# Row 7811

Visit Number: 76040dfc558e8268c65a94ade53c61854d75a9ba76c360a81315bd358849f638

Masked\_PatientID: 7803

Order ID: 4f247decd3ccd7d63735418bb02e8cac2a8d8eaca646003d890690f7f4cfa382

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 30/1/2017 10:59

Line Num: 1

Text: HISTORY met gallbladder CA with duodenal infilatraion repeating CT to look assess liver abscess after 3/52 IV abx TECHNIQUE Scans of the thorax, abdomen and pelvis were acquired after the administration of intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison was made with the CT study dated 11/1/17. Tip of the right sided central venous catheter is in the right atrium. Previously noted interlobular septal thickening and engorged pulmonary vessels are less prominent in appearance now, indicating interval improvement in the patient’s pulmonary venous congestion. There is also interval reduction in size of the bilateral pleural effusions with only minimal amount remaining bilaterally. The previously identified pulmonary nodule in the lateral segment of the middle lobe is no longer appreciated in this study. The nodule in the left lower lobe (Se 401-69) is slightly less prominent and measures 3mm in size compared to 4mm previously. No new pulmonary nodule or consolidation is detected. Mild scarring is seen at the lung apices. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. The heart is normal in size. No pericardial effusion is seen. A lobulated ill-defined heterogeneous mass with central necrosis is again visualized in the gallbladder fossa which invades into segments V and IVB of the liver. This mass has increased in size since the previous studyand now measures approximately 11.2 x 9.0 x 7.1 cm in size. The extent of hepatic invasion appears to have worsened. The mass is inseparable from antro-pyloric region of stomach, D1, proximal D2, the hepatic flexure of colon. There is evidence of gastric outlet obstruction and resultant distention of the stomach. A feeding tube is seen coiled within the stomach, with its tip in the distal stomach. The 2.2 x 2.3 x 2.9 cm rim-enhancing collection in the segment IVa/b (Se 501-32) is smaller in size and its internal gas pockets have resolved. There are a few other non-specific hypodense lesions in the liver ( for example, segment VI – Se 501-22 and 42) which are largely stable in size although the lesion in the caudate lobe (Se 501-20) is more prominent in appearance. Stable calcification is again noted at the hepatic dome. There is again some perihepatic fat stranding. Worsening periportal lymphadenopathy (Se 501-39) is noted, causing compression of the main portal vein. There are also a few prominent paraceliac lymph nodes. The spleen, pancreas, adrenal glands and kidneys appear unremarkable. The prostate gland show normal features. Dependent debris is noted in the urinary bladder, although mural thickening at the posterior wall cannot be excluded. Colonic diverticulosis is noted, most prominent in the sigmoid colon, with no associated inflammatory changes. No free intraperitoneal fluid is detected. No destructive bony lesion is seen. CONCLUSION Since the recent CT of 11/01/17, 1. The large necrotic tumour originating from the gallbladder fossa has increased in size, with worsening hepatic invasion. There is also evidence of gastric outlet obstruction now. The abscesscollection in segment IVa/b of the liver is smaller now. A few other stable/more prominent hypodense liver lesions, probably metastatic deposits. 2. Worsening periportal lymphadenopathy. 3. Interval improvement in the pulmonary venous congestion and bilateral pleural effusions. May need further action Reported by: <DOCTOR>

Accession Number: c93b6b6978abd7d664cda05326314eee990876ac87a5fff0f954475826b12887

Updated Date Time: 31/1/2017 12:02

## Layman Explanation

This radiology report discusses HISTORY met gallbladder CA with duodenal infilatraion repeating CT to look assess liver abscess after 3/52 IV abx TECHNIQUE Scans of the thorax, abdomen and pelvis were acquired after the administration of intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison was made with the CT study dated 11/1/17. Tip of the right sided central venous catheter is in the right atrium. Previously noted interlobular septal thickening and engorged pulmonary vessels are less prominent in appearance now, indicating interval improvement in the patient’s pulmonary venous congestion. There is also interval reduction in size of the bilateral pleural effusions with only minimal amount remaining bilaterally. The previously identified pulmonary nodule in the lateral segment of the middle lobe is no longer appreciated in this study. The nodule in the left lower lobe (Se 401-69) is slightly less prominent and measures 3mm in size compared to 4mm previously. No new pulmonary nodule or consolidation is detected. Mild scarring is seen at the lung apices. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. The heart is normal in size. No pericardial effusion is seen. A lobulated ill-defined heterogeneous mass with central necrosis is again visualized in the gallbladder fossa which invades into segments V and IVB of the liver. This mass has increased in size since the previous studyand now measures approximately 11.2 x 9.0 x 7.1 cm in size. The extent of hepatic invasion appears to have worsened. The mass is inseparable from antro-pyloric region of stomach, D1, proximal D2, the hepatic flexure of colon. There is evidence of gastric outlet obstruction and resultant distention of the stomach. A feeding tube is seen coiled within the stomach, with its tip in the distal stomach. The 2.2 x 2.3 x 2.9 cm rim-enhancing collection in the segment IVa/b (Se 501-32) is smaller in size and its internal gas pockets have resolved. There are a few other non-specific hypodense lesions in the liver ( for example, segment VI – Se 501-22 and 42) which are largely stable in size although the lesion in the caudate lobe (Se 501-20) is more prominent in appearance. Stable calcification is again noted at the hepatic dome. There is again some perihepatic fat stranding. Worsening periportal lymphadenopathy (Se 501-39) is noted, causing compression of the main portal vein. There are also a few prominent paraceliac lymph nodes. The spleen, pancreas, adrenal glands and kidneys appear unremarkable. The prostate gland show normal features. Dependent debris is noted in the urinary bladder, although mural thickening at the posterior wall cannot be excluded. Colonic diverticulosis is noted, most prominent in the sigmoid colon, with no associated inflammatory changes. No free intraperitoneal fluid is detected. No destructive bony lesion is seen. CONCLUSION Since the recent CT of 11/01/17, 1. The large necrotic tumour originating from the gallbladder fossa has increased in size, with worsening hepatic invasion. There is also evidence of gastric outlet obstruction now. The abscesscollection in segment IVa/b of the liver is smaller now. A few other stable/more prominent hypodense liver lesions, probably metastatic deposits. 2. Worsening periportal lymphadenopathy. 3. Interval improvement in the pulmonary venous congestion and bilateral pleural effusions. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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