# Row 13500

Visit Number: 89269aaaaf819617638cb2c50dbc65810c529ef5ce163d1d1a5ef95436a0fcbf

Masked\_PatientID: 13498

Order ID: d143828a39bc82f61b3ee6804652ba17a9731db2da5d4c22b5f1e78c02780439

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 05/2/2015 16:13

Line Num: 1

Text: HISTORY Patietn severe thrombocytopenia likely consumtion thrombocytopenia- noted large hematoma on right torso, fallin Hb around 0.5 to 1 gram daily. transfused 1 pint platelt yesyerday, pre transfusion platelet was 41. Background- parkinsonism, tardive dyskinesia, recurrent history of fall, CKD; For Oral contrast only. Kindly also note, please scan to find hematoma/internal bleeding. TECHNIQUE Non intravenous contrast Scans of chest, abdomen pelvis acquired as per department protocol. Peroral contrast was administered } FINDINGS There is dense luminal contrast in the stomach and distal small bowel loops and pelvis with associated streak artefacts obscuring some of the details. The liver appears cirrhotic. No large lesions are identified. There is mild splenomegaly, likely due to portal hypertension. Low density ascites is also present. A few small gallstones and adenomyomatosis changes. Small focal calcification in the region of pancreatic head (image 93) are likely to be outside CBD, probably in a diverticulum. Unenhanced pancreas, adrenal glands appear grossly unremarkable. Kidneys are show parenchymal thinning in keeping with known parenchymal disease changes. There is asegment of proximal small bowel which shows mild diffuse wall thickening, particularly one of the loops in the right abdomen (image 110). In this given clinical context, this may represent intramural haematoma. Minimal adjacent fat stranding is present without any pneumatosis, pneumo or haemoperitoneu. Other than a few diverticuli in colon, no other significant abnormalities. Gas in urinary bladder may be related to recent instrumentation, please correlate with relevant history. No enlarged lymph nodes. In chest, the mediastinal vasculature appears grossly normal. No mediastinal haematoma. A small low density right pleural effusion. Minimal atelectasis in the lower lungs and mild bronchial wall thickening, likely inflammatory. No mass or suspicious nodules. There is a haematoma in the right pectoralis major muscle. There is a low density area adjacent to the greater trochanter of the left femur, probably a prominent bursa (image 187). No destructive bony lesions. CONCLUSION 1. Hepatic cirrhosis with mild splenomegaly and low density ascites. No haemoperitoneum. 2. Mild diffuse wall thickening of segment of proximal small bowel. Although imaging appearances are nonspecific and rather limited by lack of intravenous contrast, in the given clinical context this may represent intramural haematoma. No pneumatosis or pneumoperitoneum. 3. Right pectoralis major haematoma. No other large haematomas identified within imaged extent. May need further action Finalised by: <DOCTOR>

Accession Number: cd5953b45e47fa891cb770ac14470a43feb0c31d8e4b4a9bf51b3f67712141be

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