# Row 11598

Visit Number: de18d64b3ffe6df151c1cd4eadb47f030bb1fc8603d76d3fd02a1bca9f7d70db

Masked\_PatientID: 11584

Order ID: 39a8a814de6175e1ddf8660ded9e6a55f1b58bfe22f5bbb5f79fa4a1cca26129

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 28/2/2017 18:58

Line Num: 1

Text: HISTORY Evan's syndrome with recent bowel perforation s/p small bowelresection. Recent acute desaturation and hypotension. gram positive bacilli grown in the blood. CT TAP to look for source of infection/ TRO perforation TECHNIQUEScans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison was made to the previous CT done on 11/02/17. A right-sided PICC line, right internal jugular line, endotracheal tube and nasogastric tube are in satisfactory position. There is dense consolidation seen in both lower lobes, and patchy consolidation in both upper lobes and consolidation in the middle lobe. Bilateral moderate sized pleural effusions are also seen with fluid tracking along the fissures. No axillary, mediastinal or hilar lymphadenopathy is seen. No pericardial effusion is seen. The tracheo-bronchial airway is patent with no intraluminal mass or nodule. The liver shows normal attenuation. There is no suspicious hepatic lesion. There is normal opacification of the portal venous vessels. Periportal oedema is noted. There is no gallbladder calculus and there is normal enhancement of the gallbladder wall. Gallbladder wall oedema is noted. The biliary tree is not dilated. Previous splenectomy noted. The adrenals and pancreas are unremarkable. There is interval development of more wedge-shaped hypodense areas in both kidneys likely representing new areas of infarct. The visualised segments of the main renal arteries are well opacified with no mural thickening to suggest vasculitis. No hydronephrosis or hydroureter. No perinephric stranding is noted. There is mural oedema of the colon along the entire length of the colon which likely represents colitis. A double barrel ileostomy is seen in the right side of the abdomen. Normal enhancement of the rest of the bowel wall is seen. There is loculated ascites seen with fluid in the pericholecystic, bilateral paracolic gutters and pelvis. Of note, the largest is in the left side of the abdomen measuring 5.9 x 2.2 x 5.1 cm (9-111, 12-62). There is enhancement of the peritoneum suggestive of peritonitis. No intraperitoneal free air is noted. The urinary bladder is collapsed. The prostate appears normal. No bladder calculus is seen. An indwelling urinary catheter is seen. There is no intra-abdominal or pelvic lymphadenopathy. There is no destructive bony lesion. Generalised diffuse subcutaneous oedema is noted in the abdomen and pelvis. CONCLUSION 1. There is interval worsening of the consolidation seen in both lungs and bilateral pleural effusions representing worsening chest infection. 2. There is interval development of multiple wedge-shaped hypodense areas in both kidneys representing new areas of infarct. No overt evidence of vasculitis in the renal arteries. 3. Loculated ascites is seen. The largest collection is seen in the left side of the abdomen. 4. There is enhancement of the peritoneal lining, suggesting peritonitis. 5. Mural oedema along the entire length of the colon is suggestive of colitis. 6. Generalised diffuse subcutaneous soft tissue oedema is likely due to third-space fluid shift. May need further action Reported by: <DOCTOR>

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