# Row 7339

Visit Number: 1e750b84fefdb7457f03f2bb55325f871b1ed84c7a1b16f3c28b756bacb8d47e

Masked\_PatientID: 7326

Order ID: e354f1c09071fa47e8bd8a5fda51da9fa46bcc1e684bd48977c01795726905e1

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 01/2/2016 12:33

Line Num: 1

Text: HISTORY b/g acute undifferentiated leukemia (with neutropenic sepsis), spiking persistent fever with choletatic LFTs, TRO intraabdo/lung sepsis TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison is made to the prior CT study dated 29 June 2015. Note is made of the chest radiograph dated 29 January 2016. CHEST Right subclavian central venous catheter is seen with tip in the distal superior vena cava. The heart is enlarged. Triple-vessel coronary artery calcification is noted. There is interval development of moderate pericardial effusion with maximum depth of 1.8cm, increase in size of bilateral pleural effusions with adjacent passive atelectasis (right now larger than left), and diffuse subcutaneous fat stranding. This is likely related to cardiac failure or fluid overload. Multiple tiny nodules are seen in bilateral lungs, the largest in the left upper lobemeasuring 0.8 x 1.0 cm (series 7/40). These are predominantly peripheral in location. No cavitation or ground-glass halo is noted. These are likely infective in nature, specifically fungal. The central airways are patent. A 1.2cm left lower paratracheal node is noted (series 5/34). Other small volume nodes are seen in the mediastinum and hilum, likely reactive. The visualised thyroid and oesophagus are grossly unremarkable. ABDOMEN AND PELVIS Motion artefact limits evaluation of the abdomen and pelvis. A short segment loop of ileum in the peri-umbilical region shows mural thickening. There is adjacent fat stranding (series 8/77). No evidence of radio-opaque foreign body is seen in the vicinity of this focalinflammation. No discrete abscess, free intra-abdominal gas or significantly enlarged lymph node is noted. Trace ascites is seen (series 8/122). The stomach, small and large bowel are unremarkable in calibre and distribution. No focal suspicious hepatic lesion is seen. Mild periportal edema is seen. Uncomplicated tiny 0.2 cm gallbladder neck calculus is seen (series 8/42). The biliary tree is not dilated. The pancreas, spleen, adrenals are unremarkable. The kidneys show normal sizes and symmetrical enhancement. No solid renal lesion is seen. No hydronephrosis is detected. The urinary bladder is poorly distended and cannot be accurately assessed. The prostate and seminal vesicles are grossly unremarkable. No destructive bone lesion is seen. Prominent degenerative change is noted at L4-5. CONCLUSION Since the CT study of 29 Jun 2015, 1. Interval development of multiple scattered pulmonary nodules. In the given clinical context, these are likely fungal infection. 2. A short segment of ileum in the periumbilical region shows mural thickening with adjacent focal fat stranding. Findings are non-specific and could be infective/inflammatory. 3. Third space losses are likely related to cardiac failure or fluid overload. In particular, there is moderate pericardial effusion with maximum depth of 1.8cm. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: ebb0f11bc5c0de8491271eb333c1cc7766f9bdf360cec5f17d1e037367f7a5f8

Updated Date Time: 01/2/2016 16:24

## Layman Explanation

This radiology report discusses HISTORY b/g acute undifferentiated leukemia (with neutropenic sepsis), spiking persistent fever with choletatic LFTs, TRO intraabdo/lung sepsis TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison is made to the prior CT study dated 29 June 2015. Note is made of the chest radiograph dated 29 January 2016. CHEST Right subclavian central venous catheter is seen with tip in the distal superior vena cava. The heart is enlarged. Triple-vessel coronary artery calcification is noted. There is interval development of moderate pericardial effusion with maximum depth of 1.8cm, increase in size of bilateral pleural effusions with adjacent passive atelectasis (right now larger than left), and diffuse subcutaneous fat stranding. This is likely related to cardiac failure or fluid overload. Multiple tiny nodules are seen in bilateral lungs, the largest in the left upper lobemeasuring 0.8 x 1.0 cm (series 7/40). These are predominantly peripheral in location. No cavitation or ground-glass halo is noted. These are likely infective in nature, specifically fungal. The central airways are patent. A 1.2cm left lower paratracheal node is noted (series 5/34). Other small volume nodes are seen in the mediastinum and hilum, likely reactive. The visualised thyroid and oesophagus are grossly unremarkable. ABDOMEN AND PELVIS Motion artefact limits evaluation of the abdomen and pelvis. A short segment loop of ileum in the peri-umbilical region shows mural thickening. There is adjacent fat stranding (series 8/77). No evidence of radio-opaque foreign body is seen in the vicinity of this focalinflammation. No discrete abscess, free intra-abdominal gas or significantly enlarged lymph node is noted. Trace ascites is seen (series 8/122). The stomach, small and large bowel are unremarkable in calibre and distribution. No focal suspicious hepatic lesion is seen. Mild periportal edema is seen. Uncomplicated tiny 0.2 cm gallbladder neck calculus is seen (series 8/42). The biliary tree is not dilated. The pancreas, spleen, adrenals are unremarkable. The kidneys show normal sizes and symmetrical enhancement. No solid renal lesion is seen. No hydronephrosis is detected. The urinary bladder is poorly distended and cannot be accurately assessed. The prostate and seminal vesicles are grossly unremarkable. No destructive bone lesion is seen. Prominent degenerative change is noted at L4-5. CONCLUSION Since the CT study of 29 Jun 2015, 1. Interval development of multiple scattered pulmonary nodules. In the given clinical context, these are likely fungal infection. 2. A short segment of ileum in the periumbilical region shows mural thickening with adjacent focal fat stranding. Findings are non-specific and could be infective/inflammatory. 3. Third space losses are likely related to cardiac failure or fluid overload. In particular, there is moderate pericardial effusion with maximum depth of 1.8cm. Further action or early intervention required Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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