# Row 10367

Visit Number: 2893627a925fbdcfc8274f87c0fccd4d421a1686e7b02d8a757ba51e7065bd7d

Masked\_PatientID: 10366

Order ID: 37e808d0d8d616de53cff7720e7d6c014b44caf6f8afc773f5ecfb1024129d53

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 31/5/2018 12:18

Line Num: 1

Text: HISTORY possible stroke with myoclonic jerks ?PE; Admitted for pancreatitis with PEA collapsed ESRF with transplanted kidney TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS The patient is intubated and NG tube is in situ. There is complete volume loss of the left lower lobe, likely atelectasis. The visualised left lower lobe airways are patent. Partial volume loss of the right lower lobe is also present. The pulmonary trunk, right and left pulmonary arteries and visualised segmental branches of the pulmonary arteries are otherwise patent, no convincing CT evidence of pulmonary embolism. There are small bilateral pleural effusions. Nosuspicious pulmonary mass. No significantly enlarged axillary, mediastinal or hilar lymph node. The heart appears enlarged. Low density ascites is present in the abdomen and pelvis. The pancreas is swollen with peripancreatic fluid and fat stranding, in keeping with known pancreatitis. The enhancement pancreas is satisfactory. There is no obvious gallstone. Intrahepatic ducts and common bile duct are not liver or spleen. No suspicious mass in the visualised liver, spleen or gallbladder. There is dilatation of the small bowel loops, indicating small bowel intestinal obstruction. The dilatation extends to the distal ileum (11-69), no obvious mass is visualised at the site of transition. There is mural oedema of therectum and sigmoid colon. There is suspicion of intramural gas in the sigmoid colon (11-121). In the transverse colon, dilatation of the colon is visualised and there is patchy hypo enhancement in the wall of the transverse colon (11-33) with pericolic fat stranding. The visualised branches of the mesenteric arteries and veins are otherwise patent. The urinary bladder is collapsed and Foley catheter is in situ. The transplant kidney in the right iliac fossa is noted with thinning of the parenchyma, suggesting failed graft. Adrenal glands are unremarkable. The native kidneys are small in size and hypodense lesions in the native and transplant kidneys are probably cysts. No hydronephrosis. There is an arterial catheter in the left common femoral artery. No aggressive bony lesion. CONCLUSION No convincing CT evidence of pulmonary thromboembolism. There is complete volume loss of the left lower lobe but the airways are patent, suggesting atelectasis. Partial right lower lobe volume loss is also present. No suspicious pulmonary mass. There are small bilateral pleural effusions. There is oedema of the rectum and sigmoid colon with suspicion of intramural gas. The transverse colon appears distended as well with segments of poor mural enhancement in the transverse colon. Ischaemic colitis should be considered. There is low density ascites in the abdomen and pelvis. Dilatation of the small bowel loops is visualised with transitionin the distal ileum but no obvious mass is visualised at the site of transition. The visualised branches of the mesenteric arteries and veins appear patent. Swollen and oedematous pancreas is in keeping with known acute interstitial pancreatitis. There is no obvious dilatation of the common bile duct or intrahepatic ducts. No obvious gallstone. Further action or early intervention required Finalised by: <DOCTOR>

Accession Number: d4fd706b750f5bb34ec50a0622b48bb0d2d9e7d9ae1f2409223ffbf7107ea9d6

Updated Date Time: 31/5/2018 13:09