# Row 8699

Visit Number: ee3fc7c2c53cccb33776934addb14ef82899d31d406a9e7d25aa31748506a245

Masked\_PatientID: 8677

Order ID: 755470051069e0467137da3744d865b03e3344539dba212db7b0e047f84061d5

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 06/7/2018 16:24

Line Num: 1

Text: HISTORY right pleural effusion likely related to fluid overload but in view of Hb drop and prior history of bloody effusion (not hemothorax) TECHNIQUE Scans of the thorax were acquired after the administration of Intravenous contrast: Omnipaque 350 Contrast volume (ml): 50 FINDINGS Comparison made with the last CT scan of 18 Jun 2018. The loculated right pleural effusion shows interval decrease in size. Loculated fluid is seen tracking along the horizontal and oblique fissures. Compressive atelectasis of the right lower lobe is unchanged while there is increased aeration in the right upper lobe. Within the pleural effusion, there are areas of high attenuation (HU~55), raising suspicion of blood products. Small focus of consolidation in the left upper lobe may represent infective change (6-29). Stable 0.5 cm nodule in the left upper lobe is noted (curr 6-23, prev 401-26). There is increased subcutaneous oedema in the bilateral chest wall, right more than left. There are borderline right paratracheal lymph nodes measuring up to 0.8cm in short axis diameter (5-18), probably reactive. There is possible stenosis at the insertion of the right brachiocephalic vein (7-51) there isalso a tiny focus of calcification previously present as well. The well-defined ovoid filling defect in the proximal right brachiocephalic vein just upstream to the site of possible stenosis raises the possibility of a small thrombus. Cardiomegaly is evident. No pericardial effusion is seen. There are extensive coronary artery calcifications. A calcified nodule is noted in the thyroid isthmus. In the limited sections of the upper abdomen, the partially imaged gallbladder reveals mural oedema. The partially imaged left kidney is noted to be atrophic and scarred. Old T12 compression fracture is again noted. CONCLUSION The loculated right pleural effusion has decreased in size. Within the pleural effusion, there are again areas of high attenuation, raising suspicion of blood products, of indeterminate age. Suggest clinical assessment to rule out repeated bleeding. Diffuse subcutaneous oedema and gallbladder mural oedema may be related to fluid overload status/third spacing of fluid. There is possible stenosis at the ostium of the right brachiocephalic vein. An ovoid filling defect in the proximal right brachiocephalic vein just upstream to the site of possible stenosis raises the possibility of a small thrombus. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: 88d66a0febff89239db4bdae00615c235b68d543ca7c08f392f37a8f2c75aa95

Updated Date Time: 06/7/2018 18:19

## Layman Explanation

This radiology report discusses HISTORY right pleural effusion likely related to fluid overload but in view of Hb drop and prior history of bloody effusion (not hemothorax) TECHNIQUE Scans of the thorax were acquired after the administration of Intravenous contrast: Omnipaque 350 Contrast volume (ml): 50 FINDINGS Comparison made with the last CT scan of 18 Jun 2018. The loculated right pleural effusion shows interval decrease in size. Loculated fluid is seen tracking along the horizontal and oblique fissures. Compressive atelectasis of the right lower lobe is unchanged while there is increased aeration in the right upper lobe. Within the pleural effusion, there are areas of high attenuation (HU~55), raising suspicion of blood products. Small focus of consolidation in the left upper lobe may represent infective change (6-29). Stable 0.5 cm nodule in the left upper lobe is noted (curr 6-23, prev 401-26). There is increased subcutaneous oedema in the bilateral chest wall, right more than left. There are borderline right paratracheal lymph nodes measuring up to 0.8cm in short axis diameter (5-18), probably reactive. There is possible stenosis at the insertion of the right brachiocephalic vein (7-51) there isalso a tiny focus of calcification previously present as well. The well-defined ovoid filling defect in the proximal right brachiocephalic vein just upstream to the site of possible stenosis raises the possibility of a small thrombus. Cardiomegaly is evident. No pericardial effusion is seen. There are extensive coronary artery calcifications. A calcified nodule is noted in the thyroid isthmus. In the limited sections of the upper abdomen, the partially imaged gallbladder reveals mural oedema. The partially imaged left kidney is noted to be atrophic and scarred. Old T12 compression fracture is again noted. CONCLUSION The loculated right pleural effusion has decreased in size. Within the pleural effusion, there are again areas of high attenuation, raising suspicion of blood products, of indeterminate age. Suggest clinical assessment to rule out repeated bleeding. Diffuse subcutaneous oedema and gallbladder mural oedema may be related to fluid overload status/third spacing of fluid. There is possible stenosis at the ostium of the right brachiocephalic vein. An ovoid filling defect in the proximal right brachiocephalic vein just upstream to the site of possible stenosis raises the possibility of a small thrombus. 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.