


**Department of Radiology**

**Patient Details** : Mr. BADAN BARMAN | Male | 37Yr 5Mth 14Days  
**UHID** : AC01.0004002237 **Patient Location:** OP  
**Patient Identifier:** AHCOPP151633   
**DRN** : 319114025 **Completed on :** 10-JUL-2019 17:38  
**Ref Doctor** : Dr. SESHADRI VENKATESH P

**320 SLICE CT WHOLE ABDOMEN ALONG WITH ENTEROGRAPHY**

**Report ::**

Clinical History: Complaints of left hypochondrial pain. OGD (06.07.2019) – Reflux esophagitis. Colonoscopy (06.07.2019) – Normal. USG (05.07.2019) – Normal.

**Procedure:**

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 Axial 0.5 mm thin section CT scans was performed through the abdomen with intravenous non ionic contrast of about 100 ml and negative oral contrast (carboxymethylcellulose solution) after a mild bowel preparation. A plain scan was followed by an arterial and a late venous phase scans. After a study of the axial section, thorough reconstruction were performed in the 3D volume rendered, MIP, multiplanar and curved planes and then studied. Appropriate volume rendered images were then made in order to demonstrate the pathology.

**Report:**

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 No evidence of any dilatation, narrowing, wall thickening or abnormal wall enhancement is seen in the small bowel or colon. The mesentery appears unremarkable.

The mesenteric arteries and veins appear unremarkable.

The liver shows normal anatomical configuration with uniform density and no area of altered attenuation or enhancement with I.V.contrast.

There is no dilatation of the intra hepatic biliary radicles or common bile duct.

Right and left hepatic arteries take off the proper hepatic artery.

The portal venous system and hepatic veins are patent.

Gall bladder is normal and well distended. There is no evidence of CT demonstrable high density calculus. Its walls reveal no abnormal thickening or enhancement.

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Pancreas reveals no significant parenchymal volume loss or abnormal enhancement. Main pancreatic duct is not dilated. No evidence of any calculi or calcification is seen. Peripancreatic fat planes appear unremarkable.

The spleen appears normal.

Both adrenal glands appear normal.

The right kidney is normal in size and measures 9.5 x 4.7 cms. It reveals a normal parenchymal enhancement with no focal lesions. There is no evidence of any calculi. No evidence of any dilatation of the pelvicalyceal system is seen. It is supplied by a single renal artery which reveals no significant stenosis. The right ureter is normal in course and calibre.

The left kidney is normal in size and measures 9.8 x 4.6 cms. It reveals a normal parenchymal enhancement with no focal lesions. There is no evidence of any calculi. No evidence of any dilatation of the pelvicalyceal system is seen. It is supplied by a single renal artery which reveals no significant stenosis. The left ureter is normal in course and calibre.

The urinary bladder is normal in contour. Its walls appear of normal thickness and enhancement. No obvious intraluminal abnormality noted.

The prostate and seminal vesicles appear unremarkable.

No significant lymphadenopathy or free fluid is seen in the abdomen.

Aorta appears normal. Coeliac, superior mesenteric artery, inferior mesenteric artery reveals no significant stenosis.

IVC and iliac veins are patent.

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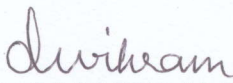
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CONCLUSION:

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CT findings reveal no significant abnormality.

  
{Dr. ROCHITA V RAMANAN}  
SRK

  
{Dr. M.S VIKRAM}

NOTE:

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- \*Patient tolerated the procedure well.
  - \*Clinical correlation is necessary for imaging findings.
  - \*Please see your treating physician with this report.

--- END OF THE REPORT ---

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