# Row 5195

Visit Number: a0cb73a1d1f0d87f59dfd6fb8cd16bb4f254a58e4fb58cd088bfb47634251d1c

Masked\_PatientID: 5194

Order ID: 54556c7ddb4c893222043e3ab2f13546983d6afc4389e21c76a71a2bd63340a3

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 01/12/2017 11:46

Line Num: 1

Text: HISTORY Suspected mets versus PTB. Weight loss 4kg over 3months.CXR 14/7/17 done at Hougang Polyclinic: Nodular opacities seen scattered in the right upper zone, and bilateral lower zone. Exclude SOL, infective changes TECHNIQUE Scans of the thorax were acquired after the administration of Intravenous contrast: Omnipaque 350 Contrast volume (ml): 50 FINDINGS There are no prior relevant scans available for comparison. Chest radiographs dated 14/07/2017 and 24/05/2012 were reviewed. Nodularity opacities and focal areas of airspace consolidation are noted predominantly in the lower lobes, worse on the left. Centrilobular nodules in a tree-in-bud configuration are also noted in the lower lobes. Associatedbronchial thickening and inspissated mucous in the airway are noted. A 1.6 x 0.8 cm focal area of opacification is also seen in the posterior segment of the right upper lobe, associated with adjacent bronchial dilatation and distal atelectasis. No pleural effusion is present. The central airways are patent. The mediastinal vessels opacify normally. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. The heart is normal in size. No pericardial effusion is seen. The limited sections of the upper abdomen viscera are unremarkable. No bony destructive lesion is noted. CONCLUSION Centrilobular nodularity, focal areas of consolidation, bronchial wall thickening and mucous plugging are seen predominantly in the lower lobes. These correspond with the opacities noted on recent chest radiograph. Overall features are in keeping with active inflammatory/ infective in nature. Clinical correlation is suggested. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: 76a53a0d8aebcd5605c2fea2bb03a292ee65d3024e9e765aadf41e0823e01e92

Updated Date Time: 06/12/2017 11:38

## Layman Explanation

This radiology report discusses HISTORY Suspected mets versus PTB. Weight loss 4kg over 3months.CXR 14/7/17 done at Hougang Polyclinic: Nodular opacities seen scattered in the right upper zone, and bilateral lower zone. Exclude SOL, infective changes TECHNIQUE Scans of the thorax were acquired after the administration of Intravenous contrast: Omnipaque 350 Contrast volume (ml): 50 FINDINGS There are no prior relevant scans available for comparison. Chest radiographs dated 14/07/2017 and 24/05/2012 were reviewed. Nodularity opacities and focal areas of airspace consolidation are noted predominantly in the lower lobes, worse on the left. Centrilobular nodules in a tree-in-bud configuration are also noted in the lower lobes. Associatedbronchial thickening and inspissated mucous in the airway are noted. A 1.6 x 0.8 cm focal area of opacification is also seen in the posterior segment of the right upper lobe, associated with adjacent bronchial dilatation and distal atelectasis. No pleural effusion is present. The central airways are patent. The mediastinal vessels opacify normally. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. The heart is normal in size. No pericardial effusion is seen. The limited sections of the upper abdomen viscera are unremarkable. No bony destructive lesion is noted. CONCLUSION Centrilobular nodularity, focal areas of consolidation, bronchial wall thickening and mucous plugging are seen predominantly in the lower lobes. These correspond with the opacities noted on recent chest radiograph. Overall features are in keeping with active inflammatory/ infective in nature. Clinical correlation is suggested. Further action or early intervention required Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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