# Row 2897

Visit Number: 28ffb95cb7b40a0cd065b69f19fd9dfd0b62ea0b5970e0a53093dcb865509143

Masked\_PatientID: 2892

Order ID: 8bdde598b9436656b403b6991beed01e5ec7c600b3bab698c094ff63cd4693df

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 17/3/2019 12:05

Line Num: 1

Text: HISTORY , Esophagus, completed concurrent chemoRT in nov18. On surveillance. Now presented with haemoptysis and SOB\ To restage ? relapse of disease; . TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350- Volume (ml): 65 FINDINGS Comparison is made to the CT chest, abdomen and pelvis dated 23 November 2018 (NCC). Interstudy differences in timing of scan acquisition limits comparison. CHEST There is interval increase in size and extent of mass centred in the mid-thoracic oesophagus, now with extensive mediastinal infiltration. It invades the carina and left main bronchus. It infiltrates along bilateral central bronchi, worse on the left which shows irregular narrowing. New pockets of mediastinal gas are seen, with cluster adjacent to the left main bronchus, raising the suspicion of tumour fistulation (se 402\35). The mass significantly narrows the left main pulmonary artery and mildly narrows the right main pulmonary artery. There is moderate stenosis of both left upper and lower pulmonary veins, with minimal narrowing of the right upper and lower pulmonary veins. There is upstream oesophageal dilatation and air-fluid level. There is resultant collapse of the left lower lobe, with hypoenhancing area within it possibly representing superimposed infection. New left upper lobe consolidation, bilateral patchy ground-glass changes are likely infective\inflammatory. New tiny lingula nodule, nonspecific (se 401\46). Previously noted left upper lobe nodule is obscured by consolidation. New small bilateral pleural effusions (left more than right) are seen. New moderate pericardial effusion is seen, without obvious enhancement or nodularity. Moderate coronary artery calcification is noted. The aorta is of normal calibre. ABDOMEN AND PELVIS Percutaneous gastrostomy tube is in situ. Stable mild mural oedema of the distal stomach, with narrowing of the gastric antrum.Gastro-oesophageal varices are again seen. The bowel loops show normal calibre. Uncomplicated colonic diverticula are noted. The appendix is normal. No suspicious hepatic lesion is seen. The gallbladder is unremarkable. Stable prominence ofthe biliary tree. The pancreas, spleen and adrenals are unremarkable. The kidneys enhance symmetrically without evidence of hydronephrosis. The urinary bladder shows smooth outline. The prostate is not enlarged. No significantly enlarged abdominal or pelvic node is seen. Trace ascites is noted. No destructive bone lesion is seen. T10 mild compression fracture is likely osteoporotic. CONCLUSION Since the CT chest, abdomen and pelvis of 23 November 2018 (NCC), Intervalincrease in size and extent of oesophageal mass, now with extensive mediastinal infiltration. New pockets of mediastinal gas is seen, with cluster of gas adjacent to the left main bronchus, raising the suspicion of tumour fistulation. New moderate pericardial effusion. Resultant collapse\consolidation of the left lower lobe, with hypoenhancing area within it possibly representing superimposed infection. New left upper lobe consolidation and bilateral patchy ground-glass changes arelikely infective\inflammatory. Clinical correlation for aspiration suggested. Report Indicator: Further action or early intervention required Reported by: <DOCTOR>

Accession Number: c01a9297587690ac6635451e49cd6f8ebc21b819811925c724d6dba97c240ea1

Updated Date Time: 18/3/2019 13:20

## Layman Explanation

This radiology report discusses HISTORY , Esophagus, completed concurrent chemoRT in nov18. On surveillance. Now presented with haemoptysis and SOB\ To restage ? relapse of disease; . TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350- Volume (ml): 65 FINDINGS Comparison is made to the CT chest, abdomen and pelvis dated 23 November 2018 (NCC). Interstudy differences in timing of scan acquisition limits comparison. CHEST There is interval increase in size and extent of mass centred in the mid-thoracic oesophagus, now with extensive mediastinal infiltration. It invades the carina and left main bronchus. It infiltrates along bilateral central bronchi, worse on the left which shows irregular narrowing. New pockets of mediastinal gas are seen, with cluster adjacent to the left main bronchus, raising the suspicion of tumour fistulation (se 402\35). The mass significantly narrows the left main pulmonary artery and mildly narrows the right main pulmonary artery. There is moderate stenosis of both left upper and lower pulmonary veins, with minimal narrowing of the right upper and lower pulmonary veins. There is upstream oesophageal dilatation and air-fluid level. There is resultant collapse of the left lower lobe, with hypoenhancing area within it possibly representing superimposed infection. New left upper lobe consolidation, bilateral patchy ground-glass changes are likely infective\inflammatory. New tiny lingula nodule, nonspecific (se 401\46). Previously noted left upper lobe nodule is obscured by consolidation. New small bilateral pleural effusions (left more than right) are seen. New moderate pericardial effusion is seen, without obvious enhancement or nodularity. Moderate coronary artery calcification is noted. The aorta is of normal calibre. ABDOMEN AND PELVIS Percutaneous gastrostomy tube is in situ. Stable mild mural oedema of the distal stomach, with narrowing of the gastric antrum.Gastro-oesophageal varices are again seen. The bowel loops show normal calibre. Uncomplicated colonic diverticula are noted. The appendix is normal. No suspicious hepatic lesion is seen. The gallbladder is unremarkable. Stable prominence ofthe biliary tree. The pancreas, spleen and adrenals are unremarkable. The kidneys enhance symmetrically without evidence of hydronephrosis. The urinary bladder shows smooth outline. The prostate is not enlarged. No significantly enlarged abdominal or pelvic node is seen. Trace ascites is noted. No destructive bone lesion is seen. T10 mild compression fracture is likely osteoporotic. CONCLUSION Since the CT chest, abdomen and pelvis of 23 November 2018 (NCC), Intervalincrease in size and extent of oesophageal mass, now with extensive mediastinal infiltration. New pockets of mediastinal gas is seen, with cluster of gas adjacent to the left main bronchus, raising the suspicion of tumour fistulation. New moderate pericardial effusion. Resultant collapse\consolidation of the left lower lobe, with hypoenhancing area within it possibly representing superimposed infection. New left upper lobe consolidation and bilateral patchy ground-glass changes arelikely infective\inflammatory. Clinical correlation for aspiration suggested. Report Indicator: 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.