# Row 3786

Visit Number: 24bcb91c989389478b068b1e8e61ec1d51db86d3227b9cb5b7d8177057adcaca

Masked\_PatientID: 3775

Order ID: b3ecacda29a58146d113ba2894c8257e3e3255cc97a0eb0d26bd754fa37bf58f

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 07/6/2019 20:51

Line Num: 1

Text: HISTORY Abdominal bloatedness for evaluation asthma with GVHD TECHNIQUE Contrast enhanced scans of the thorax, abdomen and pelvis. Unenhanced high-resolution thoracic scans obtained during attempted inspiration and expiration. Intravenouscontrast: Iopamiro 370 - Volume (ml): 70 FINDINGS Comparison made with the high resolution CT thorax of 8 January 2019. There is mild diffuse bronchial wall thickening associated with mild bilateral focal air trapping. No suspicious pulmonary nodule, mass or consolidation is seen. The central airways are patent. No pleural effusion is detected. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. The major mediastinal vessels demonstrate grossly preserved opacification. Heart size is normal. No pericardial effusion is seen. There are stable tiny hypodensities in hepatic segment VII and VI (18-16 and 35), too small to characterise but likely cysts. No new suspicious focal hepatic lesion is detected. The gallbladder is contracted. No significant biliary ductal dilatation is seen. The spleen is normal in size with no focal intrasplenic lesions seen. The pancreas and adrenal glands appear unremarkable. There is symmetrical renal enhancement. A tiny hypodensity in the left renal upper pole is nonspecific but likely a cyst. No hydronephrosis is detected. The urinary bladder appears grossly unremarkable. There is a well-circumscribed 2.7 cm right adnexalcyst, likely ovarian in origin (18-100). The retroflexed uterus appears unremarkable for age. Bowel calibre and distribution are within normal limits. No significantly enlarged para-aortic or pelvic lymph node is identified. A trace amount of free pelvic fluid is likely physiological. There is mild divarication of the rectus muscles (separated by about 3.3 cm, image 18-58). No destructive bone lesion is seen. CONCLUSION 1. Mild diffuse bronchial wall thickening with mild bilateral focal air trapping. In the given clinical context, the findings are suggestive of bronchiolitis. 2. No suspicious intra-abdominal mass or dilated bowel loop detected. 3. Incidental 2.7 cm right adnexal cyst, likely a prominent ovarian follicle or less likely a cyst. This can be followed up with ultrasound to confirm resolution. Report Indicator: May need further action Finalised by: <DOCTOR>

Accession Number: 9dbd26a59ed8e532a92c86992601bb4f7079f8d007736faa5706a74165e7dbf7

Updated Date Time: 10/6/2019 9:33

## Layman Explanation

This radiology report discusses HISTORY Abdominal bloatedness for evaluation asthma with GVHD TECHNIQUE Contrast enhanced scans of the thorax, abdomen and pelvis. Unenhanced high-resolution thoracic scans obtained during attempted inspiration and expiration. Intravenouscontrast: Iopamiro 370 - Volume (ml): 70 FINDINGS Comparison made with the high resolution CT thorax of 8 January 2019. There is mild diffuse bronchial wall thickening associated with mild bilateral focal air trapping. No suspicious pulmonary nodule, mass or consolidation is seen. The central airways are patent. No pleural effusion is detected. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. The major mediastinal vessels demonstrate grossly preserved opacification. Heart size is normal. No pericardial effusion is seen. There are stable tiny hypodensities in hepatic segment VII and VI (18-16 and 35), too small to characterise but likely cysts. No new suspicious focal hepatic lesion is detected. The gallbladder is contracted. No significant biliary ductal dilatation is seen. The spleen is normal in size with no focal intrasplenic lesions seen. The pancreas and adrenal glands appear unremarkable. There is symmetrical renal enhancement. A tiny hypodensity in the left renal upper pole is nonspecific but likely a cyst. No hydronephrosis is detected. The urinary bladder appears grossly unremarkable. There is a well-circumscribed 2.7 cm right adnexalcyst, likely ovarian in origin (18-100). The retroflexed uterus appears unremarkable for age. Bowel calibre and distribution are within normal limits. No significantly enlarged para-aortic or pelvic lymph node is identified. A trace amount of free pelvic fluid is likely physiological. There is mild divarication of the rectus muscles (separated by about 3.3 cm, image 18-58). No destructive bone lesion is seen. CONCLUSION 1. Mild diffuse bronchial wall thickening with mild bilateral focal air trapping. In the given clinical context, the findings are suggestive of bronchiolitis. 2. No suspicious intra-abdominal mass or dilated bowel loop detected. 3. Incidental 2.7 cm right adnexal cyst, likely a prominent ovarian follicle or less likely a cyst. This can be followed up with ultrasound to confirm resolution. Report Indicator: May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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