# Row 11166

Visit Number: 0d949dabb0918502a4228bbc95ec1da82961d0cbf12a545712d5d5241afc2524

Masked\_PatientID: 11165

Order ID: 70711d9c14c1f55c582e494605885f919f0c10eb16479ab114353bf4715ab6bf

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 17/3/2016 17:57

Line Num: 1

Text: HISTORY LUL nodule; Incidental finding of LUL nodule 1.6cm. No family history of cancer. Non-smoker. No previous TB or contact. No cervical lymph node. Heart and lungs were clear. TECHNIQUE Scans acquired as per department protocol. 50ml of Iopamiro 370 given intravenously. FINDINGS No prior study is available for comparison. There is a 1.6 x 1.8 cm (AP x TR) solid round lung nodule in the apico-posterior segment of the left upper lobe (img 5-27). The nodule exhibits intrinsic calcification with no cavitation and is most likely a benign granuloma. There are also a few scattered tiny nodules in the left lung (img 5-23, 29, 31, 37 etc), some of which are calcified and are probable granulomas. There isan area of scarring in the left lower lobe (img 5-39). In the right lung, there are also a few 2-3mm tiny nodules, one with calcification, some of which forming ‘ tree in bud’ appearance in the right upper lobe (img 5-21 and 24). No consolidation or pleural effusion is detected. The central airways are patent. There are enlarged paratrachael, precarinal, aortopulmonary and bilateral hilar lymph nodes. The largest lymph node is in the right paratracheal region measuring 3.6 x 3.3cm (img 4-26). No nodal necrosis or calcification. The heart is not enlarged. No pericardial effusion is seen. There is a 1.2 cm lymph node adjacent to the lesser curvature of stomach (img 4- 85). No destructive bone lesion is detected. CONCLUSION A dominant left apical calcified pulmonary nodule, most likely a benign granuloma. Other smaller nodules and some scarring is also present in upper lobes bilaterally, which are likely sequelae of previous granulomatous infection. Prominent mediastinal and small volume bilateral hilar lymphadenopathy without nodal necrosis or calcification. Differential diagnoses for thes nodesinclude granulomatous disease (mycobacterial infection or sarcoid). Lymphoma would be a less likely differential diagnosis too. Further workup and histological correlation is advised. Borderline prominent upper abdominal node as well. May need further action Reported by: <DOCTOR>

Accession Number: 0af69b13024521f239be30a1e5896c44bdcb0aa0234b39c4f6b7b766be6a6877

Updated Date Time: 18/3/2016 10:27