# Row 7215

Visit Number: afb8f7d78d33b6e528a0c991e7c6daa400df56ad3639eff104aa8986bbf25262

Masked\_PatientID: 7195

Order ID: fb177bd74d77bd5ac5ac32226bb67828420aa5f425f49fc4d87ceb47ad913dc6

Order Name: CT Chest and Abdomen

Result Item Code: CTCHEABD

Performed Date Time: 16/10/2016 12:05

Line Num: 1

Text: HISTORY Sternal wound with purulent discharge-; TVD-CABG done Liver Absces DM ESRF TECHNIQUE Contrast enhanced axial CT scan of the chest, abdomen and pelvis was performed in the porto-venous phase. Coronal reconstruction was also obtained. Intravenous contrast: Omnipaque 350 - Volume (ml): 70 FINDINGS Comparison is made with the previous CT study dated 10.10.2016. There is image blurring due to motion artefacts, particularly of the thorax. CHEST The patient is status post CABG. Midline sternotomy and wires are noted from recent surgery. There is a thin rim enhancing, elongated, lobulated fluid collection at the left retrosternal region measuring up to 3.0 x 2.4 cm (402-31). It appears to communicate with the previously noted collection seen anterior to the right atrium with tip of drain within. This component is slightly larger, now measuring about 4.3 x 2.0 cm (501-18) There is also a suprasternal collection measuring 3.3 x 2.5 cm(402-14). There is interval increase in the bilateral pleural effusions, now of moderate size with associated atelectatasis, especially of the lower lobes. The heart is enlarged. Extensive native coronary arteries calcifications and RCA/LCA bypass grafts are noted. No significant pericardial effusion. No significantly enlarged intra-thoracic node is seen. The great vessels enhance normally. ABDOMEN & PELVIS The large peripheral wedge shaped hypoenhancing areas within both hepatic lobes (manly segment III, IVA and VI) are less hypodense and less well defined, compatible with improvement of ischaemia/infarct. There is no evidence of a rim enhancing hepatic abscess. Periportal edema is evident, especially around the branches supplying the ischaemic areas. The main portal veins and its larger branches are patent, as are the hepatic veins. The rim-enhancing fluid collection around the pancreatic tail is larger, now measuring about 3.4 x 4.5 x 3.4cm (Im 501-33 & 503-28) vs. previously 2.9 x 2.3 x 2.0 cm (Im 601/40, 503/29). A new smaller such collection measuring approximately 1.3 x 1.7 cm (Im 501-42) is also present in the body of the pancreas. The main pancreatic duct is not dilated. No solid enhancing pancreatic mass is detected Few small uncomplicated calcified gallstones are present. Other hyperdense lesions measuring up to 1 cm in size could represent gallstones or polyps. Stable mild dilatation of the segment VII intrahepatic ducts. The common duct is not dilated. The adrenals are unremarkable. Both kidneys are small with multiple cysts, some hyperdense. Previously described small wedge-shaped peripheral hypo-enhancing foci within the spleen and both kidneys have largely resolved. Extensive small bowel and colonic (mid transverse to descending) mural thickening is again seen in the visualised abdmen. No overt pneumatosis intestinalis or pneumoperitoneum is detected. There is interval worsening of abdominal ascites. No pneumoperitoneum is seen. No significantly enlarged lymph nodes are present within the abdomen. The abdominal aorta is of normal calibre. Degenerative changes are present in the spine. No suspicious osseous lesion is detected. CONCLUSION 1. Previous CABG. Rim enhancing substernal fluid collection with paracardiac component, slightly larger. There is also a suprasternal collection that may communicate with the substernal collection but this is notdefinitely seen. 2. Hepatic peripheral wedge shape hypoenhancing regions are less hypodense, in keeping with improving hepatic ischemia. No definite portal vein thrombus. 3. Interval worsening of abdominal ascites with stable diffuse bowelmural thickening again noted. Bilateral pleural effusion are also larger. Underlying portal hypertension with concomitant venous congestion needs to be considered. 4. Rim-enhancing fluid collection around the pancreatic tail is larger with anew smaller such collection now present in the body of the pancreas. These are likely to be inflammatory in aetiology. The critical findings were conveyed to the clinician in-charge of the patient Dr Tracy by Dr Saravana Kumar on 16.10.2016at 1310 hrs. Read-back was performed. May need further action Saravana Kumar Swaminathan , Senior Resident , 16844J Finalised by: <DOCTOR>

Accession Number: e1b723a44aa8a7202a32aa3c5f192b095dbfa655d1d8bb17e746c2338d5ac7d1

Updated Date Time: 17/10/2016 10:06

## Layman Explanation

This radiology report discusses HISTORY Sternal wound with purulent discharge-; TVD-CABG done Liver Absces DM ESRF TECHNIQUE Contrast enhanced axial CT scan of the chest, abdomen and pelvis was performed in the porto-venous phase. Coronal reconstruction was also obtained. Intravenous contrast: Omnipaque 350 - Volume (ml): 70 FINDINGS Comparison is made with the previous CT study dated 10.10.2016. There is image blurring due to motion artefacts, particularly of the thorax. CHEST The patient is status post CABG. Midline sternotomy and wires are noted from recent surgery. There is a thin rim enhancing, elongated, lobulated fluid collection at the left retrosternal region measuring up to 3.0 x 2.4 cm (402-31). It appears to communicate with the previously noted collection seen anterior to the right atrium with tip of drain within. This component is slightly larger, now measuring about 4.3 x 2.0 cm (501-18) There is also a suprasternal collection measuring 3.3 x 2.5 cm(402-14). There is interval increase in the bilateral pleural effusions, now of moderate size with associated atelectatasis, especially of the lower lobes. The heart is enlarged. Extensive native coronary arteries calcifications and RCA/LCA bypass grafts are noted. No significant pericardial effusion. No significantly enlarged intra-thoracic node is seen. The great vessels enhance normally. ABDOMEN & PELVIS The large peripheral wedge shaped hypoenhancing areas within both hepatic lobes (manly segment III, IVA and VI) are less hypodense and less well defined, compatible with improvement of ischaemia/infarct. There is no evidence of a rim enhancing hepatic abscess. Periportal edema is evident, especially around the branches supplying the ischaemic areas. The main portal veins and its larger branches are patent, as are the hepatic veins. The rim-enhancing fluid collection around the pancreatic tail is larger, now measuring about 3.4 x 4.5 x 3.4cm (Im 501-33 & 503-28) vs. previously 2.9 x 2.3 x 2.0 cm (Im 601/40, 503/29). A new smaller such collection measuring approximately 1.3 x 1.7 cm (Im 501-42) is also present in the body of the pancreas. The main pancreatic duct is not dilated. No solid enhancing pancreatic mass is detected Few small uncomplicated calcified gallstones are present. Other hyperdense lesions measuring up to 1 cm in size could represent gallstones or polyps. Stable mild dilatation of the segment VII intrahepatic ducts. The common duct is not dilated. The adrenals are unremarkable. Both kidneys are small with multiple cysts, some hyperdense. Previously described small wedge-shaped peripheral hypo-enhancing foci within the spleen and both kidneys have largely resolved. Extensive small bowel and colonic (mid transverse to descending) mural thickening is again seen in the visualised abdmen. No overt pneumatosis intestinalis or pneumoperitoneum is detected. There is interval worsening of abdominal ascites. No pneumoperitoneum is seen. No significantly enlarged lymph nodes are present within the abdomen. The abdominal aorta is of normal calibre. Degenerative changes are present in the spine. No suspicious osseous lesion is detected. CONCLUSION 1. Previous CABG. Rim enhancing substernal fluid collection with paracardiac component, slightly larger. There is also a suprasternal collection that may communicate with the substernal collection but this is notdefinitely seen. 2. Hepatic peripheral wedge shape hypoenhancing regions are less hypodense, in keeping with improving hepatic ischemia. No definite portal vein thrombus. 3. Interval worsening of abdominal ascites with stable diffuse bowelmural thickening again noted. Bilateral pleural effusion are also larger. Underlying portal hypertension with concomitant venous congestion needs to be considered. 4. Rim-enhancing fluid collection around the pancreatic tail is larger with anew smaller such collection now present in the body of the pancreas. These are likely to be inflammatory in aetiology. The critical findings were conveyed to the clinician in-charge of the patient Dr Tracy by Dr Saravana Kumar on 16.10.2016at 1310 hrs. Read-back was performed. May need further action Saravana Kumar Swaminathan , Senior Resident , 16844J Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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