# Row 106

Visit Number: 7b5cdc1a3ab02d1f4d0ce0ec11143998a6c8da9bbd16219b7c7e39b865afc138

Masked\_PatientID: 104

Order ID: 39281f1cf98e46930be5c5fb8ef3aeef58687ea471682b21cb5e5fe61aa013b0

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 31/8/2018 14:33

Line Num: 1

Text: HISTORY metastatic pancreatic cancer with procal 10 and septic shock ? source TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS Comparison was made with the CTscan of 20 June 2018. CHEST The tip of the right central venous line is noted in the superior vena cava. Post left mastectomy. No evidence of local recurrence. The mediastinal vessels opacify normally. Small volume right supraclavicular,right paratracheal lymph node are nonspecific. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. The heart is normal in size. No pericardial effusion is seen. New 1 cm nodule in the lingula is highly suspicious for metastasis (image 501/36). Few other 2-3 mm tiny subcentimetre nodules in the right upper lobe (Im 501/41), right lower lobe (Im 501/44) and along left major fissure (Im 501/35) are also highly suspicious for metastases. Bilateral moderate low density pleural effusions are noted adjacent atelectasis. Mild smooth interlobular septal thickening in both lungs are likely due to fluid overload. Scarring in the anterior aspect of the left lung due to previous radiation is stable. Few tiny hypodense nodules are noted in both lobes of thyroid. ABDOMEN AND PELVIS 4 x 2.5 cm enhancing mass in the head of the pancreas shows interval progression. The mass shows evidence of necrosis. The interval worsening of the main pancreatic duct dilatation in the body and tail region associated with atrophy. Multiple lymphadenopathy in the portacaval, celiac axis, peripancreatic and porta hepatis regions show interval worsening. The largest lymph node inthe portacaval region measures 3.6 x 3.9 cm (401/51) with evidence of necrosis. Multiple prominent para-aortic, aortocaval and retrocaval lymph nodes are also noted. Biliary stent is noted in situ with aerobilia. No biliary dilatation. Extensive liver metastases show significant interval worsening. The larger lesion in the left lobe measures up to 4.5 x 3 cm (401/37). The gallbladder is well distended and shows air pockets within. The spleen, adrenal glands appear unremarkable.Both kidneys are unremarkable except for a stable scarring in the left renal lower pole. Urinary bladder is empty with a Foley catheter in situ. Fat containing lesion in the posterior wall of the uterus may represent lipoleiomyoma. Endometrial cavity is distended measuring up to 10 mm. Moderate free intraperitoneal fluid is detected. Diffuse subcutaneous oedema is noted in the chest, abdomen and pelvis. Tiny sclerotic focus in the right pedicle of T4 vertebra is faintly visualised. The no destructive osseous lesion. CONCLUSION The since the previous CT done on June 2018; - Interval worsening of the primary malignancy in the head of the pancreas and the upper abdominal lymphadenopathy which appeared necrotic - Significant interval worsening of the liver metastases - New pulmonary metastases - Bilateral moderate low density pleural effusions, ascites and diffuse subcutaneous oedema associated with interlobular septal thickening are likely due to fluid overload. May need further action Finalised by: <DOCTOR>

Accession Number: 8ccab6d44ae5b34c90926ad65cce6e0fdc054d334d17f7526c181dec25286b4e

Updated Date Time: 31/8/2018 15:30

## Layman Explanation

This radiology report discusses HISTORY metastatic pancreatic cancer with procal 10 and septic shock ? source TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS Comparison was made with the CTscan of 20 June 2018. CHEST The tip of the right central venous line is noted in the superior vena cava. Post left mastectomy. No evidence of local recurrence. The mediastinal vessels opacify normally. Small volume right supraclavicular,right paratracheal lymph node are nonspecific. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. The heart is normal in size. No pericardial effusion is seen. New 1 cm nodule in the lingula is highly suspicious for metastasis (image 501/36). Few other 2-3 mm tiny subcentimetre nodules in the right upper lobe (Im 501/41), right lower lobe (Im 501/44) and along left major fissure (Im 501/35) are also highly suspicious for metastases. Bilateral moderate low density pleural effusions are noted adjacent atelectasis. Mild smooth interlobular septal thickening in both lungs are likely due to fluid overload. Scarring in the anterior aspect of the left lung due to previous radiation is stable. Few tiny hypodense nodules are noted in both lobes of thyroid. ABDOMEN AND PELVIS 4 x 2.5 cm enhancing mass in the head of the pancreas shows interval progression. The mass shows evidence of necrosis. The interval worsening of the main pancreatic duct dilatation in the body and tail region associated with atrophy. Multiple lymphadenopathy in the portacaval, celiac axis, peripancreatic and porta hepatis regions show interval worsening. The largest lymph node inthe portacaval region measures 3.6 x 3.9 cm (401/51) with evidence of necrosis. Multiple prominent para-aortic, aortocaval and retrocaval lymph nodes are also noted. Biliary stent is noted in situ with aerobilia. No biliary dilatation. Extensive liver metastases show significant interval worsening. The larger lesion in the left lobe measures up to 4.5 x 3 cm (401/37). The gallbladder is well distended and shows air pockets within. The spleen, adrenal glands appear unremarkable.Both kidneys are unremarkable except for a stable scarring in the left renal lower pole. Urinary bladder is empty with a Foley catheter in situ. Fat containing lesion in the posterior wall of the uterus may represent lipoleiomyoma. Endometrial cavity is distended measuring up to 10 mm. Moderate free intraperitoneal fluid is detected. Diffuse subcutaneous oedema is noted in the chest, abdomen and pelvis. Tiny sclerotic focus in the right pedicle of T4 vertebra is faintly visualised. The no destructive osseous lesion. CONCLUSION The since the previous CT done on June 2018; - Interval worsening of the primary malignancy in the head of the pancreas and the upper abdominal lymphadenopathy which appeared necrotic - Significant interval worsening of the liver metastases - New pulmonary metastases - Bilateral moderate low density pleural effusions, ascites and diffuse subcutaneous oedema associated with interlobular septal thickening are likely due to fluid overload. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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