# Row 6053

Visit Number: 1eae03a5c1f605b3dc0dc651ffc583641ee13ba9e1dfc07fec09cd5d762f4b3a

Masked\_PatientID: 6052

Order ID: 318edc96a7f62e89881ad425bd09b6cd417d9b53641f54e3266c5ee0a4a1b475

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 14/6/2017 14:35

Line Num: 1

Text: HISTORY ill-defined left infra hilar opacity seen noted in CXR TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS No prior CT examination available for comparison. There is a lobulated mass approximately measuring 5.2 x 5.4 cm in the left lower lobe that corresponds to the opacity seen on the chest radiograph. It abuts the descending thoracic aorta to about 90 degrees. There is encasement and narrowing of the superior and posterior segmental bronchi as well as the left lower lobe bronchus. The appearances are suspicious for underlying primary malignancy. Tissue diagnosis may be obtainable via bronchoscopy. Distal bronchial wall thickening and mild septal thickening are noted in the left lung base. The mass has infiltrated into the adjacent left upper lobe across the fissure and is contiguous with confluent left hilar adenopathy. There is further soft tissue thickening and encasement of the left upper lobe bronchus which is mildly narrowed. A few tiny nodules are seen in the left upper lobe measuring up to 5 mm (image 401-41 12). Mild septal thickening is also present in the left upper lobe suspicious for early lymphangitic spread. A small left pleural effusion is present without overt evidence of pleural thickening or nodularity. Multiple enlarged lymph nodes are present in the para-aortic, subcarinal, and right and left paratracheal lymph nodes, the largest node in the subcarinal region measures 1.9 cm in short axis. Some of the nodes in the right paratracheal region appear low in attenuation which may be due to necrosis. A few small volume subcentimetre nodes are seen in the right prevertebral and prevascular locations superiorly. No enlarged supraclavicular or axillary lymph node is seen. There are a few tiny 2-3 mm nodules in the right lower lobe (images 401-69, 79 22) as well as a 4 mm ground-glass lesion in the superior segment of the same lobe (image 401-63). The heart size is mildly enlarged. There is no pericardial effusion. A small hypodense lesion in segment 6/7 is too small to characterise. The partially visualised, adrenal glands are grossly unremarkable. There is no focal destructive bony lesion. There is a small nodule in the left upper posterior back in the subcutaneous plane involving the dermis which may represent sebaceous cyst. CONCLUSION Left lower lobe pulmonary mass is highlysuspicious for a primary malignancy. There is extension of the tumour into the adjacent left upper lobe with soft tissue encasement and narrowing of the left upper and lower lobe bronchi. There is confluent left hilar adenopathy and multiple significantly enlarged ipsilateral and contralateral mediastinal adenopathy. Mild septal thickening is also noted in the left upper lobe suspicious for early lymphangitic spread. A few tiny nodules are also noted in the left upper lobe as well as in the right lower lobe which are suspicious in this context. A small left pleural effusion is present. May need further action Reported by: <DOCTOR>

Accession Number: 72c9079f1f7277c4bd814568f83d0bd6ce467936cc271e38a871f0f86e17ab5b

Updated Date Time: 14/6/2017 15:39

## Layman Explanation

This radiology report discusses HISTORY ill-defined left infra hilar opacity seen noted in CXR TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS No prior CT examination available for comparison. There is a lobulated mass approximately measuring 5.2 x 5.4 cm in the left lower lobe that corresponds to the opacity seen on the chest radiograph. It abuts the descending thoracic aorta to about 90 degrees. There is encasement and narrowing of the superior and posterior segmental bronchi as well as the left lower lobe bronchus. The appearances are suspicious for underlying primary malignancy. Tissue diagnosis may be obtainable via bronchoscopy. Distal bronchial wall thickening and mild septal thickening are noted in the left lung base. The mass has infiltrated into the adjacent left upper lobe across the fissure and is contiguous with confluent left hilar adenopathy. There is further soft tissue thickening and encasement of the left upper lobe bronchus which is mildly narrowed. A few tiny nodules are seen in the left upper lobe measuring up to 5 mm (image 401-41 12). Mild septal thickening is also present in the left upper lobe suspicious for early lymphangitic spread. A small left pleural effusion is present without overt evidence of pleural thickening or nodularity. Multiple enlarged lymph nodes are present in the para-aortic, subcarinal, and right and left paratracheal lymph nodes, the largest node in the subcarinal region measures 1.9 cm in short axis. Some of the nodes in the right paratracheal region appear low in attenuation which may be due to necrosis. A few small volume subcentimetre nodes are seen in the right prevertebral and prevascular locations superiorly. No enlarged supraclavicular or axillary lymph node is seen. There are a few tiny 2-3 mm nodules in the right lower lobe (images 401-69, 79 22) as well as a 4 mm ground-glass lesion in the superior segment of the same lobe (image 401-63). The heart size is mildly enlarged. There is no pericardial effusion. A small hypodense lesion in segment 6/7 is too small to characterise. The partially visualised, adrenal glands are grossly unremarkable. There is no focal destructive bony lesion. There is a small nodule in the left upper posterior back in the subcutaneous plane involving the dermis which may represent sebaceous cyst. CONCLUSION Left lower lobe pulmonary mass is highlysuspicious for a primary malignancy. There is extension of the tumour into the adjacent left upper lobe with soft tissue encasement and narrowing of the left upper and lower lobe bronchi. There is confluent left hilar adenopathy and multiple significantly enlarged ipsilateral and contralateral mediastinal adenopathy. Mild septal thickening is also noted in the left upper lobe suspicious for early lymphangitic spread. A few tiny nodules are also noted in the left upper lobe as well as in the right lower lobe which are suspicious in this context. A small left pleural effusion is present. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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