# Row 13306

Visit Number: 713b319af3c72fecbfda54b2038dca87853580d563c60ef3b3eb5db3984e8478

Masked\_PatientID: 13289

Order ID: 25bcfef860f70c568058619976c52ba4b06c23e432cdeef95e7f18e073a3dd3a

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 29/6/2017 20:37

Line Num: 1

Text: HISTORY left pleural effusion for evaluation - ?infection (parapneumonic effusion vs empyema) hepatic encephalopathy secondary to constipation/overdiuresis sepsis ?source - with DIC and borderline BP; b/g pulmonary HTN secondary to chronic VTE (CTEPH) , Child's A Hep B liver cirrhosis, chronic DVT TECHNIQUE CT chest, abdomen and pelvis was performed with oral contrast. FINDINGS THORAX The CT study of 30/3/2017 was reviewed. The low-density left pleural effusion is slightly to moderately larger, with rightward mediastinal shift and compressive atelectasis of left lung. The trachea and major bronchi are patent with no obstructing endobronchial mass. No pleural mass or overt thickening is seen, within limits of unenhanced CT. No gas pocket is seen within the pleural effusion. A thin sliver of right pleural effusion is noted, largely stable from before. Patchy ill-defined ground-glass opacities are seen in the right lung, slightly worse in theright upper lobe with mild interlobular septal thickening. The aerated portion of the left upper lobe is relatively unremarkable apart from minimal interlobular septal thickening in the anterior aspect. No enlarged mediastinal, axillary or supraclavicular node is seen. Stable calcified density in the superior mediastinum (3-20) is non-specific and may be a calcified node. The pulmonary trunk is mildly dilated (35mm), suggestive of pulmonary arterial hypertension. Previously-noted chronic pulmonary emboli are not well-assessed on current unenhanced CT. Heart size is at upper limits of normal. No pericardial effusion is seen. ABDOMEN AND PELVIS The CT study of 7/2/2017 and 20/10/2016 was reviewed. No pneumoperitoneum or drainable fluid collection is seen. The liver contour is nodular, in keeping with known cirrhosis. Previous radiofrequency ablation to segment 8 lesion is unchanged in size. Main portal and superior mesenteric vein thrombosis again show dystrophic calcifications, and cavernous transformation of the portal vein is noted. The gallbladder is collapsed, and no biliary ductal dilatation is seen. There is splenomegaly and splenic varices, largely stable from before and represents portal hypertension. Embolisation coils are seen in the left upper abdomen, in keeping with known splenic artery aneurysm, with resultant streak artefacts. A thin hyperdense layer within the pelvis (3-171) may represent debris or clots. Rest ofthe ascites shows fluid attenuation and has increased. No localised collection is seen. There is prominent stranding along the mesenteric vessels, suggestive of congestion and may be related to portal hypertension. Bulky appearance of the right adrenal gland is unchanged. No contour deforming mass is seen in the pancreas, kidneys and left adrenal gland. There is no hydronephrosis. The catherised urinary bladder is collapsed. The uterus is unremarkable and no adnexal mass is seen. Tip of the nasogastric tube is seen within the stomach. The pylorus shows thickening of its posterior wall (3-93). There is interval mild apparent thickening of the ascending colon with no focal mass or overt pericolic stranding. Rest of thebowel are unremarkable. No omental caking or enlarged nodes seen. No destructive bony lesion is seen. Extensive subcutaneous fat stranding may be related to underlying fluid overload state. CONCLUSION Since last CT of Feb-Mar 2017, 1.Worsened left pleural effusion with mass effect. No obvious adjacent infective changes. No suspicious pleural mass or thickening within limits of plain scan. 2. Findings in the right lung can be due to pulmonary edema or infective changes. 3. Stable dilatation of pulmonary trunk, suggestive of pulmonary hypertension. 4. Established cirrhosis with portal vein cavernous transformation, SMV and portal vein thrombosis. Ascites has worsened. 5. Right colon thickening is non-specific, and may be due to underdistension or related to underlying colitis or portal hypertension. Suggest clinical correlation. 6. Asymmetrical thickening of the pylorus. This can be due to varices, inflammation or solid lesion. OGD suggested. 7.Other minor findings as described. May need further action Reported by: <DOCTOR>

Accession Number: c2a7885eccd3dcafc3752d24456a5f771d6bd420723441cebb5594f66269feb3

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