# Row 6563

Visit Number: 3ab6486c2ff88d0657e2ece191dab3b1e96a85743c2c74ebfbb580d545d8a7ad

Masked\_PatientID: 6560

Order ID: 7274608fde3750b2199a9a3c2b7ba269719613eed4aea0ca633bc18283f9cb7e

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 02/11/2018 21:06

Line Num: 1

Text: HISTORY Metastatic breast CA with known PE, right sided pleural effusion, s/p effective drainage Persistent SOB and tachycardia for evaluation To rule out worsening PE TECHNIQUE CT chest (pulmonary angiography) was acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Reference is made to prior chest radiograph dated 1 November 2018 and CT guided drainage procedure dated 27 October 2018. The patient is status post right mastectomy and axillary surgery. Large irregular nodular and infiltrative soft tissue mass is noted in the right chest wall (se 5-56), the nodular component measuring approximately 7.5 x 6.6 x 2.0 cm (se 5-51, se 9-72), in continuity with the right chest wall muscle and overlying skin, in keeping with local tumour recurrence. Another irregular nodular soft tissue is seen in the right inferolateral chest wall measuring 3.8 x 1.9 x 1.1 cm (se 9-50, 5-78), inseparable from underlying muscle. Enlarged right supraclavicular (se 5-15 4.6 x 4.2 cm) and left axillary lymph nodes (se 9-47, largest 2 cm short axis) are noted. Sensitive bilateral pulmonary metastasis is present. There is extensive right pleural metastasis with loculated right pleural effusion. The pleural mass is inseparable from the consolidated right upper lobe. Mass effect on the mediastinum is visualised, compressing on the right atrium as well as the SVC. The SVC appears severely compressed. Right pleural chest drain is in place and there is small amount of right pneumothorax. Two right sided pleural drainage catheters are noted, with tips in the right lower lobe pleura. There is interval reduction of right posterior hydropneumothorax. Loculated pleural effusion anteriorly overlying the middle lobe is largely stable, with associated middle lobe collapse. Enlarged mediastinal adenopathy is noted in the anterior mediastinum (se 5-42, 4.4 x 2.2 cm), left perihilar (se 5-37) and subcarina (se 5-45). There is no filling-defect in the pulmonary trunk, main pulmonary arteries and its lobar and segmental branches. The pulmonary trunk is not dilated. The right ventricle: left ventricle ratio is less than 1. There is no reflux of contrast into the inferior vena cava. Itraluminal filling defects in the left superior pulmonary venous segment (se 5-38) is suspicious for thrombus formation. The cardiac size is not enlarged. No pericardial effusion is identified. The tip of the left-sided venous port is located in the superior vena cava. In the visualised upper abdomen, hypodense appearance of the liver suggest steatosis. There is suspicion of a possible ill-defined hypodense lesion in segmentfour measuring 1 cm (5-103). Several lymph nodes are visualised in the upper abdomen in the gastrohepatic ligament region and retrocaval region, suspicious for nodal metastasis. Sclerotic appearance of the sternum is in keeping with bone metastasis. Patchy lytic sclerotic appearance also visualised in some of the right sided ribs. The extent of bone metastasis may be better assessed with bone scan. CONCLUSION 1. Post right mastectomy with evidence of local recurrence, right chest wall disease, right supraclavicular and left axillary lymphadenopathy. 2. Multiple bilateral pulmonary and pleural metastasis with enlarged left hilar and mediastinal lymphadenopathy, as detailed. 3. No CT evidence of pulmonary embolism but there is a tiny filling defect in the left superior pulmonary vein, suspicious for thrombus within the pulmonary vein. 5. Bone metastasis in the sternum. Heterogeneous appearance in some of the right sided ribs raises the possibility of metastasis. Suggest bone scan for further evaluation. Enlarged retroperitoneal lymph nodes in the visualised upper abdomen are suspicious for nodal metastasis. Possible ill-defined hypodense lesion in the partially imaged liver. Hepatic metastasisis not excluded. May need further action Kee Tze Phei , Senior Resident , 17033Z Finalised by: <DOCTOR>

Accession Number: 6535e218e689c67e2f54a1ae5890ae614144a403ecd63256498b103334dc10b7

Updated Date Time: 03/11/2018 10:36

## Layman Explanation

This radiology report discusses HISTORY Metastatic breast CA with known PE, right sided pleural effusion, s/p effective drainage Persistent SOB and tachycardia for evaluation To rule out worsening PE TECHNIQUE CT chest (pulmonary angiography) was acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Reference is made to prior chest radiograph dated 1 November 2018 and CT guided drainage procedure dated 27 October 2018. The patient is status post right mastectomy and axillary surgery. Large irregular nodular and infiltrative soft tissue mass is noted in the right chest wall (se 5-56), the nodular component measuring approximately 7.5 x 6.6 x 2.0 cm (se 5-51, se 9-72), in continuity with the right chest wall muscle and overlying skin, in keeping with local tumour recurrence. Another irregular nodular soft tissue is seen in the right inferolateral chest wall measuring 3.8 x 1.9 x 1.1 cm (se 9-50, 5-78), inseparable from underlying muscle. Enlarged right supraclavicular (se 5-15 4.6 x 4.2 cm) and left axillary lymph nodes (se 9-47, largest 2 cm short axis) are noted. Sensitive bilateral pulmonary metastasis is present. There is extensive right pleural metastasis with loculated right pleural effusion. The pleural mass is inseparable from the consolidated right upper lobe. Mass effect on the mediastinum is visualised, compressing on the right atrium as well as the SVC. The SVC appears severely compressed. Right pleural chest drain is in place and there is small amount of right pneumothorax. Two right sided pleural drainage catheters are noted, with tips in the right lower lobe pleura. There is interval reduction of right posterior hydropneumothorax. Loculated pleural effusion anteriorly overlying the middle lobe is largely stable, with associated middle lobe collapse. Enlarged mediastinal adenopathy is noted in the anterior mediastinum (se 5-42, 4.4 x 2.2 cm), left perihilar (se 5-37) and subcarina (se 5-45). There is no filling-defect in the pulmonary trunk, main pulmonary arteries and its lobar and segmental branches. The pulmonary trunk is not dilated. The right ventricle: left ventricle ratio is less than 1. There is no reflux of contrast into the inferior vena cava. Itraluminal filling defects in the left superior pulmonary venous segment (se 5-38) is suspicious for thrombus formation. The cardiac size is not enlarged. No pericardial effusion is identified. The tip of the left-sided venous port is located in the superior vena cava. In the visualised upper abdomen, hypodense appearance of the liver suggest steatosis. There is suspicion of a possible ill-defined hypodense lesion in segmentfour measuring 1 cm (5-103). Several lymph nodes are visualised in the upper abdomen in the gastrohepatic ligament region and retrocaval region, suspicious for nodal metastasis. Sclerotic appearance of the sternum is in keeping with bone metastasis. Patchy lytic sclerotic appearance also visualised in some of the right sided ribs. The extent of bone metastasis may be better assessed with bone scan. CONCLUSION 1. Post right mastectomy with evidence of local recurrence, right chest wall disease, right supraclavicular and left axillary lymphadenopathy. 2. Multiple bilateral pulmonary and pleural metastasis with enlarged left hilar and mediastinal lymphadenopathy, as detailed. 3. No CT evidence of pulmonary embolism but there is a tiny filling defect in the left superior pulmonary vein, suspicious for thrombus within the pulmonary vein. 5. Bone metastasis in the sternum. Heterogeneous appearance in some of the right sided ribs raises the possibility of metastasis. Suggest bone scan for further evaluation. Enlarged retroperitoneal lymph nodes in the visualised upper abdomen are suspicious for nodal metastasis. Possible ill-defined hypodense lesion in the partially imaged liver. Hepatic metastasisis not excluded. May need further action Kee Tze Phei , Senior Resident , 17033Z Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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