



LANKA HOSPITALS

සුවිච්චි සැලසුම • CARING CURING • பராமரித்தல் குணமாக்கல்

Patient Name	: Ms. S. Niroshani	Age : 40 Years
Referred By	: Dr. Umagowry Saravanamuttu (Consultant Oncologist)	
Bill No	: CS 25690303	
CT No	: OP/ 5323,24/2025	
Date	: 28-08-2025	
Indication	: Left breast CA	

CECT SCAN OF CHEST, ABDOMEN & PELVIS

Spiral scans were done following oral rectal water and IV, contrast.

Chest

Skin thickening of left breast with ill defined confluent masses in the UOQ.No chest wall infiltration.

Enlarged few left axillary lymphnodes, largest 10 x 11mm.

Right axillary lymphnode 11 x 5mm, fatty hilum preserved.These appear reactive.

No mediastinal or hilar lymphadenopathy.

Both lung parenchyma show normal CT architecture except a 4 x 4mm ground glass nodule in the right upper lobe anterior segment.

Lung volumes are preserved.

No evidence of bronchiectasis or interstitial thickening.

No 'ground glass' opacities, consolidation or generalized fibrosis in the left lobe.

No pleural thickening. No calcified or non-calcified pleural plaques.

No pleural effusion or pneumothorax.

Trachea, its bifurcation, main bronchi and the central intra pulmonary branches are normal in caliber and outlines.

Heart is normal in size and configuration.

No pericardial effusion.

Great vessels are normal in caliber and outline.

Visualized bones are normal.

Abdomen

Liver is prominent and show uniform attenuation pattern. No focal masses.

No evidence of fatty infiltration or generalized parenchymal disease.

Bile ducts are not dilated.

Intra and extra hepatic portion of the Portal vein, as well as the splenic vein are normal in calibre and outline. No evidence of thrombosis.

Gall bladder is adequately distended with normal calibre wall. No gall stones or polyps.