# Row 2600

Visit Number: 739d9fce84bd5a9b0222748c20352cbefa26b8752cc72c3c419febfd25a58fa0

Masked\_PatientID: 2598

Order ID: 35deda26300f3a041ad27bcacd0221687a9d75a00d821997a2485361b4a140b7

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 11/12/2019 14:38

Line Num: 1

Text: HISTORY acute onset hyponatremia TRO malignancy TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison CT chest dated 28 May 2019. No comparison CT abdomen and pelvis. Diffuse fat stranding likely secondary to third space losses, which limits evaluation of this study. Patchy ground-glass change in bilateral upper lobes with associated interlobular septal thickening may be related to pulmonary oedema. No suspicious pulmonary nodule or mass in the aerated lung. Central airways are patent. Moderate bilateral pleural effusions. No grossly enlarged thoracic node. The heart is grossly enlarged. Severe coronary artery calcification. No pericardial effusion. Thoracic aorta is normal in calibre. Visualised thyroid oesophagus are grossly unremarkable. Liver outline is mildly nodular raising the possibility of cirrhosis. Periportal oedema is nonspecific. New subcapsular fatty structure in the right subdiaphragmatic space, measuring 1.3 cm, of uncertain signfiicance (series 8/57). Gallbladder, biliary tree, spleen and right adrenal are unremarkable. Mild nodularity of the left adrenal may be due to hyperplasia. Branching small cystic structures in the pancreatic head may be tiny BD-IPMNs without suspicious feature (series 7/53). The main pancreatic duct is not dilated and there is no focal parenchymal atrophy. Right renal lower pole cyst with thin septation. Other bilateral renal hypodensities are too small to characterise. No hydronephrosis. Urinary bladder is under distended. Prostate is mildly enlarged. Bowel loops are normal in calibre. Appendix is normal. Mild diffuse gastric oedema may represent gastritis. Fat containing left inguinal hernia. Small volume ascites. No significantly enlarged abdominal or pelvic node. Abdominal aorta is normal in calibre. No destructive bone lesion. Right anterior 4th rib fracture. T12-L1 compression fractures, likely osteoporotic. Left pectoralis major intramuscular fatty lesion is partially imaged, likely a lipoma. CONCLUSION No suspicious mass in the chest, abdomen or pelvis. Evidence of congestive cardiac failure and possible cirrhosis. Report Indicator: May need further action Finalised by: <DOCTOR>

Accession Number: 4438ceaee8494e50ee94ec0e47b6e4e12ffded039aced294556a1b0b8a094aef

Updated Date Time: 11/12/2019 15:32

## Layman Explanation

This radiology report discusses HISTORY acute onset hyponatremia TRO malignancy TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison CT chest dated 28 May 2019. No comparison CT abdomen and pelvis. Diffuse fat stranding likely secondary to third space losses, which limits evaluation of this study. Patchy ground-glass change in bilateral upper lobes with associated interlobular septal thickening may be related to pulmonary oedema. No suspicious pulmonary nodule or mass in the aerated lung. Central airways are patent. Moderate bilateral pleural effusions. No grossly enlarged thoracic node. The heart is grossly enlarged. Severe coronary artery calcification. No pericardial effusion. Thoracic aorta is normal in calibre. Visualised thyroid oesophagus are grossly unremarkable. Liver outline is mildly nodular raising the possibility of cirrhosis. Periportal oedema is nonspecific. New subcapsular fatty structure in the right subdiaphragmatic space, measuring 1.3 cm, of uncertain signfiicance (series 8/57). Gallbladder, biliary tree, spleen and right adrenal are unremarkable. Mild nodularity of the left adrenal may be due to hyperplasia. Branching small cystic structures in the pancreatic head may be tiny BD-IPMNs without suspicious feature (series 7/53). The main pancreatic duct is not dilated and there is no focal parenchymal atrophy. Right renal lower pole cyst with thin septation. Other bilateral renal hypodensities are too small to characterise. No hydronephrosis. Urinary bladder is under distended. Prostate is mildly enlarged. Bowel loops are normal in calibre. Appendix is normal. Mild diffuse gastric oedema may represent gastritis. Fat containing left inguinal hernia. Small volume ascites. No significantly enlarged abdominal or pelvic node. Abdominal aorta is normal in calibre. No destructive bone lesion. Right anterior 4th rib fracture. T12-L1 compression fractures, likely osteoporotic. Left pectoralis major intramuscular fatty lesion is partially imaged, likely a lipoma. CONCLUSION No suspicious mass in the chest, abdomen or pelvis. Evidence of congestive cardiac failure and possible cirrhosis. Report Indicator: May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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