# Row 2574

Visit Number: 789d1b63f02a47c3ab1ff1eec55303db9d8f97605192cb445bdbf8ddb5ab348d

Masked\_PatientID: 2574

Order ID: ce0ad00492846a7528626dac0083b4fd28b8010c85b2ae6b55c249129b9364ee

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 15/11/2017 20:02

Line Num: 1

Text: HISTORY CTangio Right upper lobe mass. satellite nodule staging scan - to evaluate for other sites of disease TECHNIQUE Contrast enhanced CT Thorax, Abdomen and Pelvis was performed. Axial and coronal images were obtained. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 Positive Rectal Contrast FINDINGS Reference made to the CT Angiographic study and chest radiograph dated 14 Nov 2017. CHEST Note is again made of a spiculated, irregular right upper lobe mass measuring 3.5 x 3.3 cm (6-24) with internal foci of coarse calcification and surrounding parenchymal distortion. There is no evidence of cavitation or surrounding ground-glass changes. Overall findings are suspicious for a primary lung malignancy. A smaller right upper lobe central nodule measuring 1.1 cm (6-35, 5-35) is suspicious for a satellite nodule. Other tiny peri-fissural and subpleural nodules for example, right oblique fissural nodule measuring 0.4 cm (6-35) and right lower lobe superior segment measuring 0.4 cm (6-47) are non-specific. There is no consolidation or pleural effusion. There are enlarged conglomerate right hilar nodes contiguous with mediastinal lymphadenopathy suspicious for disease. Right hilar adenopathy measuring 2.6 cm (5-47) whilst the largest mediastinal node in the right lower paratracheal region measuring 2 cm (5-40). There is resultant narrowing of the right upper lobe bronchus. Enlarged right supraclavicular nodes are also present, the largest measuring 1 cm in short axis axial diameter (5-9) but measuring 3.6 cm in height (10-54), suspicious for nodal metastasis. No axillary lymphadenopathy detected. Trace pericardial fluid is noted. The heart size is normal.ABDOMEN & PELVIS The liver shows a 3.4 cm hypodensity in segment VIII, likely a septated cyst. There are multiple other subcentimetre liver hypodensities which are too small to characterise and nonspecific. Inferior hepatic vein supplying segment VI is noted. There is thickening and cystic change of the gallbladder fundus suggestive of adenomyomatosis. No gallstone is seen. The biliary tree is not dilated. The pancreas is unremarkable. There is a subcentimetre hypodense focus in the spleen which is non-specific (image 7/21). There is a well-defined nodule in the left adrenal gland measuring 1.5 cm showing attenuation of about 50-60HU. This is indeterminate in this study. In the left kidney lower pole there isan indeterminate region of hypoattenuation. It may be related to inflammation. Mild adjacent perinephric stranding is noted. The right kidney is unremarkable. Both renal veins and IVC place with no filling defect. Coarse calcification is noted within the prostate gland. The urinary bladder is suboptimally distended. The bowel loops are of normal calibre. A few unenlarged upper abdominal lymph nodes are seen. No significantly enlarged pelvic lymph node detected. There is no intra-abdominal or pelvic free fluid. Lucent lesions with internal coarsened trabeculae within the T7 and T12 vertebral bodies are features of osseous haemangiomas. Two other lucencies in the T1 and T2 vertebral bodies are nonspecific. CONCLUSION 1. Spiculated, irregular right upper lobe apical mass is suspicious for a primary lung malignancy. A smaller right upper lobe central nodule may represent a satellite nodule. Histological correlation is suggested. 2. Right hilar, mediastinal and right supraclavicular lymphadenopathy are suspicious for nodal disease. 3. Indeterminate left adrenal nodule. Further evaluation is suggested. 4. Indeterminate left kidney lower pole hypoenhancing focus with mild surrounding stranding may be related to inflammation/infection. 5. Non-specific subcentimetre hypodense focus in the spleen. 6. No significant lymphadenopathy in the abdomen and pelvis. 7. Nonspecific lucent lesions in the T1 and T2 vertebral bodies. Osseous haemangiomasin T7 and T12 vertebral bodies. May need further action Reported by: <DOCTOR>

Accession Number: 1864c4833a3b3d261b5f9a56749218bc09409ac8c146cb873efab27327a5971b

Updated Date Time: 16/11/2017 12:33

## Layman Explanation

This radiology report discusses HISTORY CTangio Right upper lobe mass. satellite nodule staging scan - to evaluate for other sites of disease TECHNIQUE Contrast enhanced CT Thorax, Abdomen and Pelvis was performed. Axial and coronal images were obtained. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 Positive Rectal Contrast FINDINGS Reference made to the CT Angiographic study and chest radiograph dated 14 Nov 2017. CHEST Note is again made of a spiculated, irregular right upper lobe mass measuring 3.5 x 3.3 cm (6-24) with internal foci of coarse calcification and surrounding parenchymal distortion. There is no evidence of cavitation or surrounding ground-glass changes. Overall findings are suspicious for a primary lung malignancy. A smaller right upper lobe central nodule measuring 1.1 cm (6-35, 5-35) is suspicious for a satellite nodule. Other tiny peri-fissural and subpleural nodules for example, right oblique fissural nodule measuring 0.4 cm (6-35) and right lower lobe superior segment measuring 0.4 cm (6-47) are non-specific. There is no consolidation or pleural effusion. There are enlarged conglomerate right hilar nodes contiguous with mediastinal lymphadenopathy suspicious for disease. Right hilar adenopathy measuring 2.6 cm (5-47) whilst the largest mediastinal node in the right lower paratracheal region measuring 2 cm (5-40). There is resultant narrowing of the right upper lobe bronchus. Enlarged right supraclavicular nodes are also present, the largest measuring 1 cm in short axis axial diameter (5-9) but measuring 3.6 cm in height (10-54), suspicious for nodal metastasis. No axillary lymphadenopathy detected. Trace pericardial fluid is noted. The heart size is normal.ABDOMEN & PELVIS The liver shows a 3.4 cm hypodensity in segment VIII, likely a septated cyst. There are multiple other subcentimetre liver hypodensities which are too small to characterise and nonspecific. Inferior hepatic vein supplying segment VI is noted. There is thickening and cystic change of the gallbladder fundus suggestive of adenomyomatosis. No gallstone is seen. The biliary tree is not dilated. The pancreas is unremarkable. There is a subcentimetre hypodense focus in the spleen which is non-specific (image 7/21). There is a well-defined nodule in the left adrenal gland measuring 1.5 cm showing attenuation of about 50-60HU. This is indeterminate in this study. In the left kidney lower pole there isan indeterminate region of hypoattenuation. It may be related to inflammation. Mild adjacent perinephric stranding is noted. The right kidney is unremarkable. Both renal veins and IVC place with no filling defect. Coarse calcification is noted within the prostate gland. The urinary bladder is suboptimally distended. The bowel loops are of normal calibre. A few unenlarged upper abdominal lymph nodes are seen. No significantly enlarged pelvic lymph node detected. There is no intra-abdominal or pelvic free fluid. Lucent lesions with internal coarsened trabeculae within the T7 and T12 vertebral bodies are features of osseous haemangiomas. Two other lucencies in the T1 and T2 vertebral bodies are nonspecific. CONCLUSION 1. Spiculated, irregular right upper lobe apical mass is suspicious for a primary lung malignancy. A smaller right upper lobe central nodule may represent a satellite nodule. Histological correlation is suggested. 2. Right hilar, mediastinal and right supraclavicular lymphadenopathy are suspicious for nodal disease. 3. Indeterminate left adrenal nodule. Further evaluation is suggested. 4. Indeterminate left kidney lower pole hypoenhancing focus with mild surrounding stranding may be related to inflammation/infection. 5. Non-specific subcentimetre hypodense focus in the spleen. 6. No significant lymphadenopathy in the abdomen and pelvis. 7. Nonspecific lucent lesions in the T1 and T2 vertebral bodies. Osseous haemangiomasin T7 and T12 vertebral bodies. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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