# Row 4647

Visit Number: d2bd47a20a92c9cdb6b62404466f912a23a3e03b7a1e3a745fa74848f5386d48

Masked\_PatientID: 4646

Order ID: 2ac6327febc88adcaec29874e310c43cf2ca914aa23d4fd97bac1ffac2854ae8

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 24/10/2017 12:53

Line Num: 1

Text: HISTORY Pancytopaenia in patient with h/o treated DLBCL (2011) TRO relapsed DLBCL with BM involvement vs myelodysplasia TECHNIQUE Contrast enhanced CT of the thorax, abdomen and pelvis was performed. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison is made with the CT Chest, Abdomen and Pelvis of 12/05/2017. Motion artefacts from breathing are noted, limiting sensitivity of analysis. THORAX There is interval development of bilateral pleural effusions, moderate on the right and small on the left. These are associated with compressive atelectasis. A small amount of fluid is also seen along the minor fissure (image 10-32). Interlobular septal thickening and faint ground-glass opacities in both the lower lobes may be related to fluid overload. A few non-specific subcentimetre pulmonary nodules are as detailed: - Along the minor fissure, measuring 0.5 x 0.4 cm (image 6-50). This shows marginal increase in size when compared to the prior CT of 12/05/2017 where it measured 0.5 x 0.3 cm (prior study image 4-70). - Along the right major fissure, measuring 0.3 cm, stable (image 6-66). - In the subpleural aspect of the right lower lobe posterior-basal segment, measuring 0.4 cm, stable (image 6-65). A few other nodular densities in the right and left lower lobes appear linear and may represent atelectasis (e.g. image 6-77 and 10-35). Stable pleural thickening, scarring, traction bronchiectasis and volume loss is again seen in the left upper lobe. Calcified pleural plaques are again seen in the left lung. A few prominent lower paratracheal, bilateral hilar and left supraclavicular lymph nodes are seen, not significantly enlarged by size criteria. A stable calcified subcarinal lymph node is again seen, possibly related to prior granulomatous infection. The heart is enlarged. There is a small pericardial effusion. The thoracic oesophagus is patulous. ABDOMEN AND PELVIS A0.5 cm hypodensity in segment 4b of the liver is too small for accurate characterisation (image 7-35). There is mild non-specific peri-portal oedema. The gallbladder, pancreas, spleen and both adrenal glands are unremarkable. The spleen is normalin size. Two small splenunculi are noted. Both kidneys enhance symmetrically. A 0.3 cm hypodensity in the lower pole of the right kidney is too small for accurate characterisation (image 11-23). A 0.7 cm cyst is seen in the lower pole of the left kidney (image 7-54). There is no enhancing renal mass. No hydronephrosis or urinary calculus is detected. The urinary bladder is grossly unremarkable. The prostate gland is mildly enlarged with central gland calcifications. The unprepared bowel loops are normal in calibre. There is no ascites or free intraperitoneal gas. No significantly enlarged abdominal or pelvic lymph node is detected. A 1.8 x 1.5 cm hypodense collection adjacent to the left ischial tuberosity may represent bursitis (image 7-146). Degenerative changes are seen in the visualised spine. No destructive bony lesion is detected. CONCLUSION 1. Interval development of bilateral pleural effusions with interlobular septal thickening in both lower lobes may be related to fluid overload. Clinical correlation is suggested. 2. There are prominent left supraclavicular, bilateral hilar and bilateral paratracheal lymph nodes which are not significantly enlarged by size criteria. There is nosignificantly enlarged lymph node in the thorax, abdomen or pelvis. No splenomegaly is detected. 3. The subcentimetre pulmonary nodules are non-specific. Other stable/minor findings are as detailed in the body of the report. May need further action Reported by: <DOCTOR>

Accession Number: 029fabb33d9af1ab7700b3a3f147e2bc80515beec45a353f7b36c5a04aeffcb0

Updated Date Time: 24/10/2017 18:10

## Layman Explanation

This radiology report discusses HISTORY Pancytopaenia in patient with h/o treated DLBCL (2011) TRO relapsed DLBCL with BM involvement vs myelodysplasia TECHNIQUE Contrast enhanced CT of the thorax, abdomen and pelvis was performed. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison is made with the CT Chest, Abdomen and Pelvis of 12/05/2017. Motion artefacts from breathing are noted, limiting sensitivity of analysis. THORAX There is interval development of bilateral pleural effusions, moderate on the right and small on the left. These are associated with compressive atelectasis. A small amount of fluid is also seen along the minor fissure (image 10-32). Interlobular septal thickening and faint ground-glass opacities in both the lower lobes may be related to fluid overload. A few non-specific subcentimetre pulmonary nodules are as detailed: - Along the minor fissure, measuring 0.5 x 0.4 cm (image 6-50). This shows marginal increase in size when compared to the prior CT of 12/05/2017 where it measured 0.5 x 0.3 cm (prior study image 4-70). - Along the right major fissure, measuring 0.3 cm, stable (image 6-66). - In the subpleural aspect of the right lower lobe posterior-basal segment, measuring 0.4 cm, stable (image 6-65). A few other nodular densities in the right and left lower lobes appear linear and may represent atelectasis (e.g. image 6-77 and 10-35). Stable pleural thickening, scarring, traction bronchiectasis and volume loss is again seen in the left upper lobe. Calcified pleural plaques are again seen in the left lung. A few prominent lower paratracheal, bilateral hilar and left supraclavicular lymph nodes are seen, not significantly enlarged by size criteria. A stable calcified subcarinal lymph node is again seen, possibly related to prior granulomatous infection. The heart is enlarged. There is a small pericardial effusion. The thoracic oesophagus is patulous. ABDOMEN AND PELVIS A0.5 cm hypodensity in segment 4b of the liver is too small for accurate characterisation (image 7-35). There is mild non-specific peri-portal oedema. The gallbladder, pancreas, spleen and both adrenal glands are unremarkable. The spleen is normalin size. Two small splenunculi are noted. Both kidneys enhance symmetrically. A 0.3 cm hypodensity in the lower pole of the right kidney is too small for accurate characterisation (image 11-23). A 0.7 cm cyst is seen in the lower pole of the left kidney (image 7-54). There is no enhancing renal mass. No hydronephrosis or urinary calculus is detected. The urinary bladder is grossly unremarkable. The prostate gland is mildly enlarged with central gland calcifications. The unprepared bowel loops are normal in calibre. There is no ascites or free intraperitoneal gas. No significantly enlarged abdominal or pelvic lymph node is detected. A 1.8 x 1.5 cm hypodense collection adjacent to the left ischial tuberosity may represent bursitis (image 7-146). Degenerative changes are seen in the visualised spine. No destructive bony lesion is detected. CONCLUSION 1. Interval development of bilateral pleural effusions with interlobular septal thickening in both lower lobes may be related to fluid overload. Clinical correlation is suggested. 2. There are prominent left supraclavicular, bilateral hilar and bilateral paratracheal lymph nodes which are not significantly enlarged by size criteria. There is nosignificantly enlarged lymph node in the thorax, abdomen or pelvis. No splenomegaly is detected. 3. The subcentimetre pulmonary nodules are non-specific. Other stable/minor findings are as detailed in the body of the report. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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