Patient: xxxx, xxxxxx DOB: xx/xx/xxxx SSN: xxx-xx-xxxx
Referring Physician: xxxx, xxxx Report Copies: xxxxxx, xxxxxx

CT Exam neck, chest, abdomen, pelvis (70491, 71260, 74160, 72193)
Technologist: xxxx xxxxxx, CRT, RT(R) **Date:** 02/05/2007
Dose: 400 ml Volumen, 186 ml IV Optiray 300

Clinical: Lymphadenopathy.
Comparison Study: CT scan on 05/04/06.
Procedure: 5 mm axial images were obtained helically through the neck, chest, abdomen and pelvis status post administration of non-ionic intravenous contrast material and oral contrast. ^{18}FDG PET examination performed in conjunction with this study is reported separately.
Findings:
Visualize paranasal sinuses and structures of the posterior fossa are unremarkable.

The aerodigestive tract is normal in appearance.

The thyroid is normal in appearance.

There are several enlarged lymph nodes present surrounding the right submandibular gland. On image 28, a submental lymph node measures 9 mm in short axis. On image 24, a rounded, nodular density measures 1.8 cm in short axis. This abuts the submandibular gland, but appears to be separate from it, concerning for an enlarged lymph node. Directly medial to this, on image 25, a lymph node 9 mm in short axis is identified. Several lymph nodes are identified posterior to the right internal jugular vein in the supraclavicular region. On image 31, a lymph node measures 9 mm in short axis in this region. On image 29, an additional 1.1 cm lymph node is present. No additional adenopathy is identified within the neck.

There is no evidence of axillary, mediastinal or hilar lymphadenopathy. There is again noted to be a 5 mm subpleural nodule at the posterior right upper lobe near the apex, as seen on image 43. A stable 2 mm subpleural nodule is present at the anterior right upper lobe, as seen on image 56. There is now an irregular nodular opacity measuring 1.0 x 1.1 cm at the posterior and inferior left upper lobe, as seen on images 49-53. This may reflect endobronchial debris or an infectious infiltrate, given the nodular, irregular appearance. This was not present on the prior examination. Mild paraseptal emphysema is re-demonstrated, greatest at the mid and upper lung fields.

The heart size is normal. There is no evidence of pleural or pericardial effusion.

The liver remains normal in size and contour. There are again noted to be several, low-attenuation lesions present within the liver. Two small lesions are present at the lateral segment of the left hepatic lobe measuring 2 mm each, as seen on images 78 and 79. A 1.1 cm lesion is present at the medial segment of the left hepatic lobe. At the anterior segment of the right hepatic lobe, a 4 mm lesion is present. The largest of these lesions measures

fluid density and is consistent with a cyst. Additional lesions also most likely reflect simple hepatic cysts and are stable, dating back to the 2003 examination.

No additional hepatic lesions are identified. The gallbladder and biliary tree are normal.

The spleen, pancreas and left adrenal gland are normal in appearance. There is a very small nodule present at the lateral crus of the right adrenal gland, measuring 6 mm. This is too small to adequately characterize. This is stable, dating back to the 2006 and to the 2003 examinations and likely reflects a small, benign adenoma. Several, low-attenuation lesions at the kidneys artery stable in appearance. The largest is present in the right kidney, measuring 1.0 cm. These are too small to adequately characterize, but, given their stability, they likely reflect simple renal cysts.

The bowel remains normal in course and caliber. There is no evidence of abdominal or pelvic adenopathy. There is no evidence of ascites.

The urinary bladder is normal.

The uterus is again noted to be globular in appearance, with multiple, rounded myomata present. The right ovary is unremarkable. The left ovary is not definitively identified. Bones and soft tissues are unremarkable.

Impression:

Mild right neck adenopathy in the submandibular and submental regions.

Small, stable subpleural nodules present in the right upper lobe.

Irregular nodular opacity present at the inferior and posterior left upper lobe likely reflects an infectious or inflammatory endobronchial process: Follow up to resolution is advised, however. Recommend a repeat examination with a non-contrast CT scan in approximately 3-4 months through this region.

Multiple, stable, low-attenuation lesions present within the liver and kidneys, consistent with hepatic and renal cysts.

Myomatous uterus.

Thank you for your referral.

Dictated and electronically signed by:
William Harvey, M.D.
02/09/2007