# Row 1773

Visit Number: 6db35c8cc31695c0a31540f3dce343d7aa4ecc4434044214007fbe5c2569d9ec

Masked\_PatientID: 1766

Order ID: d856ab3b5235200d094b7794a1a8b203eeef72708ed9625047fde9e03d6b0c73

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 30/1/2016 11:52

Line Num: 1

Text: HISTORY febrile neutropenia referred ID suggested to proceed with CT TAP in view of prolonged neutropenia, thinking of enterocolitis mainly, and also to evaluate for any atypical lung pathologies; on IV meropenem and IV vancomycinwith daily subcut GCSF TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS Comparison is made with the previous CT of December 2015 as well as the MRI of March 2015 and CTof May 2011. The area of consolidation in the lateral segment of the middle lobe has improved but there is new airspace consolidation in the medial segment of the same lobe. New areas of consolidation are also noted in the right lung lower lobe apical segment and anterior basal segment. Minor dependent atelectasis is seen in bilateral lower lobes. Small - prominent mediastinal lymph nodes are nonspecific, most prominent in the precarinal and subcarinal stations. Smallbilateral pleural effusions, slightly larger in the right. The tip of the right subclavian venous catheter is in the right atrium. A few scattered tiny hypodensities in both lobes of the liver, too small to characterise probably cysts as manywere present in 2011. There are stones in the gallbladder. The biliary tracts are not dilated. The spleen, pancreas, adrenals and both kidneys are unremarkable. The urinary bladder is not well distended but at the dome there is asymmetric wall thickening present since 2011 which may due to chronic inflammation. Please correlate clinically. The colon appears largely collapsed. As such the wall thickness cannot be accurately assessed and the appearance of the ascending colon to the transverse colon is indeterminate for some degree of submucosal oedema. The bowel is not dilated. No enlarged pelvic or para-aortic lymph nodes are detected. Small volume aortocaval lymph node is nonspecific. Trace amount of ascites in the pelvis. There is increased stranding in the subcutaneous fat and also increased density in the small bowel mesentery which could be due to a generalised oedematous state. The bone settings show no destructive lesion. CONCLUSION New areas of consolidation in the right lung is in keeping with recurrent infection. Previously present infection in the lateral segment of the middle lobe shows partial resolution. Indeterminate appearance of the collapsed ascending andtransverse colon:? submucosal edema vs colitis. Please correlate clinically. Known / Minor Finalised by: <DOCTOR>

Accession Number: 7b86a8ab029734b8bda5eadf245063f6653066dcd22af9d17ebdee9e7ec9d2a1

Updated Date Time: 30/1/2016 13:31

## Layman Explanation

This radiology report discusses HISTORY febrile neutropenia referred ID suggested to proceed with CT TAP in view of prolonged neutropenia, thinking of enterocolitis mainly, and also to evaluate for any atypical lung pathologies; on IV meropenem and IV vancomycinwith daily subcut GCSF TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS Comparison is made with the previous CT of December 2015 as well as the MRI of March 2015 and CTof May 2011. The area of consolidation in the lateral segment of the middle lobe has improved but there is new airspace consolidation in the medial segment of the same lobe. New areas of consolidation are also noted in the right lung lower lobe apical segment and anterior basal segment. Minor dependent atelectasis is seen in bilateral lower lobes. Small - prominent mediastinal lymph nodes are nonspecific, most prominent in the precarinal and subcarinal stations. Smallbilateral pleural effusions, slightly larger in the right. The tip of the right subclavian venous catheter is in the right atrium. A few scattered tiny hypodensities in both lobes of the liver, too small to characterise probably cysts as manywere present in 2011. There are stones in the gallbladder. The biliary tracts are not dilated. The spleen, pancreas, adrenals and both kidneys are unremarkable. The urinary bladder is not well distended but at the dome there is asymmetric wall thickening present since 2011 which may due to chronic inflammation. Please correlate clinically. The colon appears largely collapsed. As such the wall thickness cannot be accurately assessed and the appearance of the ascending colon to the transverse colon is indeterminate for some degree of submucosal oedema. The bowel is not dilated. No enlarged pelvic or para-aortic lymph nodes are detected. Small volume aortocaval lymph node is nonspecific. Trace amount of ascites in the pelvis. There is increased stranding in the subcutaneous fat and also increased density in the small bowel mesentery which could be due to a generalised oedematous state. The bone settings show no destructive lesion. CONCLUSION New areas of consolidation in the right lung is in keeping with recurrent infection. Previously present infection in the lateral segment of the middle lobe shows partial resolution. Indeterminate appearance of the collapsed ascending andtransverse colon:? submucosal edema vs colitis. Please correlate clinically. Known / Minor Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

No diseases detected.  
No specific organs mentioned.  
No symptoms mentioned.