suggest the primary cancer: gynecological, colo-rectal or gastric origin, but with a low sensitivity.

Prostate cancer is uncommonly suggested with CT: this is the role of digital rectal examination, blood test and biopsy, with the contribution of MRI. CT can help to suspect prostate cancer when pelvic lymph nodes or/and bone lesions are detected (ribs, spine, pelvis and hips).

In our case, peritoneal carcinomatosis was detected during the follow-up in a patient with an abdominal discomfort and abnormal blood tests. We did not have the histological proof of peritoneal carcinomatosis but CT was highly suggestive. The final diagnosis of this complication was conclude based on the positive impact of the change of therapy.

As a conclusion, peritoneal carcinomatosis is an uncommon finding in patients with prostate cancer. It can be detected during routine abdominal CT performed during the follow-up of this group of patients. The CT findings are similar to what is observed in colorectal and gynecologic cancers.

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VARIATIONS OF THE HEPATIC ARTERY

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Dear Sir,

We read the article titled as 'Multidetector CT of hepatic artery pathologies' by Karaosmanoglu et al. (1), published in JBR–BTR (95: 345-349, 2012) with a great interest. This article will be a useful guide for radiologists in their future experiences. In the paper, MDCT angiography has been referred as a very fast and efficient method in identifying hepatic artery variations and pathologies for radiologists. The Authors conclude that MDCT gives both arterial and venous phase images in almost every plane that allows radiologists to inform the clinicians, more accurately and in a shorter time.

The authors identified the hepatic artery variations observed nearly in half of the cases, with Michel's classification method. This classification system was first described by Michel (2) who dissected 200 cadavers to determine anatomic variations of hepatic artery in 1955. In the following years few studies describing hepatic artery variations have been published by Vandamme et al. (3) and Suzuki et al. (4) Covey et al. (5). The later literature reported few additional differences compared to Michel et al. (2). The standard hepatic artery anatomy was 61.3% by Covey et al., and 55% in Michel's original report in 1955. The major difference was frequency of replaced left hepatic artery that was 2.63 times more frequent in Covey et al. (3.8% in 600 patients) compared to that of Michel's report (10.0% in 200 cadavers).

In our institution we have about 50 cases with Y-90 radioembolization. In these cases we embolize gastroduodenal and left gastric arteries. At the fourth week of embolization, we take hepatic angiograms and inject Y-90 substance. These hepatic angiograms indicate a large variation and development of collaterals after the embolization. Additional to interindividual variability, there may be some differences even in the same patients depending of the condition. Therefore MDCT is mandatory for imaging and radiologists should consider this situation.

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