# Row 2918

Visit Number: 7da3cd778fef47e5d53637fb74509ded80ec99c2fcf103a99dcdf54fd9193955

Masked\_PatientID: 2914

Order ID: 5a61411de6388c56c34e56fb26d45a0e73ec12ba3274951272e72bc66efdd97d

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 12/7/2018 17:17

Line Num: 1

Text: HISTORY right facial swellnig, cough productive of purulent spitum worst with food, bghx NSCLC, NPC TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS Comparison made with CT of 25/4/2018. Status post left lower (Aug 2011) and middle lobectomies (Apr 2014). Scarring at both lung bases with calcifications on the left and mild right lower lobe bronchiectasis are likely due to previous granulomatousinfection. Slight scarring in the medial aspect of the right upper zone may be due to previous treatment. No interstitial fibrosis or emphysema noted. A 9 mm nodule at the medial aspect of the right upper lobe (401-29) is unchanged from before. A few tiny nodules measuring 1-2mm in anterior right lung apex (401-25) are also nonspecific. Patchy consolidation in right lower lobe is likely infective. There are also new patchy ground-glass changes scattered in rest of both lungs (401-30, 63, 74), likely of similar aetiology. Small bilateral pleural effusions show no pleural thickening or mass. Heart size is not enlarged but there is mild distension of the right-sided chambers. Coronary and aortic calcifications seen. Ectasia of the ascending aorta measures 36 mm. Pulmonary vasculature enhance normally with no filling defect. The SVC is patent with no obvious narrowing. There is no engorgement of the jugular veins to suggest SVC obstruction. No enlarged supraclavicular, axillary, mediastinal or hilar nodes seen. No mediastinal or supraclavicular mass noted. Limited sections of the upper abdomen shows stable 7 mm segment 7/8 liver cyst and bilateral renal cysts measuring up to 30 mm at left mid kidney. Prominent bony outgrowth at the right scapula stable with no interval destruction, likely a chondromatous tumour. Stable extensive sclerotic metastasis involving C7, T2-5, L1 and right lateral clavicle again noted. Subtle skin thickening over both anterior lower neck extending down the left upper chest are non-specific. No emphysematous changes noted. Suggest clinical correlation for cellulitis. CONCLUSION 1. No SVC obstruction. 2. No supraclavicular/mediastinal mass or lymphadenopathy. 3. Status post left lower and middle lobectomies. No ominous mass noted. Stable 9mm right upper lobe nodule and few tiny nodules in anterior right apex are non-specific. 4. Interval patchy ground-glass changes with prominent consolidation in right lower lobe are likely infective. 5. Stable lesion of the right scapula likely chondromatous tumour. Stable sclerotic bony metastases also seen. 6. Other minor findings as described. May need furtheraction Finalised by: <DOCTOR>

Accession Number: e02846fa7e188441873928d6e3389aeb04616c1e7d1219b44c354b1a9d457729

Updated Date Time: 12/7/2018 18:59

## Layman Explanation

This radiology report discusses HISTORY right facial swellnig, cough productive of purulent spitum worst with food, bghx NSCLC, NPC TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS Comparison made with CT of 25/4/2018. Status post left lower (Aug 2011) and middle lobectomies (Apr 2014). Scarring at both lung bases with calcifications on the left and mild right lower lobe bronchiectasis are likely due to previous granulomatousinfection. Slight scarring in the medial aspect of the right upper zone may be due to previous treatment. No interstitial fibrosis or emphysema noted. A 9 mm nodule at the medial aspect of the right upper lobe (401-29) is unchanged from before. A few tiny nodules measuring 1-2mm in anterior right lung apex (401-25) are also nonspecific. Patchy consolidation in right lower lobe is likely infective. There are also new patchy ground-glass changes scattered in rest of both lungs (401-30, 63, 74), likely of similar aetiology. Small bilateral pleural effusions show no pleural thickening or mass. Heart size is not enlarged but there is mild distension of the right-sided chambers. Coronary and aortic calcifications seen. Ectasia of the ascending aorta measures 36 mm. Pulmonary vasculature enhance normally with no filling defect. The SVC is patent with no obvious narrowing. There is no engorgement of the jugular veins to suggest SVC obstruction. No enlarged supraclavicular, axillary, mediastinal or hilar nodes seen. No mediastinal or supraclavicular mass noted. Limited sections of the upper abdomen shows stable 7 mm segment 7/8 liver cyst and bilateral renal cysts measuring up to 30 mm at left mid kidney. Prominent bony outgrowth at the right scapula stable with no interval destruction, likely a chondromatous tumour. Stable extensive sclerotic metastasis involving C7, T2-5, L1 and right lateral clavicle again noted. Subtle skin thickening over both anterior lower neck extending down the left upper chest are non-specific. No emphysematous changes noted. Suggest clinical correlation for cellulitis. CONCLUSION 1. No SVC obstruction. 2. No supraclavicular/mediastinal mass or lymphadenopathy. 3. Status post left lower and middle lobectomies. No ominous mass noted. Stable 9mm right upper lobe nodule and few tiny nodules in anterior right apex are non-specific. 4. Interval patchy ground-glass changes with prominent consolidation in right lower lobe are likely infective. 5. Stable lesion of the right scapula likely chondromatous tumour. Stable sclerotic bony metastases also seen. 6. Other minor findings as described. May need furtheraction Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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