# Row 11330

Visit Number: b3eceac6da2af3d585d365f1930eb38950cb58ebbd6c3df004a7ecaff32d5104

Masked\_PatientID: 11311

Order ID: f260f87b7e72d63c335e4dd88391cd34158b6c668af1de39cb920e4e5e523638

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 19/6/2017 18:52

Line Num: 1

Text: HISTORY 40/Indian/Male Metastatic periampullary adenoca prev s/p Whipple's, now with mets to lung, LN, pericardium and intraabdominal + retroperitoneal LNs Admitted for SOB with tachycardia, Well's score 4 Now febrile, Bil 35 > 73 and ALP 1200+ from 500 TRO PE and look for HBS obstruction TECHNIQUE Scans of the thorax, abdomen and pelvis were acquired after the administration of Intravenous contrast: Omnipaque 350 - Volume (ml): 130 FINDINGS Comparison was madewith the CT scan of 2 June 2017 Technically poor CT pulmonary angiogram study with systemic arteries and pulmonary veins enhancing more than the pulmonary arteries. There is no gross filling-defect in the pulmonary trunk, main pulmonary arteries or the lobar and segmental branches. The pulmonary trunk is not dilated. There is no reversal of LV:RV ratio, bowing of the interventricular septum or reflux of contrast into the hepatic veins to suggest right heart strain. The heart is not enlarged. Interval decrease in size of pericardial effusion with sliver of residual pericardial fluid. Stable necrotic right supraclavicular node measuring about 1 cm short axis (602-8). Mediastinal adenopathy slightly larger. For example, para-aortic node is larger, measuring 1.8 cm short axis from 1.4 cm and shows interval necrosis (current 602-31 v 402-31). Subcarinal also slightly larger. Stable bilateral hilar adenopathy. Bilateral internal mammary adenopathy stable. Paracardiac nodes are stable or slightly larger. For example, anterior paracardiac node now measures 8 mm in short axis from 4 mm (current 602-74 v 402-78) Extensive right pleural soft tissue nodularity is worse. For example comparing current 602-27 v 402-29). However, loculated right pleural effusion is slightly smaller. There is evidence of previous right-sided talc pleurodesis. There is significant increase in size of left-sided pleural effusion, now moderate sized. Previously noted nodule in the lingula is denser and more prominent, suspicious for metastasis (current 605-64 v 406-67). No new pulmonary nodule detected. There is associated passive atelectasis in both lungs. Status post Whipple’s procedure. There is mild dilatation of the bilio-pancreatic limb which is fluid filled, measuring up to 3.7 cm in diameter. This extends up to the hepatico-jejunostomy anastomosis, distal to which the small bowel is collapsed. However no gross mass is seen at this point. Pneumobilia has resolved. The biliary tree is not overtly dilated. The gastrojejunostomy is patent. The rest of the bowel loops are not dilated. Interval increase in low density ascites. There are multiple peritoneal nodules and serosal metastases seen along the surface of the small bowel and colon. They appear generally worse. Extensive mesenteric and retroperitoneal adenopathy. Some of the mesenteric nodes are larger- for example node in the right upper quadrant lung measures 1.7 cm in short axis from 1.3 cm (current 301-60 v 601-53); Another Mesenteric node is larger and necrotic, measuring 1.6 cm from 1.3 cm (current 301-76 v 601-71). There are also multiple enlarged left gastric nodes, grossly stable. New ill-defined soft tissue nodules in the upper anterior abdominal wall midline are indeterminate for metastatic nodules versus subcutaneous injection (301-57). Portal veins are patent with marked periportal oedema. No focal lesions seen in the liver, spleen, adrenal glands, remnant pancreas. Stable mildly dilated main pancreatic duct. Status post cholecystectomy. Stable cyst in the right kidney upper pole. The bladder is distended. Prostate gland is not enlarged. There is no destructive bony lesion. Stable nonspecific sclerotic foci scattered in the spine. . CONCLUSION Since the 2nd of June 2017, 1. Within limits stated above, No definite filling defect seen in the pulmonary arteries. 2. There is mild dilatation of thebilio-pancreatic limb up to HJ site. In addition pneumobilia has resolved. This could be due to a stricture at the HJ. 3. Extensive right-sided pleural metastases worse. Left pleural effusion markedly larger. Loculated right pleural effusion slightly smaller. Pericardial effusion smaller. 4. Lingula nodule appears more prominent, suspicious for metastasis. 5. Interval worsening of ascites, peritoneal and serosal metastases. 6. Some mediastinal, and paracardiac nodes are larger. Stable right supraclavicular, bilateral hilar, internal mammary adenopathy. 7. Some mesenteric nodes are larger. Grossly stable retroperitoneal and left gastric adenopathy. 8. New ill-defined soft tissue nodules in the upper anterior abdominal wall midline are indeterminate for metastatic nodules versus subcutaneous injection. Kindly correlate clinically. May need further action Finalised by: <DOCTOR>

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