# Row 5823

Visit Number: 8852071f1cfcaa1499029e922ec0b612ae03edf8b0e0ffa2747d555379e127e1

Masked\_PatientID: 5821

Order ID: 39042b0740019536ad3614347708a17d36fd325155bb05c4b71071e53e16d9d2

Order Name: CT Aortogram (Chest, Abdomen)

Result Item Code: AORTOCA

Performed Date Time: 14/8/2015 15:27

Line Num: 1

Text: HISTORY CT Angio thorax/ abdo/pelvis to exclude aneurysm Known MDS RAEB 2 , new dusky toes multiple - left 5th toe/ big toe, right 5th toe. seen by vascular for CT to assess for aneurysm as a source TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Compared with the previous CT liver study dated 09/12/2014. Note also made of previous CT chest study dated 15/04/2014. Left sided aortic arch, with usual branching pattern arch vessels. The thoracic and abdominal aorta are normal in calibre without any focal aneurysm or dissection. Atheromatous changes in form of calcified plaques present in distal arch and scattered throughout the length of the thoracoabdominal aorta as well as iliac vessels but without causing significant stenosis. There are some soft plaques seen protruding into the lumen of the descending thoracic aorta for example (401 - 44 and 53). No periaortic haematomas. The visceral branches of abdominal aorta appear grossly patent. The iliac and common femoral arteries in their visualised extent are grossly patent but show scattered atheromatous plaques. Small volume mediastinal nodes, not enlarged by sizecriteria. Small left supraclavicular lymph nodes are also present, which are stable. Rest of the mediastinal vasculature enhances normally. The central pulmonary arteries are mildly dilated, the pulmonary trunk measures up to 3.2 cm in diameter, probably indicating a degree of pulmonary arterial hypertension. There is a trace right effusion with associated minor atelectasis. The lungs show emphysematous changes and scattered scarring bilaterally. There are two subcentimetre nodules in the left lower lobe (401 - 55 and 60). These were not present on previous CT study and are indeterminate. Some nonspecific nodularity along right major fissure as well (401 - 55). There is some intraluminal density in the right main bronchus (401 - 37), likely retained secretions. The liver is again noted to be cirrhotic. There is a focus of lipidolol uptake in right hepatic lobe near dome with a large heterogeneously enhancing mass surrounding it, measuring about 9.4 x 8.3 cm which has increased in size compared to previous CT Study. Other previously seen lesions in both hepatic lobes are however not well visualised in this arterial phase only study. The portal vein appears grossly patent in this arterialphase scan. A solitary gallstone in gallbladder. No features of cholecystitis or biliary dilatation. There is mild splenomegaly, indicating underlying portal hypertension. Again noted is a 3 x 2.2 cm enhancing nodule in the pancreas tail (401 - 98). This nodule enhances similar to spleen. Although it has increased in size compared to previous CT studies, it most likely represents a splenic rest in pancreatic tail. Bilateral renal hypodensities, too small for characterisation but stable, likely cysts. The adrenal glands and bowel loops appear grossly normal. The prostate shows a few metallic densities within, likely related to previous brachytherapy beads. A small calcified densities present in the right side of theurinary bladder (401 - 178)), interval new finding. This could be either in the wall of the bladder (dystrophic calcification) or may represent small calculi. There is mild fullness of the ureters bilaterally. Mild thickening of the under distended urinary bladder may represent a degree of cystitis, stable. Some small volume lymph nodes in upper abdomen and porta, may just be reactive. no ascites. No destructive bony lesions. CONCLUSION 1. Normal calibred aorta with noevidence of aortic aneurysm or dissection. Atheromatous changes in distal arch and scattered throughout thoracoabdominal aorta and iliac vessels, but without causing significant stenosis. Some prominent soft plaques noted protruding into the aortic lumen in mid thoracic aorta as described. 2. Cirrhotic liver with splenomegaly. Large hypervascular mass surrounding a previous focus of Lipiodolol in right dome of the liver which shows interval increase in size in keeping with progressive HCC. Other previously seen hypervascular lesions are not well seen in this arterial phase scan only. 3. Enhancing nodule in pancreatic tail though larger from previous scan appear to enhance similar to the spleen and may represent intrapancreatic splenunculus. 4. Emphysematous changes in lungs. Two small nodules in left lower lobe not previously seen, indeterminate. 5. Small focus of calcification along right wall of the urinary bladder may either represent dystrophic calcification in the wall or small calculi. May need further action Finalised by: <DOCTOR>

Accession Number: 90d2e8c68263ec855676bcb12007c24f1c0903c45fc50ed52fddef5b90fdd164

Updated Date Time: 14/8/2015 16:42

## Layman Explanation

This radiology report discusses HISTORY CT Angio thorax/ abdo/pelvis to exclude aneurysm Known MDS RAEB 2 , new dusky toes multiple - left 5th toe/ big toe, right 5th toe. seen by vascular for CT to assess for aneurysm as a source TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Compared with the previous CT liver study dated 09/12/2014. Note also made of previous CT chest study dated 15/04/2014. Left sided aortic arch, with usual branching pattern arch vessels. The thoracic and abdominal aorta are normal in calibre without any focal aneurysm or dissection. Atheromatous changes in form of calcified plaques present in distal arch and scattered throughout the length of the thoracoabdominal aorta as well as iliac vessels but without causing significant stenosis. There are some soft plaques seen protruding into the lumen of the descending thoracic aorta for example (401 - 44 and 53). No periaortic haematomas. The visceral branches of abdominal aorta appear grossly patent. The iliac and common femoral arteries in their visualised extent are grossly patent but show scattered atheromatous plaques. Small volume mediastinal nodes, not enlarged by sizecriteria. Small left supraclavicular lymph nodes are also present, which are stable. Rest of the mediastinal vasculature enhances normally. The central pulmonary arteries are mildly dilated, the pulmonary trunk measures up to 3.2 cm in diameter, probably indicating a degree of pulmonary arterial hypertension. There is a trace right effusion with associated minor atelectasis. The lungs show emphysematous changes and scattered scarring bilaterally. There are two subcentimetre nodules in the left lower lobe (401 - 55 and 60). These were not present on previous CT study and are indeterminate. Some nonspecific nodularity along right major fissure as well (401 - 55). There is some intraluminal density in the right main bronchus (401 - 37), likely retained secretions. The liver is again noted to be cirrhotic. There is a focus of lipidolol uptake in right hepatic lobe near dome with a large heterogeneously enhancing mass surrounding it, measuring about 9.4 x 8.3 cm which has increased in size compared to previous CT Study. Other previously seen lesions in both hepatic lobes are however not well visualised in this arterial phase only study. The portal vein appears grossly patent in this arterialphase scan. A solitary gallstone in gallbladder. No features of cholecystitis or biliary dilatation. There is mild splenomegaly, indicating underlying portal hypertension. Again noted is a 3 x 2.2 cm enhancing nodule in the pancreas tail (401 - 98). This nodule enhances similar to spleen. Although it has increased in size compared to previous CT studies, it most likely represents a splenic rest in pancreatic tail. Bilateral renal hypodensities, too small for characterisation but stable, likely cysts. The adrenal glands and bowel loops appear grossly normal. The prostate shows a few metallic densities within, likely related to previous brachytherapy beads. A small calcified densities present in the right side of theurinary bladder (401 - 178)), interval new finding. This could be either in the wall of the bladder (dystrophic calcification) or may represent small calculi. There is mild fullness of the ureters bilaterally. Mild thickening of the under distended urinary bladder may represent a degree of cystitis, stable. Some small volume lymph nodes in upper abdomen and porta, may just be reactive. no ascites. No destructive bony lesions. CONCLUSION 1. Normal calibred aorta with noevidence of aortic aneurysm or dissection. Atheromatous changes in distal arch and scattered throughout thoracoabdominal aorta and iliac vessels, but without causing significant stenosis. Some prominent soft plaques noted protruding into the aortic lumen in mid thoracic aorta as described. 2. Cirrhotic liver with splenomegaly. Large hypervascular mass surrounding a previous focus of Lipiodolol in right dome of the liver which shows interval increase in size in keeping with progressive HCC. Other previously seen hypervascular lesions are not well seen in this arterial phase scan only. 3. Enhancing nodule in pancreatic tail though larger from previous scan appear to enhance similar to the spleen and may represent intrapancreatic splenunculus. 4. Emphysematous changes in lungs. Two small nodules in left lower lobe not previously seen, indeterminate. 5. Small focus of calcification along right wall of the urinary bladder may either represent dystrophic calcification in the wall or small calculi. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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