# Row 1879

Visit Number: f7febe2f146de762d531948890adec757285677ac36e33261c82d33baef9b7c5

Masked\_PatientID: 1870

Order ID: 9f6c611de9cd69469f96549fa7f99a66648af372648460a1429c9fc184ee9e2f

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 13/12/2017 9:02

Line Num: 1

Text: HISTORY Primary peritoneal cancer, new R pleural effusion, likely recurrence TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS Previous CT abdomen and pelvis dated 1 September 2017 and CT chest dated 20 July 2017 were reviewed. CHEST Interval development of a large right pleural effusion with suggestion of pleural thickening/enhancement (se 5/57). Associated atelectasis of most of the right lung; part of the right upper lobe remains aerated. No left pleural effusion. No suspicious pulmonary nodule, mass or consolidation in the left lung. There is resultant leftward mediastinal shift. Mediastinal structures still opacify normally. No significant pericardial effusion. No significant supraclavicular, mediastinal, hilar or axillary adenopathy. Included thyroid gland is unremarkable. ABDOMEN AND PELVIS The patient is status post total hysterectomy and bilateral salpingo-oophorectomy (THBSO), omentectomy, peritonectomy, low anterior section with defunctioning ileostomy (and subsequent reversal), resection of peritoneal disease, appendicectomy and cholecystectomy. Stable subcutaneous stranding at the midline anteriorabdomen. Resolution of rim-enhancing fluid collection near the previous stoma site. There is residual subcutaneous and adjacent rectus abdominis thickening. Resolution of previous small bowel dilatation. There is evidence of peritoneal disease with scalloping of the hepatic surface and nodular soft tissue beneath the right hemidiaphragm. Ovoid hypodense nodule adjacent to the anastomotic site of the low anterior resection has been gradually increasing in size, suspicious for serosaldeposit (se 7/110). There is also diffuse mild mural thickening of the bowel loops, suspicious for serosal disease. Slight omental nodularity is also observed. No pneumoperitoneum or discrete adenopathy. No suspicious focal hepatic lesion. Hepatic and portal veins opacify normally. Biliary tree is not dilated. Pancreas, spleen, adrenals, kidneys and partially distended urinary bladder are unremarkable. BONES There is no destructive bony lesion. CONCLUSION 1. Interval large right pleural effusion with suggestion of pleural thickening/enhancement posteriorly, suspicious for pleural involvement of disease. Almost complete collapse of the right lower lobe/middle lobe and leftward mediastinal shift. 2. Diffuse peritoneal disease, in keeping with recurrence. 3. Resolution of rim-enhancing fluid collection near the previous stoma site. 4. Resolution of previous small bowel dilatation. 5. Other findings as described above. May need further action Reported by: <DOCTOR>

Accession Number: 7134338cb158cdd4c06e5b73a7daf7d1386639dcb14c7d9fa3badd6cba96c924

Updated Date Time: 13/12/2017 13:07

## Layman Explanation

This radiology report discusses HISTORY Primary peritoneal cancer, new R pleural effusion, likely recurrence TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS Previous CT abdomen and pelvis dated 1 September 2017 and CT chest dated 20 July 2017 were reviewed. CHEST Interval development of a large right pleural effusion with suggestion of pleural thickening/enhancement (se 5/57). Associated atelectasis of most of the right lung; part of the right upper lobe remains aerated. No left pleural effusion. No suspicious pulmonary nodule, mass or consolidation in the left lung. There is resultant leftward mediastinal shift. Mediastinal structures still opacify normally. No significant pericardial effusion. No significant supraclavicular, mediastinal, hilar or axillary adenopathy. Included thyroid gland is unremarkable. ABDOMEN AND PELVIS The patient is status post total hysterectomy and bilateral salpingo-oophorectomy (THBSO), omentectomy, peritonectomy, low anterior section with defunctioning ileostomy (and subsequent reversal), resection of peritoneal disease, appendicectomy and cholecystectomy. Stable subcutaneous stranding at the midline anteriorabdomen. Resolution of rim-enhancing fluid collection near the previous stoma site. There is residual subcutaneous and adjacent rectus abdominis thickening. Resolution of previous small bowel dilatation. There is evidence of peritoneal disease with scalloping of the hepatic surface and nodular soft tissue beneath the right hemidiaphragm. Ovoid hypodense nodule adjacent to the anastomotic site of the low anterior resection has been gradually increasing in size, suspicious for serosaldeposit (se 7/110). There is also diffuse mild mural thickening of the bowel loops, suspicious for serosal disease. Slight omental nodularity is also observed. No pneumoperitoneum or discrete adenopathy. No suspicious focal hepatic lesion. Hepatic and portal veins opacify normally. Biliary tree is not dilated. Pancreas, spleen, adrenals, kidneys and partially distended urinary bladder are unremarkable. BONES There is no destructive bony lesion. CONCLUSION 1. Interval large right pleural effusion with suggestion of pleural thickening/enhancement posteriorly, suspicious for pleural involvement of disease. Almost complete collapse of the right lower lobe/middle lobe and leftward mediastinal shift. 2. Diffuse peritoneal disease, in keeping with recurrence. 3. Resolution of rim-enhancing fluid collection near the previous stoma site. 4. Resolution of previous small bowel dilatation. 5. Other findings as described above. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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