# Row 7398

Visit Number: f73c221aea2aff5f13e90f2a47516543c1a97b3b5b37812f28d50e1c8b4c2605

Masked\_PatientID: 7396

Order ID: f49a57a8faf0f84d0e02cdf5c8af38dd4562e7ccfe2afb1911cf51c2feb6f660

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 18/8/2016 18:46

Line Num: 1

Text: HISTORY L empyema s/p chest tube insertion. Not draining well from chest tube. To look at chest tube position before deciding for fibrinolytics or decortication TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Nil FINDINGS Prior CT thorax study of 17 Aug 2016 was reviewed. Interim insertion of left chest drain is noted with resultant subcutaneous emphysema in the left chest wall. The drain is directed cranially with its tip situated close to the mediastinum (205-47) and anterior to the collapsed left left lung. Of note, the side hole of the drain is applied against the collapsed left lung (205-49). The massive left pleural effusion is larger, and the left lung is completely collapsed. The lingula is again noted to be slightly more hyperdense, suggestive of consolidation. Small calcific foci around the collapsed left lung could represent calcified granulomas. Mild mediastinal shift to the right is largely unchanged. Gas pockets within the effusion are in keeping with submitted history of empyema. Some slightly hyperdense debris is noted. The right lung is unremarkable, save for minor scarring at the medial middle lobe. Stable prominent left supraclavicular, left lower paratracheal, para-aortic, sub-aortic and left retrocrural lymph nodes are likely reactive in nature. The previously noted elliptical appearing periesophageal soft tissue lesion appears grossly stable (202-45). It is inseparable from the oesophageal wall and the configuration is unusual for adenopathy. Small pericardial effusion is stable in extent. Bilateral gynaecomastia is noted. There is no destructive bone lesion. Within limits of non-enhanced study, the visualised upper abdomen is grossly unremarkable. CONCLUSION 1. Interim insertion of left chest drain. The drain is directed cranially and the tip lies close to the mediastinum. Of note, the side hole of the drain is applied against the collapse lung. This may account for poor drainage. Re-adjustment of drain is advised. 2. Massive effusion is larger but the mediastinal shift to the right is unchanged. Gas within the effusion is again seen, in keeping with submitted history of empyema. 3. Stable indeterminate elliptical soft tissue lesion closely related to the esophagus and inseparable from the esophageal wall. The shape is unusual for adenopathy and possibility of a submucosal esophageal mass cannot be excluded. Note: Dr Alex Tan Weixian was informed by Dr Cheong Wei Kiong on 18 Aug 2016 at 7:10 pm. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: d93f7acfdfb4de7b724ced6cf750f69d66ed9a4e96f828238afce445355c8285

Updated Date Time: 19/8/2016 9:24

## Layman Explanation

This radiology report discusses HISTORY L empyema s/p chest tube insertion. Not draining well from chest tube. To look at chest tube position before deciding for fibrinolytics or decortication TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Nil FINDINGS Prior CT thorax study of 17 Aug 2016 was reviewed. Interim insertion of left chest drain is noted with resultant subcutaneous emphysema in the left chest wall. The drain is directed cranially with its tip situated close to the mediastinum (205-47) and anterior to the collapsed left left lung. Of note, the side hole of the drain is applied against the collapsed left lung (205-49). The massive left pleural effusion is larger, and the left lung is completely collapsed. The lingula is again noted to be slightly more hyperdense, suggestive of consolidation. Small calcific foci around the collapsed left lung could represent calcified granulomas. Mild mediastinal shift to the right is largely unchanged. Gas pockets within the effusion are in keeping with submitted history of empyema. Some slightly hyperdense debris is noted. The right lung is unremarkable, save for minor scarring at the medial middle lobe. Stable prominent left supraclavicular, left lower paratracheal, para-aortic, sub-aortic and left retrocrural lymph nodes are likely reactive in nature. The previously noted elliptical appearing periesophageal soft tissue lesion appears grossly stable (202-45). It is inseparable from the oesophageal wall and the configuration is unusual for adenopathy. Small pericardial effusion is stable in extent. Bilateral gynaecomastia is noted. There is no destructive bone lesion. Within limits of non-enhanced study, the visualised upper abdomen is grossly unremarkable. CONCLUSION 1. Interim insertion of left chest drain. The drain is directed cranially and the tip lies close to the mediastinum. Of note, the side hole of the drain is applied against the collapse lung. This may account for poor drainage. Re-adjustment of drain is advised. 2. Massive effusion is larger but the mediastinal shift to the right is unchanged. Gas within the effusion is again seen, in keeping with submitted history of empyema. 3. Stable indeterminate elliptical soft tissue lesion closely related to the esophagus and inseparable from the esophageal wall. The shape is unusual for adenopathy and possibility of a submucosal esophageal mass cannot be excluded. Note: Dr Alex Tan Weixian was informed by Dr Cheong Wei Kiong on 18 Aug 2016 at 7:10 pm. 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.