# Row 10716

Visit Number: 89dfad581a5066357bbb3d93514d241fed9c922827e36075dbf60553be4c3402

Masked\_PatientID: 10709

Order ID: e1fc02150fb2b10bc8d0e4c2b001320cfdbf7c62af05f968cd9f4dad43d24c42

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 26/2/2019 14:39

Line Num: 1

Text: HISTORY metastatic lung adenocarcinomaalso has chronic diarrheapersistent fever; TRO intraabdominal source vs. obstructive pneumonia\lung abscess TECHNIQUE Scans of the abdomen were acquired after the administration of intravenous contrast medium. Intravenous contrast: Omnipaque 350 Contrast volume (ml): 65 FINDINGS Comparison made with CT of 14\1\2019. A rounded mass in the medial posterior aspect of the right lung apex, suspicious for primary lung malignancy has increased from prior 32 x 27 mm to now 55 x 42 mm (402-32). Adjacent right posterior 4th rib erosion is slightly increased (402-29). There is extensive adjacent pleural thickening circumferential throughout the right upper hemithorax, in keeping with extensive pleural metastasis. At the right mid zone, there is prominent mass like lesion increasing from prior 34 x 60 mm to now 55 x 61 mm (402-55) which appears to be fissural\pleural in location on sagittal reconstruction (5001-1). Extensive lobulated fissural and perifissural nodules in the right lung base is also increased, associated with increasing right basal pleural effusion that shows new pleural thickening, in keeping with progression of pleural metastasis. The primary mass and the pleural thickening is inseparable from soft tissue in the right hilum and adjacent enlarged right paratracheal nodal disease increasing from prior 24 mm to now 32 mm in short axis. Increased narrowing of the right mainstem bronchus is noted measuring up to 3 mm (401-46). There is also interval worsening of several right hilar, subcarinal, bilateral predominantly right mediastinal lymphadenopathy. Slightly increased in left supraclavicular nodes (402-4) up to 6 mm is nonspecific. No axillary lymphadenopathy. There is increasing reticulonodular thickening in the aerated right upper lobe, suspicious for progression of lymphangitis carcinomatosis. This is less apparent in the aerated right lower and middle lobe. Progressive pleural disease in the right lung base obscured some of the previously noted lung metastases. No convincing consolidation is noted with the findings in the right lung likely neoplastic. There is no lung abscess. Stable tiny 2 mm nodulein the lateral aspect of the basal right left lower lobe (401-75) is unchanged. There is centrilobular emphysema scattered in the upper zones of the left lung. A new moderate left plantar pleural effusion with no pleural thickening is noted. Minimal compressive atelectasis noted in the left lung base. Heart size is not enlarged. A sliver of pericardial effusion is seen. Ectasia of the ascending aorta, thoracic aortic arteriosclerotic disease and few ulcerated plaques along the aorticarch are again noted. Tumour encasement of the distal right pulmonary artery and the right upper and lower pulmonary veins are noted with stable mild narrowing of the right upper pulmonary vein, otherwise patent. No suspicious focal hepatic lesion detected. Post cholecystectomy clips is noted. No biliary obstruction discerned. Portal and hepatic veins enhance normally. No hydronephrosis noted. A few tiny hypodensities in both kidneys are too small to characterise but likely represent cysts. The adrenals, spleen, pancreas, urinary bladder and seminal vesicles are unremarkable. The prostate is mildly prominent. Stable mild thickening of the rectal wall likely represents proctitis. No focal mass is noted. A clip is noted atthe distal descending colon. There is under distension of the hepatic flexure. Rest of the bowel shows normal wall enhancement, with no convincing focal mass or abnormal thickening. No free air or localised rim enhancing collection is noted. Minimal tubular soft tissue along the right paracolic gutter (501-78) are likely to represent blood vessels. No ascites, peritoneal thickening or omental caking is noted. There is diffuse soft tissue stranding especially in the subcutaneous fat on the right, more likely due to third space loss. The abdominal aorta is again noted tortuous with extensive mixed atherosclerotic changes, with a fusiform aneurysm of the infrarenal aorta measuring 37 x 31 mm (501-74) with no interval dissection, acute intramural haematoma, periaortic stranding or extravasation. No obvious enlarged lymph nodes seen in the abdomen, pelvis and inguinal region. There is interval increase of a 12 mm lucent lesion with ill-defined sclerotic margin inthe medial aspect of the right iliac bone (501-106), nonspecific but concerning for a bony metastasis. Stable subchondral changes at the right glenohumeral joint is otherwise likely degenerative. Stable tiny sclerotic focus at T11 vertebra may be a bone island. CONCLUSION Since last CT of Jan 2019, 1. Progression of primary lung malignancy at right lung apex with increased adjacent rib erosion. 2. Marked worsening of pleural metastasis in the right hemithorax surrounding all lobes, with new lymphangitis carcinomatosis of the right upper lobe. 3. Progression of the intrathoracic lymphadenopathy, largest at the right paratracheal region. 4. Stable ulcerated plaques of the aortic arch and fusiform aneurysm of the infrarenal abdominal aorta. 5. No convincing nodal or visceral metastasis in the abdomen and pelvis. 6. Mild proctitis noted. No free air. No other overt focus of inflammation in the abdomen and pelvis. 7. Increasing small lytic lesion in the right iliac bone is suspicious for bony metastasis. 8. Prominent third space loss in the subcutaneous and mesenteric fat. 9. Other minor findings as described. Report Indicator: May need further action Finalised by: <DOCTOR>

Accession Number: 4fe13e71bb3211a6f027b3040cb1776bb451d3c8a1876000eb79a770cb75ff4d

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