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*1.5/3T MRI • Extremity MRI • Open MRI • CT • DEXA • X-Ray • Ultrasound • 3D Mammography • Breast MRI*

SAMEER P. DESAI, MD
1 WASHINGTON BLVD STE 9
TRENTON, NJ 08691

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|---|---|
| **RE:** | **MALAGRINO, JAMES** |
| **DOB:** | **09-Jun-1942** |
| DOS: | 12-Jun-2025 11:40:00 AM |
| ACC. #: | RAM58863791 |
| MRN: | 000171814 |

CT scan chest abdomen and pelvis with contrast

HISTORY: C34.90

Study was performed during injection of 75 mL Omnipaque 350. Patient received oral contrast prior to procedure. Examination is compared to CT chest from February 28, 2024 .-I have older CT of the abdomen 10/26/2017 to compare

Study was performed using iterative dose reduction software. Automated exposure control utilized.

Patient has had surgery to the right lung. Volume loss is present with mediastinal shift to the right. There are lymph nodes identified in the mediastinum which have increased in size from prior exam. The largest of these is seen on the left side adjacent to the esophagus seen image #38 series 2 measuring 12.7 x 9.6 mm. On prior examination this measured only a few millimeters. Also within the right upper mediastinum there are 2 lymph nodes seen image 27 series 2 measuring up to 11.7 mm x 6 mm. These also have increased in size from prior exam.

Surgical clips are seen throughout the mediastinum. There is no thoracic aortic aneurysm.

There is a tiny hiatal hernia. At least moderate coronary artery calcifications present.

Evaluation of the lungs demonstrates areas of pleural and parenchymal scarring to be present in the right lung. This is most apparent anteriorly in the mid to upper chest. This is seen around image 64 series 6 measuring about 3.6 x 1.5 cm. This is ill-defined and similar to prior exam. Also medially along the posterior mediastinum there is bronchiectasis and ill-defined density typical of radiation therapy changes. This is also similar to prior exam. Laterally within the right upper chest there is pleural thickening and irregularities present also felt to be similar to prior exam.

Pleural nodular density is seen anteriorly on the right image 81 series 6 measuring up to 8.4 mm. This is unchanged. Areas of scarring are again noted in the right lower chest near the diaphragm unchanged with some groundglass infiltrate and linear opacities. I do not see a focal abnormality in the right lung which I would consider suspicious at this time.

Evaluation of the left lung demonstrates mild apical pleural and parenchymal scarring. This is unchanged. There is some tree-in-bud abnormalities present within the left upper lobe most apparent image 77 series 6. This is similar to prior exam. On image #85 within the left lower lobe a nodular density is seen measuring about 6.4 mm x 7.3 mm. This

Signed by WILLIAM MECHANIC, MD at 6/14/2025 8:18:54 AM GMT+00:00

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appears to have increased in size from prior exam where I can measure about 4.5 x 6.5 mm. This is less masslike on the coronal images. The finding is nonspecific..

Within the left lower lobe there are small areas of ill-defined groundglass opacity tree-in-bud abnormalities. This is more prominent than on prior examination. This includes a focal opacity measuring 9 mm left lower lobe image 101. Branching nodular opacity is seen in the left lower lobe image #99 series 6 measuring up to 8.4 mm. This is new from prior exam as well.

Mild fatty infiltration of the liver is seen. I do not see abnormality which I would consider suspicious at this time. Patient has had cholecystectomy. There is dilatation of common bile duct measuring 15 mm. This is similar to prior exam. No calcifications seen within the duct. Patient has had a prior surgery to the upper abdomen. There are surgical clips present around the stomach. No mass lesion is seen in the region. No obstruction is seen of the anastomosis of the stomach and small bowel. No pancreatic or adrenal mass lesion is seen

No splenic enlargement or focal splenic abnormality is noted.

Evaluation of the kidneys demonstrate no evidence of hydronephrosis. There is a 3 mm calculus within the left kidney. No focal suspicious renal abnormality is noted.

There is no abdominal aortic aneurysm or enlarged retroperitoneal lymph nodes. There is a small volume of plaque thrombus within the abdominal aorta inferiorly with the aorta measuring up to 2 cm. No stenosis of any significance is seen.

The cecum is at the upper limits of normal in caliber. The sigmoid colon is not well distended. There is thickening of the wall in multiple diverticula present. This is likely on the basis of chronic diverticular disease. This is similar to the prior CT scan. The colon would be better evaluated with a direct visualization.

No small bowel abnormality is noted. There is no evidence for a fecal impaction of colon.

Urinary bladder mildly thick-walled anteriorly. There are inguinal hernias present bilaterally. The bladder the left side extends into the left inguinal canal. Small bowel loop is also seen extending into the superior aspect of both inguinal canals. These findings are unchanged

Prostate gland is enlarged measuring 4.8 x 3.2 cm.

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The lower portion of the rectum is not well distended limiting its evaluation.

I do not see evidence of pelvic lymphadenopathy.

No suspicious osseous lesions are noted. There is a mild compression of the L1 vertebral body which is unchanged.

IMPRESSION:

1. There are areas of pleural and parenchymal scarring in the right lung similar to prior exam.
2. There are areas of ill-defined groundglass opacity and tree-in-bud abnormalities in the left lower lobe which are more prominent than on prior exam. There are scattered focal nodular opacity present new from prior exam... My suspicion is that this represent inflammatory or infectious process. Close follow-up examination in 3 months would be recommended.
3. There are lymph nodes in the mediastinum which have increased in size from prior exam. These are nonspecific. These could be reactive lymph nodes. Neoplastic process cannot be excluded.
4. No mass lesion is seen in the abdomen or pelvis.
5. There is thickening of the wall of the sigmoid colon with multiple diverticula present. This is likely on the basis of chronic diverticular disease. This appears similar to prior exam.
6. Other findings as described above.

Electronically signed by: William Mechanic MD 06/14/2025 08:18 AM EDT RP Workstation: RAIWRS65943

Signed by WILLIAM MECHANIC, MD at 6/14/2025 8:18:54 AM GMT+00:00

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