# Row 1705

Visit Number: 7d125c2ac4e34c71feb5db96741c73871ac90e9cfdb315aaad4740e535d7e966

Masked\_PatientID: 1699

Order ID: 4296d9b342be5e2f7cad590089cc8d68b995b59342450f2b578bff8799c64b7b

Order Name: CT Chest and Abdomen

Result Item Code: CTCHEABD

Performed Date Time: 01/8/2019 9:12

Line Num: 1

Text: HISTORY right upper lobe pulmonary MALT HCC s/p left hemihepatectomy TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison is made to the CT chest dated 17 September 2018 (NCC), and the CT liver dated 4 February 2019. The MRI liver dated 26 July 2018 also reviewed. Stable spiculated nodule in the right upper lobe measuring 2.8 x 1.8cm (Se 23/44 v.s. Prev 300/61). This is in keeping with biopsy proven MALT lymphoma (histo, 28 Jun 2018). No new suspicious pulmonary nodule or mass is seen. Background emphysema is noted. The central airways are patent. No pleural effusion is seen. No significantly enlarged thoracic node is seen. Theheart is not enlarged. The aorta is of normal calibre. Coronary artery calcification is seen. No significant pericardial effusion is detected. Vague thyroid nodules are nonspecific. The oesophagus is grossly unremarkable. Bilateral gynecomastia is seen. Status post left hemihepatectomy (6 Apr 2016) and thermal ablation of segment 7 HCC (28 Jun 2018). No definite suspicious hepatic lesion is currently seen. Stable tiny subcapsular arterially enhancing foci in segment 5 (series 7/48, 40, 34) which becomes isodense on the subsequent phases, possibly perfusional. Stable segment 7 portovenous shunt from the right posterior sectoral portal vein to the right hepatic vein. Stable prominent bile ducts along the surgical margin. Stable multiple hepatic hypodensities, the larger ones cysts while the smaller ones are too small to characterise. The liver is fatty. The portal vein is patent. The right hepatic artery arises from the superior mesenteric artery (replaced).Stable prominent bile ducts at the resection margin. The common duct is not dilated. Tiny density at the gallbladder fundus may represent adherent calculus or polyp (series 10/43). The pancreas is unremarkable. The spleen is stably prominent, 12.9 cm in cranial caudal dimension (series 24/27). The adrenals are mildly nodular possibly due to hyperplasia. Bilateral renal hypodensities are noted, the larger ones cysts while the smaller ones are too small to characterise. One is hyperdense in the left lower pole, possibly hyperdense cyst (series 3/67). No hydronephrosis is detected. The visualised bowel loops are normal in calibre. Uncomplicated colonic diverticula are noted. No significantly enlarged abdominal node orascites is seen. No destructive bone lesion is seen. CONCLUSION Since the prior CT chest of 17 Sept 2018 and the CT liver of 4 Feb 2019, Stable right upper lobe nodule, in keeping with biopsy proven MALT lymphoma. No definite suspicious hepatic lesion is seen. Report Indicator: Known / Minor Finalised by: <DOCTOR>

Accession Number: c46f1ac57ee330f8476eef234a83687382b5622e4f7007ca0355ad89776b2086

Updated Date Time: 01/8/2019 14:44

## Layman Explanation

This radiology report discusses HISTORY right upper lobe pulmonary MALT HCC s/p left hemihepatectomy TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison is made to the CT chest dated 17 September 2018 (NCC), and the CT liver dated 4 February 2019. The MRI liver dated 26 July 2018 also reviewed. Stable spiculated nodule in the right upper lobe measuring 2.8 x 1.8cm (Se 23/44 v.s. Prev 300/61). This is in keeping with biopsy proven MALT lymphoma (histo, 28 Jun 2018). No new suspicious pulmonary nodule or mass is seen. Background emphysema is noted. The central airways are patent. No pleural effusion is seen. No significantly enlarged thoracic node is seen. Theheart is not enlarged. The aorta is of normal calibre. Coronary artery calcification is seen. No significant pericardial effusion is detected. Vague thyroid nodules are nonspecific. The oesophagus is grossly unremarkable. Bilateral gynecomastia is seen. Status post left hemihepatectomy (6 Apr 2016) and thermal ablation of segment 7 HCC (28 Jun 2018). No definite suspicious hepatic lesion is currently seen. Stable tiny subcapsular arterially enhancing foci in segment 5 (series 7/48, 40, 34) which becomes isodense on the subsequent phases, possibly perfusional. Stable segment 7 portovenous shunt from the right posterior sectoral portal vein to the right hepatic vein. Stable prominent bile ducts along the surgical margin. Stable multiple hepatic hypodensities, the larger ones cysts while the smaller ones are too small to characterise. The liver is fatty. The portal vein is patent. The right hepatic artery arises from the superior mesenteric artery (replaced).Stable prominent bile ducts at the resection margin. The common duct is not dilated. Tiny density at the gallbladder fundus may represent adherent calculus or polyp (series 10/43). The pancreas is unremarkable. The spleen is stably prominent, 12.9 cm in cranial caudal dimension (series 24/27). The adrenals are mildly nodular possibly due to hyperplasia. Bilateral renal hypodensities are noted, the larger ones cysts while the smaller ones are too small to characterise. One is hyperdense in the left lower pole, possibly hyperdense cyst (series 3/67). No hydronephrosis is detected. The visualised bowel loops are normal in calibre. Uncomplicated colonic diverticula are noted. No significantly enlarged abdominal node orascites is seen. No destructive bone lesion is seen. CONCLUSION Since the prior CT chest of 17 Sept 2018 and the CT liver of 4 Feb 2019, Stable right upper lobe nodule, in keeping with biopsy proven MALT lymphoma. No definite suspicious hepatic lesion is seen. Report Indicator: Known / Minor Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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