Patient 1

Result Date and Time	Description	Status
	CHEST 2 VIEWS, FRONTAL PA AND LATERAL	Final

PA AND LATERAL VIEWS OF THE CHEST ON 3/29/07

HISTORY: COUGH

COMPARISON: NONE

FINDINGS:

THE HEART SIZE AND PULMONARY VASCULATURE APPEAR NORMAL.

THERE IS A RIGHT UPPER LOBE CONSOLIDATION. FIRST CONSIDERATION IS INFECTIOUS. EQUIVOCAL CAVITATION. CONSIDER TUBERCULOSIS. NO PLEURAL EFFUSIONS OR PNEUMOTHORAX.

FOLLOW-UP TO RESOLUTION IS SUGGESTED.
THIS EXAMINATION AND REPORT HAVE BEEN REVIEWED BY THE
ATTENDING RADIOLOGIST WHOSE NAME APPEARS ON THIS REPORT

Patient 1

Result Date and Time	Description	Status
	CT CHEST/ABDOMEN/PELVIS WITH CONTRAST	Final

CT OF THE CHEST, ABDOMEN, AND PELVIS ON 4/3/2007.

HISTORY: THE MARCH 30, 2007 CHEST RADIOGRAPH OF THIS 69 YEAR OLD WOMAN WAS REPORTED TO BE SUSPICIOUS FOR A CAVITY ACCOMPANYING RIGHT UPPER LOBE LUNG CONSOLIDATION. MYCOBACTERIUM TUBERCULOSIS IS A DIAGNOSTIC CONSIDERATION.

COMPARISON: NO PRIOR CT STUDIES.

PROCEDURE: THE CHEST, ABDOMEN, AND PELVIS WERE SCANNED WITH 5 MM COLLIMATION USING BOTH ORAL AND INTRAVENOUS CONTRAST MATERIAL. ADDITIONAL 2.5 MM COLLIMATED SCANNING WAS DONE THROUGH THE RIGHT UPPER LOBE.

FINDINGS:

THERE ARE ENLARGED LYMPH NODES PRECARINAL AND ADJACENT TO THE AORTIC ARCH. THE RIGHT HILUS IS OBSCURED BY LUNG CONSOLIDATION SO IT CANNOT BE DETERMINED IF THERE ARE ENLARGED RIGHT HILAR LYMPH NODES.

THERE IS PATCHY CONSOLIDATION AND POORLY DEFINED IRREGULAR NODULAR OPACITIES OF THE APICAL AND ANTERIOR SEGMENTS OF THE RIGHT UPPER LOBE ALONG WITH MORE DENSE CONSOLIDATION OF THE POSTERIOR SEGMENT. A 2.5 CM CAVITY OF THE POSTERIOR SEGMENT CONTAINS A SMALL AMOUNT OF FLUID, AND THERE IS BRONCHIECTASIS OF THE SEGMENT. THE POSTERIOR SEGMENTAL BRONCHUS OF THE RIGHT UPPER LOBE IS MARKEDLY NARROWED BUT PATENT. THERE IS MINIMAL PARASPINAL CONSOLIDATION OF THE RIGHT LOWER LOBE.

THE LIVER, SPLEEN, PANCREAS, ADRENAL GLANDS, AND KIDNEYS ARE NORMAL.

THERE IS NO INTRAPERITONEAL OR RETROPERITONEAL LYMPHADENOPATHY.

THERE ARE NO PELVIC MASSES. THERE ARE SIGMOID DIVERTICULI. THERE IS A CYSTOCELE ALONG WITH MARKED CAUDAL DISPLACEMENT OF THE PELVIC FLOOR.

CONCLUSION:

IN ADDITION TO CONSOLIDATION OF THE RIGHT UPPER LOBE, THERE IS BRONCHIECTASIS AND 2.5 CM CAVITY OF THE POSTERIOR SEGMENT ALONG WITH A FEW ENLARGED LYMPH NODES AS DESCRIBED ABOVE. FIRST CONSIDERATION IS INFECTION, AND THESE FINDINGS COULD BE DUE TO MYCOBACTERIUM TUBERCULOSIS. NEOPLASM IS POSSIBLE BUT LESS LIKELY. FURTHER EVALUATION IS RECOMMENDED.

Addendum Begins

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THERE IS A CALCIFIED GRANULOMA OF THE RIGHT UPPER LOBE.

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Addendum Ends

Patient 2

Result Date and Time	Description	Status
	CHEST, SINGLE VIEW, FRONTAL (AP PORTABLE TECHNIQUE)	**Final**

""" PRELIMINARY REPORT BY RADIOLOGY RESIDENT. THE
FINAL REPORT WILL BE SUBMITTED AT THE BOTTOM OF THIS DOCUMENT BY THE
ATTENDING RADIOLOGIST. """

DXCPORTCHEST, SINGLE VIEW , FRONTAL (AP PORTABLE TECHNIQUE)
HISTORY: SHORTNESS OF BREATH ABSENT BREATH SOUNDS ON LEFT.
EXAM DATE: 3/30/2007 5:42:00 AM
COMPARISON: NONE

FINDINGS:
THERE IS A LARGE PNEUMOTHORAX ON THE LEFT WITH NEAR COMPLETE COLLAPSE
OF THE LEFT LUNG AND WITH A COMPONENT OF TENSION CAUSING SHIFT OF THE
MEDIASTINUM TOWARD THE RIGHT AND DEPRESSION OF THE LEFT HEMIDIAPHRAGM.
SURGICAL SUTURE IS IDENTIFIED ALONG THE RIGHT PARATRACHEAL REGION.
THE HEART SIZE IS NOT ENLARGED. THERE ARE NO GROSS PARENCHYMAL
LESIONS ON THE RIGHT. THERE IS NO EVIDENCE OF A PNEUMOTHORAX ON THE
RIGHT.
THESE FINDINGS WERE DISCUSSED WITH ATTENDING FROM THE EMERGENCY
DEPARTMENT AT THE TIME OF INTERPRETATION.

::: ATTENDING FINAL REPORT:
IN AGREEMENT WITH ABOVE. :::
THIS EXAMINATION AND REPORT HAVE BEEN REVIEWED BY THE
ATTENDING RADIOLOGIST WHOSE NAME APPEARS ON THIS REPORT

Patient 2

Result Date and Time	Description	Status
	CT CHEST/THORAX WITH CONTRAST	Final

""" PRELIMINARY REPORT BY RADIOLOGY RESIDENT. THE
FINAL REPORT WILL BE SUBMITTED AT THE BOTTOM OF THIS DOCUMENT BY THE
ATTENDING RADIOLOGIST. """

DATE: 4/3/2007 1:19:00 PM
HISTORY: 52 YEAR OLD WITH SPONTANEOUS PNEUMOTHORAX, CHEST TUBE
REMOVED AT 9 A.M.
COMPARISON: NONE
TECHNIQUE: 5 MM AXIAL IMAGES WERE OBTAINED THROUGH THE CHEST
FOLLOWING THE ADMINISTRATION OF NONIONIC INTRAVENOUS CONTRAST
MATERIAL.

FINDINGS:
MODERATE LEFT CHEST WALL SUBCUTANEOUS EMPHYSEMA EXTENDING INTO THE NECK IS NOTED.
THERE IS A TINY RESIDUAL PNEUMOTHORAX AT THE LEFT LUNG BASE (IMAGE 46). THERE ARE EMPHYSEMATOUS CHANGES THROUGHOUT THE LUNGS INCLUDING SEVERAL BILATERAL SUBPLEURAL BLEBS.
THERE IS NO THORACIC LYMPHADENOPATHY.
THERE IS ATELECTASIS AND/OR CONSOLIDATION IN THE MEDIAL LEFT LOWER LOBE AND POSTERIOR RIGHT LOWER LOBE. ADDITIONAL LINEAR OPACITIES IN BOTH LOWER LOBES LIKELY REPRESENT ATELECTASIS. OPACITY ALONG THE LEFT MAJOR FISSURE CORRESPONDS TO RECENTLY REMOVED CHEST TUBE TRACT.
A NONSPECIFIC NODULAR OPACITY IN THE RIGHT MIDDLE LOBE (IMAGE 43) IS NOTED.
THERE ARE NO PLEURAL EFFUSIONS.
THERE IS A SMALL NONSPECIFIC LOW ATTENUATION LESION IN THE LEFT LOBE OF THE THYROID.
THE VISUALIZED INTRAHEPATIC BILIARY DUCTS ARE MILDLY DILATED. THE LEFT ADRENAL GLAND IS THICKENED. THE RIGHT ADRENAL GLAND IS UNREMARKABLE.

IMPRESSION:
TINY RESIDUAL PNEUMOTHORAX. DIFFUSE EMPHYSEMATOUS CHANGES AND SEVERAL BILATERAL SUBPLEURAL BLEBS.
NONSPECIFIC LOW ATTENUATION THYROID LESION CAN BE FURTHER EVALUATED WITH ULTRASOUND IF CLINICALLY WARRANTED.
THESE FINDINGS WERE DISCUSSED WITH THE CLINICAL SERVICE, AT 2 P.M. ON 4/3/07.
""" ATTENDING FINAL REPORT """
AGREE WITH ABOVE
THIS EXAMINATION AND REPORT HAVE BEEN REVIEWED BY THE
ATTENDING RADIOLOGIST WHOSE NAME APPEARS ON THIS REPORT

Patient 3

Result Date and Time	Description	Status
	CHEST, SINGLE VIEW, FRONTAL (AP PORTABLE	Final

TECHNIQUE)

EXAM: DXCPORT - CHEST, SINGLE VIEW , FRONTAL (AP PORTABLE TECHNIQUE)

DATE OF EXAM: 3/30/07

HISTORY: shortness of breath and cough

COMPARISON:9/3/06

FINDINGS: INTERVAL DEVELOPMENT OF A SPICULATED OPACITY IN THE REGION OF THE AORTICOPULMONARY WINDOW WHICH IS SUSPICIOUS FOR A MASS. RECOMMEND FOLLOW UP AND FURTHER EVALUATION WITH CHEST CT AS NECESSARY.

THE HEART AND PULMONARY VASCULARITY ARE NORMAL. THERE IS NO PLEURAL EFFUSION.

FINDINGS DISCUSSED WITH ATTENDING PHYSICIAN AT THE TIME OF THIS DICTATION.
THIS EXAMINATION AND REPORT HAVE BEEN REVIEWED BY THE
ATTENDING RADIOLOGIST WHOSE NAME APPEARS ON THIS REPORT

Patient 3

Result Date and Time	Description	Status
4/3/07 8:16 AM	CT CHEST/THORAX WITH CONTRAST	Final
Signed By		

EXAM: CT CHEST/THORAX WITH CONTRAST

DATE OF EXAM: 4/3/2007

COMPARISON: CT SCAN OF THE CHEST FROM NOVEMBER 8, 2002; PLAIN RADIOGRAPHS OF THE CHEST FROM March 30, 2007

HISTORY: 53 YEAR OLD WITH LONG HISTORY OF SMOKING, SEVERAL PULMONARY NODULES SEEN ON PREVIOUS CT SCAN; NOW PRESENTING WITH COUGH, SHORTNESS OF BREATH AND SPICULATED OPACITY IN THE LEFT UPPER LOBE ON THE PLAIN RADIOGRAPH FROM 3/30/2007

PROCEDURE: 5 MM AXIAL IMAGES WERE ACQUIRED THROUGH THE CHEST FOLLOWING THE ADMINISTRATION OF NONIONIC INTRAVENOUS AND ORAL CONTRAST.

FINDINGS:

1. THERE IS SEGMENTAL ATELECTASIS AND CONSOLIDATION WITH AIR BRONCHOGRAMS IN THE LEFT UPPER LOBE EXTENDING FROM THE HILUS PERIPHERALLY WITH PATCHY GROUND GLASS OPACITIES IN THE REMAINDER OF THE LEFT UPPER LOBE. INTRALUMINAL FILLING DEFECT IN THE PROXIMAL LEFT UPPER LOBAR SEGMENTAL BRONCHUS COULD BE MUCUS OR AN ENDOBRONCHIAL LESION.

FIRST DIAGNOSTIC CONSIDERATION IS PNEUMONIA, BUT FOLLOW-UP IS RECOMMENDED TO RULE OUT AN UNDERLYING LESION.

2. THE LESS THAN 6 MM NODULAR OPACITIES IN THE LEFT UPPER LOBE (IMAGE 27), LINGULA (IMAGE 33), AND RIGHT MIDDLE LOBE (IMAGE 30) HAVE NOT SIGNIFICANTLY CHANGED.

3. A SMALL LEFT PLEURAL EFFUSION IS NEW. THERE IS NO PERICARDIAL EFFUSION.

4. THERE ARE AN INCREASED NUMBER OF UNENLARGED MEDIASTINAL AND LEFT HILAR LYMPH NODES.
5. THERE ARE NO ADRENAL LESIONS.

6. DEFORMITY OF THE CORTEX OF THE UPPER POLE OF THE RIGHT KIDNEY AND THE SMALL EXOPHYTIC RIGHT UPPER POLE LESION ARE STABLE.
THIS EXAMINATION AND REPORT HAVE BEEN REVIEWED BY THE
ATTENDING RADIOLOGIST WHOSE NAME APPEARS ON THIS REPORT

Patient 4

Result Date and Time	**Description**	**Status**
	CHEST 2 VIEWS, FRONTAL PA AND LATERAL	**Final**

Result

EXAM: PA AND LATERAL CHEST RADIOGRAPHS

DATE:

HISTORY:SHORTNESS OF BREATH, COUGH, FEVER, HIV, AIDS

COMPARISON: Yes

FINDINGS:

CARDIAC SILHOUETTE IS NOT ENLARGED. PULMONARY VASCULATURE APPEARS NORMAL.

THERE IS A NEW RIGHT UPPER LOBE CONSOLIDATION. NO PLEURAL EFFUSIONS OR PNEUMOTHORAX.

CONCLUSION: RIGHT UPPER LOBE PNEUMONIA.
THIS EXAMINATION AND REPORT HAVE BEEN REVIEWED BY THE
ATTENDING RADIOLOGIST WHOSE NAME APPEARS ON THIS REPORT

Patient 4

Result Date and Time	**Description**	**Status**
	CT CHEST/THORAX WITH CONTRAST	**Final**

Result

EXAM: CT CHEST

DATE:

COMPARISON: Yes

PROCEDURE: 5 MM IMAGES WERE OBTAINED FROM THE THORACIC INLET THROUGH THE ADRENAL GLANDS FOLLOWING THE ADMINISTRATION OF INTRAVENOUS NONIONIC CONTRAST MATERIAL.

HISTORY: AIDS PATIENT WITH RIGHT UPPER LOBE PNEUMONIA, NOW WITH CHILLS AND NIGHT SWEATS.

FINDINGS:

THERE IS NEW CONSOLIDATION IN THE RIGHT UPPER LOBE, POSTERIOR SEGMENT, CONTAINING AIR BRONCHOGRAMS. THERE ARE ALSO NEW PATCHY OPACITIES IN THE SUPERIOR SEGMENT OF THE RIGHT LOWER LOBE AND IN THE POSTERIOR BASAL SEGMENT OF THE LEFT LOWER LOBE. A TINY BUT SIMILAR-APPEARING DENSITY IN THE POSTERIOR BASAL SEGMENT OF THE RIGHT LOWER LOBE MAY BE THE EARLY STAGES OF A SIMILAR PROCESS IN THIS REGION.

BILATERAL PROMINENT BUT NONENLARGED AXILLARY LYMPH NODES ARE STABLE. NUMEROUS PROMINENT AND MILDLY ENLARGED MEDIASTINAL LYMPH NODES ARE AGAIN NOTED, UNCHANGED IN SIZE. A SUBCARINAL LYMPH NODE MEASURES 1.7 X 1.1 CM (IMAGE 27) COMPARED TO 1.7 X 1.3 CM PREVIOUSLY. THE SUPERIOR MEDIASTINAL LYMPH NODE MEASURES 1.2 X 0.9 CM (IMAGE 14) COMPARED TO 1.1 X 1.0 CM PREVIOUSLY.

THERE IS NO NEW PARENCHYMAL OR PLEURAL MASS. THERE IS NO PLEURAL OR PERICARDIAL EFFUSION.

SPLENOMEGALY IS REDEMONSTRATED. THE VISUALIZED PORTIONS OF THE OTHER UPPER ABDOMINAL ORGANS ARE
UNREMARKABLE.

SURGICAL HARDWARE IN THE LOWER CERVICAL SPINE.

IMPRESSION:
1. NEW CONSOLIDATION IN THE RIGHT UPPER LOBE AND NEW PATCHY OPACITIES IN BOTH LOWER LOBES. INFECTION IS THE FIRST CONSIDERATION.
2. PROMINENT MEDIASTINAL AND BILATERAL AXILLARY LYMPH NODES ARE STABLE.

THIS EXAMINATION AND REPORT HAVE BEEN REVIEWED BY THE
ATTENDING RADIOLOGIST WHOSE NAME APPEARS ON THIS REPORT