# Row 458

Visit Number: d638429ecc999c3d5542d8c8873278a9a4b100a9edf6b0593f776c9a36e71020

Masked\_PatientID: 456

Order ID: 9d51a14370d9c5a34e53817f7dacb3e811355a0f9ae3563f5c78cf039c7295c6

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 13/12/2015 14:31

Line Num: 1

Text: HISTORY newly diagnosed sigmoid tumour. For staging TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS CT abdomen and pelvis of 07/02/2014 was reviewed. There isno comparison CT thorax. THORAX There are ground-glass changes with small patchy foci of consolidation in the lungs, predominantly in the perihilar regions. There is scarring with calcified granulomata in the lung apices, especially on theright. Emphysematous changes also present in both lungs predominantly at the upper lobe. There are bilateral pleural effusions, with part of the right effusion being loculated at the right oblique fissure. Compressive atelectasis/consolidation is seen in the lower lobe of the left lung. Right sided calcified pleural plaques are also seen posteriorly. An AICD is in situ with its tip at the right ventricle. Cardiomegaly is noted and there is no pericardial effusion. There are coronary arterial calcifications and stents. There are few prominent mediastinal lymph nodes, with a subcarinal node being borderline enlarged. The rest of the lymph nodes are still considered small volume based on size criteria. There is bilateral gynecomastia. In the thyroid gland, there are few subcentimetre hypodensities, difficult to further characterise on CT. ABDOMEN PELVIS In the distal descending colon, there is a short segment of enhancing colonic wall thickening (13/33) which is very suspicious for a the colonic tumour as given the history. No upstream bowel dilatation is appreciated. There are few small volume regional lymph node which is indeterminate in nature. No significantly enlargedlymph node is seen in the abdomen or the pelvis. Once again, malrotation of the bowel is seen, with the duodenojejunal junction located to the right of the midline and the superior mesenteric vein located anterior to the left of the superiormesenteric artery. The colon remains predominantly on the left. No focal hepatic lesion is appreciated. Focal fatty change is seen in periphery of segment of the liver, near the falciform ligament. There are some dependent hyperdense material in the gallbladder, most likely due to sludge. No gallbladder wall thickening or biliary dilatation is appreciated. The spleen, adrenal glands and the atrophic pancreas are unremarkable. In both kidneys, there few subcentimetre hypodense foci, too small for characterisation. no overt mass is seen in the urinary bladder. Prostate gland is not enlarged. No ascites is identified. In the medial right thigh (adductor magnus muscle), there is a intramuscular predominantly fat containing lesion with a tiny eccentric tiny soft tissue focus. It measures 2.1 x 1.6 x 2.9 cm and may be an intramuscular lipoma. No bony destruction is seen. CONCLUSION There is a short segment hyper enhancing distal descending colonic wall thickening, likely representing the tumour given in the history. A few small volume regional lymph nodes are indeterminate in nature. The known bowel malrotation is seen with no evidence of midgut volvulus. Marginally enlarged subcarinal lymph node is nonspecific and may be reactive. Continued follow-up is advised. There are bilateral pleural effusions which is partially loculated on the right. Ground-glass changes and patchy consolidation are seen in both lungs, in particularly at the perihilar regions. Clinical correlation is advised to assess for cardiac failure or pulmonary oedema. A few nonspecific small thyroid nodules. May need further action Finalised by: <DOCTOR>

Accession Number: acb22e84a5ded1ddda72fe6de7647f9329e72103f3a0dd4027d98798218d1072

Updated Date Time: 14/12/2015 9:52

## Layman Explanation

This radiology report discusses HISTORY newly diagnosed sigmoid tumour. For staging TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 75 FINDINGS CT abdomen and pelvis of 07/02/2014 was reviewed. There isno comparison CT thorax. THORAX There are ground-glass changes with small patchy foci of consolidation in the lungs, predominantly in the perihilar regions. There is scarring with calcified granulomata in the lung apices, especially on theright. Emphysematous changes also present in both lungs predominantly at the upper lobe. There are bilateral pleural effusions, with part of the right effusion being loculated at the right oblique fissure. Compressive atelectasis/consolidation is seen in the lower lobe of the left lung. Right sided calcified pleural plaques are also seen posteriorly. An AICD is in situ with its tip at the right ventricle. Cardiomegaly is noted and there is no pericardial effusion. There are coronary arterial calcifications and stents. There are few prominent mediastinal lymph nodes, with a subcarinal node being borderline enlarged. The rest of the lymph nodes are still considered small volume based on size criteria. There is bilateral gynecomastia. In the thyroid gland, there are few subcentimetre hypodensities, difficult to further characterise on CT. ABDOMEN PELVIS In the distal descending colon, there is a short segment of enhancing colonic wall thickening (13/33) which is very suspicious for a the colonic tumour as given the history. No upstream bowel dilatation is appreciated. There are few small volume regional lymph node which is indeterminate in nature. No significantly enlargedlymph node is seen in the abdomen or the pelvis. Once again, malrotation of the bowel is seen, with the duodenojejunal junction located to the right of the midline and the superior mesenteric vein located anterior to the left of the superiormesenteric artery. The colon remains predominantly on the left. No focal hepatic lesion is appreciated. Focal fatty change is seen in periphery of segment of the liver, near the falciform ligament. There are some dependent hyperdense material in the gallbladder, most likely due to sludge. No gallbladder wall thickening or biliary dilatation is appreciated. The spleen, adrenal glands and the atrophic pancreas are unremarkable. In both kidneys, there few subcentimetre hypodense foci, too small for characterisation. no overt mass is seen in the urinary bladder. Prostate gland is not enlarged. No ascites is identified. In the medial right thigh (adductor magnus muscle), there is a intramuscular predominantly fat containing lesion with a tiny eccentric tiny soft tissue focus. It measures 2.1 x 1.6 x 2.9 cm and may be an intramuscular lipoma. No bony destruction is seen. CONCLUSION There is a short segment hyper enhancing distal descending colonic wall thickening, likely representing the tumour given in the history. A few small volume regional lymph nodes are indeterminate in nature. The known bowel malrotation is seen with no evidence of midgut volvulus. Marginally enlarged subcarinal lymph node is nonspecific and may be reactive. Continued follow-up is advised. There are bilateral pleural effusions which is partially loculated on the right. Ground-glass changes and patchy consolidation are seen in both lungs, in particularly at the perihilar regions. Clinical correlation is advised to assess for cardiac failure or pulmonary oedema. A few nonspecific small thyroid nodules. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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