# Row 950

Visit Number: 7fc8e327f8bc3633ded23b044e7fdb65c423da479a79977c937543f21b0af0ad

Masked\_PatientID: 948

Order ID: 924869628abdbfa19db0c3bc0ca0f1c7eb78357e0ca8e0fbada8d4c5cc5e3698

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 25/4/2016 19:11

Line Num: 1

Text: HISTORY ICU case - admitted for thrombotic thrombocytopenic purpura with renal exophytic mass seen on renal ultrasound to do a CT for workup ? paraneoplastic vs autoimmune thrombotic thrombocytopenic purpura TECHNIQUE CT of the abdomen pelvis was obtained after administering oral contrast. Intravenous contrast was not administered in view of the renal impairment. FINDINGS Ultrasound kidneys dated 21/04/2016 was reviewed. Bilateral moderate pleural effusions withcompressive atelectasis in the lower lobes are noted. The adjacent lower lobes show mild atelectasis as well as bronchial wall thickening, linear and patchy ground-glass opacities. Patchy ground-glass opacities are also seen scattered in the upper lobes and middle lobe bilaterally. There is no discrete pulmonary nodule, dense consolidation or cavitation. Positions of the endotracheal tube and right IJ central venous catheter are satisfactory. Nasogastric tube is also in situ withtip in the stomach. Moderate pericardial effusion also noted. Increased attenuation of the mediastinal fat is seen. No lymphadenopathy is detected. No contour deforming focal lesion is noted in the liver, spleen and the pancreas. Increased density noted within the gallbladder may suggest sludge. Pericholecystic fluid is also noted. No evidence of CBD dilatation. The bilateral adrenal glands are unremarkable. The lesion of concern in the right kidney noted in the upper pole, partly exophytic measuring about 3.2 X 2.6 X 2.2 cm (craniocaudal x transverse x AP). It has attenuation value of about 35 HU and demonstrates hyperdensity in its anterior aspect. It cannot be characterised further in this noncontrast study. There are no significantly enlarged para-aortic lymph nodes. No evidence of calculus or hydronephrosis on either side. The catheterised bladder is empty. The bowel loops are normal in calibre and distribution. However few loops of small wall demonstrate mild mural oedema (201/1 16). Few uncomplicated colonic diverticula are also observed. Increased attenuation of the mesenteric fat and nonspecific presacral soft tissue density noted. Small amount of free fluid is noted in the pelvis. No destructive bony lesion is seen in the chest or in the abdomen. CONCLUSION 1. There is an isodense partly exophytic nodule in the right renal upper pole and cannot be characterised further in this noncontrast study. The differential diagnoses include a hyperdense cyst and a neoplastic lesion. 2. Bilateral moderate pleural effusions, pericardial effusion, pericholecystic fluid, small amount of fluid in the pelvis, subcutaneous oedema are attributed to systemic cause like hypoproteinaemia or fluid overload. 3. The lungs show patchy linear and ground-glass opacities mainly in the lower lobes associated with bronchial wall thickening. The appearances may be due to pulmonary oedema or atypical infection in the acute setting. I note the chest radiograph dated 22/02/2016 showing bilateral lower zone patchy opacities with volume loss, which raise the possibility of underlying interstitial lung disease. However, this is difficult to assess on this CT in view of the superimposed acute changes. If clinically appropriate, consider follow-up HRCT following this acute episode. May need further action Reported by: <DOCTOR>

Accession Number: 7c46d8b5aec275367245fc07e4a4401bd55c69649ad07e123516e12155164b78

Updated Date Time: 26/4/2016 10:02

## Layman Explanation

This radiology report discusses HISTORY ICU case - admitted for thrombotic thrombocytopenic purpura with renal exophytic mass seen on renal ultrasound to do a CT for workup ? paraneoplastic vs autoimmune thrombotic thrombocytopenic purpura TECHNIQUE CT of the abdomen pelvis was obtained after administering oral contrast. Intravenous contrast was not administered in view of the renal impairment. FINDINGS Ultrasound kidneys dated 21/04/2016 was reviewed. Bilateral moderate pleural effusions withcompressive atelectasis in the lower lobes are noted. The adjacent lower lobes show mild atelectasis as well as bronchial wall thickening, linear and patchy ground-glass opacities. Patchy ground-glass opacities are also seen scattered in the upper lobes and middle lobe bilaterally. There is no discrete pulmonary nodule, dense consolidation or cavitation. Positions of the endotracheal tube and right IJ central venous catheter are satisfactory. Nasogastric tube is also in situ withtip in the stomach. Moderate pericardial effusion also noted. Increased attenuation of the mediastinal fat is seen. No lymphadenopathy is detected. No contour deforming focal lesion is noted in the liver, spleen and the pancreas. Increased density noted within the gallbladder may suggest sludge. Pericholecystic fluid is also noted. No evidence of CBD dilatation. The bilateral adrenal glands are unremarkable. The lesion of concern in the right kidney noted in the upper pole, partly exophytic measuring about 3.2 X 2.6 X 2.2 cm (craniocaudal x transverse x AP). It has attenuation value of about 35 HU and demonstrates hyperdensity in its anterior aspect. It cannot be characterised further in this noncontrast study. There are no significantly enlarged para-aortic lymph nodes. No evidence of calculus or hydronephrosis on either side. The catheterised bladder is empty. The bowel loops are normal in calibre and distribution. However few loops of small wall demonstrate mild mural oedema (201/1 16). Few uncomplicated colonic diverticula are also observed. Increased attenuation of the mesenteric fat and nonspecific presacral soft tissue density noted. Small amount of free fluid is noted in the pelvis. No destructive bony lesion is seen in the chest or in the abdomen. CONCLUSION 1. There is an isodense partly exophytic nodule in the right renal upper pole and cannot be characterised further in this noncontrast study. The differential diagnoses include a hyperdense cyst and a neoplastic lesion. 2. Bilateral moderate pleural effusions, pericardial effusion, pericholecystic fluid, small amount of fluid in the pelvis, subcutaneous oedema are attributed to systemic cause like hypoproteinaemia or fluid overload. 3. The lungs show patchy linear and ground-glass opacities mainly in the lower lobes associated with bronchial wall thickening. The appearances may be due to pulmonary oedema or atypical infection in the acute setting. I note the chest radiograph dated 22/02/2016 showing bilateral lower zone patchy opacities with volume loss, which raise the possibility of underlying interstitial lung disease. However, this is difficult to assess on this CT in view of the superimposed acute changes. If clinically appropriate, consider follow-up HRCT following this acute episode. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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