# Row 1841

Visit Number: f0c6be0cecd4e5ec5992bedd007d06404a5d7d32f9f388d2444e5f17ac5e2f0d

Masked\_PatientID: 1839

Order ID: e4735db408f69a241f4b5e8b2015fc86ad9f064d5077b7a23c68cc90f9e4d2b3

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 05/12/2019 14:00

Line Num: 1

Text: HISTORY CT TAP with triphasic scan for restaging admitted from OPS for b/l LL swelling likely decompensated liver cirrhosis; 66year old female with multifocall HCC (HBV related) with no mets or portal vein thrombosis s/p local therapy of y90 and sorafenib, but stopped ivo mixed respose and G3 HFS currently not on any tx b/g known liver cirrhosis (child pugh B) TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Previous CT dated 23 August 2019 was reviewed. ABDOMEN AND PELVIS The liver is cirrhotic. Dominant mass in segment 5/8 is slightly smaller, currently measuring 5.9 cm (701/38). There are patchy arterially enhancing areas at the inferior border of the mass, concerning for viable tumour (501/46). There are also innumerable arterially enhancing bilobar hepatic lesions demonstrating washout, in keeping with multifocal HCC. There is at least one lesion in segment 5 which is larger: from 1.1 cm to 1.9 cm (701/45 vs prior 23/59). Replaced left hepatic artery arising from the left gastric artery. The middle hepatic artery arises from the right hepatic artery. The spleen is not enlarged. Multiple portosystemic collaterals at the lower peri-oesophageal, perigastric and perisplenic regions. Increased low density ascites, currently moderate volume. The portal venous system, splenic vein and SMV are patent. Several stable prominent but mostly subcentimetre left gastric, common hepatic, periportal and upper retroperitoneal lymph nodes are presumed to be reactive. No pneumoperitoneum. The gallbladder, biliary tree, pancreas and adrenals are unremarkable. Stable tiny nonobstructing left renal lower pole calculus. Kidneys enhance symmetrically. No hydronephrosis. Partially distended urinary bladder is unremarkable. Uterus is not enlarged; no suspicious adnexal mass. Bowel loops are not dilated. Appendix is not inflamed. Apparent diffuse gastric mural thickening is nonspecific and can be related to hypoalbuminaemia. THORAX AND BONES No suspicious pulmonary nodule, mass or consolidation. Mild atelectasis scattered in both lungs. Trachea and central airways are patent. There is no pleural effusion. Stable small volume supraclavicular mediastinal nodes are nonspecific. No hilar or axillary lymphadenopathy. Heart appears mildly enlarged. Mediastinal structures opacify satisfactorily. The azygos vein is dilated. No pericardial effusion.Imaged thyroid gland is unremarkable. No gross suspicious bony destruction. There is irregularity at the right femoral head as well as several subchondral cysts at the right femoro-acetabular joint likely related to significant degenerative change. Diffuse subcutaneous oedema. CONCLUSION Background liver cirrhosis with manifestations of portal hypertension. Since CT Dated 23 Aug 2019: 1. Status post Y90 embolisation. Although the dominant segment 5/8 hepatic mass is smaller, there is patchy arterial enhancement at its inferior border concerning for viable tumour. Innumerable bilobar arterially enhancing hepatic lesions demonstrating washout in keeping with multifocal HCC. At least one is bigger (segment 5). 2. No convincing CT evidence of distant metastasis in this study. 3. Oher findings as described above. Report Indicator: Further action or early intervention required Finalised by: <DOCTOR>

Accession Number: c3f14c1af28a80bd8328d336dedbdd6e21ab2f5f60589da5ea1d8f3a2beaf018

Updated Date Time: 05/12/2019 15:18

## Layman Explanation

This radiology report discusses HISTORY CT TAP with triphasic scan for restaging admitted from OPS for b/l LL swelling likely decompensated liver cirrhosis; 66year old female with multifocall HCC (HBV related) with no mets or portal vein thrombosis s/p local therapy of y90 and sorafenib, but stopped ivo mixed respose and G3 HFS currently not on any tx b/g known liver cirrhosis (child pugh B) TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Previous CT dated 23 August 2019 was reviewed. ABDOMEN AND PELVIS The liver is cirrhotic. Dominant mass in segment 5/8 is slightly smaller, currently measuring 5.9 cm (701/38). There are patchy arterially enhancing areas at the inferior border of the mass, concerning for viable tumour (501/46). There are also innumerable arterially enhancing bilobar hepatic lesions demonstrating washout, in keeping with multifocal HCC. There is at least one lesion in segment 5 which is larger: from 1.1 cm to 1.9 cm (701/45 vs prior 23/59). Replaced left hepatic artery arising from the left gastric artery. The middle hepatic artery arises from the right hepatic artery. The spleen is not enlarged. Multiple portosystemic collaterals at the lower peri-oesophageal, perigastric and perisplenic regions. Increased low density ascites, currently moderate volume. The portal venous system, splenic vein and SMV are patent. Several stable prominent but mostly subcentimetre left gastric, common hepatic, periportal and upper retroperitoneal lymph nodes are presumed to be reactive. No pneumoperitoneum. The gallbladder, biliary tree, pancreas and adrenals are unremarkable. Stable tiny nonobstructing left renal lower pole calculus. Kidneys enhance symmetrically. No hydronephrosis. Partially distended urinary bladder is unremarkable. Uterus is not enlarged; no suspicious adnexal mass. Bowel loops are not dilated. Appendix is not inflamed. Apparent diffuse gastric mural thickening is nonspecific and can be related to hypoalbuminaemia. THORAX AND BONES No suspicious pulmonary nodule, mass or consolidation. Mild atelectasis scattered in both lungs. Trachea and central airways are patent. There is no pleural effusion. Stable small volume supraclavicular mediastinal nodes are nonspecific. No hilar or axillary lymphadenopathy. Heart appears mildly enlarged. Mediastinal structures opacify satisfactorily. The azygos vein is dilated. No pericardial effusion.Imaged thyroid gland is unremarkable. No gross suspicious bony destruction. There is irregularity at the right femoral head as well as several subchondral cysts at the right femoro-acetabular joint likely related to significant degenerative change. Diffuse subcutaneous oedema. CONCLUSION Background liver cirrhosis with manifestations of portal hypertension. Since CT Dated 23 Aug 2019: 1. Status post Y90 embolisation. Although the dominant segment 5/8 hepatic mass is smaller, there is patchy arterial enhancement at its inferior border concerning for viable tumour. Innumerable bilobar arterially enhancing hepatic lesions demonstrating washout in keeping with multifocal HCC. At least one is bigger (segment 5). 2. No convincing CT evidence of distant metastasis in this study. 3. Oher findings as described above. Report Indicator: Further action or early intervention required Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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