# Row 6058

Visit Number: 4143fbff03c0d1fa1f02530c3d03fb8203eddcbd1f34d9f715d1294f38ca33fb

Masked\_PatientID: 6052

Order ID: 3c979fae1a1d5bd22933fcf5208185a9739f83b68d6aed9bbec6957841699dde

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 19/10/2018 20:08

Line Num: 1

Text: HISTORY met NSCLC on pall chemo post #4 docetaxel TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison done with the prior study 7 August 2018. Interval insertion of a left pleural drainage catheter with tip curled at the lateral hemithorax. Interval decrease in size of fluid component of left pleural effusion. However lung has not completely re-expanded resulting in a hydropneumothorax. There is suggestion of mild pleural enhancement in the basal region which is indeterminate (There is seen, mass like consolidation in the in the left lower lobe and lingula extending to the hilum, inseparable from left hilar adenopathy and the collapsed lung. Peribronchial soft tissue thickening is again seen in the left upper and lower lobe, suspicious for tumor infiltration. There are numerous tiny (1-3mm) nodules in the aerated right lower lobe in keeping with metastases. The previously mentioned right upper lobe nodules are not well seen. However, comparison is limited due presence of motion artefact both on his scan and on the previous scan but they appear to be less numerous compared with the scan of May 2018. There is interval development of a small right pleural effusion. Multiple small volume mediastinal nodes are noted, some which shows further decrease in size. For example prevascular node now measures 7 mm in short axis from 10 mm (5-32). Subcarinal node is also slightly smaller, now measuring 8mm in short axis (5-46) Stable mildly enlarged right hilar node measuring 10 mm short axis. Stable small supraclavicular nodes. Heart is not enlarged. There is no significant pericardial effusion. Tiny hypodensity in segment VI of the liver is too small to characterise . The gallbladder is distended with hyperdense sludge within. There is diffuse gallbladder wall oedema, nonspecific. The biliary tree is not dilated. The pancreas, spleen,, adrenal glands are unremarkable. Stable elongated 0.3 x 1.1 cm left midpole cyst. Another tiny hypodensity in the left midpole is too small to characterise but stable. Mild symmetrical perinephric fluid is nonspecific. No hydronephrosis. The bladder is catheterised and is collapsed. Mild prostatomegaly. The bowel loops are normal in calibre. There is an uncomplicated cecal diverticulum. There is no significant enlarged abdominal or pelvic lymph node. Small amount of free intraperitoneal fluid is nonspecific. Bilateral subcutaneous fluid stranding, mainly in the flanks could represent anasarca. Patchy sclerotic metastases in the spine and pelvis are generally more sclerotic, could represent flare response. For example comparing T11 and T12 (current 9-25 v 300-41) CONCLUSION Since the 7th of Aug 2018, 1. Interval insertion of left pleural drainage catheter. The pleural effusion has decreased but the lungs has failed to re-expand resulting in a moderate sized left hydropneumothorax. There is now a small right pleural effusion. 2. Mass like consolidation in the left lower lobe extending to upper lobe and lingula, contiguous with left hilar adenopathy probably representing the primary tumor. It is difficult to distinguish from the collapsed lung. There are again seen multiple tiny nodules in the aerated right lower lobe in keeping with metastases. Comparison is difficult due to respiratory motion but they appear smaller and less numerous compared with May 2018 scan. 3. Small volume mediastinal nodes are again seen and some are slightly smaller. Grossly stable right borderline enlarged right hilar nodes. 4. Patchy sclerotic metastases in the spine and pelvis are generally more sclerotic, could represent flare response. . May need further action Finalised by: <DOCTOR>

Accession Number: 7ddeb13d0c63fe4b2b71795048eb8ac384632e5ea5c9f0dd62159ee690c3f605

Updated Date Time: 19/10/2018 21:33

## Layman Explanation

This radiology report discusses HISTORY met NSCLC on pall chemo post #4 docetaxel TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison done with the prior study 7 August 2018. Interval insertion of a left pleural drainage catheter with tip curled at the lateral hemithorax. Interval decrease in size of fluid component of left pleural effusion. However lung has not completely re-expanded resulting in a hydropneumothorax. There is suggestion of mild pleural enhancement in the basal region which is indeterminate (There is seen, mass like consolidation in the in the left lower lobe and lingula extending to the hilum, inseparable from left hilar adenopathy and the collapsed lung. Peribronchial soft tissue thickening is again seen in the left upper and lower lobe, suspicious for tumor infiltration. There are numerous tiny (1-3mm) nodules in the aerated right lower lobe in keeping with metastases. The previously mentioned right upper lobe nodules are not well seen. However, comparison is limited due presence of motion artefact both on his scan and on the previous scan but they appear to be less numerous compared with the scan of May 2018. There is interval development of a small right pleural effusion. Multiple small volume mediastinal nodes are noted, some which shows further decrease in size. For example prevascular node now measures 7 mm in short axis from 10 mm (5-32). Subcarinal node is also slightly smaller, now measuring 8mm in short axis (5-46) Stable mildly enlarged right hilar node measuring 10 mm short axis. Stable small supraclavicular nodes. Heart is not enlarged. There is no significant pericardial effusion. Tiny hypodensity in segment VI of the liver is too small to characterise . The gallbladder is distended with hyperdense sludge within. There is diffuse gallbladder wall oedema, nonspecific. The biliary tree is not dilated. The pancreas, spleen,, adrenal glands are unremarkable. Stable elongated 0.3 x 1.1 cm left midpole cyst. Another tiny hypodensity in the left midpole is too small to characterise but stable. Mild symmetrical perinephric fluid is nonspecific. No hydronephrosis. The bladder is catheterised and is collapsed. Mild prostatomegaly. The bowel loops are normal in calibre. There is an uncomplicated cecal diverticulum. There is no significant enlarged abdominal or pelvic lymph node. Small amount of free intraperitoneal fluid is nonspecific. Bilateral subcutaneous fluid stranding, mainly in the flanks could represent anasarca. Patchy sclerotic metastases in the spine and pelvis are generally more sclerotic, could represent flare response. For example comparing T11 and T12 (current 9-25 v 300-41) CONCLUSION Since the 7th of Aug 2018, 1. Interval insertion of left pleural drainage catheter. The pleural effusion has decreased but the lungs has failed to re-expand resulting in a moderate sized left hydropneumothorax. There is now a small right pleural effusion. 2. Mass like consolidation in the left lower lobe extending to upper lobe and lingula, contiguous with left hilar adenopathy probably representing the primary tumor. It is difficult to distinguish from the collapsed lung. There are again seen multiple tiny nodules in the aerated right lower lobe in keeping with metastases. Comparison is difficult due to respiratory motion but they appear smaller and less numerous compared with May 2018 scan. 3. Small volume mediastinal nodes are again seen and some are slightly smaller. Grossly stable right borderline enlarged right hilar nodes. 4. Patchy sclerotic metastases in the spine and pelvis are generally more sclerotic, could represent flare response. . May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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