# Patient ID: 5387, Performed Date: 20/2/2018 15:20

## Raw Radiology Report Extracted

Visit Number: 46cb2182df260c67226a721fde92eef51c1ad819ecbb5cba508898b06fc77185

Masked\_PatientID: 5387

Order ID: bdcd508f632c202e106dc458e670806b8b17b632fa8e5e51f94d41229fdf1b86

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 20/2/2018 15:20

Line Num: 1

Text: HISTORY bronchial- esophageal fistya s/p bronchial and esophageal stents desaturation ? pneumonitis, to look for any mediastinal collections TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS Comparison was made with previous CT examination dated 02/01/2018. There is an endotracheal tube with the tip well above the level of the carina. Bronchial stent is sent along the distal right main, intermediate and right lower lobar bronchi. The right upper and middle lobe bronchi are patent although the origin of the latter is narrowed. Dense consolidations and patchy ground-glass opacifications are present in the right upper lobe. In the posterior segment of the right upper lobe, there is an irregular cavitating lesion approximately measuring 6.4 x 6 cm (image 402-28) with an air-fluid level, suspicious for an abscess. At the medial aspect of this cavity and anterior to the gastric conduit, there is a linear density (image 402-34) which may represent surgical material. Consolidations are also present in both lower lobes and dependent aspect of the left upper lobe and lingula. Small nodular changes and ground-glass opacitiesare scattered elsewhere in the left upper lobe and lateral segment of the middle lobe. These are likely to represent infective changes. Surgical sutures are also noted along the gastric conduit. A stent is present in the upper portion of thegastric conduit; of note a strut is pointing in to lumen at its proximal end. A feeding tube is also present, the lower portions are partially visualized in the jejunum. A few prominent nodes are seen in the mediastinum measuring up to 0.9 cm node in the precarinal region. Soft tissue thickening and stranding in the mediastinal fat may be postsurgical in nature. No rim enhancing fluid collection is however detected in the mediastinum. The heart size is within normal limits. Coronary atherosclerotic calcifications predominantly in the LAD territory noted. The ascending thoracic aorta is mildly ectatic measuring 4.7 cm in diameter. There are small bilateral pleural effusions. No underlying pleural thickening is noted.Stable hypodense lesions in segments 3 and 4 of the liver are probably cysts. Small amount of fluid is noted around the liver. The other visualised upper abdominal organs are grossly unremarkable. No destructive bony lesion detected. CONCLUSION Extensive consolidations in both lungs as described with scattered ground-glass/nodular changes elsewhere. These are likely to represent infective changes. The cavitating lesion with an air-fluid level in the right upper lobe posterior segment is suspicious for an abscess in this context. Bilateral small pleural effusions. Bronchial stent is in-situ extending along the right distal main, intermediate bronchus and right lower lobar bronchial origin. Prominent mediastinal nodes and fat stranding in the surgical bed are likely to represent postsurgical changes. No rim enhancing mediastinal fluid collection is seen. Further action or early intervention required Finalised by: <DOCTOR>

Accession Number: 85a730cf4c83fb05ddbb0c9e6b2df6e368931a5d65e300571be5eb08956efc10

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## Layman Explanation

Error generating summary.

## Summary

Error generating summary.