# Row 12268

Visit Number: 49cc1aa0422a6e355f34dfa574a0b803a2a97789079a6ebaacf252656f737451

Masked\_PatientID: 12267

Order ID: 6959bbda058b3da07b19ff6f00c254158e8c4ef3ef19febf6ac5d979a37bf86f

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 18/8/2015 11:07

Line Num: 1

Text: HISTORY nephrotic syndrome to exclude malignancy incrase Ca 125 and Ca 19-9 TECHNIQUE Unenhanced scans of the thorax, abdomen and pelvis. Positive oral contrast medium administered. FINDINGS No relevant prior CT is available for review. There is a partially calcified 1.5 x 0.9 cm right breast nodule (image 201 - 24). No grossly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is seen. Several small calcified left hilar lymph nodes are present. The heart is normal in size. No pericardial effusion is detected. There is a tiny calcified granuloma in the left lung apex. No suspicious pulmonary nodule or mass is seen. The central airways are patent. Mild bronchial wall is nonspecific and may be due to inflammation. Bilateral pleural effusions are seen, larger on the right where there is compressive atelectasis of the right lower lobe. There is a calcified granuloma in the right hepatic lobe. Scattered subcentimetre hypodensities are seen in the liver, which cannot be characterised. The gallbladder is contracted and contains several calculi. The spleen, pancreas and adrenal glands appear grossly unremarkable. A few tiny calyceal calculi are seen in both kidneys. There is a vague 0.8 cm hyperdense lesion in the left renal lower pole (image 201-113), possibly a hyperdense cyst. No hydronephrosis is detected. The urinary bladder appears unremarkable. Focal coarse calcification at the uterine fundus is probably a fibroid. Bowel calibre and distribution are within normal limits. There is mild small bowel wall thickening, which may be related to underlying hypoproteinaemia. Mild ascites is present. No grossly enlarged retroperitoneal lymph node is detected. There is generalised subcutaneous fat stranding. No destructive bone lesion is seen. CONCLUSION 1. Bilateral pleural effusions, ascites, mild small bowel wall thickening and subcutaneous fat stranding may be due to hypoproteinaemia in the context of nephrotic syndrome. 2. Scattered subcentimetre hepatic hypodensities, too small to characterise. 3. Vague 0.8 cm hyperdense left renal lower pole lesion, possibly a hyperdense cyst. 4. Partially calcified1.5 x 0.9 cm right breast nodule. 5. Uncomplicated gall bladder and bilateral renal calculi. 6. Small calcified left hilar lymph nodes and left lung apical granuloma, in keeping with prior granulomatous disease. May need further action Finalised by: <DOCTOR>

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