# Row 5352

Visit Number: e29017b26641f408cc426c19287be7ce7397aa2e5dfa16bee3c77a2692adca8b

Masked\_PatientID: 5352

Order ID: 4c13c84ec5c08060a01f0b076d13ea6e69d966eff45baf1421e275ffcc120e22

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 02/1/2018 13:50

Line Num: 1

Text: HISTORY Left lower lobe consolidation TRO pulmonary CA TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Iopamiro 370 - Volume (ml): 50 FINDINGS No comparison CT thorax available. Note is made of CXR of 5/12/2017 and 27/11/2013. An irregular lobulated mass in the basal left lower lobe is suspicious for a primary malignancy. This measures 70 x 55 x 50 mm with central necrosis. This closely abuts a few tributaries of the left lower lobar vein anteriorly. There is no chest wall invasion. Minimal adjacent atelectasis and minimal mucus plugging. A small simple left pleural effusion is present. A 3 mm geographic nodule with calcification is noted in the anterior aspect of the left upper lobe (6-49) likely granuloma. An obtuse focus at the lateral aspect of the left upper lobe (6-43) shows low attenuation of -15 to 10HU, likely benign and pleural based in nature. A 2 mm oval nodule with rim calcification in the right lung apex (6-11) is likely a granuloma. A tiny 3mm rim opacity at basal right lower lobe (6-80) may be due to focal mucus plugging. An apparent opacity in the vicinity on coronal view (30-20) not seen on the axial view is due to motion artefact. Minimal ill-defined scarring is noted in the several foci, for example lateral aspect of the right upper lobe (6-33). No confluent consolidation, interstitial fibrosis or bronchiectasis is noted. Small amount of centrilobular emphysema noted, mostly in the upper zones. The major airways are patent. Borderline prominent left hilar nodes measures up to 8 mm (5-55). Small volume mediastinal nodes are not enlarged by size criteria and shows normal morphology. No supraclavicular or axillary adenopathy. Heart size is normal. No pericardial effusion is seen. Mediastinal vasculature enhance normally. Atherosclerotic calcifications noted mainly along the aortic arch. Limited sections of the upper abdomen in arterial phase show a few calcified gallstones. The adrenals are not enlarged. No destructive bony lesion is seen. Bilateral old rib fractures noted. CONCLUSION 1. Large mass in left lower lobe is suspicious for a primary lung malignancy. 2. No chest wall invasion is noted. There is a small simple left pleural effusion. 3. No convincing lung metastasis is noted. The other findings in both lungs may be due to granulomata and infective changes, and may be follow-up. 4. Small volume left hilar nodes are indeterminate. 5. Other minor findings as described. May need further action Finalised by: <DOCTOR>

Accession Number: bdc9b5adcea18679106acbda2c0f6f19d391c458225954348c23568a2984b8db

Updated Date Time: 09/1/2018 10:46

## Layman Explanation

This radiology report discusses HISTORY Left lower lobe consolidation TRO pulmonary CA TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Iopamiro 370 - Volume (ml): 50 FINDINGS No comparison CT thorax available. Note is made of CXR of 5/12/2017 and 27/11/2013. An irregular lobulated mass in the basal left lower lobe is suspicious for a primary malignancy. This measures 70 x 55 x 50 mm with central necrosis. This closely abuts a few tributaries of the left lower lobar vein anteriorly. There is no chest wall invasion. Minimal adjacent atelectasis and minimal mucus plugging. A small simple left pleural effusion is present. A 3 mm geographic nodule with calcification is noted in the anterior aspect of the left upper lobe (6-49) likely granuloma. An obtuse focus at the lateral aspect of the left upper lobe (6-43) shows low attenuation of -15 to 10HU, likely benign and pleural based in nature. A 2 mm oval nodule with rim calcification in the right lung apex (6-11) is likely a granuloma. A tiny 3mm rim opacity at basal right lower lobe (6-80) may be due to focal mucus plugging. An apparent opacity in the vicinity on coronal view (30-20) not seen on the axial view is due to motion artefact. Minimal ill-defined scarring is noted in the several foci, for example lateral aspect of the right upper lobe (6-33). No confluent consolidation, interstitial fibrosis or bronchiectasis is noted. Small amount of centrilobular emphysema noted, mostly in the upper zones. The major airways are patent. Borderline prominent left hilar nodes measures up to 8 mm (5-55). Small volume mediastinal nodes are not enlarged by size criteria and shows normal morphology. No supraclavicular or axillary adenopathy. Heart size is normal. No pericardial effusion is seen. Mediastinal vasculature enhance normally. Atherosclerotic calcifications noted mainly along the aortic arch. Limited sections of the upper abdomen in arterial phase show a few calcified gallstones. The adrenals are not enlarged. No destructive bony lesion is seen. Bilateral old rib fractures noted. CONCLUSION 1. Large mass in left lower lobe is suspicious for a primary lung malignancy. 2. No chest wall invasion is noted. There is a small simple left pleural effusion. 3. No convincing lung metastasis is noted. The other findings in both lungs may be due to granulomata and infective changes, and may be follow-up. 4. Small volume left hilar nodes are indeterminate. 5. Other minor findings as described. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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