# Row 475

Visit Number: 53a498ddb6849e1719667b7964c17c858d59cb5c3a9951ceb100aff5416630a0

Masked\_PatientID: 456

Order ID: 0cdaf10c4382927fe9e90fa2888875c86d152f192e21354ddb8335190c53cd38

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 03/12/2016 11:21

Line Num: 1

Text: HISTORY Malignant (likely NSCLC) pleural effusion with left sided drain in-situ since 14/11/16. Fluid appears less on CXR.; Previous adenoca sigmoid colon resected, declined adjuvant chemo TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS Comparison made with the previous CT examination dated 15/11/2016. There is moderate sized left pleural effusion although significantly decreased in volume since the previous CT of 15/11/2016. The left-sided chest drainage tube has been removed. There is small amount of air within the pleural space in the nondependent aspect which may be related to recent intervention. The pleural fluid is of low density, and the previously seen dense haemorrhagic foci have resolved. However there is underlying mild diffuse thickening of the parietal pleura as well as visceral pleura without mediastinal pleural thickening. Partial collapse of the left lowerlobe secondary to the effusion is noted. Upper lobe predominant centrilobular and paraseptal emphysematous changes are noted bilaterally. At the extreme left apex, there is an ill-defined soft tissue mass approximately measuring 3.2 x 2 cm (image 602-7). It extends slightly superior to the left first rib with associated bony erosion (image 602-3) and it abuts the left subclavian artery which remains patent (image 602 - 10). The mass also abuts the left T2 vertebra and posterior second rib without bony erosion. No significantly enlarged supraclavicular, mediastinal or axillary node is seen. A small prevascular 4 mm node is unchanged. There is mild cardiomegaly with AICD leads in situ. Coronary stent in LAD is noted. No pericardial effusion present. Right-sided pleural calcifications are again noted. Stable right apical sca The adrenal glands are unremarkable. The other visualised upper abdominal solid organs show no overt abnormality. CONCLUSION Mass lesion in the left lung apex with associated left first rib bony erosion is suspicious for primary superior sulcus malignancy. Moderate left pleural effusion with interval reduction in volume and resolution of the haemorrhagic foci. Small amount of air is also noted within the left pleural space possibly procedure related. There is underlying diffuse pleural thickening and I note that the pleural fluid cytology showed malignant cells. No significant enlarged intrathoracic node. Background emphysema. May need further action Finalised by: <DOCTOR>

Accession Number: 1c3bd1c232384f72370c6a640a7fbb62e4ee47250e8565ede5bb54a84a7a0d96

Updated Date Time: 03/12/2016 13:15

## Layman Explanation

This radiology report discusses HISTORY Malignant (likely NSCLC) pleural effusion with left sided drain in-situ since 14/11/16. Fluid appears less on CXR.; Previous adenoca sigmoid colon resected, declined adjuvant chemo TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS Comparison made with the previous CT examination dated 15/11/2016. There is moderate sized left pleural effusion although significantly decreased in volume since the previous CT of 15/11/2016. The left-sided chest drainage tube has been removed. There is small amount of air within the pleural space in the nondependent aspect which may be related to recent intervention. The pleural fluid is of low density, and the previously seen dense haemorrhagic foci have resolved. However there is underlying mild diffuse thickening of the parietal pleura as well as visceral pleura without mediastinal pleural thickening. Partial collapse of the left lowerlobe secondary to the effusion is noted. Upper lobe predominant centrilobular and paraseptal emphysematous changes are noted bilaterally. At the extreme left apex, there is an ill-defined soft tissue mass approximately measuring 3.2 x 2 cm (image 602-7). It extends slightly superior to the left first rib with associated bony erosion (image 602-3) and it abuts the left subclavian artery which remains patent (image 602 - 10). The mass also abuts the left T2 vertebra and posterior second rib without bony erosion. No significantly enlarged supraclavicular, mediastinal or axillary node is seen. A small prevascular 4 mm node is unchanged. There is mild cardiomegaly with AICD leads in situ. Coronary stent in LAD is noted. No pericardial effusion present. Right-sided pleural calcifications are again noted. Stable right apical sca The adrenal glands are unremarkable. The other visualised upper abdominal solid organs show no overt abnormality. CONCLUSION Mass lesion in the left lung apex with associated left first rib bony erosion is suspicious for primary superior sulcus malignancy. Moderate left pleural effusion with interval reduction in volume and resolution of the haemorrhagic foci. Small amount of air is also noted within the left pleural space possibly procedure related. There is underlying diffuse pleural thickening and I note that the pleural fluid cytology showed malignant cells. No significant enlarged intrathoracic node. Background emphysema. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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