# Row 9748

Visit Number: 2e48b652e6eccfaf263185626566a4150d40d58ecfe924b80429696d9c6d1039

Masked\_PatientID: 9729

Order ID: c23255f8b20d14117b453fe59e70cbc0ee1ea8d7709f9085f80830c49b114b2d

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 06/2/2019 15:43

Line Num: 1

Text: HISTORY AMS ?septic encephalopathy ?source TECHNIQUE Scans of the thorax, abdomen and pelvis were acquired after the administration of Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS The prior CT chest dated 4 January 2019 and prior CT peripheral angiography dated 12 December 2018 were noted. THORAX There is moderate to large right pleural effusion with adjacent compressive atelectasis. The right pleural effusion has increased since the last study. A small left pleural effusion is also noted with compressive atelectasis in the left lower lobe, slightly decreased since the prior study. There is again tubular opacity in the lingular segment of the left upper lobe (06-43 vs previous 201 - 46) representing mucus bronchial plugging. Bilateral patchy consolidations have almost resolved with residual and ground-glass changes now present. Dependent low density material in the tracheal lumen is possibly retained secretions. A 1.3 x 0.9 cm nodule in the superior mediastinum in paratracheal location is of same density as that of the contiguous right lobe of thyroid and may represent a thyroid nodule (05-18). Otherwise no significantly enlarged axillary, supraclavicular, mediastinal, hilar lymph node is seen. The mediastinal vessels opacify normally. The heart is mildly enlarged. No significant pericardial effusion is seen. ABDOMEN AND PELVIS No suspicious focal hepatic lesion is identified. The hepatic and portal veins opacify normally. There is no biliary dilatation. A few gallstones are noted with no associated inflammatory change. There is suggestion of 0.3 cm intraductal calculus in the main pancreatic duct at the head of the pancreas. There is no upstream ductal dilatation. The spleen and the adrenal glands are grossly unremarkable. Both kidneys are small with thinned out parenchyma in keeping with renal parenchymal disease. Bilateral renal cysts noted. Further renal hypodensities are too small to characterise. There is no hydronephrosis. Nonspecific bilateral perinephric fat stranding is present. Tip of the feeding tube is in the stomach. The small and large bowel loops are of normal calibre. The urinary bladder is partly distended, limiting assessment. The prostate is not enlarged. No significantly enlarged intra-abdominal pelvic lymph node is seen. No ascites. There is mild fluid and fat stranding in the presacral space which isnonspecific. The bones are osteopenic. There is interval increase in the lytic change at the lower endplate fracture of T11 vertebral body, suspicious for spondylitis. No gross paravertebral collection is seen within the limitations of the study. CONCLUSION 1. Interval increase in the lytic change at the T11 vertebral lower endplate fracture, suspicious for spondylitis in the given clinical context. No gross paravertebral collection is seen within the limitations of the study. 2. Bilateral pleural effusions (right more than left). The bilateral patchy consolidations have almost resolved. 3. Uncomplicated cholelithiasis. Pancreatic ductal calculus with no upstream ductal dilatation. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: e74163180eaf7445a03b7218ca8c8b424a591351c1c9a95661c8252093e279d5

Updated Date Time: 07/2/2019 12:43