# Row 9644

Visit Number: 609609c1efee6ed73207e4b8404596d13284f5c2c3e77facb23c857ce6284c84

Masked\_PatientID: 9638

Order ID: 4b3799f7403e048565b903793b8b79195df0f44ce20a3a4f91969c1394792486

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 11/6/2020 19:12

Line Num: 1

Text: HISTORY severe asthma TRO lung parenchymal abnormalities TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS Comparison made with NTFH CT of 26/2/2019. There is interval resolution of the tree in bud disease in the right upper lobe. No other areas of tree in bud disease noted. No cavitating or miliary disease. The lung apices shows no fibrocalcific changes. Bronchial wall thickening is still noted in the right upper and middle lobes, as well as the central aspect of the lower lobes bilaterally, suggestive of bronchitis. In the posterior aspect of the apical left lower lobe, there is increased prominence of a tubular opacity (6-46) which is continuous with the airway best appreciated on coronal view (11-25, 26), present previously and now more pronounced, in keeping with mucus plugging. Another segment of mucus plugging previously noted more medially in the apical left lower lobe (prior 506-30). Small amount of subpleural consolidation or atelectasis is noted in the medial middle lobe and inferior lingula. Rest of both lungs are clear, with no other sites of consolidation or patchy ground-glass changes. No lung mass or sinister nodule noted. No interstitial fibrosis, bronchiectasis or emphysema is evident. Major airways are patent. Mildly prominent right hilar and subcarinal nodes are unchanged from before, measuring up to 11 mm on the right probably reactive. No other enlarged supraclavicular, axillary, hilar or mediastinal nodes seen. The thyroid is unremarkable. Intimal calcifications at the aortic arch. The pulmonary arteries are not enlarged. Heart size is normal. No pericardial or pleural effusion. Limited sections of the upper abdomen in arterial phase are unremarkable. No destructive bony lesion is seen. CONCLUSION Since last CT of Feb 2019, 1. Persistent bronchial wall thickening bilaterally in keeping with bronchitis. Interval resolution of the tree in bud disease in right upper lobe. 2. Interval small area of consolidation in the middle lobe and lingula. No bronchiectasis. Persistent segment of mucus plugging in apical left lower lobe (501-1) while another segment more medially previously has resolved. This is infective/inflammatory, of which non-TB mycobacterial infection is one of the consideration, differential being early/mild allergic bronchopulmonary aspergillosis though no other frank glove-likemucus plugging noted. 3. Stable prominent right hilar and subcarinal nodes, likely reactive. 4. Other minor findings as described. Report Indicator: May need further action Finalised by: <DOCTOR>

Accession Number: 0075c303d887356112c6eba2b09d77769f9715cd86d25d08a2843a86afbecee1

Updated Date Time: 12/6/2020 9:52

## Layman Explanation

This radiology report discusses HISTORY severe asthma TRO lung parenchymal abnormalities TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS Comparison made with NTFH CT of 26/2/2019. There is interval resolution of the tree in bud disease in the right upper lobe. No other areas of tree in bud disease noted. No cavitating or miliary disease. The lung apices shows no fibrocalcific changes. Bronchial wall thickening is still noted in the right upper and middle lobes, as well as the central aspect of the lower lobes bilaterally, suggestive of bronchitis. In the posterior aspect of the apical left lower lobe, there is increased prominence of a tubular opacity (6-46) which is continuous with the airway best appreciated on coronal view (11-25, 26), present previously and now more pronounced, in keeping with mucus plugging. Another segment of mucus plugging previously noted more medially in the apical left lower lobe (prior 506-30). Small amount of subpleural consolidation or atelectasis is noted in the medial middle lobe and inferior lingula. Rest of both lungs are clear, with no other sites of consolidation or patchy ground-glass changes. No lung mass or sinister nodule noted. No interstitial fibrosis, bronchiectasis or emphysema is evident. Major airways are patent. Mildly prominent right hilar and subcarinal nodes are unchanged from before, measuring up to 11 mm on the right probably reactive. No other enlarged supraclavicular, axillary, hilar or mediastinal nodes seen. The thyroid is unremarkable. Intimal calcifications at the aortic arch. The pulmonary arteries are not enlarged. Heart size is normal. No pericardial or pleural effusion. Limited sections of the upper abdomen in arterial phase are unremarkable. No destructive bony lesion is seen. CONCLUSION Since last CT of Feb 2019, 1. Persistent bronchial wall thickening bilaterally in keeping with bronchitis. Interval resolution of the tree in bud disease in right upper lobe. 2. Interval small area of consolidation in the middle lobe and lingula. No bronchiectasis. Persistent segment of mucus plugging in apical left lower lobe (501-1) while another segment more medially previously has resolved. This is infective/inflammatory, of which non-TB mycobacterial infection is one of the consideration, differential being early/mild allergic bronchopulmonary aspergillosis though no other frank glove-likemucus plugging noted. 3. Stable prominent right hilar and subcarinal nodes, likely reactive. 4. 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.