# Row 9675

Visit Number: 763a29204a30483f5ea3cd7f14988aa53c38330ea6cf6739461cd6d27652b4a9

Masked\_PatientID: 9671

Order ID: beb73a14296cd32baf3bbe0ff8f2591387f195e406b08f21b1fae0fac41daa48

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 19/10/2017 17:16

Line Num: 1

Text: HISTORY Likely metastatic TCC with brain mets for staging TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison is made to the CT dated 15 August 2017. CHEST No suspicious pulmonary nodule or mass is seen. Triangular opacity adjacent to the right oblique fissure measuring 0.6 cm is likely to represent focal atelectasis (se 401/48). Calcified granuloma is noted in the atelectatic left lower lobe. Interval decrease in size of bilateral pleural effusions associated with compressive atelectasis of the lower lobes. Trachea and large airways are patent. Small volume mediastinal nodes are noted (e.g., bilateral lower paratracheal, subcarinal); although these are more prominent from before, they may still be reactive. No significantly enlarged supraclavicular, axillary or hilar node is seen. Right internal jugular double-lumen central venous catheter is noted with tip in the right atrium. Incidental aberrant right subclavian artery is noted, with mild ectasia and atherosclerosis at its origin. Coronary artery calcification is seen. Previous pericardial effusion has resolved. Stable bilateral thyroid hypodensities, measuring up to 2.0 cm in the left thyroid lobe. ABDOMEN AND PELVIS Status post right radical nephrectomy (25 Mar 2009) and left nephroureterectomy (adrenal sparing, 2 Jun 2017). Stable enlargement of the left adrenal gland, likely due tocompensatory hypertrophy. No gross mass is seen to suggest local recurrence in either renal bed. Interval mild improvement in stranding and fluid adjacent to the left adrenal, spleen and upper abdominal aorta which may be postsurgical change. Interval near-complete resolution of fluid collection at the left VUJ resection margin. The urinary bladder is collapsed with thickened walls possibly due to underdistension. Underlying malignancy cannot be excluded or confirmed. Prostatomegaly is seen. Uncomplicated gallstones. The biliary tree is not dilated. The pancreas and spleen are unremarkable. Again there are several portosystemic collaterals in the periportal, perigastric and perisplenic regions. No overt the contour irregularity of the liver or splenomegaly. Tiny hepatic segment 2 calcified granulomas are noted. Stable scattered tiny hepatic hypodensities are too small to characterise. Nonspecific mild mesorectal fat stranding is noted. No evidence of intestinal obstruction. Scattered uncomplicated colonic diverticula are seen. The appendix is normal. Mild fluid stranding is observed in the abdomen. The abdominal aorta is of normal calibre. Old L1 compression fracture is noted. Vague sclerotic focus at the posterior aspect of T6 vertebra is stable since the study of 17 May 2017 and indeterminate (se 402/44). Stable degenerative grade 1 anterolisthesis of L4 over L5. Right gluteal cutaneous subcutaneous round density is likelya sebaceous cyst. CONCLUSION Since the study of 15 Aug 2017, No convincing evidence of local recurrence, nodal disease or distant metastasis in the chest, abdomen or pelvis. Presumed post-surgical changes at the left renal bed and left VUJ resection margin have improved. The collapsed urinary bladder cannot be accurate assessed in this study. Cystoscopic evaluation may be considered if clinically indicated. Vague sclerotic focus at the posterior aspect of T6 vertebra is stable since the study of 17 May 2017 and indeterminate. May need further action Reported by: <DOCTOR>

Accession Number: 36c9636061629035ad7f8add3b682dcbdd1fc6267ab4504a4c99e65b15a8c640

Updated Date Time: 19/10/2017 19:27