BUNDABERG BASE HOSPITAL
Department of Medical Imaging - Patient Report

Patient Name: KEMPS GERARD W
UR Number: 007900 DOB:
Series Number: 14 Sex: M
Attend.Date: 10 DEC 04 Attend Number: 148862
Current Date: 10 DEC 04

Examinations: CT - ABDOMEN,CT - CHEST
Referred: DR P MIACH,BUNDABERG HEALTH SERVICE,PO BOX 34,BUNDABERG,
Location: WD10
Reported By: SG:3880 DR JOHN BRANSON

CLINICAL HISTORY;

Oesophageal malignancy.

CT OF THE CHEST, ABDOMEN AND PELVIS.

TECHNIQUE: Contrast enhanced spiral acquisition. Patient in chronic renal failure.

FINDINGS;

There appears to be considerable thickening of the wall of the thoracic oesophagus from the level of the gastroesophageal junction at least as far as the carina. The findings of oesophageal malignancy on OGD are noted. On the left lateral aspect of the oesophageal wall there is partial infiltration of the surrounding fat and partial loss of definition of the fat plane between the oesophageal wall and the proximal descending thoracic aorta. There appears to be at least one moderately enlarged right para-tracheal lymph node, as well as one mildly enlarged subcarinal lymph node but no generalised inferior mediastinal lymphadenopathy is seen. No enlarged superior mediastinal lymph nodes are seen. The hila appear unremarkable. Focal pulmonary scarring is seen in the left upper lobe. No acute airspace consolidation or atelectasis is seen. There are a few relatively minor para-septal bullae. There are at least four focal intra-pulmonary lesions lying posteriorly in the right lower lobe, the largest of these measuring approximately 12mm in diameter and showing some spiculation of the margins. The others are somewhat smaller. At the peripheri of both lungs, lying in what appears to be a pleural based location there are several small densities seen bilaterally. There is no pleural calcification, but some of these peripheral opacities appear to be pleural based, while others are more difficult to assess. A fairly prominent area of pleural plaque or thickening is seen in the right lung base. No pleural abnormality seen. NO axillary abnormality seen. Below the diaphragm the liver, biliary tree, spleen, pancreas and adrenal glands have a satisfactory appearance. No retro-crural , para-aortic, mesenteric or pelvic lymphadenopathy is seen. The abdominal aorta is somewhat tortuous and shows calcified plaque and is mildly ectatic but no frank aneurysm formation is seen. The common iliac arteries are also somewhat ectatic and show atheromatous unfolding. IVC

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satisfactory. The right kidney is significantly reduced in size, the left kidney also somewhat smaller than average. Neither kidney appears hydronephrotic. The urinary bladder and prostate appear unremarkable. No abnormality of the bowel is seen. No abdominal free fluid or fluid collection noted.

CONCLUSION; Thickened oesophageal wall below the level of the carina with some infiltration of the associated fat planes. Mediastinal lymphadenopathy as described, but no further lymphadenopathy. There are several intra-pulmonary nodules at the right lung base, of which the largest has a spiculated margin. The possibility of metastatic lesions would have to be considered. A primary malignancy is not entirely excluded. There is also some localised pleural thickening as well as several indeterminate peripheral opacities which appear to be pleural based. No pleural calcification is seen but the possibility of non-calcified pleural plaque associated with asbestos exposure is not excluded. NO sign of abdominal or pelvic lymphadenopathy or masses is seen. No sign of hepatic metastatic disease. Small kidneys, particularly the right kidney, in keeping with the history of chronic renal failure.

DICTATED û BUT NOT READ