# Row 6596

Visit Number: 15bae66401b57456b1c0deb9aca314526cc64777b81e8d3739b35441add190c7

Masked\_PatientID: 6580

Order ID: 3340263cdefda2522ca66bd1a75fba0479fb40966e47497c13ad00cb30164de3

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 01/2/2019 10:51

Line Num: 1

Text: HISTORY Right lower lobectomy for cancer, for follow-up TECHNIQUE Plain CT of the thorax was acquired. No intravenous contrast was given. FINDINGS Comparison made with the last CT scan of 8 Aug 2018. Post right lower lobectomy. No suspicious pulmonary nodule or pleural effusion is seen. No pulmonary consolidation. The previous consolidation in the middle lobe has mostly resolved with mild ground glass opacities probably representing post-infective changes now seen (Img. 5-62). Other scattered centrilobular nodules in the right upper and middle lobe seen in the previous CT probably representing infective or inflammatory changes have mostly resolved with mild residual ground glass densities. A stable tiny 0.3 cm perifissural nodule is noted in the middle lobe (Img. 5-36). Mild pleural thickening is now noted mainly along the lateral aspect as well as in the para vertebral location. Secondary subpleural atelectasis/scarring is noted in the middle lobe. Subsegmental atelectasis is noted in the left lower lobe. Mild right perihilar bronchial wall thickening is probably inflammatory. Mild paraseptal emphysema noted. The tip of an AICD is located within the right ventricle. A stable prominent right paratracheal lymph node measuring 0.8 cm is visualised (Img. 4-17). Stable small volume bilateral paratracheal and AP window lymph nodes are also seen. Within limits of an unenhanced CT, no obvious hilar lymphadenopathy is noted. The heart is enlarged. Curvilinear fatty infiltration in the left ventricular wall at the apex likely sequelae of previous ischaemia. No pericardial effusion is seen. Coronary artery bypass grafts and mediastinal clips are noted. Calculi are noted in the gallbladder and in the distal common bile duct (Img. 4-110). No overt dilatation of the common bile duct is seen on this unenhanced CT. Stable cortical scarring of the right kidney is seen. A few uncomplicated colon diverticula are noted. No destructive bony process is seen. Degenerative changes are noted in the imaged spine. Median sternotomy wires are noted. CONCLUSION 1. Post right lower lobectomy. No new suspicious pulmonary mass to suggest local recurrence is seen. No overt thoracic adenopathy. 2. The previous consolidation in the middle lobe has mostly resolved; mild residual ground glass opacities are noted elsewhere, probably representing post-infective or inflammatory changes. 3. Mild nonspecific right pleural thickening is now seen; attention on follow up suggested. 4. Gallstones and distal CBD calculi are again seen without causing significant biliary dilatation. May need further action Reported by: <DOCTOR>

Accession Number: 163287c4c22ad71c7a16d7f04e8f99c8044b3988287a09aa807460bfd000952e

Updated Date Time: 01/2/2019 14:23

## Layman Explanation

This radiology report discusses HISTORY Right lower lobectomy for cancer, for follow-up TECHNIQUE Plain CT of the thorax was acquired. No intravenous contrast was given. FINDINGS Comparison made with the last CT scan of 8 Aug 2018. Post right lower lobectomy. No suspicious pulmonary nodule or pleural effusion is seen. No pulmonary consolidation. The previous consolidation in the middle lobe has mostly resolved with mild ground glass opacities probably representing post-infective changes now seen (Img. 5-62). Other scattered centrilobular nodules in the right upper and middle lobe seen in the previous CT probably representing infective or inflammatory changes have mostly resolved with mild residual ground glass densities. A stable tiny 0.3 cm perifissural nodule is noted in the middle lobe (Img. 5-36). Mild pleural thickening is now noted mainly along the lateral aspect as well as in the para vertebral location. Secondary subpleural atelectasis/scarring is noted in the middle lobe. Subsegmental atelectasis is noted in the left lower lobe. Mild right perihilar bronchial wall thickening is probably inflammatory. Mild paraseptal emphysema noted. The tip of an AICD is located within the right ventricle. A stable prominent right paratracheal lymph node measuring 0.8 cm is visualised (Img. 4-17). Stable small volume bilateral paratracheal and AP window lymph nodes are also seen. Within limits of an unenhanced CT, no obvious hilar lymphadenopathy is noted. The heart is enlarged. Curvilinear fatty infiltration in the left ventricular wall at the apex likely sequelae of previous ischaemia. No pericardial effusion is seen. Coronary artery bypass grafts and mediastinal clips are noted. Calculi are noted in the gallbladder and in the distal common bile duct (Img. 4-110). No overt dilatation of the common bile duct is seen on this unenhanced CT. Stable cortical scarring of the right kidney is seen. A few uncomplicated colon diverticula are noted. No destructive bony process is seen. Degenerative changes are noted in the imaged spine. Median sternotomy wires are noted. CONCLUSION 1. Post right lower lobectomy. No new suspicious pulmonary mass to suggest local recurrence is seen. No overt thoracic adenopathy. 2. The previous consolidation in the middle lobe has mostly resolved; mild residual ground glass opacities are noted elsewhere, probably representing post-infective or inflammatory changes. 3. Mild nonspecific right pleural thickening is now seen; attention on follow up suggested. 4. Gallstones and distal CBD calculi are again seen without causing significant biliary dilatation. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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