# Row 5065

Visit Number: 1caa5ad2b9b8889ab601d18400f1a2ecb173b6b56e39acf9f4b6bc05d68756ca

Masked\_PatientID: 5062

Order ID: 72c60554ec6968411582f4bab9d42d04165bdb882952a23a8ac0bcdb60b18378

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 16/9/2019 8:36

Line Num: 1

Text: HISTORY Abd distention TRO mechanical obstruction and TRO bowel ischemia TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 70 FINDINGS The prior CT thoracolumbar spine dated 11 September 2019 was noted. A feeding tube is seen with its tip at the gastric pylorus. There is predominant large bowel dilatation measuring up to 8.9 cm at the cecum. There is gradual transition of calibre at the splenic flexure with evidence of faecal loading in the descending colon and the proximal sigmoid colon. Distal to this, there is a segment of collapsed sigmoid colon which could be due to decompression from the rectal tube. Pockets of non-dependent gas along the periphery of the ascending colon that stop at the intraluminal gas-fluid level likely represent pseudopneumatosis. There is also mild dilatation of small bowel loops with no definite transition point. Small hypodensity in segment IVB of the liver is too small to characterise. There is no biliary dilatation. No radiodense gallstone is seen within the distended gallbladder. The spleen, pancreas and the adrenal glands are unremarkable. There is a 1.8 cm cyst at the lower pole of the left kidney. Further bilateral renal hypodensities are too small to characterise. No hydronephrosis. The urinary bladder is catheterised. The uterus is atrophied. No adnexal mass is seen. No significantly enlarged intra-abdominal lymph node is seen. Trace ascites is present. Fat containing inguinal hernias are noted with small amount of fluid. There is pulmonary consolidation in both lower lobes. Possible trace right pleural effusion. There is no filling defect seen within the pulmonary trunk, main pulmonary arteries and the visualised lobar and segmental branches to suggest pulmonary thromboembolism. The heart is enlarged. No features to suggest right heart strain. Note is made of an aberrant right subclavian artery. No pericardial effusion. No significantly enlarged intrathoracic lymph node. There is posterior spinal instrumentation spanning from T10-L1. Multiple right-sided rib fractures are noted. CONCLUSION The bowel dilatation is possibly related to ileus. Pockets of non-dependent gas along the periphery of the ascending colon that stop at the intraluminal gas-fluid level likely represent pseudopneumatosis. No pulmonary thromboembolism. No right heart strain. Pulmonary consolidation in both lower lobes. Report Indicator: May need further action Finalised by: <DOCTOR>

Accession Number: 5eac9c507c09dd540996b7314f763008df83d3e8e46423c3a4f3abebdc3448c6

Updated Date Time: 16/9/2019 10:51

## Layman Explanation

This radiology report discusses HISTORY Abd distention TRO mechanical obstruction and TRO bowel ischemia TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 70 FINDINGS The prior CT thoracolumbar spine dated 11 September 2019 was noted. A feeding tube is seen with its tip at the gastric pylorus. There is predominant large bowel dilatation measuring up to 8.9 cm at the cecum. There is gradual transition of calibre at the splenic flexure with evidence of faecal loading in the descending colon and the proximal sigmoid colon. Distal to this, there is a segment of collapsed sigmoid colon which could be due to decompression from the rectal tube. Pockets of non-dependent gas along the periphery of the ascending colon that stop at the intraluminal gas-fluid level likely represent pseudopneumatosis. There is also mild dilatation of small bowel loops with no definite transition point. Small hypodensity in segment IVB of the liver is too small to characterise. There is no biliary dilatation. No radiodense gallstone is seen within the distended gallbladder. The spleen, pancreas and the adrenal glands are unremarkable. There is a 1.8 cm cyst at the lower pole of the left kidney. Further bilateral renal hypodensities are too small to characterise. No hydronephrosis. The urinary bladder is catheterised. The uterus is atrophied. No adnexal mass is seen. No significantly enlarged intra-abdominal lymph node is seen. Trace ascites is present. Fat containing inguinal hernias are noted with small amount of fluid. There is pulmonary consolidation in both lower lobes. Possible trace right pleural effusion. There is no filling defect seen within the pulmonary trunk, main pulmonary arteries and the visualised lobar and segmental branches to suggest pulmonary thromboembolism. The heart is enlarged. No features to suggest right heart strain. Note is made of an aberrant right subclavian artery. No pericardial effusion. No significantly enlarged intrathoracic lymph node. There is posterior spinal instrumentation spanning from T10-L1. Multiple right-sided rib fractures are noted. CONCLUSION The bowel dilatation is possibly related to ileus. Pockets of non-dependent gas along the periphery of the ascending colon that stop at the intraluminal gas-fluid level likely represent pseudopneumatosis. No pulmonary thromboembolism. No right heart strain. Pulmonary consolidation in both lower lobes. 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.