# Row 260

Visit Number: 5b44eb709a414ae034c5fac5d6920dd78f45a966e2c6ff12df222f3386dae929

Masked\_PatientID: 253

Order ID: 3080d6e18d2419f346405f4874227bd34f3084d72e424655cc1c9b60b418085c

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 21/8/2015 14:05

Line Num: 1

Text: HISTORY Hemoptysis TRO CA; previous PTB with LLL nodule heavy smoker with emphysema now hemoptysis (egfr in 4/2015 was 76) TECHNIQUE Scans of the thorax were acquired after intravenous administration of 100 ml of Omnipaque 350. FINDINGS The previous CT chest done 21 June 2011 and chest radiograph done 15 July 2013 were reviewed. There is an infiltrative soft tissue mass in the right perihilar region possibly confluent with hilar adenopathy encasing the lobar bronchi. It is difficult to measure the true extent although approximately measures 5.2 x 3.5 cm (8/37). There is severe narrowing of the right upper lobe bronchus and moderate narrowing of the bronchus intermedius, middle and right lower lobe bronchi. Tumour infiltration of the right lower lobe bronchus is seen. Severe narrowing of the right upper lobe pulmonary artery is noted. Patchy consolidation is seen in the anterior and posterior segments of the right upper lobe, which may be post-obstructive in aetiology. Interlobular septal thickening is also present, which may also be due to post-obstructive changes although lymphangitis carcinomatosa cannot be excluded. Hypodense material is seen within the right lower lobe segmental bronchi, which could represent mucus plugging. Mild patchy opacification of the right lower lobe posterobasal segment is noted, probably also post-obstructive. No pleural effusion is present. Two new pulmonary nodules are seenin the left lower lobe posterior segment (0.7 x 0.5 cm, 5/85 and 1.1 x 0.8 cm, 5/77); which are suspicious for metastases. Stable cluster of nodules in the left lower lobe apical segment with slight reduction in size of the dominant nodule (5/48 vs previous 5/47), possibly representing post-inflammatory change. Background centrilobular emphysematous changes are noted in both lungs, worse in the upper lobes. Enlarged mediastinal lymph nodes in the right upper paratracheal (2.0 x 1.8 cm, 4/35), right prevascular (1.2 x 1.0 cm, 4/39) and subcarinal (1.4 x 2.4 cm, 4/49) stations are seen. Mild compression of the left brachiocephalic vein and superior vena cava by enlarged mediastinal nodes is seen. The heart is normal in size. No pericardial effusion is seen. A stable subcentimetre hypodensity is noted in segment 7 of the liver (4/102), which is too small to characterise. Few stable tiny calcifications are noted in the pancreas, suggestive of prior chronicpancreatitis. The rest of the visualised upper abdomen is unremarkable. No destructive bony lesion is seen. CONCLUSION 1. Infiltrative mass in the right perihilar region confluent with hilar adenopathy causing encasement and compression of the lobar bronchi and right upper lobe pulmonary artery. Findings are suspicious for bronchogenic carcinoma. Histological correlation is suggested. 2. Two new pulmonary nodules in the left lower lobe, suspicious for metastases. 3. Enlarged mediastinal lymph nodes, suspicious for metastatic adenopathy. 4. Patchy consolidation in the right upper and lower lobes, which may be post-obstructive in aetiology. Interlobular septal thickening seen within the right upper lobe may also be post-obstructive in nature but lymphangitis carcinomatosa is not excluded. 5. Background centrilobular emphysematous changes in both lungs. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: 0d3344af352ea2f02efd71a7134a3134bd15ba50c956b227c92496257b1a491c

Updated Date Time: 26/8/2015 14:06

## Layman Explanation

This radiology report discusses HISTORY Hemoptysis TRO CA; previous PTB with LLL nodule heavy smoker with emphysema now hemoptysis (egfr in 4/2015 was 76) TECHNIQUE Scans of the thorax were acquired after intravenous administration of 100 ml of Omnipaque 350. FINDINGS The previous CT chest done 21 June 2011 and chest radiograph done 15 July 2013 were reviewed. There is an infiltrative soft tissue mass in the right perihilar region possibly confluent with hilar adenopathy encasing the lobar bronchi. It is difficult to measure the true extent although approximately measures 5.2 x 3.5 cm (8/37). There is severe narrowing of the right upper lobe bronchus and moderate narrowing of the bronchus intermedius, middle and right lower lobe bronchi. Tumour infiltration of the right lower lobe bronchus is seen. Severe narrowing of the right upper lobe pulmonary artery is noted. Patchy consolidation is seen in the anterior and posterior segments of the right upper lobe, which may be post-obstructive in aetiology. Interlobular septal thickening is also present, which may also be due to post-obstructive changes although lymphangitis carcinomatosa cannot be excluded. Hypodense material is seen within the right lower lobe segmental bronchi, which could represent mucus plugging. Mild patchy opacification of the right lower lobe posterobasal segment is noted, probably also post-obstructive. No pleural effusion is present. Two new pulmonary nodules are seenin the left lower lobe posterior segment (0.7 x 0.5 cm, 5/85 and 1.1 x 0.8 cm, 5/77); which are suspicious for metastases. Stable cluster of nodules in the left lower lobe apical segment with slight reduction in size of the dominant nodule (5/48 vs previous 5/47), possibly representing post-inflammatory change. Background centrilobular emphysematous changes are noted in both lungs, worse in the upper lobes. Enlarged mediastinal lymph nodes in the right upper paratracheal (2.0 x 1.8 cm, 4/35), right prevascular (1.2 x 1.0 cm, 4/39) and subcarinal (1.4 x 2.4 cm, 4/49) stations are seen. Mild compression of the left brachiocephalic vein and superior vena cava by enlarged mediastinal nodes is seen. The heart is normal in size. No pericardial effusion is seen. A stable subcentimetre hypodensity is noted in segment 7 of the liver (4/102), which is too small to characterise. Few stable tiny calcifications are noted in the pancreas, suggestive of prior chronicpancreatitis. The rest of the visualised upper abdomen is unremarkable. No destructive bony lesion is seen. CONCLUSION 1. Infiltrative mass in the right perihilar region confluent with hilar adenopathy causing encasement and compression of the lobar bronchi and right upper lobe pulmonary artery. Findings are suspicious for bronchogenic carcinoma. Histological correlation is suggested. 2. Two new pulmonary nodules in the left lower lobe, suspicious for metastases. 3. Enlarged mediastinal lymph nodes, suspicious for metastatic adenopathy. 4. Patchy consolidation in the right upper and lower lobes, which may be post-obstructive in aetiology. Interlobular septal thickening seen within the right upper lobe may also be post-obstructive in nature but lymphangitis carcinomatosa is not excluded. 5. Background centrilobular emphysematous changes in both lungs. Further action or early intervention required Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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