# Row 3335

Visit Number: 60e46ed126fc505161ed5f226c046b4963e93901b08cee8a6737351479052907

Masked\_PatientID: 3314

Order ID: 5fa8319c383f2f63389554c49226828757a86d19cd6108a4544ce5a7170fb331

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 17/10/2018 20:07

Line Num: 1

Text: HISTORY recurrent parapneumonic effusions requiring multiple chest drain placements TECHNIQUE Scans of the thorax were acquired after the administration of Intravenous contrast: Omnipaque 350 - Volume (ml): 70 FINDINGS No prior CT scans for comparison. Previous radiographs from September to October 2018 were reviewed. A left pleural drain is in situ, tip curled at the posterior costophrenic sulcus. Bilateral pleural effusions are seen, small on the left and moderate on the right with adjacent atelectasis. Small pneumothorax component may be due to the catheter. No pleural enhancement is seen. Small peripheral foci of atelectasis / consolidation are seen at the apical left lower lobe. No suspicious pulmonary nodule is seen in the aerated lungs. Kerley B lines are seen in the bilateral lower lobes. Right central venous line tip is in upper superior vena cava. The mediastinal vessels enhance normally. No significantly enlarged mediastinal, supraclavicular, hilar or axillary lymph node. Heart is normal in size. No pericardial effusion. The liver, gallbladder, spleen, and adrenal glands appear unremarkable. There is a 9 mm ovoid thin walled fluid density lesion at the pancreaticneck which could represent a small cyst or cystic neoplasm (8-49). The main duct is not dilated. The kidneys are atrophic in keeping with end stage renal disease. Small hypodensities are noted bilaterally, too small to characterise but likely cysts. The urinary bladder is collapsed. Prostate gland is not enlarged. The bowel loops are normal in calibre and distribution. Small amount of low density intraperitoneal fluid in keeping with ascites. Minimal hyperdense layering in the pelvic could represent debris or blood product. No rim-enhancing collections. Extensive subcutaneous fluid stranding is in keeping with anasarca. No significantly enlarged intra-abdominal or pelvic lymph node is seen. Small retroperitoneal nodes are nonspecific. Extensive vascular calcification is seen. There is no destructive bony lesion. CONCLUSION 1. Moderate right pleural effusion and small left hydropneumothorax. Left pleural drainage catheter is in situ. No discrete loculated pleural collection or associated pleural enhancement. 2. Small amount of ascites. Minimal hyperdense layering in the pelvis can be due to debris or blood product. No intra-abdominal collections are detected as per clinical concern. 3. Other minor findings as above. Known / Minor Reported by: <DOCTOR>

Accession Number: bd8b5358cd75c888aeec1df408a4e432fc558d6ddb4454316b90a7efdd3a432d

Updated Date Time: 18/10/2018 11:39

## Layman Explanation

This radiology report discusses HISTORY recurrent parapneumonic effusions requiring multiple chest drain placements TECHNIQUE Scans of the thorax were acquired after the administration of Intravenous contrast: Omnipaque 350 - Volume (ml): 70 FINDINGS No prior CT scans for comparison. Previous radiographs from September to October 2018 were reviewed. A left pleural drain is in situ, tip curled at the posterior costophrenic sulcus. Bilateral pleural effusions are seen, small on the left and moderate on the right with adjacent atelectasis. Small pneumothorax component may be due to the catheter. No pleural enhancement is seen. Small peripheral foci of atelectasis / consolidation are seen at the apical left lower lobe. No suspicious pulmonary nodule is seen in the aerated lungs. Kerley B lines are seen in the bilateral lower lobes. Right central venous line tip is in upper superior vena cava. The mediastinal vessels enhance normally. No significantly enlarged mediastinal, supraclavicular, hilar or axillary lymph node. Heart is normal in size. No pericardial effusion. The liver, gallbladder, spleen, and adrenal glands appear unremarkable. There is a 9 mm ovoid thin walled fluid density lesion at the pancreaticneck which could represent a small cyst or cystic neoplasm (8-49). The main duct is not dilated. The kidneys are atrophic in keeping with end stage renal disease. Small hypodensities are noted bilaterally, too small to characterise but likely cysts. The urinary bladder is collapsed. Prostate gland is not enlarged. The bowel loops are normal in calibre and distribution. Small amount of low density intraperitoneal fluid in keeping with ascites. Minimal hyperdense layering in the pelvic could represent debris or blood product. No rim-enhancing collections. Extensive subcutaneous fluid stranding is in keeping with anasarca. No significantly enlarged intra-abdominal or pelvic lymph node is seen. Small retroperitoneal nodes are nonspecific. Extensive vascular calcification is seen. There is no destructive bony lesion. CONCLUSION 1. Moderate right pleural effusion and small left hydropneumothorax. Left pleural drainage catheter is in situ. No discrete loculated pleural collection or associated pleural enhancement. 2. Small amount of ascites. Minimal hyperdense layering in the pelvis can be due to debris or blood product. No intra-abdominal collections are detected as per clinical concern. 3. Other minor findings as above. Known / Minor Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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