# Row 7804

Visit Number: 76040dfc558e8268c65a94ade53c61854d75a9ba76c360a81315bd358849f638

Masked\_PatientID: 7803

Order ID: f2f99f27473d6b1d51e9e9bb494790d1826f9a8401c9fffa7ff39a4af87fdb30

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 11/1/2017 11:15

Line Num: 1

Text: HISTORY Sepsis presumed Gram negative / intra-abdominal to look for infective focus / collection / abscess; metastatic Ca galbladder on palliative chemo TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS The patient is known to NCC however no previous CT scan was available for comparison at the time of reporting. Previous MRI abdomen report performed at NCC on 29 Dec 2016 was reviewed on NEHR. THORAX Small bilateral pleural effusions right more than left. Diffuse interlobular septal thickening in both lungs suggests pulmonary interstitial oedema with associated prominent pulmonary vessels consistent with pulmonary venous congestion. Patchy non-specific ground-glass opacities in the right upper lobe (Se 501-35) are also noted. A few tiny nonspecific subpleural nodules are present e.g. left lower lobe (501-70) and lateral segment middle lobe (Se 501-64). Prominent borderlineenlarged mediastinal lymph nodes are present the largest in the right lower paratracheal region measures up to 1 cm in short axis (Se 502-27), indeterminate. No enlarged hilar, axillary or supra clavicular lymph node is detected. The heart is of normal size. No pericardial effusion. The central airways are patent and thyroid gland appears normal. ABDOMEN AND PELVIS There is an illdefined large lobulated heterogeneously enhancing mass with central necrosis centred in the region of the gallbladder fossa, this likely corresponds to the known gallbladder malignancy. Medially the mass is contiguous with the gastric antrum (Se 601-62), D1 and proximal D2 (Se 603-42). There is no evidence to suggest bowel obstruction. Laterally there is tumour extension into hepatic segment V with a contiguous large rim enhancing fluid collection (Se 601-52 to 54; 603-53) measuring approximately 36 x 45 x 22mm (601-52; 603-53). This is suggestive of a large necrotic abscess however it is difficult to delineate tumour from infection in this region. Other smaller rim enhancing collections, likely abscesses are seen e.g. in segment IVa/b measuring 29 x 39 x 30mm (Se 601-45; 603;61) and more inferiorly segment IVB (Se 601-51; 603-59) measuring 21 x 21 x19mm. A few other indeterminate hypodense lesions are seen for example in segment Iva (Se 601-35) 20 x 46mm, a smaller lesion in segment VII (Se 601-36) measuring 14 x 18mm and others in segment VI (Se 601-52), (601-62) and segment III (Se 601-43). A nonspecific calcific focus is noted in the hepatic dome (Se 601-24). Tiny gas pocket in hepatic segment II is non-specific. Small volume coeliac axis and left gastric nodes are noted. The hepatic and portal veins are patent. The spleen, pancreas and adrenal glands are unremarkable. The kidneys appear normal in size and parenchymal enhancement. There is no hydronephrosis. The urinary bladder is not distended with a Foley catheter in situ. The rest of the small and large bowel loops are normal in calibre. No focal colonic mass is detected. No retroperitoneal lymphadenopathy or ascites is identified. No peritoneal nodules are present. No destructive bone lesion is seen. CONCLUSION 1. Large necrotic tumour arising from the gallbladder fossa, most likely corresponds to the known primary malignancy. There is tumour extension to hepatic segment V, IV, D1 of duodenum, proximal D2 and gastric antrum. In the liver the tumour is contiguous with a large rim enhancing fluid collection in segment V this may represent a combination of both tumour infiltration and infection. Other smaller rim enhancing fluid collections in segment V/IV are likely abscesses. 2. Multipleother indeterminate hypodense lesions scattered in the liver are suspicious for metastases. Small volume celiac and left gastric nodes. 3. Small bilateral pleural effusions, mild pulmonary oedema and venous congestion in both lungs. A few tiny nonspecific subpleural pulmonary nodules in both lower lobes. Dr Chan Jack was informed of the above findings by Dr Vimbai Chekenyere at 2:00 p.m. 11 Jan 2017. Read back obtained Further action or early intervention required Reported by: <DOCTOR>

Accession Number: b041c8a967c41c452425016ab618e6e4fe510eb54be434ceeecb589e49ac54a2

Updated Date Time: 11/1/2017 17:42

## Layman Explanation

This radiology report discusses HISTORY Sepsis presumed Gram negative / intra-abdominal to look for infective focus / collection / abscess; metastatic Ca galbladder on palliative chemo TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS The patient is known to NCC however no previous CT scan was available for comparison at the time of reporting. Previous MRI abdomen report performed at NCC on 29 Dec 2016 was reviewed on NEHR. THORAX Small bilateral pleural effusions right more than left. Diffuse interlobular septal thickening in both lungs suggests pulmonary interstitial oedema with associated prominent pulmonary vessels consistent with pulmonary venous congestion. Patchy non-specific ground-glass opacities in the right upper lobe (Se 501-35) are also noted. A few tiny nonspecific subpleural nodules are present e.g. left lower lobe (501-70) and lateral segment middle lobe (Se 501-64). Prominent borderlineenlarged mediastinal lymph nodes are present the largest in the right lower paratracheal region measures up to 1 cm in short axis (Se 502-27), indeterminate. No enlarged hilar, axillary or supra clavicular lymph node is detected. The heart is of normal size. No pericardial effusion. The central airways are patent and thyroid gland appears normal. ABDOMEN AND PELVIS There is an illdefined large lobulated heterogeneously enhancing mass with central necrosis centred in the region of the gallbladder fossa, this likely corresponds to the known gallbladder malignancy. Medially the mass is contiguous with the gastric antrum (Se 601-62), D1 and proximal D2 (Se 603-42). There is no evidence to suggest bowel obstruction. Laterally there is tumour extension into hepatic segment V with a contiguous large rim enhancing fluid collection (Se 601-52 to 54; 603-53) measuring approximately 36 x 45 x 22mm (601-52; 603-53). This is suggestive of a large necrotic abscess however it is difficult to delineate tumour from infection in this region. Other smaller rim enhancing collections, likely abscesses are seen e.g. in segment IVa/b measuring 29 x 39 x 30mm (Se 601-45; 603;61) and more inferiorly segment IVB (Se 601-51; 603-59) measuring 21 x 21 x19mm. A few other indeterminate hypodense lesions are seen for example in segment Iva (Se 601-35) 20 x 46mm, a smaller lesion in segment VII (Se 601-36) measuring 14 x 18mm and others in segment VI (Se 601-52), (601-62) and segment III (Se 601-43). A nonspecific calcific focus is noted in the hepatic dome (Se 601-24). Tiny gas pocket in hepatic segment II is non-specific. Small volume coeliac axis and left gastric nodes are noted. The hepatic and portal veins are patent. The spleen, pancreas and adrenal glands are unremarkable. The kidneys appear normal in size and parenchymal enhancement. There is no hydronephrosis. The urinary bladder is not distended with a Foley catheter in situ. The rest of the small and large bowel loops are normal in calibre. No focal colonic mass is detected. No retroperitoneal lymphadenopathy or ascites is identified. No peritoneal nodules are present. No destructive bone lesion is seen. CONCLUSION 1. Large necrotic tumour arising from the gallbladder fossa, most likely corresponds to the known primary malignancy. There is tumour extension to hepatic segment V, IV, D1 of duodenum, proximal D2 and gastric antrum. In the liver the tumour is contiguous with a large rim enhancing fluid collection in segment V this may represent a combination of both tumour infiltration and infection. Other smaller rim enhancing fluid collections in segment V/IV are likely abscesses. 2. Multipleother indeterminate hypodense lesions scattered in the liver are suspicious for metastases. Small volume celiac and left gastric nodes. 3. Small bilateral pleural effusions, mild pulmonary oedema and venous congestion in both lungs. A few tiny nonspecific subpleural pulmonary nodules in both lower lobes. Dr Chan Jack was informed of the above findings by Dr Vimbai Chekenyere at 2:00 p.m. 11 Jan 2017. Read back obtained 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.