# Row 7266

Visit Number: fef37a9c9e1dfa4c5269123c950c7948ad2ae1c3176a5f3e187284880aad02af

Masked\_PatientID: 7261

Order ID: 987d9d4f2073924a4aae6bccfea504c48c830ab7d2bb93c7d7696b5aa48c419d

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 26/3/2019 20:39

Line Num: 1

Text: HISTORY metastatic sigmoid adenoca extensive peritoneal disease large bowel IO, abdomen tender and guarded on examination TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 70 Positive Rectal Contrast FINDINGS CHEST Comparison was made with the prior study dated 19 Nov 2018. Scattered bilateral lung masses and nodules, suspicious for metastases. These demonstrate interval increase in size, for example spiculated lesions in the right upper lobe measuring 1.4 cm from previous 1.1 cm (se 401\16 vs prior 4\32) and middle lobe measuring 2.3 cm from previous 2.1 cm (se 401\46 vs prior 4\65) as well as increase in number for example new lesions at the right lung apex (0.3 cm, se 401\17-19). As before, some contain small calcifications while a few show cavitation. Stable tiny calcified granuloma in the superior segment of the left lower lobe. The central airways are patent. No significantly enlarged intra-thoracic node detected. The heart size is normal. Coronary arterial calcifications seen. No pleural or pericardial effusion. Imaged thyroid gland is unremarkable. ABDOMEN\PELVIS Prior CT KUB dated 11 Feb 2019 and CT abdomen\pelvis dated 19 Nov 2018 were reviewed. There are dilated fluid-filled small bowel loops measuring up to 5.5 cm in calibre. There is a transition point at a pelvic ileal loop (se 501\101, 503\44) where there is abrupt change in calibre. No obstructing mass seen at this transition site. Few other collapsed loops seen in the vicinity though no other convincing transition point is discerned. Several of the dilated small bowel loops appear to abut known peritoneal masses with some luminal narrowing at the left lower abdomen (se 501\95) and at the anterior abdomen (se 501\65). These along with other peritoneal deposit seen anterior to the aorta (se 501\73 vs prior 201\56) as well as deposit adjacent to the right distal ureter (se 501\104) appear largely stable. Focal soft tissue noted between the dilated proximal bowel in the upper abdomen (~2.0 cm, se 501\30) is indeterminate for another peritoneal deposit. Bowel wall enhancement is preserved. There is no free gas. No convincing pneumatosis intestinalis or portovenous gas. Small amount of ascites noted. The distal small bowel and large bowel are collapsed. Note made of prior high anterior resection and bilateral oopherectomy. Large bowel anastomotic site (se 501\96) is grossly unremarkable. Several small nodes are seen in the mesentery, more prominent than before and measuring up to 0.7 cm in short axis (se 501\60). Placement of a right ureteric stent with slight interval improvement in right hydroureteronephrosis. Left ureteric stent in situ with resolution of left hydronephrosis. Stable scarring of the left kidney related to chronic uropathy. Stable 2 cm cyst at the left renal upper pole. Other non-specific 1.2 cm hypodensity at the right renal midpole is stable. Distal ends of both ureteric stents seen within the under-distended urinary bladder. No focal hepatic lesion identified. The spleen, pancreas and adrenal glands are unremarkable. Mild mural thickening at the gallbladder fundus may be due to adenomyomatosis. No biliary dilatation noted. Atherosclerotic calcifications noted along the abdominal aorta and iliac vessels. Degenerative changes are seen in the visualized spine. Levoscoliosis of the lumbar spine noted. No destructive bony lesion identified. CONCLUSION 1. Small bowel obstruction with transition point at a pelvic ileal loop. This is probably due adhesions, seen in a background of peritoneal disease with several of the dilated loops abutting these. Small amount of ascites; no free gas or overt bowel ischaemia. While no definite second transition point is identified, there may be increased risk of closed loop obstruction - close clinical monitoring would be prudent. 2. New interloop soft tissue focus at the proximal bowel, indeterminate for a peritoneal deposit. Other peritoneal deposits appear largely stable. 3. Interval worsening of pulmonary metastases. 4. Bilateral ureteric stents in situ, with slight improvement inright hydronephrosis and resolution of left hydronephrosis. 5. Other findings as described above. Findings were discussed with ordering clinician Dr Sean Ong by Dr Tan Eu Jin on 26 Mar 2019 11.15 PM. Report Indicator: Further action or early intervention required Finalised by: <DOCTOR>

Accession Number: 548cb832edaa0e884179ee50dfe341a54b786cb293bba46a0cc450c04e03a8be

Updated Date Time: 26/3/2019 23:36

## Layman Explanation

This radiology report discusses HISTORY metastatic sigmoid adenoca extensive peritoneal disease large bowel IO, abdomen tender and guarded on examination TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 70 Positive Rectal Contrast FINDINGS CHEST Comparison was made with the prior study dated 19 Nov 2018. Scattered bilateral lung masses and nodules, suspicious for metastases. These demonstrate interval increase in size, for example spiculated lesions in the right upper lobe measuring 1.4 cm from previous 1.1 cm (se 401\16 vs prior 4\32) and middle lobe measuring 2.3 cm from previous 2.1 cm (se 401\46 vs prior 4\65) as well as increase in number for example new lesions at the right lung apex (0.3 cm, se 401\17-19). As before, some contain small calcifications while a few show cavitation. Stable tiny calcified granuloma in the superior segment of the left lower lobe. The central airways are patent. No significantly enlarged intra-thoracic node detected. The heart size is normal. Coronary arterial calcifications seen. No pleural or pericardial effusion. Imaged thyroid gland is unremarkable. ABDOMEN\PELVIS Prior CT KUB dated 11 Feb 2019 and CT abdomen\pelvis dated 19 Nov 2018 were reviewed. There are dilated fluid-filled small bowel loops measuring up to 5.5 cm in calibre. There is a transition point at a pelvic ileal loop (se 501\101, 503\44) where there is abrupt change in calibre. No obstructing mass seen at this transition site. Few other collapsed loops seen in the vicinity though no other convincing transition point is discerned. Several of the dilated small bowel loops appear to abut known peritoneal masses with some luminal narrowing at the left lower abdomen (se 501\95) and at the anterior abdomen (se 501\65). These along with other peritoneal deposit seen anterior to the aorta (se 501\73 vs prior 201\56) as well as deposit adjacent to the right distal ureter (se 501\104) appear largely stable. Focal soft tissue noted between the dilated proximal bowel in the upper abdomen (~2.0 cm, se 501\30) is indeterminate for another peritoneal deposit. Bowel wall enhancement is preserved. There is no free gas. No convincing pneumatosis intestinalis or portovenous gas. Small amount of ascites noted. The distal small bowel and large bowel are collapsed. Note made of prior high anterior resection and bilateral oopherectomy. Large bowel anastomotic site (se 501\96) is grossly unremarkable. Several small nodes are seen in the mesentery, more prominent than before and measuring up to 0.7 cm in short axis (se 501\60). Placement of a right ureteric stent with slight interval improvement in right hydroureteronephrosis. Left ureteric stent in situ with resolution of left hydronephrosis. Stable scarring of the left kidney related to chronic uropathy. Stable 2 cm cyst at the left renal upper pole. Other non-specific 1.2 cm hypodensity at the right renal midpole is stable. Distal ends of both ureteric stents seen within the under-distended urinary bladder. No focal hepatic lesion identified. The spleen, pancreas and adrenal glands are unremarkable. Mild mural thickening at the gallbladder fundus may be due to adenomyomatosis. No biliary dilatation noted. Atherosclerotic calcifications noted along the abdominal aorta and iliac vessels. Degenerative changes are seen in the visualized spine. Levoscoliosis of the lumbar spine noted. No destructive bony lesion identified. CONCLUSION 1. Small bowel obstruction with transition point at a pelvic ileal loop. This is probably due adhesions, seen in a background of peritoneal disease with several of the dilated loops abutting these. Small amount of ascites; no free gas or overt bowel ischaemia. While no definite second transition point is identified, there may be increased risk of closed loop obstruction - close clinical monitoring would be prudent. 2. New interloop soft tissue focus at the proximal bowel, indeterminate for a peritoneal deposit. Other peritoneal deposits appear largely stable. 3. Interval worsening of pulmonary metastases. 4. Bilateral ureteric stents in situ, with slight improvement inright hydronephrosis and resolution of left hydronephrosis. 5. Other findings as described above. Findings were discussed with ordering clinician Dr Sean Ong by Dr Tan Eu Jin on 26 Mar 2019 11.15 PM. Report Indicator: Further action or early intervention required Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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