# Row 13170

Visit Number: d5fb1d236e3d57cb225b3e1312e6d59957cbce7355902377f5db48481d9f6603

Masked\_PatientID: 13149

Order ID: 524e8ca999fec47a0691abe3e286075af64b92c3c8bd8fea4b597da222755648

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 16/2/2017 17:04

Line Num: 1

Text: HISTORY admitted for sepsis and hypotension likely right lower zone HAP, b/g chronic right lz effusion, recent admission for septic shock Raised peritoneal fluid cell count, to evaluate for secondary causes of peritonitis, b/g ESRFon PD TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 Positive Rectal Contrast FINDINGS CT peritoneography from 02/11/2016 was reviewed. THORAX There is a small right pleural effusion which is relatively stable since the prior CT. In the right lower lobe, there is focal atelectasis/consolidation which contains multiple small calcifications, most likely granulomata. There are few scattered calcified granulomata are seen in the middle lobe and the left lower lobe. No significantly enlarged axillary, mediastinal or hilar lymph node is seen. The heart is enlarged. There are coronary arterial calcifications with evidence of prior CABG. Mitraclip is in situ. The tip of the AICD is at the left ventricle. There is no pericardial effusion. ABDOMEN PELVIS There is contrast reflux into the distended inferior vena cava and hepatic veins, in keeping with right cardiac strain. The CT shows heterogeneous enhancement on the portal venous phase and this becomes homogeneously enhancing subsequently. This appearance is in keeping with passive hepatic congestion. There is a 12 mm segment IVB hepatic cyst. The gallbladder is filled with stones. No pericholecystic changes are seen to suggest acute inflammation and there is no biliary dilatation. There is a non- obstructing 6 x 3 mm left interpolar renal calculus. There is no suspicious renal lesion or hydronephrosis. The urinary bladder is completely collapsed. The spleen, adrenal glands and pancreas are unremarkable. The prostate gland is not enlarged. Tenchkoff catheter is in situ with the tip at the right hemipelvis. Minimal intraperitoneal fluid may be due to residual dialysate. There is no pneumoperitoneum. Bowel is normal in calibre. No intra-abdominal abscess is seen. There is a marginally enlarged bilateral inguinal lymph node. At the right inguinal region, there are some prominent collateral vessels. Several prominent yet small volume left para-aortic lymph nodes are nonspecific. There is a long segment abdominal aortic dissection measuring approximately 9.6 cm in length and involves the supra and infrarenal abdominal aorta. The false lumen is small and along the right posterior lateral aspect. The major branches of the abdominal aorta rise from the true lumen. There is no involvement of the thoracic aorta. Bilateral gyaecomastia is present. Lucent bony focus at the L1 inferior endplate is stable but nonspecific. No new bony destruction is seen. CONCLUSION Evidence of right cardiac strain with passive hepatic congestion. Prior CABG. AICD and Mitraclip in situ. Stable right pleural effusion with stable compressive atelectasis/consolidation in the right lower lobe. Minimal peritoneal fluid may be due to residual dialysate. Marginally enlarged left inguinal lymph node is of unknown aetiology. There are prominent yet small volume left para-aortic lymph nodes which are nonspecific and may be reactive. Abdominal aortic dissection involving the supra/infrarenal aorta with major branches of the aorta arising from the true lumen. Other findings include gallstones, nonobstructing left renal stone and are listed in the report. May need further action Finalised by: <DOCTOR>

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