# Row 144

Visit Number: 89076d717f612079a3613208463401cc84d0104e7dc164a7ab298115fdc4ff05

Masked\_PatientID: 123

Order ID: fb9f49dbc78598554eb976f16ce80bca77bad45e82513c890bb75a309d94f02a

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 05/11/2016 11:08

Line Num: 1

Text: HISTORY pleural effusion with ? loculation; b/g ESRF on HD persistent bilateral pleural effusion despite increasing UF TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS No prior relevant scan available for review. Chest radiographs dating back to 20 February 2016 were reviewed. Images are degraded by respiratory motion artefact. There are bilateral moderate pleural effusions, larger on the right with slight extension into the fissures. No enhancing septa or pleural nodularity is visualised within the effusions. Associated lower lobe compressive atelectasis is present. In addition, right lower lobe consolidation may represent underlying infection. There is also linear atelectasis or scarring in the lingula. The trachea and major airways are patent. A small paratracheal node is noted (6 mm on short axis). No significantly enlarged mediastinal or hilar node detected. The heart is mildly enlarged. There is atherosclerotic calcification of the imaged aorta, especially at the aorta arch. Tip of the right central venous catheter is in the lower right atrium. Focal patchy sclerosis in the lateral aspect of the right 7thrib is nonspecific. An old right 2nd rib fracture is noted. Appended upper abdomen is grossly unremarkable save for a stable small segment 4 liver cyst. CONCLUSION Bilateral moderate pleural effusions, larger on the right, with compressive atelectasis. They are longstanding on review of previous radiographs and CT. No evidence of septation or significant pleural thickening. Right lower lobe consolidation may represent superimposed infection. Clinical correlation is suggested. May need further action Finalised by: <DOCTOR>

Accession Number: 4307d4048a72e37d195ffd781a0fa6d8c08ac79ba3d66757762b7ea890e1f845

Updated Date Time: 05/11/2016 12:14

## Layman Explanation

This radiology report discusses HISTORY pleural effusion with ? loculation; b/g ESRF on HD persistent bilateral pleural effusion despite increasing UF TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS No prior relevant scan available for review. Chest radiographs dating back to 20 February 2016 were reviewed. Images are degraded by respiratory motion artefact. There are bilateral moderate pleural effusions, larger on the right with slight extension into the fissures. No enhancing septa or pleural nodularity is visualised within the effusions. Associated lower lobe compressive atelectasis is present. In addition, right lower lobe consolidation may represent underlying infection. There is also linear atelectasis or scarring in the lingula. The trachea and major airways are patent. A small paratracheal node is noted (6 mm on short axis). No significantly enlarged mediastinal or hilar node detected. The heart is mildly enlarged. There is atherosclerotic calcification of the imaged aorta, especially at the aorta arch. Tip of the right central venous catheter is in the lower right atrium. Focal patchy sclerosis in the lateral aspect of the right 7thrib is nonspecific. An old right 2nd rib fracture is noted. Appended upper abdomen is grossly unremarkable save for a stable small segment 4 liver cyst. CONCLUSION Bilateral moderate pleural effusions, larger on the right, with compressive atelectasis. They are longstanding on review of previous radiographs and CT. No evidence of septation or significant pleural thickening. Right lower lobe consolidation may represent superimposed infection. Clinical correlation is suggested. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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