# Row 6061

Visit Number: 22770ada95acf161582cd4fd585ba545170b0105af6b43e74c521960dee6274d

Masked\_PatientID: 6052

Order ID: c8927c6dbdceb85dc1dc6d4f48bf7f5b240c720c1779d563d96e67deed8aab56

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 15/11/2018 14:22

Line Num: 1

Text: HISTORY SOB and desaturation secondary to pneumonitis vs PE; Metatastic lung CA on Atezolizumab TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Comparison made with previous CT examination dated 19/10/2018. The images are degraded due to motion artefacts particularly the right lower lobe pulmonary vessels are difficult to assess. Allowing for this, no definite filling defect is identified in thepulmonary arteries to suggest embolism. The main pulmonary trunk is mildly dilated raising possibility of pulmonary hypertension. The heart size is within normal limits. Sliver of pericardial effusion is noted. Several small volume mediastinal nodes in the paratracheal and prevascular locations and as well as in the right hilum are largely unchanged. Dense confluent consolidation is again seen in the lingula and left lower lobe with obliteration of the bronchi in keeping with known primary tumour. However since the prior CT, there is interval progression of consolidation in the left upper lobe around the perihilar region with associated bronchial narrowing. Mild septal thickening is also noted in the rest of the aerated left upper lobe which may represent post obstructive changes or lymphangitis. There is a left-sided pleural drainage catheter in situ with the coiled portion in the left lateral mid thorax. Moderate left pleural effusion is still seen although the pneumothorax component has decreased. A small loculated collection of fluid and air is noted in the pleural space at the left apex measuring 3.5 x 3.4 cm. Mild smooth thickening of the left costal pleura is again seen. There is interval development of mild left mediastinal pleural thickening suspicious for pleural involvement. A small right pleural effusion with dependent atelectasis in the right lower lobe is again noted. Several tiny nodules are present in the right lower lobe and along the perifissural location (example 401-61). These are grossly stable although further assessment/comparison is difficult due to presence of motion artefacts. The central airways are patent. No gross abnormality seen in the visualised upper abdomen. Sclerotic bony lesions are again seen and 18, main, the liver and T12 vertebrae, grossly unchanged. There is a lytic lesion in the right acromion process in keeping with metastases. CONCLUSION Motion artefacts resulting in a degraded image quality. No definite evidence of pulmonary embolism within the limitations of this study. Mild dilatation of the pulmonary trunk raises possibility of pulmonary hypertension. New perihilar consolidation in the left upper lobe with associated peribronchial thickening is seen. Mild septal thickening of the aerated left upper lobe may represent postobstructive changes or lymphangitis. Interval improvement in the pneumothorax component of the left pleural effusion. Interval development of left mediastinal pleural thickening is suspicious for pleural disease. Small right pleural effusion and multiple tiny nodules in the right lower lobe are again noted. No evidence of pneumonitis in the rest of the aerated lung. Stable small volume mediastinal and right hilar nodes. Grossly stable metastatic disease in the bones. May need further action Finalised by: <DOCTOR>

Accession Number: f29b64915d4dc584edbbf5bbca1e33f6a1b3dd8dbf024f9f1aa12946772a8b42

Updated Date Time: 15/11/2018 15:35

## Layman Explanation

This radiology report discusses HISTORY SOB and desaturation secondary to pneumonitis vs PE; Metatastic lung CA on Atezolizumab TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Comparison made with previous CT examination dated 19/10/2018. The images are degraded due to motion artefacts particularly the right lower lobe pulmonary vessels are difficult to assess. Allowing for this, no definite filling defect is identified in thepulmonary arteries to suggest embolism. The main pulmonary trunk is mildly dilated raising possibility of pulmonary hypertension. The heart size is within normal limits. Sliver of pericardial effusion is noted. Several small volume mediastinal nodes in the paratracheal and prevascular locations and as well as in the right hilum are largely unchanged. Dense confluent consolidation is again seen in the lingula and left lower lobe with obliteration of the bronchi in keeping with known primary tumour. However since the prior CT, there is interval progression of consolidation in the left upper lobe around the perihilar region with associated bronchial narrowing. Mild septal thickening is also noted in the rest of the aerated left upper lobe which may represent post obstructive changes or lymphangitis. There is a left-sided pleural drainage catheter in situ with the coiled portion in the left lateral mid thorax. Moderate left pleural effusion is still seen although the pneumothorax component has decreased. A small loculated collection of fluid and air is noted in the pleural space at the left apex measuring 3.5 x 3.4 cm. Mild smooth thickening of the left costal pleura is again seen. There is interval development of mild left mediastinal pleural thickening suspicious for pleural involvement. A small right pleural effusion with dependent atelectasis in the right lower lobe is again noted. Several tiny nodules are present in the right lower lobe and along the perifissural location (example 401-61). These are grossly stable although further assessment/comparison is difficult due to presence of motion artefacts. The central airways are patent. No gross abnormality seen in the visualised upper abdomen. Sclerotic bony lesions are again seen and 18, main, the liver and T12 vertebrae, grossly unchanged. There is a lytic lesion in the right acromion process in keeping with metastases. CONCLUSION Motion artefacts resulting in a degraded image quality. No definite evidence of pulmonary embolism within the limitations of this study. Mild dilatation of the pulmonary trunk raises possibility of pulmonary hypertension. New perihilar consolidation in the left upper lobe with associated peribronchial thickening is seen. Mild septal thickening of the aerated left upper lobe may represent postobstructive changes or lymphangitis. Interval improvement in the pneumothorax component of the left pleural effusion. Interval development of left mediastinal pleural thickening is suspicious for pleural disease. Small right pleural effusion and multiple tiny nodules in the right lower lobe are again noted. No evidence of pneumonitis in the rest of the aerated lung. Stable small volume mediastinal and right hilar nodes. Grossly stable metastatic disease in the bones. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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