# Patient ID: 3451, Performed Date: 05/1/2017 13:52

## Raw Radiology Report Extracted

Visit Number: c0cffa0a4d792bd9499f36d8b0787b851e4a95eee7836431d797c3f337ce5e8c

Masked\_PatientID: 3451

Order ID: 90c0db9f897a52fbe9344e930e3d749339f41f9f914768e5aa25b49f49e0ed0f

Order Name: CT Chest, Abdomen and Pelvis

Result Item Code: CTCHEABDP

Performed Date Time: 05/1/2017 13:52

Line Num: 1

Text: HISTORY pw severe LHC pain, aw fever, raised CRP LOW and anemia seen also hard mass felt in LHC/costal margin ?splenomegaly, CXR shows left pleural effusion CT TRO intra-abdominal infection vs haem malignancy and to evaluate for any masses TECHNIQUE CT chest, abdomen and pelvis was performed with coronal reconstruction. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS No comparison CT available. Note is made of CXR of 3/1/2017. Two rim-enhancing collections with suggestion of loculations, are in keeping with abscesses. No adjacent joint or bone destruction. These are as detailed below, 1. Left upper abdominal wall, involving the left 6th intercoastal muscle anterolaterally, measuring 32 x 18 x 55 mm (8-33, 11-62). There is slight stranding of the adjacent extrapleural fat. No invasion into the adjacent pectoralis or intra-abdominal cavity. 2. Left upper quadratus lumborum anterior to left 12th intercostal space, measuring 45 x 30 x 15mm (8-30, 11-25). There is no destruction of adjacent 12th costotransverse joint, or extension into the epidural fat. REST OF THORAX A low-density left pleural effusion is likely reactive with mild adjacent atelectasis in the left lower lobe. No pleural thickening or mass is seen. A small area of consolidation is noted in the inferior lingula. No lung mass, cavitating lesion, tree-in-bud disease or sinister nodule is noted. The right lung is clear. No interstitial fibrosis, bronchiectasis or emphysema is evident. Mild left hilar nodes are likely reactive. No enlarged supraclavicular, axillary or mediastinal nodes seen. The aorta and the pulmonary arteries are normal in calibre. The heart size is normal and no pericardial effusion is seen. No destructive bony lesion is seen. REST OF ABDOMEN AND PELVIS The liver contour is smooth. No liver abscess noted. There is a 20 x 18 mm focus in the segment 4a (8-26), which demonstrates nodular discontinuous peripheral enhancement on the arterial phase and complete filling-in on the delayed phases, compatible with a haemangioma. A 4 mm hypodense lesion is noted at the liver dome, too small to characterise but probably a cyst. Minimal bile duct prominence is seen at segment 5 (8-54), non-specific. The gallbladder is unremarkable and there is no biliary ductal dilatation. The portal and hepatic veins are patent. The spleen, pancreas and adrenals and bowel are normal. The kidneys enhance symmetrically and there is no hydronephrosis, calculus or renal mass. The ureters, urinary bladder and seminal vesicles are unremarkable. The prostate shows no abscess. There is no ascites or peritoneal nodule. There is no intra-abdominal or pelvic lymphadenopathy. No destructive bony lesion is seen. CONCLUSION 1. Two abscesses noted in the lower chest/upper abdomen, both anteriorly and posteriorly. 2. Left pleural effusion is likely reactive. 3. Hemangioma in segment 4 of the liver. 4. No ominous mass is detected in the thorax, abdomen and pelvis. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: 8decfcb8a8297c3e5313416befb071d6d6794a38248529cda755fe5e59353781

Updated Date Time: 05/1/2017 18:14

## Layman Explanation

Error generating summary.

## Summary

Error generating summary.