# Row 2327

Visit Number: 7888f1241155ba50e2ae9de029486d237f2f478ac5623154d37622de338cdc8b

Masked\_PatientID: 2327

Order ID: d4c11a6f41d97d90202c297fb10ec1b8fc5c91d493585986521fa28cfb53071c

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 20/7/2018 9:22

Line Num: 1

Text: HISTORY Presented with PR Bleed. Colonoscopy showed rectosigmoid tumour (25-30cm FAV) TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 70 Positive Rectal Contrast - Volume (ml): FINDINGS CT abdomen and pelvis dated 14 May 2018 was reviewed Subcentimetre axillary, paratracheal, precarinal and bilateral hilar lymph nodes are likely reactive. No pleural or pericardial effusion. Bronchiectasis is present in the right upper and middle lobe as well as the lingula lobe. Inflammatory centrilobular ground-glass nodules and opacities are present in the right lung and mildly involving the left lower lobe, representing inflammatory nodularity. No suspicious pulmonary mass. There is a mass in the sigmoid colon measuring 3 x 2.8 cm, representing known colonic tumour. There is no proximal bowel dilatation. No significantly enlarged lymph node in the abdomen or pelvis. No suspicious hepatic mass. No biliary dilatation or gallstone. The spleen and pancreas are unremarkable. No adrenal mass. No solid renal mass. There is mild distension of the left renal pelvis which is stable with mild narrowing at the pelviureteric junction. No discrete mass is visualised at the site of narrowing. A stent is noted in the left common iliac vein. In the uterus, a hypodense lesion is visualised in the uterine body which is slightly unusual for an atrophied uterus. Endometrial cavity is not visualised. There is no adnexal mass. The bones are osteopenic and show degenerative changes. L1 compression fracture is likely osteoporosis related. CONCLUSION Chronic inflammatory changes in both lungs with bronchiectasis and inflammatory centrilobular ground-glass opacity. No suspicious pulmonary mass to suggest metastasis. The mass in the sigmoid colon is in keeping with known primary colonic tumour. There is no suspicious hepatic mass to suggest hepatic metastasis. Mild distension of the left renal pelvicaliceal system with mild tapering at the pelvic ureteric junction is probably due to mild PUJ narrowing. No obvious mass is visualised at the site of transition. The kidney show symmetrical and normal enhancement. There is a hypodense mass in the uterus which is unusual for an atrophied uterus and endometrial lining is not visualised. Suggest ultrasound pelvis for further correlation. There is no adnexal mass. May need further action Finalised by: <DOCTOR>

Accession Number: f5489f3ade8632b7ef2b4f84d50b6c0c87756f949843dc4ea3d0b044e75e62f3

Updated Date Time: 20/7/2018 16:43

## Layman Explanation

This radiology report discusses HISTORY Presented with PR Bleed. Colonoscopy showed rectosigmoid tumour (25-30cm FAV) TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 70 Positive Rectal Contrast - Volume (ml): FINDINGS CT abdomen and pelvis dated 14 May 2018 was reviewed Subcentimetre axillary, paratracheal, precarinal and bilateral hilar lymph nodes are likely reactive. No pleural or pericardial effusion. Bronchiectasis is present in the right upper and middle lobe as well as the lingula lobe. Inflammatory centrilobular ground-glass nodules and opacities are present in the right lung and mildly involving the left lower lobe, representing inflammatory nodularity. No suspicious pulmonary mass. There is a mass in the sigmoid colon measuring 3 x 2.8 cm, representing known colonic tumour. There is no proximal bowel dilatation. No significantly enlarged lymph node in the abdomen or pelvis. No suspicious hepatic mass. No biliary dilatation or gallstone. The spleen and pancreas are unremarkable. No adrenal mass. No solid renal mass. There is mild distension of the left renal pelvis which is stable with mild narrowing at the pelviureteric junction. No discrete mass is visualised at the site of narrowing. A stent is noted in the left common iliac vein. In the uterus, a hypodense lesion is visualised in the uterine body which is slightly unusual for an atrophied uterus. Endometrial cavity is not visualised. There is no adnexal mass. The bones are osteopenic and show degenerative changes. L1 compression fracture is likely osteoporosis related. CONCLUSION Chronic inflammatory changes in both lungs with bronchiectasis and inflammatory centrilobular ground-glass opacity. No suspicious pulmonary mass to suggest metastasis. The mass in the sigmoid colon is in keeping with known primary colonic tumour. There is no suspicious hepatic mass to suggest hepatic metastasis. Mild distension of the left renal pelvicaliceal system with mild tapering at the pelvic ureteric junction is probably due to mild PUJ narrowing. No obvious mass is visualised at the site of transition. The kidney show symmetrical and normal enhancement. There is a hypodense mass in the uterus which is unusual for an atrophied uterus and endometrial lining is not visualised. Suggest ultrasound pelvis for further correlation. There is no adnexal mass. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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