# Row 8655

Visit Number: f6cb16b93cff00af6bcabb4c2a47ecc09fc6d8d41acc157813f13d4a8cdd282b

Masked\_PatientID: 8648

Order ID: b083041978889eab89bda845afef408b355e23089795f89bb1012b7ab265b36c

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 06/8/2019 13:37

Line Num: 1

Text: HISTORY ESRF prev graft collection s/p drain - now with left lung nodule for f/u TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison made with CT KUB of 4/6/2019.No comparison CT thorax available. ABDOMEN AND PELVIS The transplant kidney in the right iliac fossa shows uniform parenchymal enhancement with no areas of striated hypoenhancement. There is thinning of the cortex but with preservation of thevolume in the lower pole medially. Stable fatty proliferation in the renal sinus. No hydronephrosis or transplant renal stone. The transplant renal pelvis again shows diffuse smooth urothelial thickening, likely inflammatory. The transplant renal vein and artery are patent. A stable 5 mm hypodensity at the anterior aspect of the mid transplant kidney (501-106) correspond to a previous cyst on MRI. A new 4 mm hypodensity slightly more inferiorly (501-115) possibly represent another cyst. No suspicious mass noted in the transplant kidney. Stable mild perinephric stranding. Status post percutaneous drainage of 7/6/2019. The fluid collection at the inner aspect of the right lower abdominal wall adjacent to the transplant kidney again show rim enhancement, in keeping with inflammation. There is interval decrease in size from previous 70 x 20 mm to now 40 x 10 mm (501-107). No new collection is seen. The native kidneys are small, with numerous cysts measuring up to 45 mm on the right. At the lateral aspect of the left mid lower kidney, there is again a 19 mm exophytic focus showing increased attenuation of 50 HU which is of similar attenuation to the non-contrast CT of Jun 2019, also with increased T1W signal on last MRI, likely hyperdense cyst. Extensive vascular calcifications are noted. The urinary bladder is collapsed, limiting assessment. There appears to be increased mucosal enhancement and thickening especially at the anterior aspect (501-131) which is nonspecific. The prostate is mildly enlarged with no abscess. Seminal vesicles are unremarkable. No suspicious focal hepatic lesion detected. No biliary obstruction discerned. Portal and hepatic veins enhance normally. The gallbladder shows fundal adenomyomatosis. The pancreas, spleen, and adrenals are unremarkable. There is interval long segment thickening of the ascending and transverse colon with prominence of the adjacent vasa recta, likely due to colitis. The rest of the bowel is of normal calibre and distribution, with no focal mass or abnormal thickening. Stable ovoid focus with fat and calcification at the right paracolic gutter (501-82, 503-62) is probably sequel of previous epiploic appendagitis.No free air or ascites seen. THORAX AND BONES Cardiomegaly with a sliver of pericardial effusion is noted. No pleural effusions seen. Mediastinal vasculature enhance normally. A few borderline prominent right hilar nodes are noted up to 8mm(402-50). Aortic and coronary calcifications are present. Nonspecific thyroid hypodensities noted. No lung mass or sinister nodule is noted. There is no consolidation or discrete ground-glass lesion. No interstitial fibrosis, bronchiectasis oremphysema is evident. Major airways are patent. On the right, a 4 mm nodule with central coarse calcification in posterior right apex (401-20) is likely a granuloma. There is adjacent bronchial wall thickening (401-23) as well as a few othernonspecific opacities in the same lobe (401-34). Another 3 mm nodule in the middle lobe (41-56) appears triangular and geographic on coronal view (405-67) with another similar focus also in right lower lobe (401-48). On the left, there is another two 3-4 mm ovoid or rectangular foci in subpleural left lower lobe (401-68, 63) which may be related to airway. Small focus of subpleural atelectasis also noted in the same lobe (401-72). Another focus likely representing atelectasis located more posterior was previously seen (last CT 2-3) and now resolved. A few 3 mm ill-defined opacities in the left upper lobe (401-25, 35) appear flat on coronal view (405-22, 58). L4/5 spondylosis noted. No destructive bony lesion is seen. CONCLUSION Since last CT of Jun 2019, 1. Atrophic native kidneys with transplant kidney in the right iliac fossa again showing cortical thinning. No hydronephrosis noted. Smooth urothelial thickening of the transplant renal pelvis is likely inflammatory and is unchanged from before. Interval decrease of the abdominal wall collection adjacent to the transplant kidney post drainage on 7/6/2019. No new collection is noted. 2. The urinary bladder is collapsed and suboptimal for assessment. However there appears to be mucosal thickening especially in the anterior aspect which may be inflammatory but should be followed up given past history of TURBT. Ultrasound when the urinary bladder is distended may be useful. 3. Interval right-sided colitis. No free air noted. 4. Previous focus in left lower lobe appears resolved but with another focus seen more anteriorly, probably due to atelectasis. Several non-specific nodules without overtly suspicious morphology are noted bilaterally, possibly post infective in nature. Interval follow-up to asses stability can be considered. 5. Other minor findings as described. Report Indicator: May need further action Finalised by: <DOCTOR>

Accession Number: 17813df50fb7d19a1ea25a9a584663687288af3ddac06504ff54630a2597fc0b

Updated Date Time: 06/8/2019 15:13

## Layman Explanation

This radiology report discusses HISTORY ESRF prev graft collection s/p drain - now with left lung nodule for f/u TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison made with CT KUB of 4/6/2019.No comparison CT thorax available. ABDOMEN AND PELVIS The transplant kidney in the right iliac fossa shows uniform parenchymal enhancement with no areas of striated hypoenhancement. There is thinning of the cortex but with preservation of thevolume in the lower pole medially. Stable fatty proliferation in the renal sinus. No hydronephrosis or transplant renal stone. The transplant renal pelvis again shows diffuse smooth urothelial thickening, likely inflammatory. The transplant renal vein and artery are patent. A stable 5 mm hypodensity at the anterior aspect of the mid transplant kidney (501-106) correspond to a previous cyst on MRI. A new 4 mm hypodensity slightly more inferiorly (501-115) possibly represent another cyst. No suspicious mass noted in the transplant kidney. Stable mild perinephric stranding. Status post percutaneous drainage of 7/6/2019. The fluid collection at the inner aspect of the right lower abdominal wall adjacent to the transplant kidney again show rim enhancement, in keeping with inflammation. There is interval decrease in size from previous 70 x 20 mm to now 40 x 10 mm (501-107). No new collection is seen. The native kidneys are small, with numerous cysts measuring up to 45 mm on the right. At the lateral aspect of the left mid lower kidney, there is again a 19 mm exophytic focus showing increased attenuation of 50 HU which is of similar attenuation to the non-contrast CT of Jun 2019, also with increased T1W signal on last MRI, likely hyperdense cyst. Extensive vascular calcifications are noted. The urinary bladder is collapsed, limiting assessment. There appears to be increased mucosal enhancement and thickening especially at the anterior aspect (501-131) which is nonspecific. The prostate is mildly enlarged with no abscess. Seminal vesicles are unremarkable. No suspicious focal hepatic lesion detected. No biliary obstruction discerned. Portal and hepatic veins enhance normally. The gallbladder shows fundal adenomyomatosis. The pancreas, spleen, and adrenals are unremarkable. There is interval long segment thickening of the ascending and transverse colon with prominence of the adjacent vasa recta, likely due to colitis. The rest of the bowel is of normal calibre and distribution, with no focal mass or abnormal thickening. Stable ovoid focus with fat and calcification at the right paracolic gutter (501-82, 503-62) is probably sequel of previous epiploic appendagitis.No free air or ascites seen. THORAX AND BONES Cardiomegaly with a sliver of pericardial effusion is noted. No pleural effusions seen. Mediastinal vasculature enhance normally. A few borderline prominent right hilar nodes are noted up to 8mm(402-50). Aortic and coronary calcifications are present. Nonspecific thyroid hypodensities noted. No lung mass or sinister nodule is noted. There is no consolidation or discrete ground-glass lesion. No interstitial fibrosis, bronchiectasis oremphysema is evident. Major airways are patent. On the right, a 4 mm nodule with central coarse calcification in posterior right apex (401-20) is likely a granuloma. There is adjacent bronchial wall thickening (401-23) as well as a few othernonspecific opacities in the same lobe (401-34). Another 3 mm nodule in the middle lobe (41-56) appears triangular and geographic on coronal view (405-67) with another similar focus also in right lower lobe (401-48). On the left, there is another two 3-4 mm ovoid or rectangular foci in subpleural left lower lobe (401-68, 63) which may be related to airway. Small focus of subpleural atelectasis also noted in the same lobe (401-72). Another focus likely representing atelectasis located more posterior was previously seen (last CT 2-3) and now resolved. A few 3 mm ill-defined opacities in the left upper lobe (401-25, 35) appear flat on coronal view (405-22, 58). L4/5 spondylosis noted. No destructive bony lesion is seen. CONCLUSION Since last CT of Jun 2019, 1. Atrophic native kidneys with transplant kidney in the right iliac fossa again showing cortical thinning. No hydronephrosis noted. Smooth urothelial thickening of the transplant renal pelvis is likely inflammatory and is unchanged from before. Interval decrease of the abdominal wall collection adjacent to the transplant kidney post drainage on 7/6/2019. No new collection is noted. 2. The urinary bladder is collapsed and suboptimal for assessment. However there appears to be mucosal thickening especially in the anterior aspect which may be inflammatory but should be followed up given past history of TURBT. Ultrasound when the urinary bladder is distended may be useful. 3. Interval right-sided colitis. No free air noted. 4. Previous focus in left lower lobe appears resolved but with another focus seen more anteriorly, probably due to atelectasis. Several non-specific nodules without overtly suspicious morphology are noted bilaterally, possibly post infective in nature. Interval follow-up to asses stability can be considered. 5. Other minor findings as described. Report Indicator: May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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