# Row 1126

Visit Number: c1620a44bcd374d14984b9345eaaaad7ca007f10ab5ef585abe88af10656e116

Masked\_PatientID: 1115

Order ID: ad7097915b7a0836348eed9ee97128ef713eff80a842e0f1433aaf0e4f838cea

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 10/6/2019 15:26

Line Num: 1

Text: HISTORY Persistent fever despite broad-spectrum antibiotics Previous pyelonephritis and aspiration pneumonia To assess for possible sources of infection B/g locally advanced oesophageal CA s/p chemoRT - planned for surgical resection TECHNIQUEUnenhanced scans of the thorax, abdomen and pelvis. No intravenous contrast medium administered. Positive Oral Contrast given. FINDINGS Comparison made with the CT KUB of 23 May 2019 and CT thorax of 15 May 2019. Image quality is significantly degraded by movement artefact. No new grossly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. There is grossly stable mural thickening at the lower oesophagus (2-78). Heart size is normal. No pericardial effusion is detected. New patchy bilateral airspace opacities are present, more prominent in the upper lobes bilaterally where there are areas of focal consolidation (3-50). The central airways are patent. Small bilateral pleural effusions are present, larger since 15 May 2019. No gross contour deforming hepatic mass is identified. The partially contracted gallbladder, spleen, pancreas and adrenal glands appear grossly unremarkable. There is a 4.2 x 1.7 cm crescent-shaped fluid collection at the posteroinferior aspect of the left kidney (2-134 and 7-27). Mild stranding of the adjacent fat is present. No underlying renal calculus or hydronephrosis is seen. The urinary bladder appears grossly unremarkable. The prostate glandis normal in size. There is mild colonic faecal loading. No grossly dilated bowel loop is seen. There is a small right inguinal hernia containing fat and a few small bowel loops. No grossly enlarged para-aortic or pelvic lymph node is identified. No ascites or pneumoperitoneum is seen. No destructive bone lesion detected. CONCLUSION 1. Perinephric collection (4.2 x 1.7 cm) at the left renal lower pole. In the context of persistent sepsis, this is suspicious for a perinephric abscess. 2. New patchy bilateral air-space opacities, worse in the upper lobes. These may be due to infection or inflammation. Small bilateral pleural effusions. 3. Stable mural thickening of the lower oesophagus. Report Indicator: Further action or early intervention required Finalised by: <DOCTOR>

Accession Number: 8bc43b469e6f913afd3b450f97d26b1cb95ba5d2a6018b06754ad4810e644539

Updated Date Time: 10/6/2019 16:29

## Layman Explanation

This radiology report discusses HISTORY Persistent fever despite broad-spectrum antibiotics Previous pyelonephritis and aspiration pneumonia To assess for possible sources of infection B/g locally advanced oesophageal CA s/p chemoRT - planned for surgical resection TECHNIQUEUnenhanced scans of the thorax, abdomen and pelvis. No intravenous contrast medium administered. Positive Oral Contrast given. FINDINGS Comparison made with the CT KUB of 23 May 2019 and CT thorax of 15 May 2019. Image quality is significantly degraded by movement artefact. No new grossly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. There is grossly stable mural thickening at the lower oesophagus (2-78). Heart size is normal. No pericardial effusion is detected. New patchy bilateral airspace opacities are present, more prominent in the upper lobes bilaterally where there are areas of focal consolidation (3-50). The central airways are patent. Small bilateral pleural effusions are present, larger since 15 May 2019. No gross contour deforming hepatic mass is identified. The partially contracted gallbladder, spleen, pancreas and adrenal glands appear grossly unremarkable. There is a 4.2 x 1.7 cm crescent-shaped fluid collection at the posteroinferior aspect of the left kidney (2-134 and 7-27). Mild stranding of the adjacent fat is present. No underlying renal calculus or hydronephrosis is seen. The urinary bladder appears grossly unremarkable. The prostate glandis normal in size. There is mild colonic faecal loading. No grossly dilated bowel loop is seen. There is a small right inguinal hernia containing fat and a few small bowel loops. No grossly enlarged para-aortic or pelvic lymph node is identified. No ascites or pneumoperitoneum is seen. No destructive bone lesion detected. CONCLUSION 1. Perinephric collection (4.2 x 1.7 cm) at the left renal lower pole. In the context of persistent sepsis, this is suspicious for a perinephric abscess. 2. New patchy bilateral air-space opacities, worse in the upper lobes. These may be due to infection or inflammation. Small bilateral pleural effusions. 3. Stable mural thickening of the lower oesophagus. Report Indicator: Further action or early intervention required Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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