# Row 95

Visit Number: 17db1aa46bfecdb785fbd61d43ba37e8f4695b529e456ae3eff3cfeaee661a40

Masked\_PatientID: 87

Order ID: 823dacea5b3968dfdb5920e7bc794328bc1381de2d0a53239fcb585b6ec33644

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 21/6/2016 15:39

Line Num: 1

Text: HISTORY Lung abscess because of Oesophageal SCC Completing 4 weeks of antibiotics and has newly developed ascites. to restage patient and assess lung abscess TECHNIQUE Contrast-enhanced CT chest, abdomen and pelvis was performed. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS The prior CT chest of 23/05/2016 and CT chest, abdomen and pelvis of 26/02/16 were reviewed. Tip of the feeding tube is within the third segment of the duodenum. Tip of the right PICC is near the cavoatrial junction. While accurate comparison is not possible, the known distal oesophageal tumour appears slightly more bulkier in the interim (Se 9-62). There has been interval drainage of the right lung abscess. A thin residual rim-enhancing loculated collection is seen along the posterior aspect of right lung, measuring up to 1.3 cm in thickness. A few gas locules are present within the collection. A loculated component of the right pleural effusion along the major fissure (axial dimensions 5 x 1.9 cm, Se 9-44) also shows rim-enhancement and is continuous with the aforementioned collection. Mild worsening of the bilateral pleural effusions is seen. Compressive atelectatic changes/patchy consolidation are again seen in both lower lobes. Nonspecific ground-glass changes are present in the left upper lobe. A few prominent/mildly enlarged right hilar and mediastinal nodes are again seen. Borderline enlarged right supraclavicular node as well. Minimal pericardial effusion is present. There is a large amount of free fluid in the abdomen and pelvis. The liver is cirrhotic. A stable 1.2 cm hypodense nodule is seen in segment VIII (Se 6-29). No other liver nodule is identified. No radiodense gallstones are seen. The biliary tree is not dilated. Gastro-oesophageal varices are seen. The spleen, pancreas, adrenals and kidneys show no significant abnormality. The partially distended urinary bladder is grossly unremarkable. The prostate is mildly enlarged. The bowel loops are normal in calibre. New/larger gastro-hepatic nodes, the largest being a necrotic node measuring 2.2 x 1.5 cm(Se 6-40). No enlarged para-aortic or pelvic lymph node is seen. No destructive bony lesion is detected. Extensive subcutaneous stranding is present. CONCLUSION 1. There has been interval drainage of the right lung abscess collection. A thin residual rim-enhancing loculated fluid collection is presentalong the posterior aspect of right lung. This is continuous with a loculated component of right pleural effusion along the major fissure. 2. Mild worsening of the bilateral pleural effusions. 3. The known distal oesophageal tumour appearsslightly more bulkier in the interim. 4. Stable intra-thoracic lymphadenopathy. New/larger gastro-hepatic nodes, the largest node appearing necrotic. 5. Cirrhotic liver, with a stable nodule in segment VIII. Gastro-oesophageal varices are seen. 6. Large amount of ascites. Extensive subcutaneous stranding is also seen, suggestive of fluid overload state. May need further action Reported by: <DOCTOR>

Accession Number: 5e2b9808421586cfaa46d1efc87424bf65f6ebc20746eb6ef2124c0262961b5b

Updated Date Time: 21/6/2016 17:08

## Layman Explanation

This radiology report discusses HISTORY Lung abscess because of Oesophageal SCC Completing 4 weeks of antibiotics and has newly developed ascites. to restage patient and assess lung abscess TECHNIQUE Contrast-enhanced CT chest, abdomen and pelvis was performed. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS The prior CT chest of 23/05/2016 and CT chest, abdomen and pelvis of 26/02/16 were reviewed. Tip of the feeding tube is within the third segment of the duodenum. Tip of the right PICC is near the cavoatrial junction. While accurate comparison is not possible, the known distal oesophageal tumour appears slightly more bulkier in the interim (Se 9-62). There has been interval drainage of the right lung abscess. A thin residual rim-enhancing loculated collection is seen along the posterior aspect of right lung, measuring up to 1.3 cm in thickness. A few gas locules are present within the collection. A loculated component of the right pleural effusion along the major fissure (axial dimensions 5 x 1.9 cm, Se 9-44) also shows rim-enhancement and is continuous with the aforementioned collection. Mild worsening of the bilateral pleural effusions is seen. Compressive atelectatic changes/patchy consolidation are again seen in both lower lobes. Nonspecific ground-glass changes are present in the left upper lobe. A few prominent/mildly enlarged right hilar and mediastinal nodes are again seen. Borderline enlarged right supraclavicular node as well. Minimal pericardial effusion is present. There is a large amount of free fluid in the abdomen and pelvis. The liver is cirrhotic. A stable 1.2 cm hypodense nodule is seen in segment VIII (Se 6-29). No other liver nodule is identified. No radiodense gallstones are seen. The biliary tree is not dilated. Gastro-oesophageal varices are seen. The spleen, pancreas, adrenals and kidneys show no significant abnormality. The partially distended urinary bladder is grossly unremarkable. The prostate is mildly enlarged. The bowel loops are normal in calibre. New/larger gastro-hepatic nodes, the largest being a necrotic node measuring 2.2 x 1.5 cm(Se 6-40). No enlarged para-aortic or pelvic lymph node is seen. No destructive bony lesion is detected. Extensive subcutaneous stranding is present. CONCLUSION 1. There has been interval drainage of the right lung abscess collection. A thin residual rim-enhancing loculated fluid collection is presentalong the posterior aspect of right lung. This is continuous with a loculated component of right pleural effusion along the major fissure. 2. Mild worsening of the bilateral pleural effusions. 3. The known distal oesophageal tumour appearsslightly more bulkier in the interim. 4. Stable intra-thoracic lymphadenopathy. New/larger gastro-hepatic nodes, the largest node appearing necrotic. 5. Cirrhotic liver, with a stable nodule in segment VIII. Gastro-oesophageal varices are seen. 6. Large amount of ascites. Extensive subcutaneous stranding is also seen, suggestive of fluid overload state. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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