

Specialty Teleradiology Welcomes Neuroradiologist Dr. Michael Rothman

Dr. Rothman earned his medical degree and completed an internship in Internal Medicine from the Hahnemann University School of Medicine and Hahnemann University Hospital in Philadelphia. He was a resident in Diagnostic and Interventional Radiology at the Medical College of Pennsylvania Hospital and at Sinai Hospital of Baltimore, before completing his fellowship in Neuroradiology at Northwestern Memorial Hospital in Chicago.

Dr. Rothman served as a Neuroradiologist and Assistant Professor of Radiology, Neurosurgery, and Otolaryngology/Head & Neck Surgery at the University of Maryland Medical Center for seven years, and was subsequently a consulting staff member in Neuroradiology at the Penn State Milton S. Hershey Medical Center. His practice has focused on Adult & Pediatric Neuroradiology and Sports Medicine/Orthopedic MRI. He has provided Teleradiology services in both solo and group practices since 2000.

Dr. Rothman's research interests have spanned hundreds of professional papers, posters, presentations and lectures with an emphasis on emergency neuroimaging, sports trauma, cerebrovascular disease, multiple sclerosis and tumor development, among other topics. One of his favorite research presentations was the "Evaluation of the Spine in a 1,000-year old Peruvian Mummy with 3D Virtual Navigation."



Dr. Michael Rothman
Neuroradiology

Dr. Rothman continues to lecture extensively and is accepted as an Expert Witness in multiple courts throughout the U.S.

Dr. Rothman is Board Certified by the ABR in Diagnostic Radiology and Neuroradiology and is a Senior member of the American Society of Neuroradiology. He is heavily involved in the ACR & ASNR Guideline writing and revision process, and has served on many committees for both organizations.

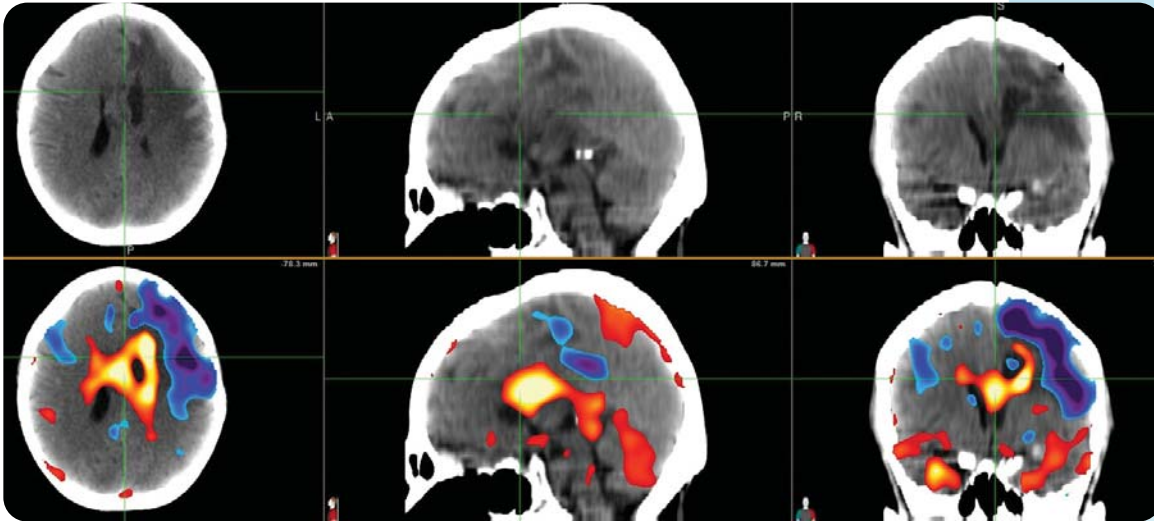
Specialty Teleradiology is proud to offer this excellent Neuroradiology service. Dr. Rothman will be an excellent extension of our current Specialty team. We are pleased to provide our clients the best Subspecialty reporting available.

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EXAM: PET/CT BRAIN IMAGING FOR GLIOBLASTOMA RESTAGING



HISTORY

56-year-old underwent partial resection of left frontal glioblastoma multiforme 07/11/11. He has refused further treatment at this time and is seeking alternative remedies.

PET

There is an irregular ametabolic fluid filled cavity in the left frontal lobe white matter which appears to communicate with subjacent anterior horn of left lateral ventricle. This is likely an ex vacuo collection secondary to previous partial tumor resection. The cavity is marginated with intense hypermetabolic tumor activity circumferentially extending inferiorly to head of caudate nucleus. Along medial margin PET tumor activity extends inferiorly into corpus callosum where it crosses midline and impresses roof of right lateral ventricle, and extends into adjacent right frontal lobe. There is extensive ametabolic vasogenic edema predominantly in left frontal lobe compressing overlying cortical sulci. There is roughly 7.5 mm midline shift from left to right at left of corpus callosum. There is reactive diffusely increased metabolic activity in inferior temporal lobes bilaterally. Small ametabolic focus in right frontal cortex appears to be related to arachnoid cyst.

CT

There is extensive left frontal vasogenic edema extending into adjacent aspect of parietal lobe marginating post resection fluid cavity in left frontal lobe which appears to communicate with anterior horn of left lateral ventricle. There is a thin mantle of tissue marginating the fluid cavity which is intensely hypermetabolic consistent with residual tumor. Similar density tissue extends along medial aspect of cavity inferiorly into corpus callosum with left to right midline shift and effacement of adjacent aspect of right lateral ventricle. On concurrent PET, this is hypermetabolic and is seen to extend into adjacent margin of deep right frontal white matter. Small right frontal cortical fluid collection appears to represent a small arachnoid cyst. There is no subfalcial or subtentorial herniation. There is no hydrocephalus or abnormal extra-axial fluid collection. Left frontal craniotomy defect present.

CONCLUSION

1. Extensive residual hypermetabolic left frontal tumor marginates surgical cavity and crosses midline through corpus callosum into right frontal deep white matter.
2. Extensive left frontoparietal vasogenic edema with cortical compression and 7.5 mm midline shift from left to right.
3. No definite subfalcial or subtentorial herniation.