

**Referred By:**

Dr Melvin Chin  
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EDMUND BLACKET BLD  
RANDWICK NSW 2031

**Dr Dennis Foster**

**DOB:** 14 June 1952

**Patient ID:** FCC215Y

**Visit Number:** 16855034

**Service Date:** 12 December 2024 10:21

**Visit Description:** CT BRAIN CHEST ABDOMEN PELVIS

**CT BRAIN, NECK, CHEST, ABDOMEN AND PELVIS**

**HISTORY:**

Stage 3B lung cancer, completed chemoradiotherapy.

**COMPARISON:**

Correlate made with the previous CT chest, abdomen and pelvis dated 06/08/2024.

**FINDINGS:**

**CT neck:** (1) Salivary glands

Bilateral parotid and submandibular glands outline normally. There is a small hypoattenuating nodule within the left lobe of the thyroid. It measures 4mm in diameter.

(3) There is no cervical chain lymphadenopathy seen (4) bilaterally.

(2) Hypoattenuating is a term used in radiology to describe an area in an imaging scan that appears darker than the surrounding tissues. Most thyroid nodules are benign, and don't cause symptoms. There was no cancerous activity in the thyroid at the previous PET scan.

(3) Cervical chain = vertebrae of the neck. Cervical lymphadenopathy refers to the enlargement of cervical lymph nodes, (lymph nodes in the neck)

(4) Bilateral = both sides (of neck)

**CT chest:** (5)

The spiculated focus in the apical segment of the right upper lobe is redemonstrated. It is smaller in size on today's examination, measuring 20 x 14mm (previously 22 x 17mm). There is no new suspicious pulmonary nodule or mass lesion seen elsewhere throughout the lungs bilaterally. (5) The original "spot" is smaller and no new spots in either lung

(6) The previously noted right hilar lymph node is smaller in size on today's examination. It measures 9 x 8mm (previously 13 x 12mm). There is no new mediastinal, perihilar or axillary lymphadenopathy.

(6) The right hilar lymph nodes are a group of lymph nodes located in the right lung, near the bronchi and main-stem bronchus. The mediastinum is the part of the chest that lies between the sternum and the spinal column, and between the lungs.

**CT abdomen and pelvis:**

(7) The hyperdensity seen within segment 5/8 of the liver is redemonstrated and slightly more well-defined on today's examination. It measures 5 x 4mm. It may reflect a cyst or a resolving partially treated lesion. There is a small further hyperdensity also seen in segment 6 of the liver posteriorly. It measures up to 4mm. In retrospect, this is also seen on the previous study and is stable. There is no new suspicious liver lesion identified. There is no adrenal mass lesion. (7) Hyperdensity refers to an abnormality that appears bright or white on a CT scan. It can be caused by a number of things. My doctors are monitoring these but they think they are cysts.

The spleen and the pancreas are within normal limits.

(8) There is cholelithiasis however no features of acute cholecystitis.

(8) Cholelithiasis is the medical term for the presence of gallstones in the gallbladder. Acute cholecystitis is inflammation of the gallbladder. It usually happens when a gallstone blocks the cystic duct.

(9) kidneys  
No renal tract abnormality is seen.

(9) There is no intra-abdominal lymphadenopathy. (9) Intra-abdominal lymphadenopathy is enlargement of lymph nodes in the abdomen.

(10) There is mild prostatomegaly. There is no intra-abdominal ascites or peritoneal nodule or mass lesion. (11)

(10) Enlargement of prostate.

(11) intra-abdominal = . Ascites = fluid build up. The peritoneum is a membrane that lines the abdominal and pelvic cavities, and covers most of the abdominal organs

There is no aggressive lytic or sclerotic bone lesion.

**COMMENT:**

(12) Findings are in keeping with partial interval disease response. The right lower lobe apical segment pulmonary nodule has decreased in size when compared with the previous study with small amount of surrounding post-treatment change. The previously noted enlarged right hilar lymph node is also smaller in size. There is no evidence of new metastatic disease elsewhere. The identified liver lesions are small, if not stable in size. The larger of the lesions which has reduced in size appears slightly more cystic on today's study.

(12) Treatment reduced the tumours and cancer activity resulting in partial remission. There is still cancer that is being controlled by the residual effects of the chemoradiation and the targeted therapy drug Tagrisso (osimertinib).



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**Dr Dennis Foster****DOB:** 14 June 1952**Patient ID:** FCC215Y**Visit Number:** 16858842**Service Date:** 13 December 2024 09:40**Visit Description:** CT BRAIN**CT BRAIN****HISTORY:** Stage III B lung cancer. Completed chemoradiotherapy.**FINDINGS:** (13) No sign of bleeding in the brain or head. (14) No lesions in the head

No acute intra or extra-axial haemorrhage. No intra-cranial space occupying lesion or midline shift. The ventricles and sulci are within normal limits for the patient's age. There is no abnormal focus of post contrast enhancement seen within the brain. Grey white matter differentiation is well preserved with no evidence of acute territorial infarction. (16) infarction = blockage. No evidence of previous stroke.

There is no acute (17) calvarial or facial bone fracture.

(17) The calvaria, also known as the cranial vault, is the convex, bone-encased portion of the skull that surrounds the brain.

There is (18) polypoid mucosal thickening of bilateral maxillary sinuses.

(18) Maxillary sinuses are hollow spaces in the bones around the nose. They are located in the cheeks. Mucosal thickening is an inflammatory reaction in the mucous lining of the sinuses that can be caused by a number of things. Polypoid = like polyps. No need to treat.

**COMMENT:** (19) inside the cranium (head)

No acute intra-cranial pathology.

(20) No evidence of intracranial metastatic disease.

(20) Hallelujah! Adenocarcinoma often metastasises to brain and spine.

**Reported by:** Dr Prue Storer

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