# Row 9668

Visit Number: 83c2e9f55d812d7651ef11dfb26522f6a0551b481b8cf4b5069fffbf0c63845a

Masked\_PatientID: 9665

Order ID: a1c8fb66ce5840194e61634ee63392f1c5f32506d7b27be65ac5e589a475354c

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 28/10/2015 10:19

Line Num: 1

Text: HISTORY 100 pack years. Haemoptysis. ? Ca lung RUL TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS No comparison CT available. CXR of 6/7/2002, 25/6/2015 and19/10/2015. The extensive patchy consolidation in the left mid and lower lungs noted on Jun CXR had resolved. There are residual ground-glass changes in the inferior posterior left upper lobe and apical left lower lobe. Basal left lower lobe shows band atelectasis/scarring (5-88, 8-12). Two tiny 5-6mm subpleural nodules in the basolateral aspect of the left costophrenic sulcus are nonspecific. Two other 4mm nodules in anterior right lower lobe (5-83) and middle lobe (5-76) showsa geographic shape and are likely benign. Similarly another 4 x 6 mm nodule in the anterior aspect of superior segment of right lower lobe (5-59) is not suspicious appearing. No consolidation is noted in both lungs. There is extensive centrilobular and panlobular emphysema, in the upper zones, increasing the risks of pneumothorax if percutaneous biopsy is contemplated. The opacity in question seen on CXR at right lung apex is again identified. This was not present on CXR of 2002, start to appear together with left lung consolidation on CXR of Jun 2015 where a nodule was seen but shows gradual decrease in fullness. This currently appears as an oblong-triangular opacity overall measuring 36 x 9 x 20mm (8-34, 5-20) with adjacent scarring. No internal cavitation seen. A tiny apical airway leads to it (5-21, 8-35). No enlarged supraclavicular, axillary, mediastinal or hilar nodes seen. The mediastinal vasculature enhance normally. Heart is not enlarged. No pericardial or pleural effusion is seen. Atherosclerotic calcifications of the aortic arch with minimal intimal irregularity are noted. There is no deep penetrating ulcer, aneurysm or dissection. Heavy coronary calcifications of triple vessel noted.Limited sections of the upper abdomen in arterial phase unremarkable apart from a few probable simple cysts (up to 7mm) in liver segment 4a dome, deep segment 5/6 and left upper kidney. No destructive bony lesion is seen. CONCLUSION 1.Overall findings are more suggestive of a post-infective or post-inflammatory lesion in right lung apex with no cavitation, although scar malignancy is not totally excluded. TB is a consideration due to its apical location. This may be followed-up on CT. If biopsy is contemplated, bronchoscopic access can be considered as adjacent emphysema predisposed to high risk of pneumothorax. 2. No other suspicious finding in the rest of the lungs. 3. There is no consolidation, resolved fromJun 2015 CXR. Likely post infective small geographic nodules in middle and right lower lobe. Few non-specific small rounded nodules in left lower lobe. 4. Other minor findings as described. May need further action Finalised by: <DOCTOR>

Accession Number: 68ae6930f3567a5cc832a35d23f8c653e7c40400417ccf1761e3b28fdd0d4e5c

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