# Row 10762

Visit Number: faa5b790559be913284a0e815d435f51d0ded94e53406735391d869b58294b2c

Masked\_PatientID: 10761

Order ID: bd67aa0df0219657a0d85f1e2b0bbcfe6a32e05346b38139164a134b65a8664e

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 05/8/2020 18:00

Line Num: 1

Text: HISTORY large rectosigmoid mass likely cancer for staging; ESRF on dialysis TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Iopamiro 370 - Volume (ml): 70 FINDINGS Previous ultrasound abdomen dated 29 October 2019 was reviewed. No suspicious pulmonary mass or consolidation. Rounded subpleural density in the posterobasal segment of the right lower lobe has a triangular/wedge-shaped configuration on the coronal image, possibly focal atelectasis (6/87, 15/12). Other smaller foci of subpleural atelectasis scattered in the lower lobes. Mild linear atelectasis in the middle lobe, lingula and left lung base. Trachea and central airways are patent. There is no pleural effusion. Small volume left supraclavicular and left axillary nodes are nonspecific. No enlarged mediastinal or hilar lymph node. There is a small right interlobar node (5/57). Imaged thyroid gland is not enlarged. There are prominent vessels in the left anterior chest wall. There is cardiomegaly and coronary arterial disease. Mediastinal structures opacify satisfactorily. No pericardial effusion. Background atherosclerotic disease with scattered calcified plaques and eccentric mural thrombi for example in the aortic arch (15/38). No suspicious focal hepatic lesion. No radiodense gallstone or biliary dilatation. Pancreas, spleen and adrenals are unremarkable. The kidneys are small and lobulated in keeping with chronic renal parenchymal disease. 0.3 cm nonobstructing right renal upper pole calculus. In the right renal lower pole, there is a heterogeneous intermediate attenuation lesion measuring (1.3 cm x 1.1 cm) (series 8, image 54) with apparent mild enhancement (1116/1). Several other bilateral renal hypodensities, larger ones are probably cysts while the subcentimetre ones are too small to accurately characterise. No hydronephrosis. Partially distended urinary bladder shows nonspecific mural thickening. Prostate gland is mildly prominent. There is an ovoid nodule at the left groin which appears to be dermal in location, of indeterminate significance (1.7 cm) (series 8, image 141). There is a circumferential intraluminal lesion at the rectosigmoid colon measuring (3.9 cm) (series 16, image 30). There is no overt extra serosal nodularity or fat stranding. Several small volume lymph nodes in the sigmoid mesentery are indeterminate (for example 16/31, 29). No enlarged abdominopelvic lymph node. No proximal bowel obstruction. No pneumoperitoneum or ascites. No suspicious bony destruction. CONCLUSION 1. Intraluminal mass in the rectosigmoid colon in keeping with submitted history. No overt extramural involvement or proximal bowel obstruction. 2. Prominent nodes in the sigmoid mesentery are indeterminate. 3. No definite CT evidence of pulmonary or hepatic metastasis. 4. Indeterminate solid neoplasm in the right renal lower pole. Suggest ultrasound correlation. 5. Other findings as described above. Report Indicator: Further action or early intervention required Finalised by: <DOCTOR>

Accession Number: 9aed313c882e8f8bb43e56899d74d43463bcc508df123de503b6c5bf58c52ad0

Updated Date Time: 07/8/2020 10:17