# Row 1083

Visit Number: c3f444c804789abbe284903fadefcab28d46764a5204292476fa902241d6534f

Masked\_PatientID: 1077

Order ID: 7b4d24c34602139b8d30dd75aab28061804c0ace660cf069da00b9f577954756

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 21/8/2020 15:15

Line Num: 1

Text: HISTORY SOB - ?PE Abdo pain ?cholecystits TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 95 FINDINGS CT pulmonary angiography dated 23 Oct 2018 was reviewed. Chest: No filling-defect is seen in the pulmonary trunk, pulmonary arteries and the segmental branches. The pulmonary trunk is not dilated. The RV: LV ratio is < 1. The heart is enlarged. No pericardial effusion is seen. No significantly enlarged mediastinal,hilar, axillary or supraclavicular lymph node is detected. Patchy ground glass opacities are again seen in both lungs, largely unchanged since the CT of 23 October 2018, possibly representing mosaic attenuation from air trapping. No pulmonary mass or consolidation. The central airways are patent. No pleural effusion is present. A few well defined nodules are noted in the left breast; these demonstrate a benign appearance. Abdomen and pelvis: Scattered colonic diverticula are seen. A short segment (5cm) of circumferential mural thickening is noted at the splenic flexure (series 6, image 59) with surrounding fat stranding, suggestive of extraserosal extension (series 7, image 90). The rest of the bowel loops are normal in calibre. The appendix is normal. No intra-abdominal collection. There is a wide neck hernia in the lower anterior abdomen, containing small/large bowels and omental fat, with no evidence of obstruction. There is marked subcutaneous fat stranding surrounding the hernia sac. The overlying skin is also thickened. The liver is fatty. No suspicious hepatic lesion is noted. The hepatic and portal veins are patent. The gallbladder is unremarkable with no radiodense gallstone, gallbladder wall thickening or pericholecystic fat stranding. The biliary tree is not dilated. The pancreas, spleen and adrenals are unremarkable. Both kidneys enhance symmetrically. Nonobstructing calculi are seen in both kidneys. No hydronephrosis. A 1.4 cm hypodensity of increased attenuated is noted in the left kidney, which may represent a hyperdense cyst. The urinary bladder shows a smooth outline. The uterus is enlarged, with several nodules; some calcified, likely related to fibroids. There is no suspicious adnexal mass. No ascites or pneumoperitoneum. Prominent retroperitoneal nodes are indeterminate, for example, the para-aortic node measures (1.0 cm) (series 6, image 62). No other significantly enlarged abdominal orpelvic lymph node is noted. The aorta is of normal calibre with atherosclerotic calcifications. No bony destructive lesion is noted. CONCLUSION 1. No CT evidence of acute pulmonary embolism. 2. No evidence of acute cholecystitis. 3. Short segment circumferential mural thickening at the splenic flexure raises suspicion for primary colonic malignancy. Surrounding fat stranding suggests extra serosal extension. Acute diverticulitis is a less likely differential in view of presence of colonic diverticula. No perforation or rim-enhancing intraabdominal collection. 5. Left breast nodules demonstrate a benign appearance. Further evaluation with dedicated breast imaging may be considered if clinically warranted. Report Indicator: Further action or early intervention required Reported by: <DOCTOR>

Accession Number: f71fcb0ede88e15c958868f657e2cc38f4ad5e1153273d3f8c710490a6e60241

Updated Date Time: 21/8/2020 18:00

## Layman Explanation

This radiology report discusses HISTORY SOB - ?PE Abdo pain ?cholecystits TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 95 FINDINGS CT pulmonary angiography dated 23 Oct 2018 was reviewed. Chest: No filling-defect is seen in the pulmonary trunk, pulmonary arteries and the segmental branches. The pulmonary trunk is not dilated. The RV: LV ratio is < 1. The heart is enlarged. No pericardial effusion is seen. No significantly enlarged mediastinal,hilar, axillary or supraclavicular lymph node is detected. Patchy ground glass opacities are again seen in both lungs, largely unchanged since the CT of 23 October 2018, possibly representing mosaic attenuation from air trapping. No pulmonary mass or consolidation. The central airways are patent. No pleural effusion is present. A few well defined nodules are noted in the left breast; these demonstrate a benign appearance. Abdomen and pelvis: Scattered colonic diverticula are seen. A short segment (5cm) of circumferential mural thickening is noted at the splenic flexure (series 6, image 59) with surrounding fat stranding, suggestive of extraserosal extension (series 7, image 90). The rest of the bowel loops are normal in calibre. The appendix is normal. No intra-abdominal collection. There is a wide neck hernia in the lower anterior abdomen, containing small/large bowels and omental fat, with no evidence of obstruction. There is marked subcutaneous fat stranding surrounding the hernia sac. The overlying skin is also thickened. The liver is fatty. No suspicious hepatic lesion is noted. The hepatic and portal veins are patent. The gallbladder is unremarkable with no radiodense gallstone, gallbladder wall thickening or pericholecystic fat stranding. The biliary tree is not dilated. The pancreas, spleen and adrenals are unremarkable. Both kidneys enhance symmetrically. Nonobstructing calculi are seen in both kidneys. No hydronephrosis. A 1.4 cm hypodensity of increased attenuated is noted in the left kidney, which may represent a hyperdense cyst. The urinary bladder shows a smooth outline. The uterus is enlarged, with several nodules; some calcified, likely related to fibroids. There is no suspicious adnexal mass. No ascites or pneumoperitoneum. Prominent retroperitoneal nodes are indeterminate, for example, the para-aortic node measures (1.0 cm) (series 6, image 62). No other significantly enlarged abdominal orpelvic lymph node is noted. The aorta is of normal calibre with atherosclerotic calcifications. No bony destructive lesion is noted. CONCLUSION 1. No CT evidence of acute pulmonary embolism. 2. No evidence of acute cholecystitis. 3. Short segment circumferential mural thickening at the splenic flexure raises suspicion for primary colonic malignancy. Surrounding fat stranding suggests extra serosal extension. Acute diverticulitis is a less likely differential in view of presence of colonic diverticula. No perforation or rim-enhancing intraabdominal collection. 5. Left breast nodules demonstrate a benign appearance. Further evaluation with dedicated breast imaging may be considered if clinically warranted. Report Indicator: Further action or early intervention required Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

No diseases detected.  
No specific organs mentioned.  
No symptoms mentioned.