# Row 13449

Visit Number: 3b80f9d63e3ec0d27f57cfcde9f67418df9ff2ba5d15fe15c227a577297a6fd3

Masked\_PatientID: 13446

Order ID: 05de061fc763e06ae8524c3cbc7e328a22e153acee912948e9f051b83579ddef

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 11/8/2020 11:32

Line Num: 1

Text: HISTORY Persistent vomiting TRO ?GJ ulcer vs stricture b/g of total panc and splenec 2018 TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 70 Positive Oral Contrast FINDINGS Comparison is made with prior CT chest, abdomen and pelvis dated 12 Oct 2019. Chest: Stable non-specific 0.3 cm subpleural nodule in the basal segment of the left lower lobe (4/82 vs prev 4/119) and stable 4 mm subpleural nodule in the lingula segment (previous 4/101, current 4/66). No consolidation and no pleural effusion is present. Central airways are patent. Mediastinal vessels opacify satisfactorily. No significantly enlarged intrathoracic lymph node is noted. Heart size is normal. No pericardial effusion is present. There are atherosclerotic calcifications of the coronary arteries. Stable non-specific extra-pulmonary low density nodule between the right 5th and 6th rib is noted (5/44). Abdomen and pelvis: Patient is status post total pancreatectomy and splenectomy (15 Oct 2018, histo: adenocarcinoma) The stomach is markedly distended. The bowel loops distal to the GJ anastomosis are collapsed. No discrete mass is seen at the anastomotic site. Anew 2.9 x 2.6 cm soft tissue mass in the pancreatectomy surgical bed is suspicious for local recurrence (9/54). This focally compresses the adjacent inferior vena cava and the superior mesenteric vein. An enlarged porta hepatis lymph node measuring 1.5 cm (short axis) (series 9, image 36) is noted. No other significantly enlarged retroperitoneal or pelvic lymph node is noted. A new (1.9 cm x 1.1 cm) (series 9, image 70) nodule is noted in the left upper abdomen, adjacent to the abdominal muscles, suspicious for peritoneal deposit. There may be another peritoneal deposit in the right of the abdomen (9/83, coronal image 50) anterior to the gastrojejunostomy. There is a stable 10 mm nodule medial to the gastric body (9/30, previous 5/125), uncertain clinical significance. Small amount of ascites is present. No pneumoperitoneum is noted. No suspicious hepatic lesion is noted. The hepatic and portal veins are patent. The gallbladder is not visualised. The biliary tree is not dilated. Both adrenals are unremarkable. Both kidneys enhance symmetrically. Bilateral renal hypodensities are seen; the larger ones are compatible with cysts and the subcentimetre ones are too small to characterise. The largest cyst is noted in the left renal lower pole, measuring 3.9 x 3.0 cm, with thin mural calcification. Non-obstructing 0.5 cm left renal lower pole calculus is seen (9/70). There is mild left renal pelvic wall enhancement, which may be inflammatory in nature. No hydronephrosis. The urinary bladder is grossly unremarkable. The prostate gland is mildly enlarged. The aorta is of normal calibre with atherosclerotic calcifications. No bony destructive lesion. Old left inferior pubic ramusfracture is noted. Interval sclerosis of the left anterior 5th and 6th ribs may be related to healing fracture. CONCLUSION 1. The stomach is markedly distended with no dilatation of the small bowel. This is likely due to obstruction atthe GJ. Anterior to the GJ, there is suggestion of a 2.2cm peritoneal nodule. 2. New mass in the pancreatectomy surgical bed is suspicious for recurrence. 3. Enlarged porta hepatis node is suspicious for adenopathy. 4. A new nodule is noted in the left upper abdomen, adjacent to the abdominal muscles, suspicious for peritoneal deposit. A stable small nodule medial to the stomach is non-specific Report Indicator: Further action or early intervention required Reported by: <DOCTOR>

Accession Number: 28bc503926782560da64e0620f8627ea3e9e854aa45a1dcd4ad08907f7fa82d8

Updated Date Time: 11/8/2020 13:17