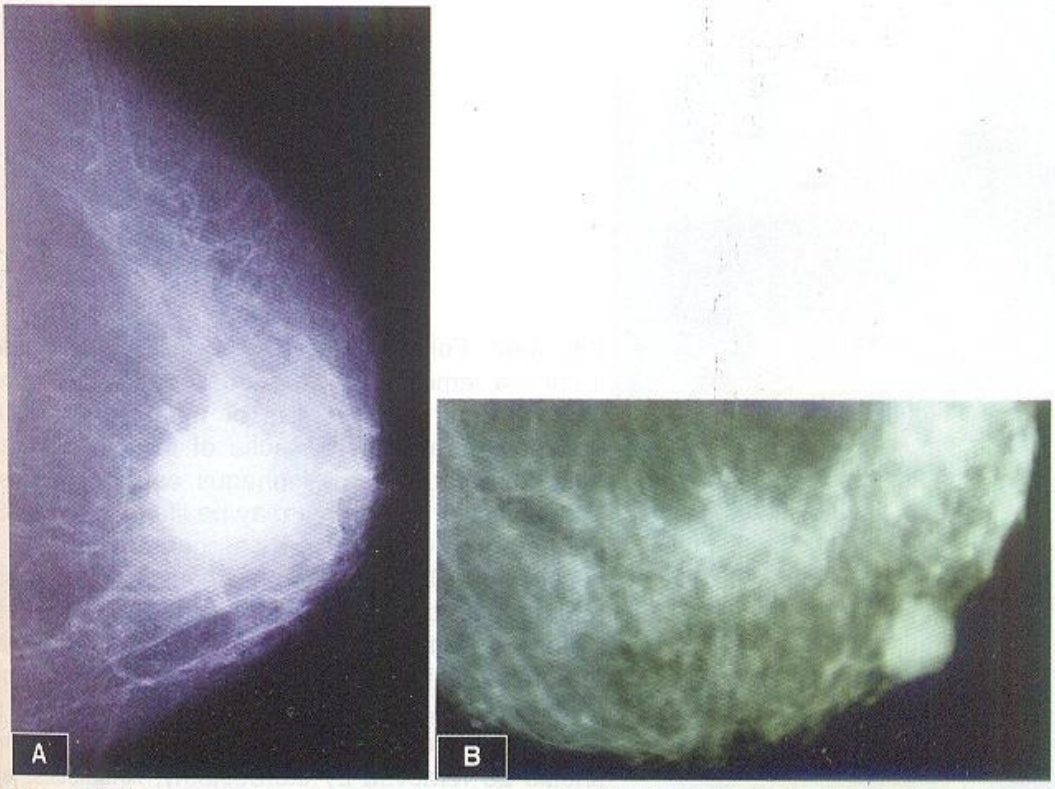


Figs 4.64A and B: X-ray neck AP and lateral view showing radiolucent air filled area – feature of laryngocele. It is a unilateral narrow necked, air- containing diverticulum resulting from herniation of laryngeal mucosa through thyrohyoid membrane where it is pierced by superior laryngeal nerve. It can be external or internal. It presents as a smooth, soft and resonant swelling in the neck adjacent to larynx which is more prominent while blowing, coughing and Valsalva manoeuvre. Cough and hoarseness are common. X-ray is diagnostic. Treatment is excision.



Figs 4.65A and B: Mammography. It is plain X-ray of breast. Cranio-caudal and medio-lateral films are taken. Microcalcification; smooth/irregular soft tissue shadow; speculations are the findings to be looked for.

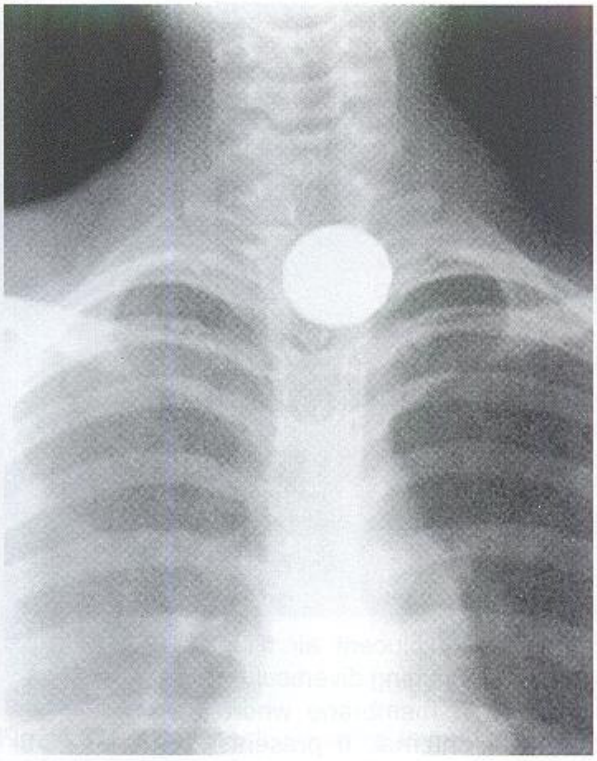


Fig. 4.66: Foreign body in trachearadio-opaque-coin. It ne bronchoscopic removal under anaesthesia. It can cause col of the lung, infection or erosion.

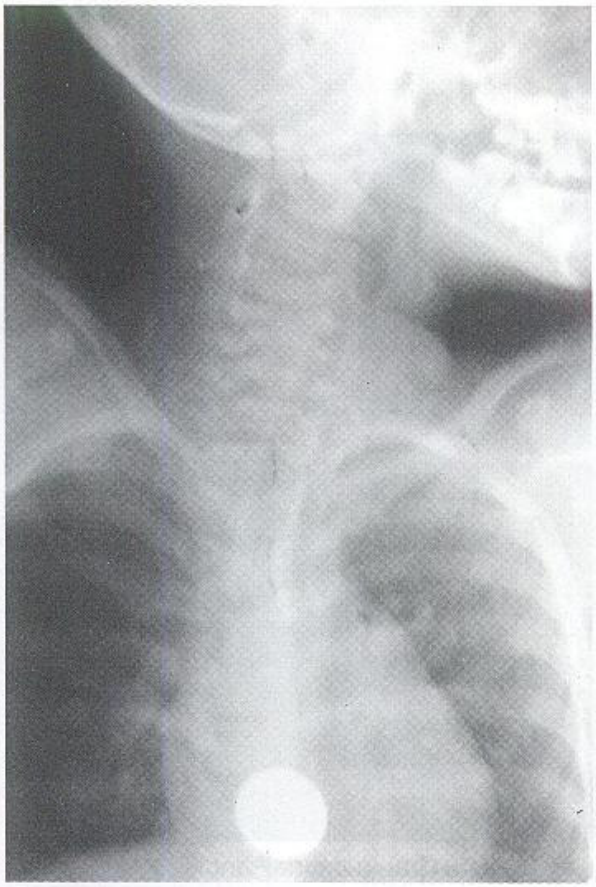
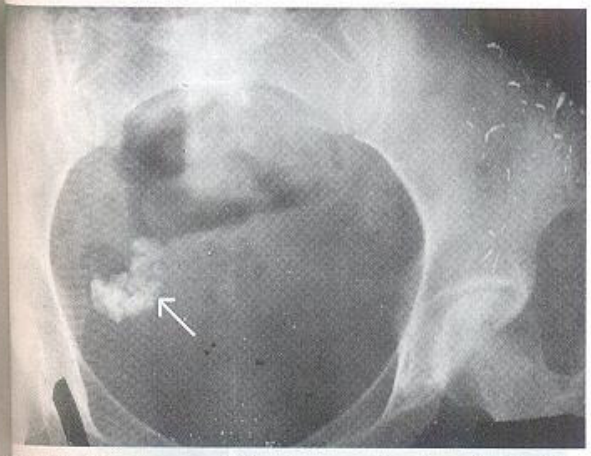
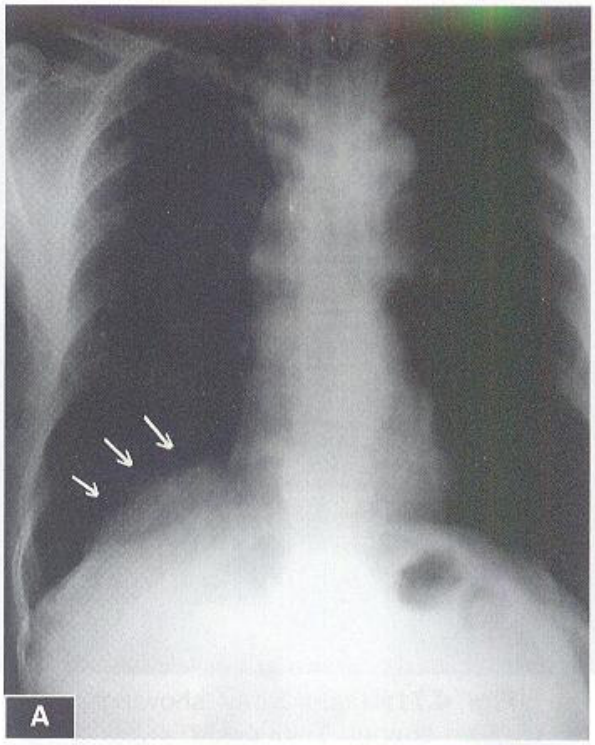


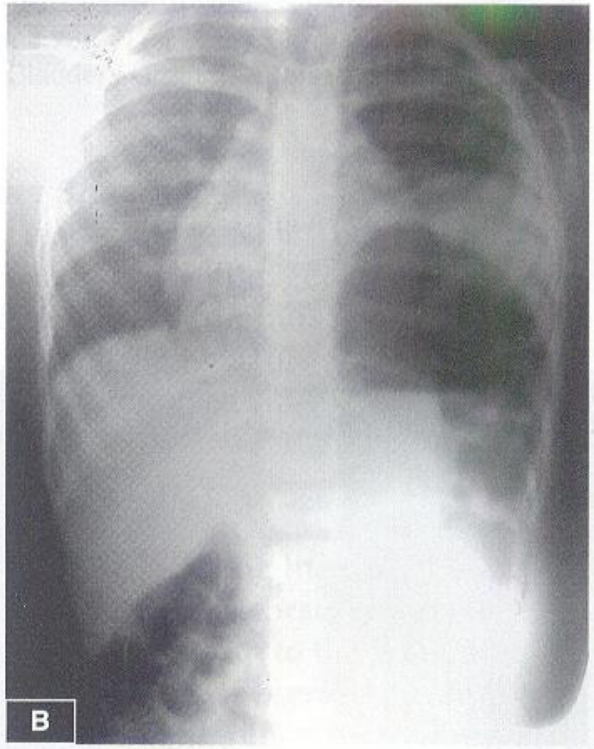
Fig. 4.67: Foreign body (COIN) in the lower oesophagus. Usu it can be removed by an endoscope. Common foreign bodies a Coins, dentures, pins, fish or meat bones. Fish or meat bo are more dangerous because of their ragged sharp edges wh often perforate the oesophagus causing mediastinitis, empye and septicaemia. Often it may be life-threatening. Sites of impact in oesophagus are cervical constriction—C_6; broncho aort constriction—T_4; diaphragmatic constriction—T_{10}; site of pre-existi malignancy or inflammatory stricture. Features are— sudde dysphagia with chest pain and breathlessness. Later presents wi features of shock, sepsis, mediastinitis and empyema.

Management— X-ray shows site and level of the foreign bod Endoscopic removal can be tried; Impacted large foreign bod should be removed by thoracotomy; Antibiotics, jejunostomy, TPN ICT are also required.

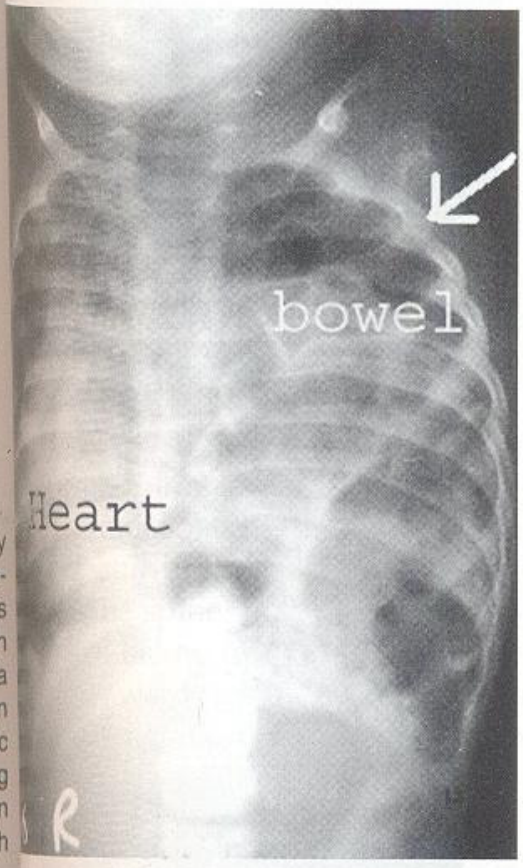


X-ray showing calcified areas in the right side pelvis. It could be teratomatous dermoid of ovary, nodes, bladder calculi, diverticula or bolus of es in ileum.





Figs 4.70A and B: X-ray showing diaphragmatic eventration on right side (localised). It differs from diaphragmatic hernia by not having sac and lungs are normal. Muscular component of diaphragm is not well developed and so eventration occurs. It is treated by plication of diaphragm using nonabsorbable sutures. Left sided diaphragmatic eventration in another X-ray is obvious and significant.



X-ray showing diaphragmatic hernia with bowel on the left side of the chest and heart shadow side.

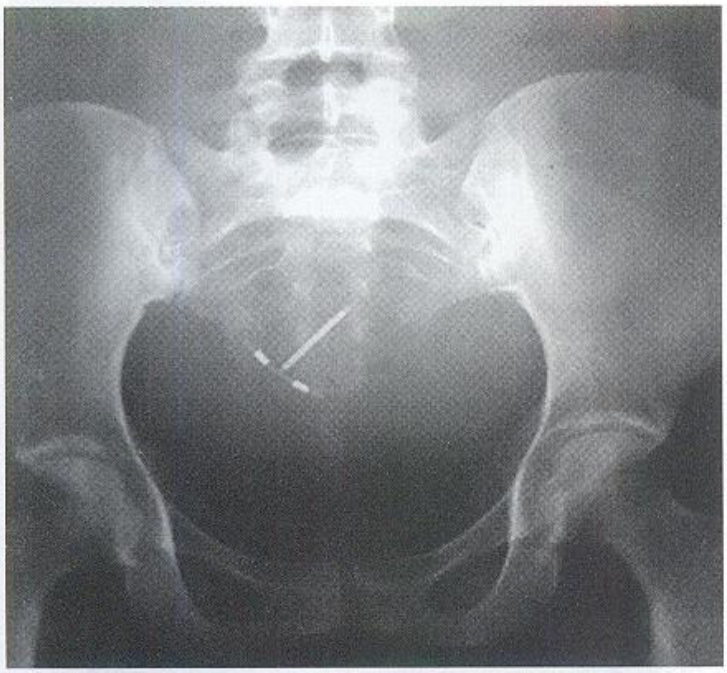
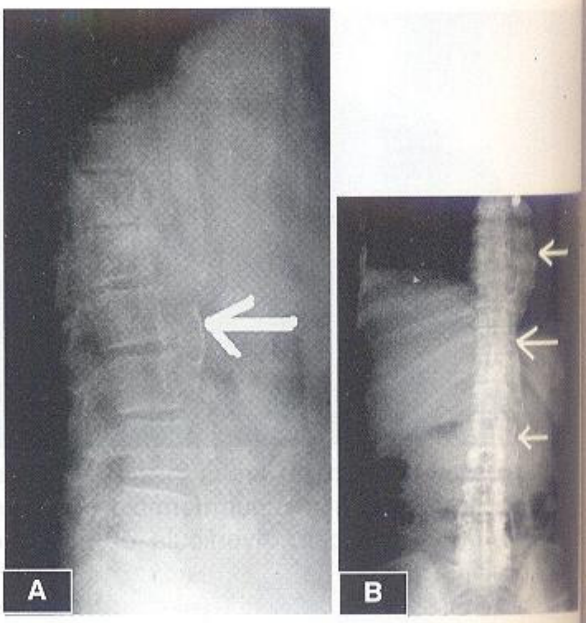


Fig. 4.71: Plain X-ray showing copper T in place.



Figs 4.73A to C: Plain X-ray showing calcified aorta and femoral arteries in an atherosclerotic patient.

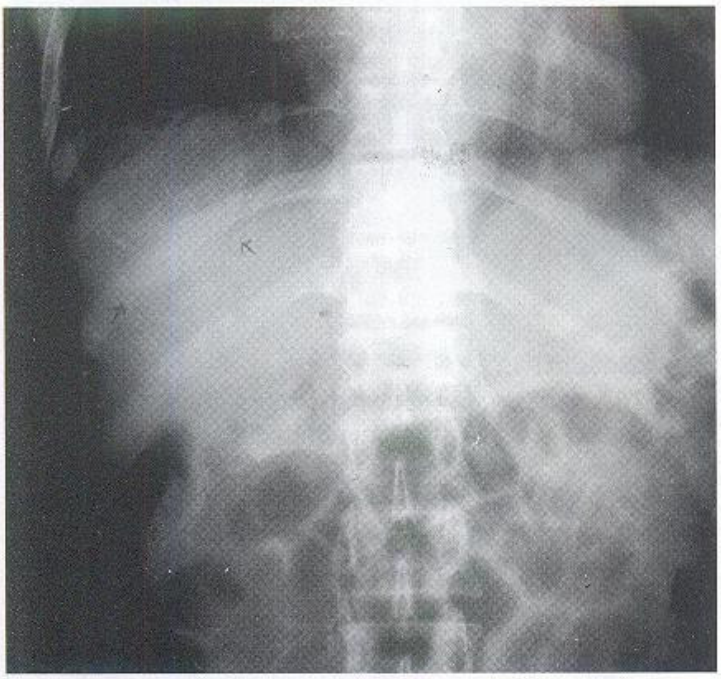


Fig. 4.72: Plain X-ray abdomen showing calcification in liver. It could be calcified amoebic liver abscess/calcified hydatid cyst.

Fig. 4.74: Plain X-ray showing stents in CBD and pancreatic ducts. It is placed in a patient who presented with recurrent pancreatitis with block/stricture in both terminal CBD and pancreatic duct. Later patient underwent choledocho-jejunostomy and pancreaticojejunostomy.