

CT SCAN ABDOMEN/PELVIS

Collected on Oct 13, 2025 2:09 PM

 Not yet reviewed by care team.

Results

EXAMINATION: CT ABDOMEN/PELVIS W/ CONTRASTPRO 10/13/2025 01:57 PM

CLINICAL HISTORY: RUQ pain; Pain after ablation

ASSOCIATED DIAGNOSIS: Right renal mass

Lumbar disc disorder

S/P cryoablation of mass of kidney

ORDERING PROVIDER: OLUWABUSOLA BINUTU

TECHNOLOGISTS NOTE:

COMPARISON: Compared to the prior MRI of the kidneys dated 8/13/2025, the CT ablation dated 9/30/2025 and the CT of the abdomen and pelvis dated 10/5/2025.

TECHNIQUE: Contiguous axial images were obtained through the abdomen and pelvis from the level of the diaphragmatic domes through the pubic symphysis following bolus administration of intravenous contrast. MPR sagittal and coronal reconstructions were obtained from the axial data. Before infusion of intravenous contrast, radiology personnel investigated the possibility of an allergic history and of any history of reaction to iodinated contrast material. Contrast Protocol: Omnipaque 350 [$>$ -or =100lb] 100 ml [$<$ 100 lb] 1 ml per 1 lb.

INTRA-PROCEDURE MEDS:

iohexol (OMNIPAQUE) 350 MG/ML injection 100 mL Route: Intravenous

FINDINGS:

Imaging is limited in the mid to lower abdominal region due to respiratory motion.

Included images of the lower thorax: The visualized lung bases are clear and interstitial markings are normal with no evidence of pleural disease.

The visualized cardiac structures are grossly normal.

Hepatobiliary: The right hepatic lobe is unchanged and measures 180 mm in the longitudinal dimension along the midclavicular line and the left hepatic lobe is mildly prominent extending across midline into the left upper quadrant superior to the stomach.

There is stable mild decreased attenuation of liver parenchyma within the anterior left hepatic lobe superior to the falciform ligament, which is consistent with focal fatty change in a benign finding.

The liver is mildly decreased in density relative to the spleen with no evidence of other focal lesions or abnormal enhancement.

The gallbladder is normal with no evidence of gallstones or inflammatory change and the intrahepatic and extrahepatic bile ducts are normal.

Pancreas: The pancreas is unchanged and normal in size and shape with no evidence of focal lesions, abnormal enhancement, ductal dilatation or inflammatory change.

Spleen: The spleen is unchanged and normal in size, shape and density with no evidence of focal lesions or abnormal enhancement.

Adrenal Glands: The adrenal glands are unchanged and normal in size and shape with no evidence of focal lesions or abnormal enhancement.

Kidneys, ureters and bladder: There is a fusiform region of nonenhancing decreased subcapsular density within the posterior medial upper pole of the right kidney measuring 46 x 25 x 39 mm (prior 49 x 24 x 40 mm) that is consistent with a region of cryoablation.

There is stable adjacent superior medial right perinephric soft tissue stranding.

There is a small area subsegmental decreased enhancement within the adjacent anterior medial aspect of the upper pole of the right kidney that is consistent with localized mild periablation edema.

The remainder of the kidneys are unchanged and normal in size and shape with no evidence of other focal lesions, other abnormal enhancement or renal stones.

The visualized intrarenal and extrarenal collecting systems and ureters are grossly normal with no evidence of ureterolithiasis.

The bladder is poorly distended and grossly normal with no evidence of bladder stones.

Abdominal and pelvic vasculature: The abdominal aorta is normal in caliber and mildly tortuous with no evidence of atherosclerotic change.

The celiac, superior mesenteric, renal and iliac arteries are normal. There is a retroaortic left renal vein.

The inferior vena cava and portal venous system are normal.

GI tract: Evaluation of the bowel is limited due to the lack of oral contrast. The stomach, duodenum and small bowel are grossly normal with no evidence of obstruction or inflammatory change.

There is mild diverticulosis of the collapsed sigmoid colon with no evidence of diverticulitis.

There is a mild amount of gas and stool throughout the right colon, transverse colon and descending colon and the remaining large bowel and partially collapsed rectum are grossly normal. The appendix is grossly normal.

Peritoneum and retroperitoneum: There is no evidence of free air or free fluid throughout the abdomen and pelvis.

Lymph Nodes: There is no evidence of adenopathy throughout the abdomen and pelvis.

Uterus and adnexa: The uterus is appropriate in size for the patient's age and grossly normal in density with no evidence of focal lesions. The endometrial canal is not visualized.

The visualized ovaries and adnexa are grossly normal.

Visualized musculoskeletal structures: The bones are normally mineralized throughout study and the visualized vertebral bodies, pedicles and posterior lamina are intact and the visualized vertebral body heights are normal.

There is stable mild degenerative change of the visualized thoracic spine with multilevel disc space narrowing, bridging osteophytes and ankylosis.

There is partial sacralization of L5 on the right with a rudimentary disc at the L5-S1 level, which is a normal variant.

There is stable marked disc space narrowing with vacuum phenomena, mild to moderate degenerative bony endplate change and moderate to marked facet joint hypertrophy at L4-5.

There is stable mild to moderate degenerative change throughout the remaining lumbar spine, sacroiliac joints and hip joints. The remainder of the bony pelvis and sacrum are unchanged and otherwise normal.

There is a stable small fat-containing umbilical hernia. The remaining muscular and visualized soft tissue structures of the body wall, pelvic and hip regions are normal.

IMPRESSION:

1. There are persistent post cryoablation changes within the posterior medial upper pole of the right kidney with mild adjacent periablation edema within the anterior medial aspect of the upper pole left kidney.
2. There is stable trace perinephric soft tissue stranding adjacent to the ablation zone that may represent perinephric edema versus hemorrhage.
3. The remainder of both kidneys are unchanged and otherwise normal.
4. There is stable mild hepatomegaly and mild fatty change of the liver.
5. There is no evidence of adenopathy.
6. There is mild diverticulosis of the sigmoid colon with no evidence of diverticulitis.
7. The remaining solid organs are normal and the remaining bowel is grossly normal.
8. There are additional findings as described above.

MACRO: None

CTDI VOL

Value
0.10 (mGy),22.37 (mGy)

PHANTOM TYPE

Value
IEC Body Dosimetry Phantom,IEC Body Dosimetry Phantom

CT DLP

Value
1196.88 (mGy.cm)

CT Series

Value
Topogram,ABD/PEL

Ordering provider: Oluwabusola Binutu
 Reading physician: Maurice Oehlsen
 Study date: Oct 13, 2025 1:57 PM
 Collection date: Oct 13, 2025 2:09 PM
 Result date: Oct 13, 2025 2:47 PM
 Result status: Final