# Row 11257

Visit Number: 7f88dd057c62e42f84c5d6e37a07ff59a6ad07ffd492eadad04d8547ad5ea844

Masked\_PatientID: 11230

Order ID: 3bb3f878307603fdb08c9d347f8ba9709fb7443264fe65b7c127769e1b401547

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 18/1/2016 10:43

Line Num: 1

Text: HISTORY smoker with 2mm lul nodule for surveilance TECHNIQUE Plain CT of the thorax was acquired. No intravenous contrast was given. FINDINGS Comparison made with the last CT scan of January 19, 2015. The previously demonstrated 2 mm nodule in anterior segment of the left upper lobe shows significant interval increase in size, now measuring 10 x 7 mm (Im 3/23). The nodule also shows spiculated margins. The 2 mm nodule in middle lobe (Im 3/69) is stable (prev Im 3/67). The 2 mm nodule along the right minor fissure (Im 6/33) is smaller compared to prior study (prev Im 6/33). No consolidation or ground-glass opacity is detected. No pleural effusion is present. Mild centrilobular emphysema is seen in bilateral upper lobes. No significantly enlarged mediastinal, axillary or supraclavicular lymph node is detected. Within limits of an unenhanced CT, no obvious hilar lymphadenopathy is noted. The heart is normal in size. No pericardial effusion is seen. The limited sections of the unenhanced upper abdomen are unremarkable. Stable sclerotic focus in the inferior tip of the left scapula may represent bone island (Im 2/48). No destructive bony process is seen. CONCLUSION The previously demonstrated nodule in anterior segment of the left upper lobe shows significant interval increase in size and shows spiculated margins. The nodule is highly suspicious for malignancy. Further action or early intervention required Finalised by: <DOCTOR>

Accession Number: 501bcf2a3c69803e1885f3353737a99aa2caa4bd9b14851c21d77a355690a8d1

Updated Date Time: 18/1/2016 11:33