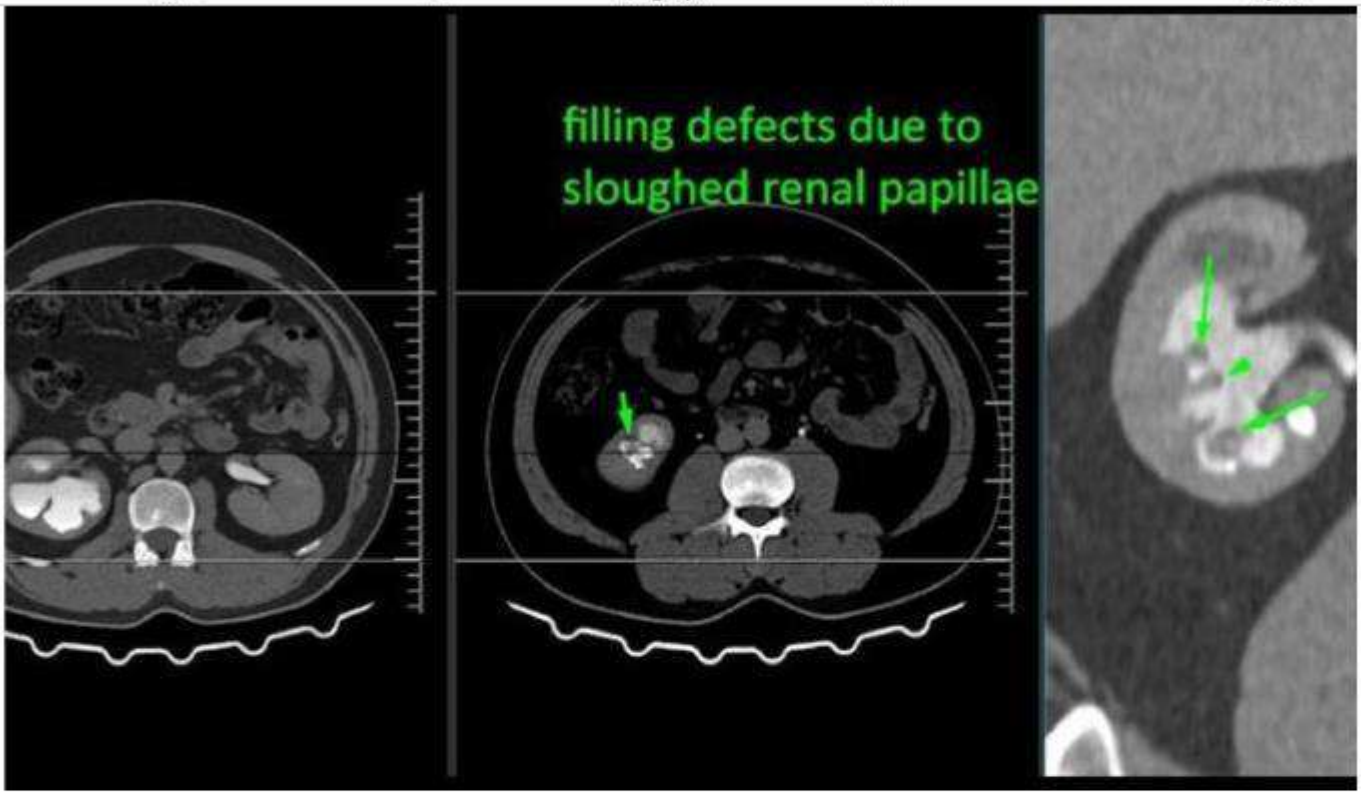
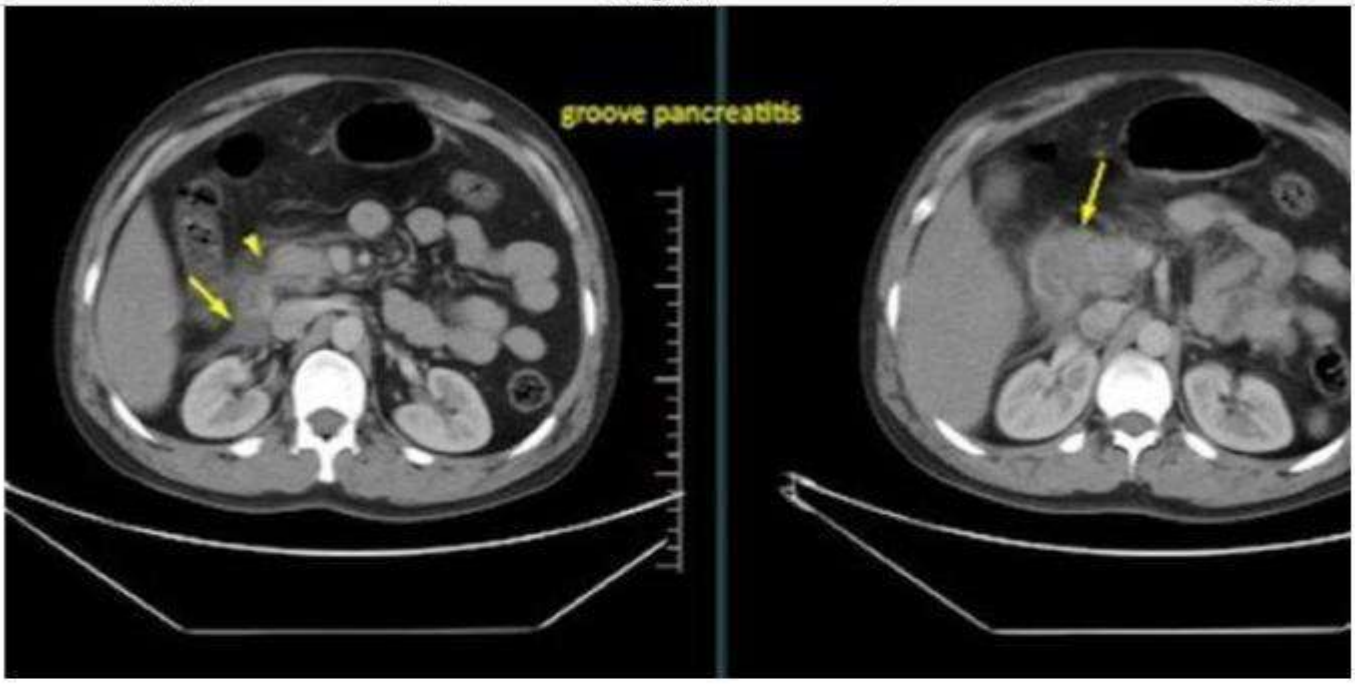


Renal papillary necrosis

Moderate right hydronephrosis with cupping of calyces demonstrating tiny filling defects within the dilated calyces – *likely suggestive of Renal Papillary Necrosis with Sloughed papillae.*

A few tiny right renal non-obstructing calculi, largest measuring 1 cm at the lower calyx (200 HU).

A few punctate left renal non-obstructing calculi. Cholelithiasis.



Groove Pancreatitis

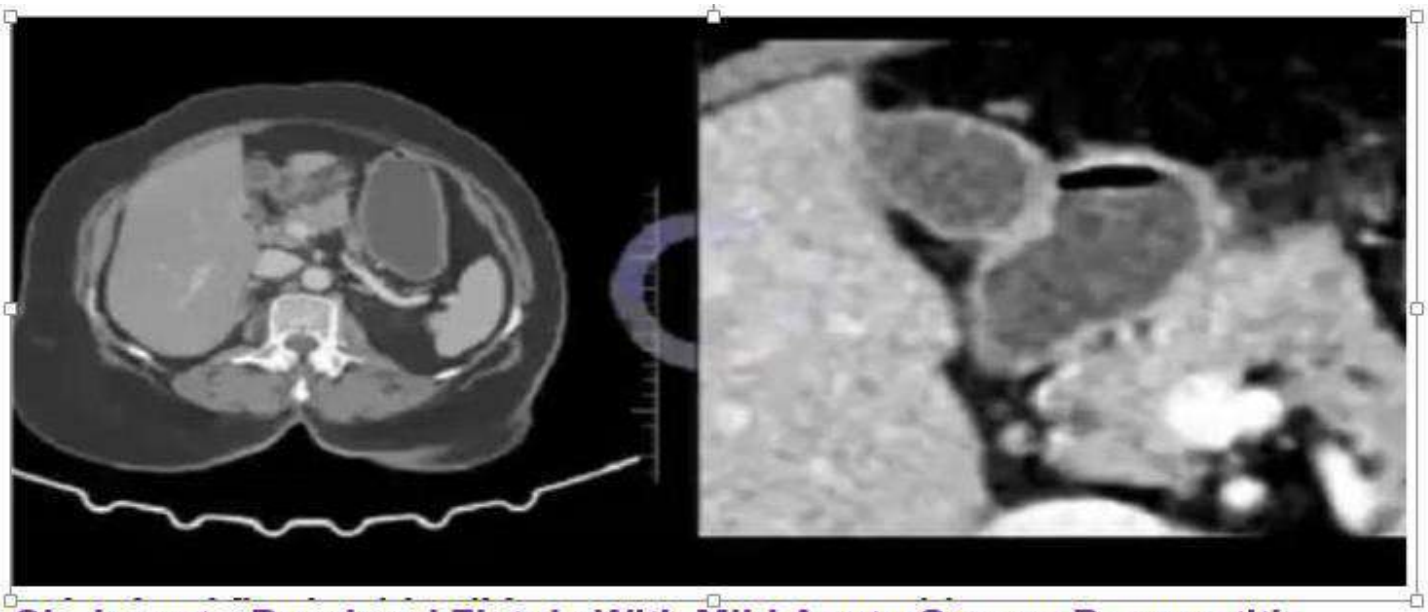
Acute pancreatitis with features favoring groove

pancreatitis (Acute interstitial oedematous

pancreatitis , CTSI = 4/10)

Small fluid density collection involving right anterior pararenal space with thickened anterior pararenal fascia

Fatty liver.
Recommend clinical correlation, S. amylase, lipase levels, follow up.



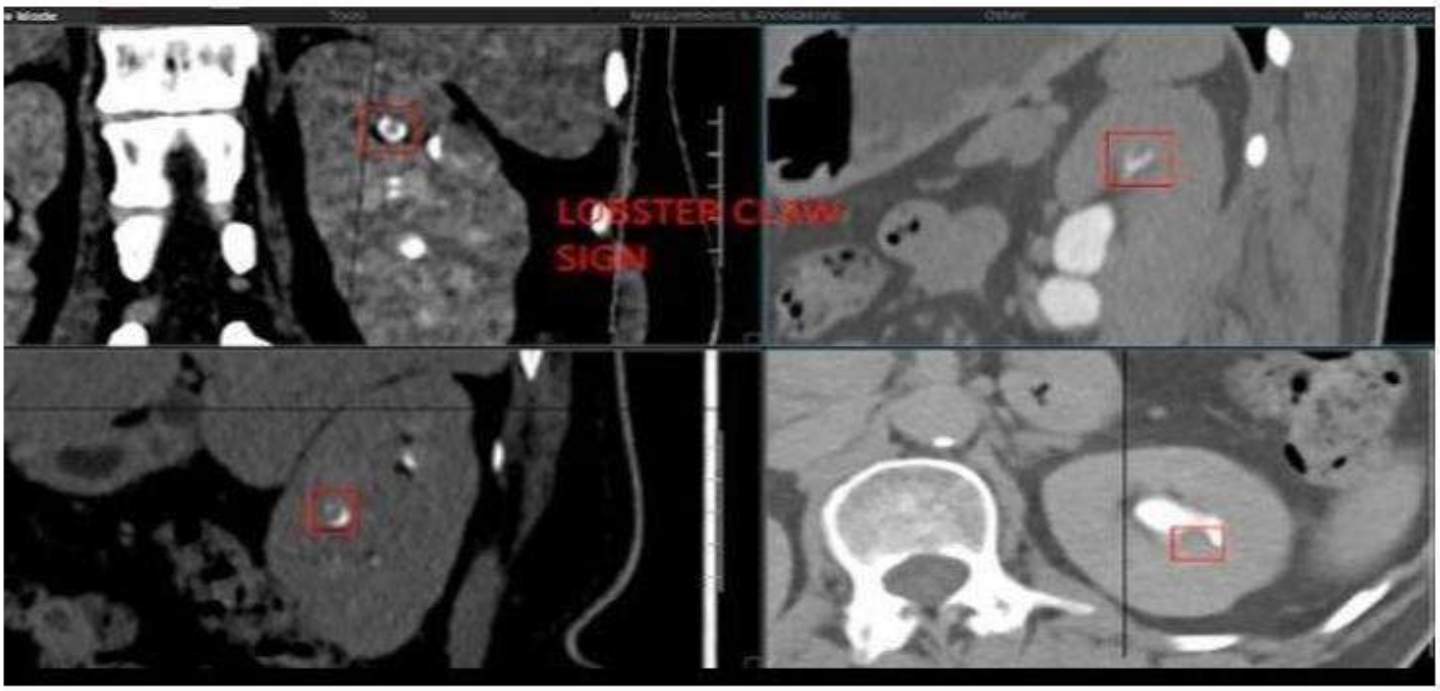
Cholecysto-Duodenal Fistula With Mild Acute Groove Pancreatitis

Minimal mural thickening at the posteromedial wall of the gastric pylorus and proximal duodenum at D1 segment with surrounding fat stranding- ***likely suggestive of peptic ulcer disease.***

The medial wall of gallbladder appears to be closely adherent to the lateral wall of D1 segment of duodenum with minimal wall thickening in this region - ***possibility of developing cholecystoduodenal fistula cannot be entirely ruled out.***

Subtle peripancreatic mesenteric fat stranding at the pancreaticoduodenal groove, anterior to the pancreatic neck – ***mild acute groove pancreatitis cannot be ruled out.***

No evidence of free fluid or collection.



BILATERAL RENAL PAPILLARY NECROSIS (LOBSTER CLAW SIGN)

Duplex left renal collecting system

Mild to moderate left hydronephrosis with cupping of calyces, evidence of forniceal excavation and a few small filling defects within the dilated calyces (due to sloughed papillae) – *likely suggestive of left renal papillary necrosis*



Multiple mildly dilated slightly thickened small bowel loops (jejunal loops) clustered in the left upper quadrant, involving the left anterior pararenal space, posterior to the inferior mesenteric vein – *likely suggestive of left paraduodenal internal hernia with low grade small bowel obstruction*.



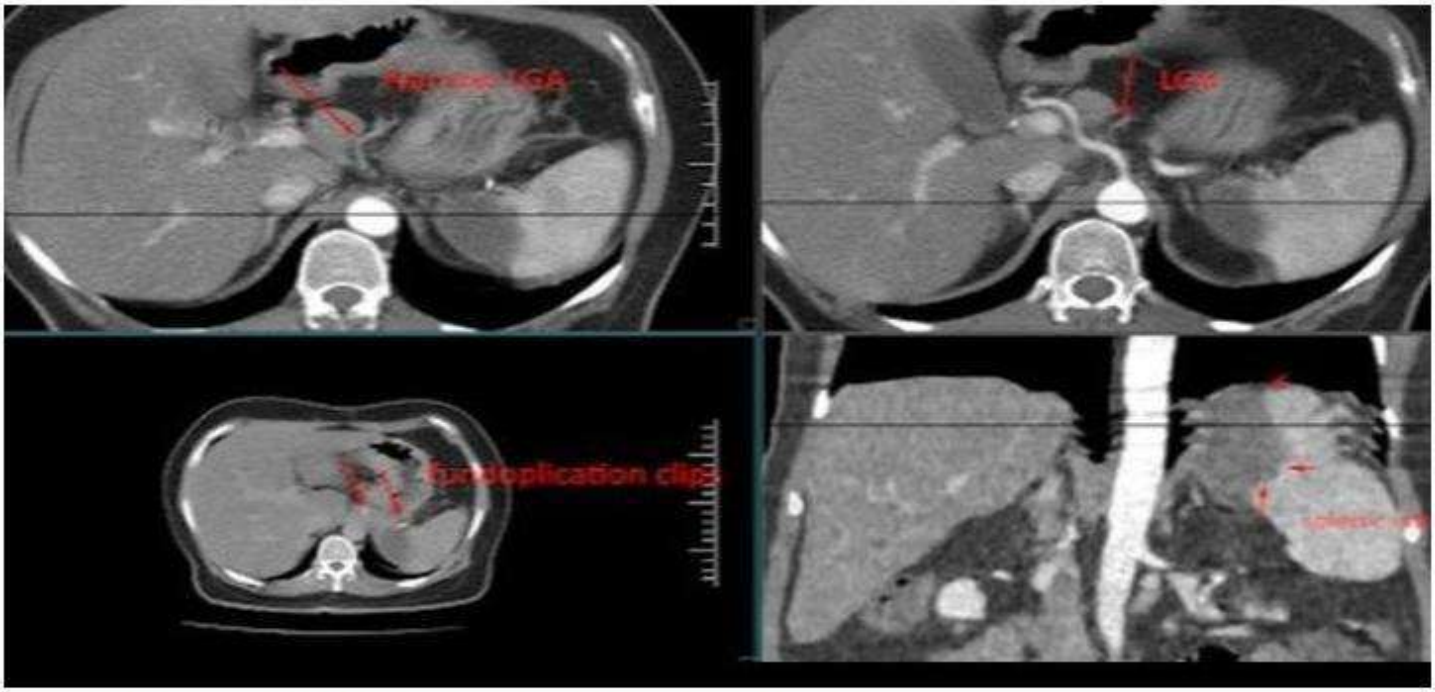
Nutcracker syndrome

Moderate hepatomegaly

Reduced aortomesenteric distance and aorto mesenteric angle with extrinsic compression of the left renal vein is noted in between the SMA and anterior wall of abdominal aorta – *may suggest vascular compression - Nutcracker syndrome in the given clinical settings of repeated hematuria.*

No evidence of filling defects. No evidence of abnormal duodenal or

stomach dilatation. No evidence of renal or ureteric calculus.



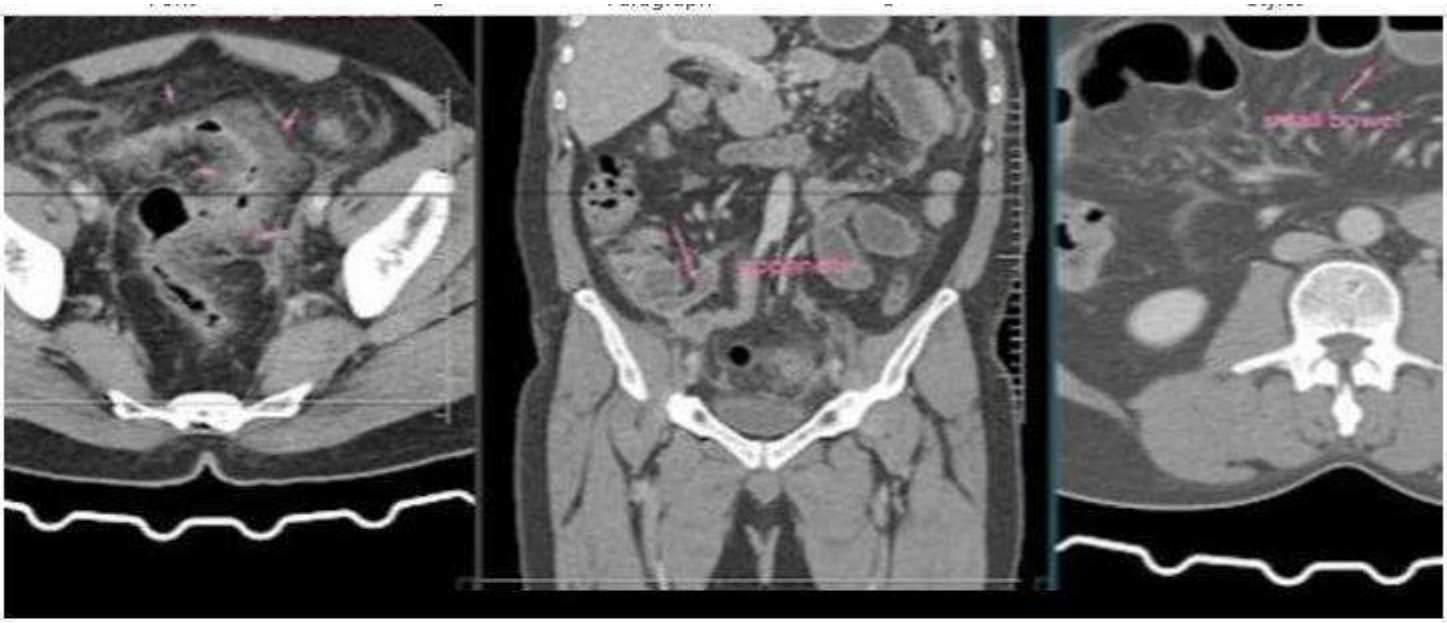
post lap-fundoplication splenic infarct

Status post laparoscopic fundoplication surgery with tiny surgical clips in the perigastric region, close to the hiatus.

A wedge shaped splenic infarct at upper pole. No CT evidence of abscess formation in this study.

Narrow left gastric artery with normal celiac and common hepatic arteries –needs clinical correlation

A small umbilical hernia
Recommend clinical correlation



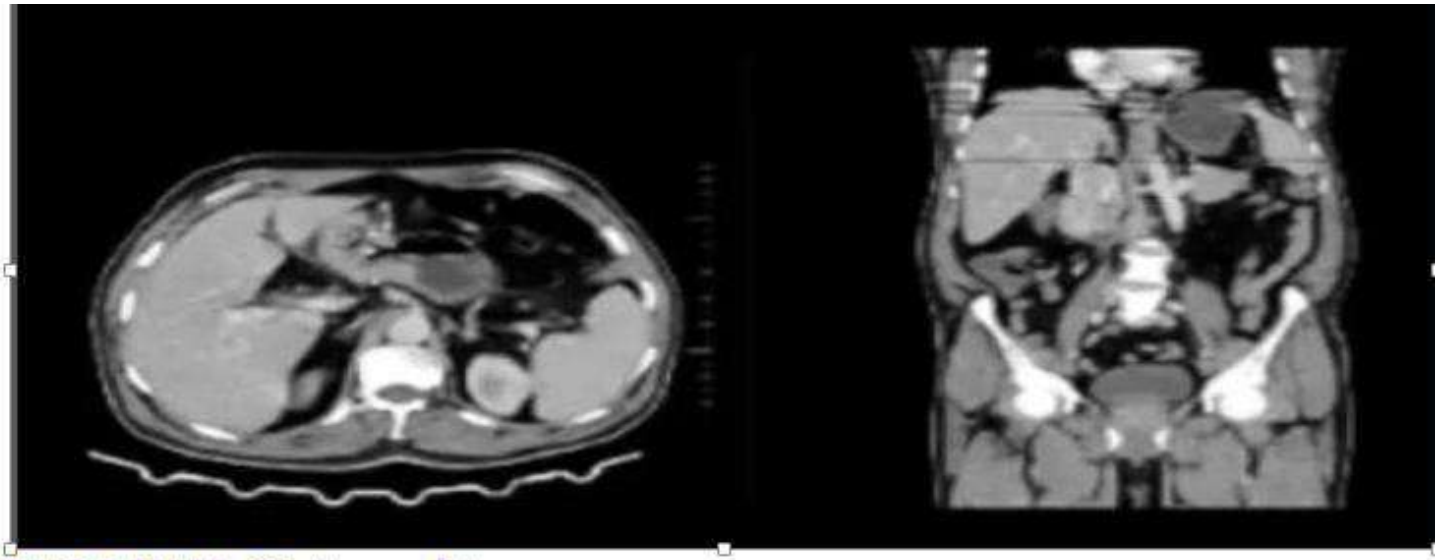
Crohns with appendiceal involvement

*** Findings suggestive of marked recto sigmoid colitis associated with distal ileitis – *likely related to inflammatory bowel disease with skip lesions such as Crohn's disease*.**

Differential considerations also include:- *tuberculosis.*

Multiple dilated small bowel loops with multiple air fluid levels demonstrating apparent transition point at the level of distal ileum in the right lower quadrant – *suggestive of low grade distal small bowel obstruction versus ileus.*

Markedly thickened appendix with wall enhancement and periappendiceal fat stranding – *suggestive of appendiceal involvement by the inflammatory bowel disease.*



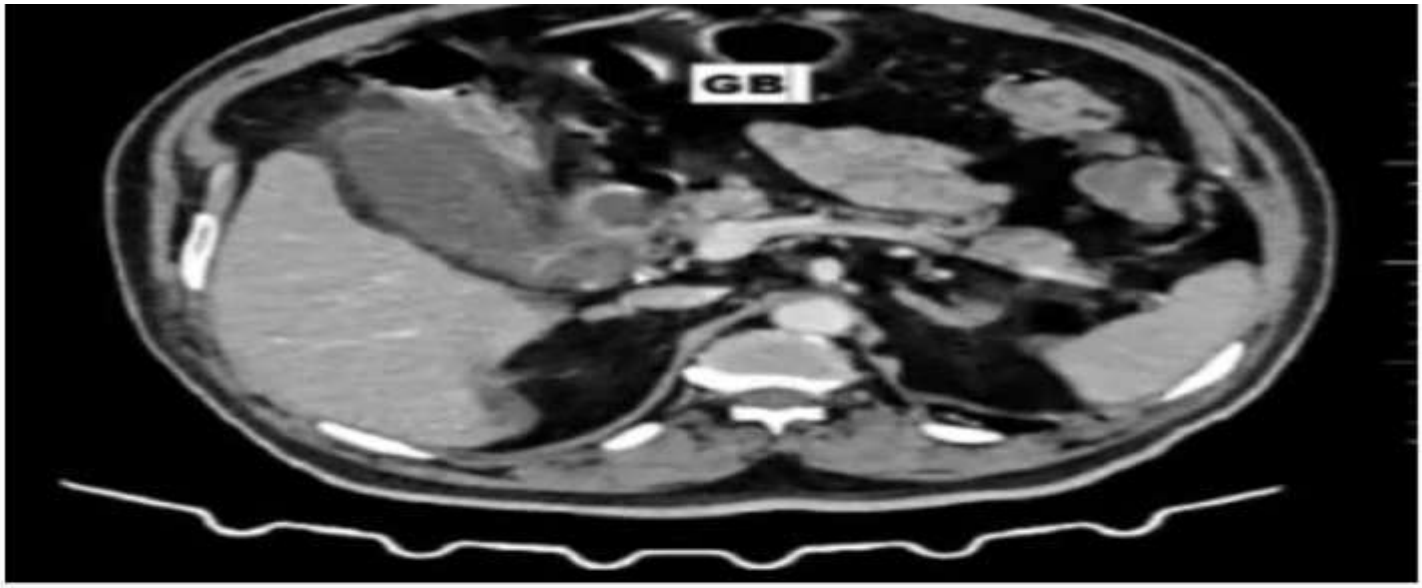
DUODENAL GI stromal tumour.

Asymmetric plaque like mural thickening of the gastric antrum, pylorus , associated with large heterogeneously enhancing intraluminal polypoid/lobulated mass lesion protruding into the proximal duodenal lumen, overall measuring 9 x 9.8 x 4.5 cm along with a 3.4 x 3.2 cm exophytic component, posterior to the D2 segment of duodenum involving the right anterior pararenal space – of concern for GI stromal tumour, likely malignant.

No evidence of gastric outlet obstruction in this study. Evidence of gastroesophageal reflux

No evidence of vascular or surrounding visceral infiltration. No significant lymphadenopathy.

Grade I prostatomegaly.



ISCHEMIC CHOLECYTITIS ASSOCIATED WITH ISCHEMIC CECAL,ASCENDING COLITIS IN A Case of IHD

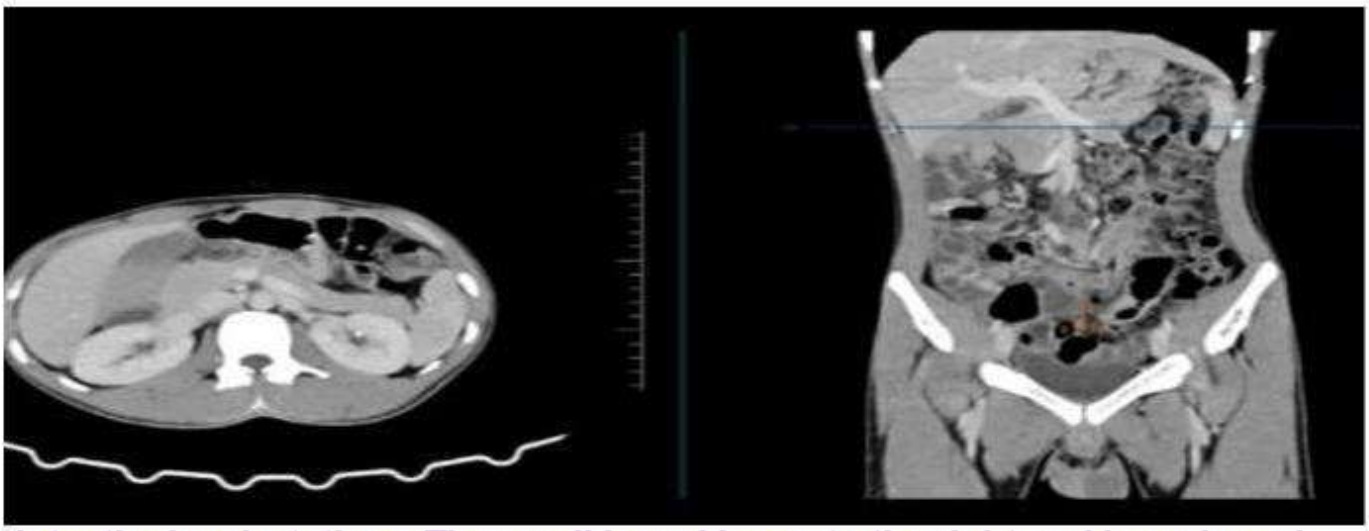
Findings suggestive of Acute cholecystitis with a few tiny calculi – of *concern for ischemic cholecystitis in the given clinical settings (calculi may not be contributory).*

Early changes of mucosal necrosis of the gall bladder

Mild dilatation of caecum and ascending colon with wall edema, tiny intra mural air loculi within caecal wall and pericolic fat stranding – *suggestive of ischemic colitis.*

Celiac artery, SMA appear unremarkable. No evidence of filling defect

2 x 1.8 cm '*duodenal diverticulum*' arising from the medial wall at the D2 segment with mild changes of duodenitis.

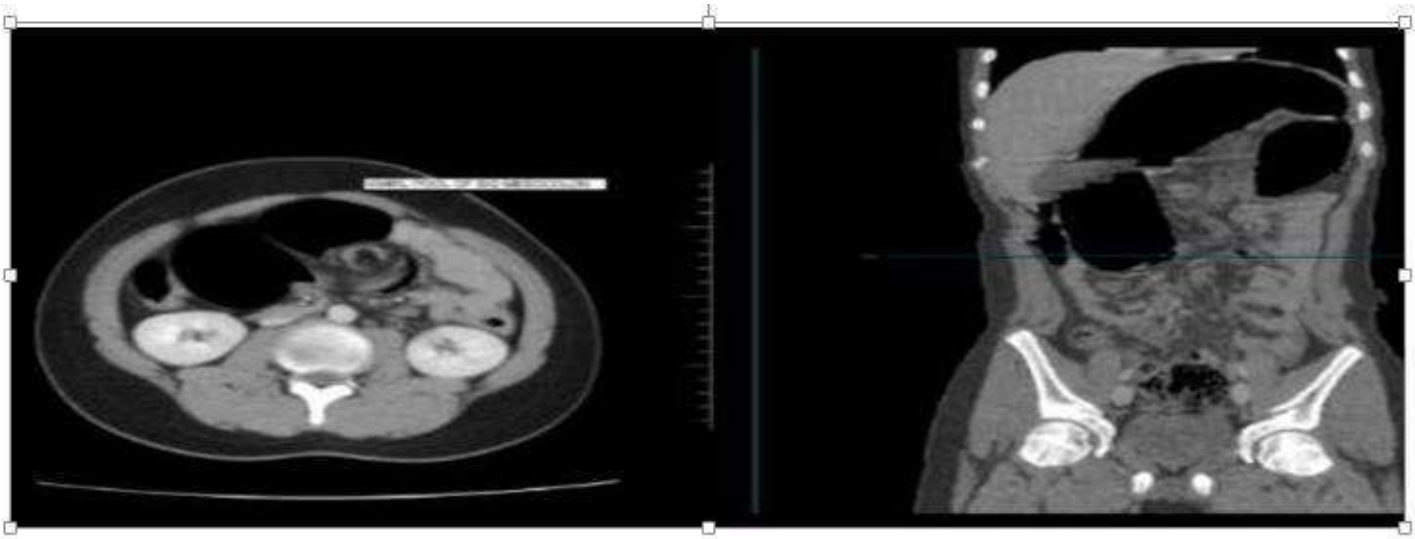


Intestinal malrotation:- The small bowel loops to the right and large bowel loops, caecum , recto sigmoid colon in left lower quadrant with reversal of SMA - SMV relationship (SMA is slightly to the right).

Marked focal / **short segment mural thickening of the terminal ileum, IC junction over an approximate length of 3.6 cm low grade distal small bowel obstruction** – ***of concern for focal inflammatory stricture versus ? neoplasm.***

Small free fluid in pelvis.

A few marginally enlarged mesenteric lymphnodes in the left lower quadrant around the IC junction



Findings represents sigmoid volvulus:

Marked twisting of the sigmoid mesocolon in left lower quadrant with whirlpool of surrounding mesenteric vessels, likely related to twisting of the sigmoid colon around its mesocolon.

A large gas filled structure without evidence of. Involving the upper abdomen, slightly to the left pointing toward left lower quadrant suggesting closed loop obstruction.

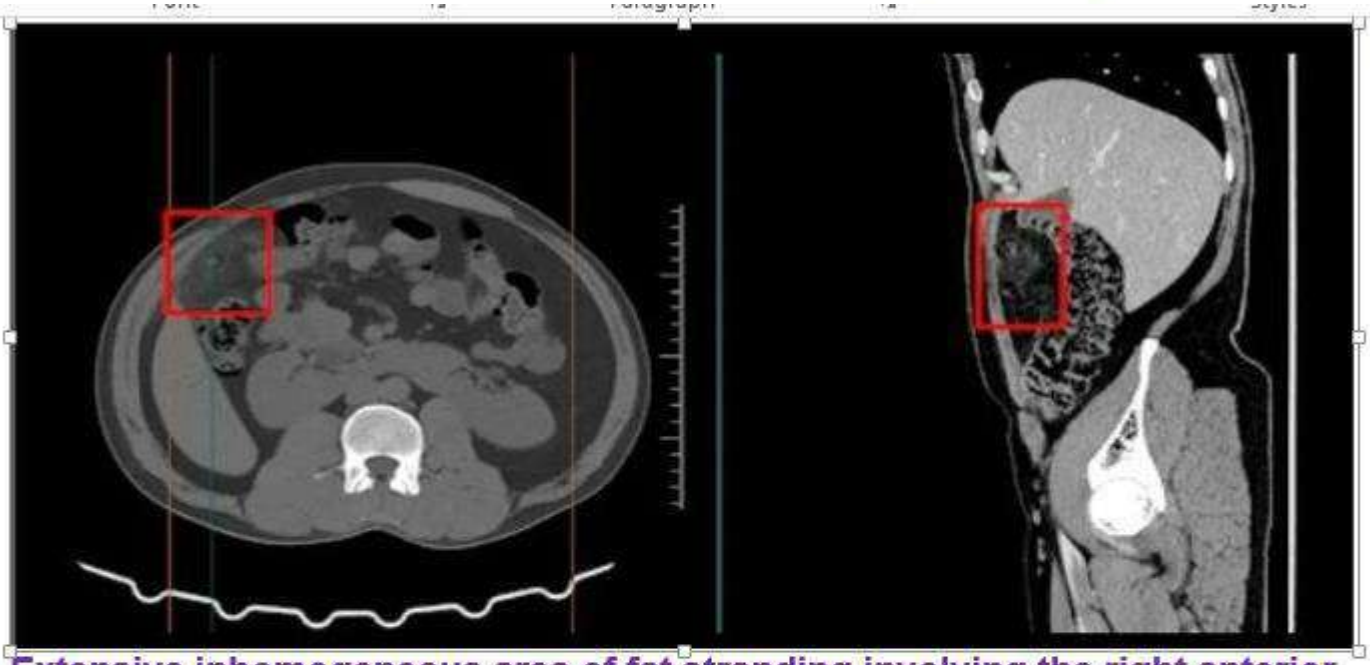
No abnormal small bowel dilatation. No evidence of abnormal bowel wall thickening or edema. No evidence of intramural air or pneumatosis in this study.

No evidence of free fluid. No evidence of pneumoperitoneum.



Cholelithiasis with minimal gall bladder wall thickening.

An approximately 5.3 x 4.4 x 2.8 cm pear shaped narrow neck luminal outpouching arising from posterior wall of body of stomach containing air fluid level – **represents a gastric diverticulum**

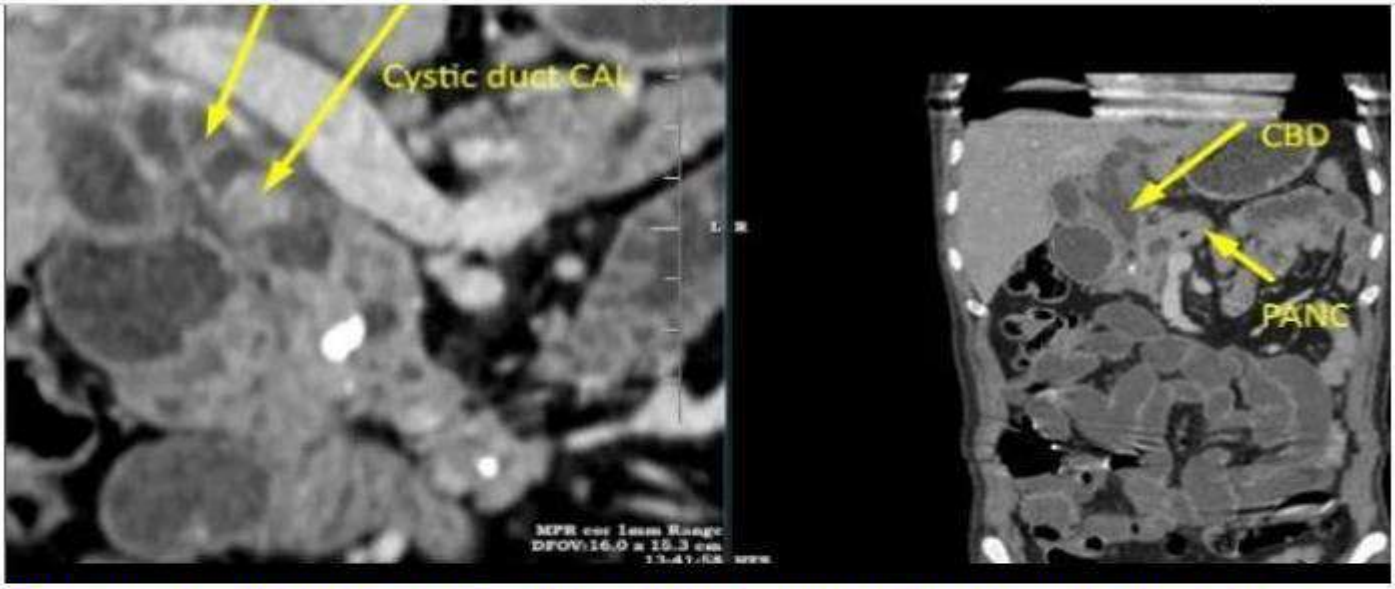


Extensive inhomogeneous area of fat stranding involving the right anterior paracolic mesenteric at the level of mid ascending colon, approximately measuring 5 cm thin supero-inferior extent – *suggestive of intraperitoneal focal fat infarction (omental infarct)*

Other differential of epiploic appendagitis is less likely.

Horseshoe kidney with preaortic isthmus at L4 vertebral

level Recommend clinical correlation, follow up.



Distended gall bladder with mild wall thickening, dilated cystic duct due to 1.4 cm calculus at the distal part of cystic duct.

Dilated CBD, CHD and central IHBR with abrupt narrowing of distal CBD at the level of pancreatic head of pancreas– likely related to terminal CBD / periampullary stricture *(a possibility of Mirizzi syndrome cannot be ruled out).*

Changes of chronic calcific pancreatitis with dilated main pancreatic duct and MPD calculi.

Bulky pancreatic head with surrounding fat stranding – *may suggest early changes of acute on chronic pancreatitis*

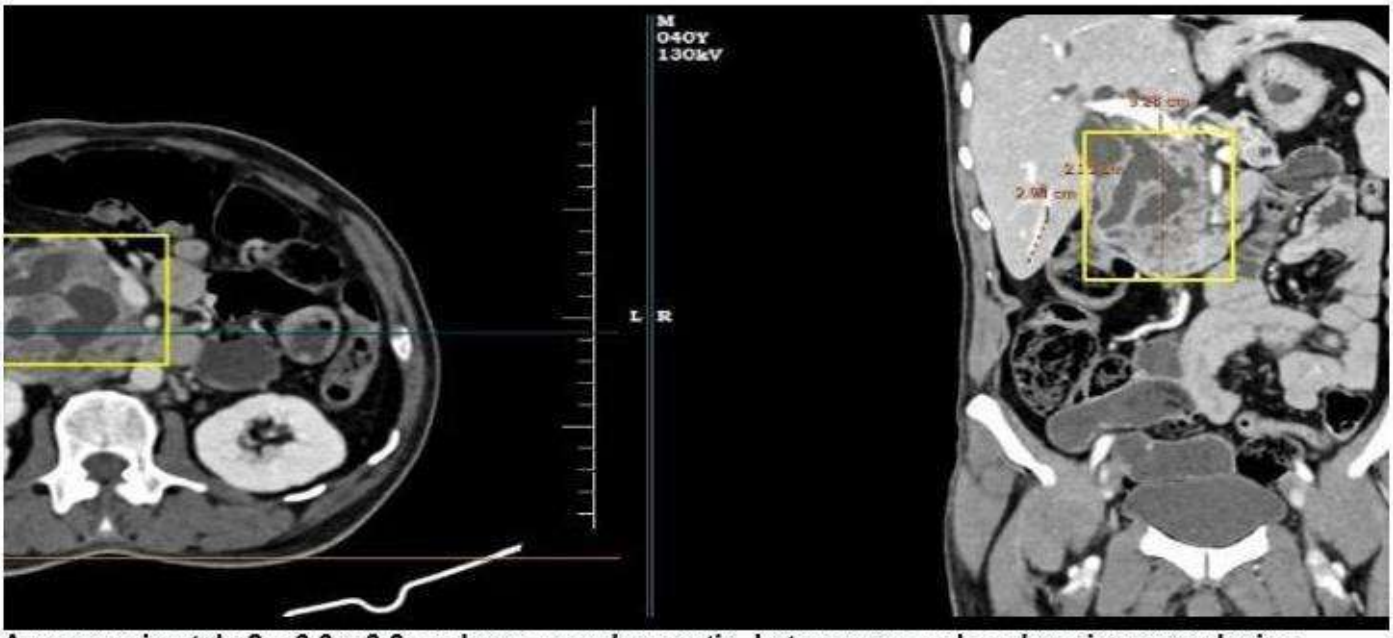
Recommend clinical correlation, S. amylase, lipase levels, follow up.



Evidence of cluster of small bowel loops positioned in the left anterior pararenal space, demonstrating mild dilatation with multiple air fluid levels – **likely suggestive of left paraduodenal hernia**

A few prominent lymphnodes at the root of mesentery and RIF.

Recommend clinical correlation, CT abdomen with contrast, follow up.

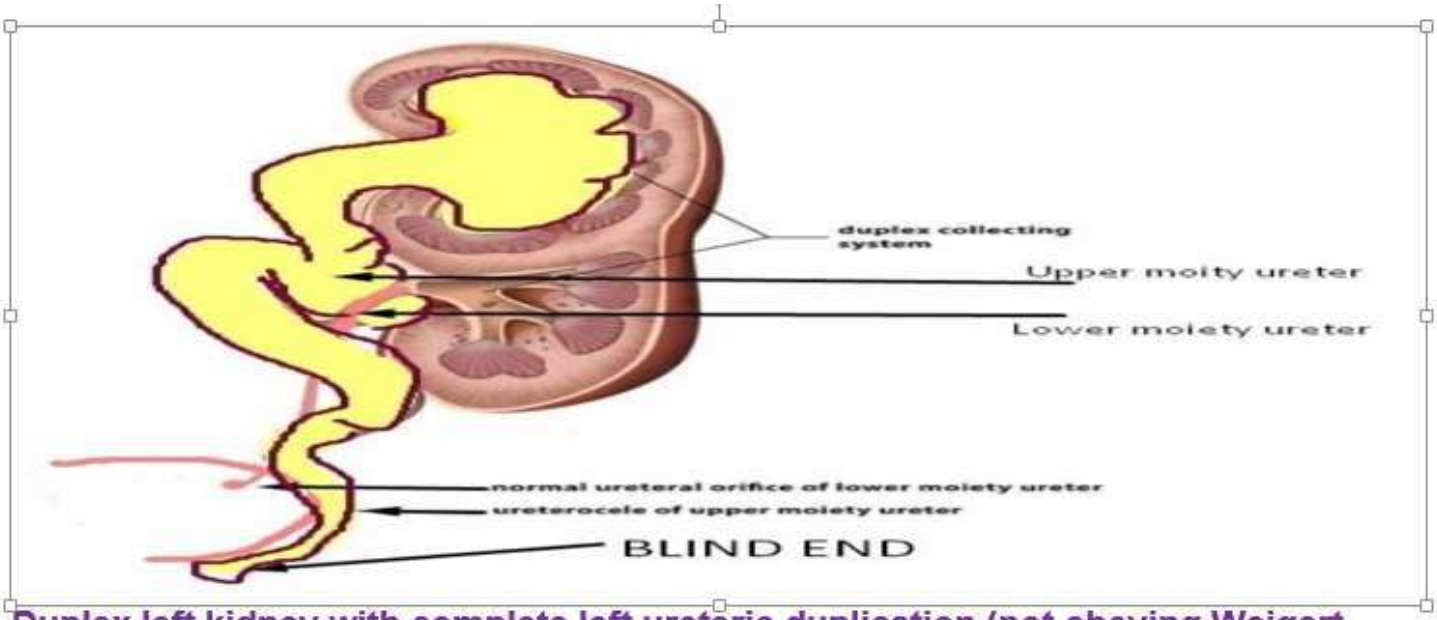


An approximately 8 x 6.6 x 6.2 cm large complex cystic, heterogeneously enhancing mass lesion involving the pancreatic head, uncinate process with surrounding mesenteric fat stranding demonstrating markedly dilated CBD and main pancreatic duct traversing through the mass lesion upto the periampullary region associated with dilated MPD branches – *of concern for extensive branch duct intraductal papillary mucinous tumour (branch duct IPMN).*

Marked dilatation of CBD, CHD, bilateral IHBR and main pancreatic duct (double duct sign).
Markedly distended gall bladder with dilated cystic duct.

The mass is partially encasing the anterior and inferior and portal vein , PV-SV confluence The medial wall of the lesion is abutting the distal celiac artery, SMA without invasion. Anterior wall of the mass is indenting the posterior wall of distal left gastric artery . Posterior wall of the mass is impinging on the anterior wall of infrahepatic IVC causing extrinsic compression of IVCA few enlarged periapancretic lymphnodes.

Recommend HPE correlation, follow up.



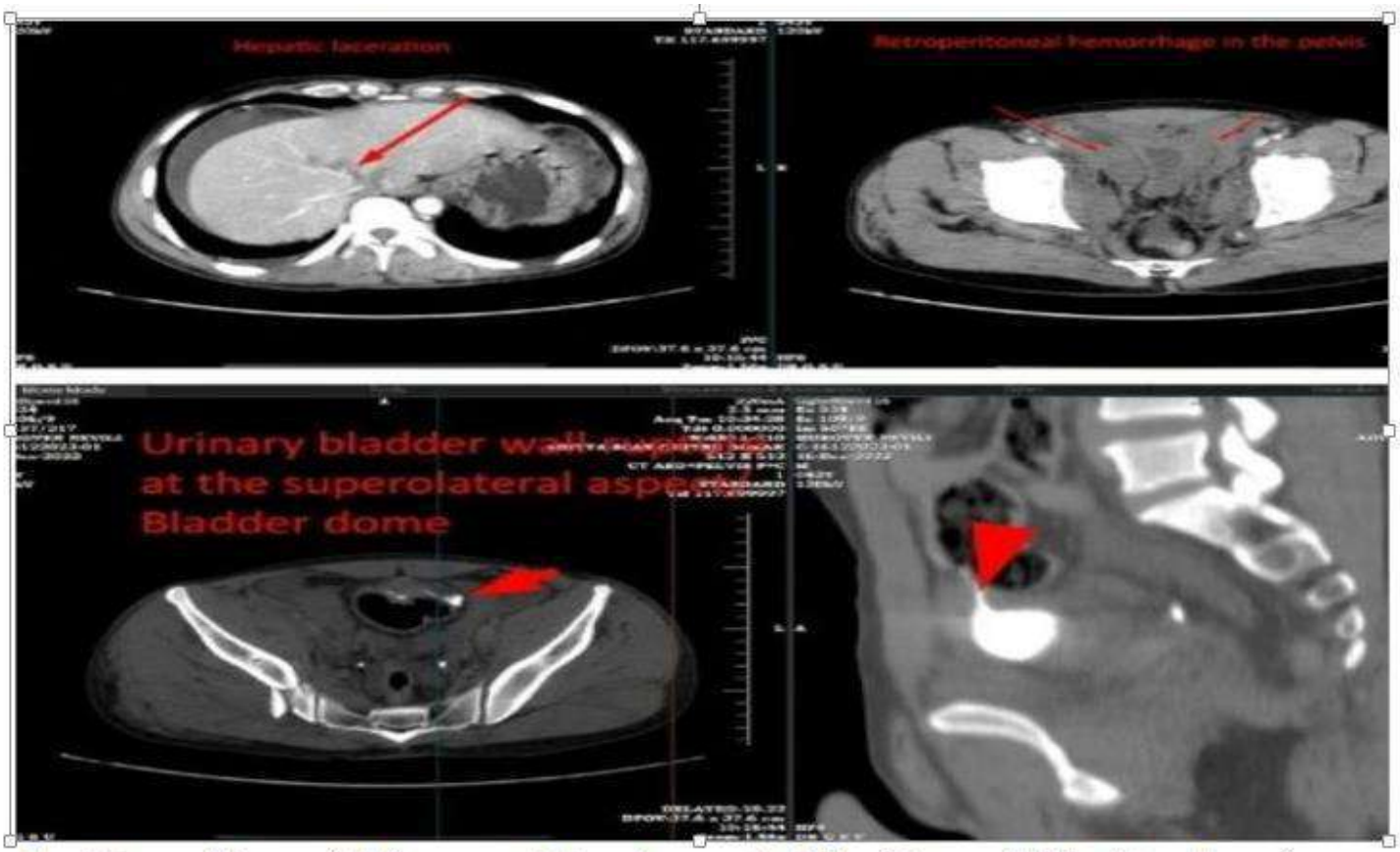
Duplex left kidney with complete left ureteric duplication (not obeying Weigert-Meyer law).

The upper and lower renal moiety are drained by 2 separate ureters.
Massively dilated and tortuous upper renal moiety ureter demonstrates ectopic extra vesical iinsertion just lateral to proximal urethra , demonstrating dilated / bulbous terminal blind end.

***This upper moiety massively dilated , blind ending left ureter remains unopacified on 1 hour delayed scan.**

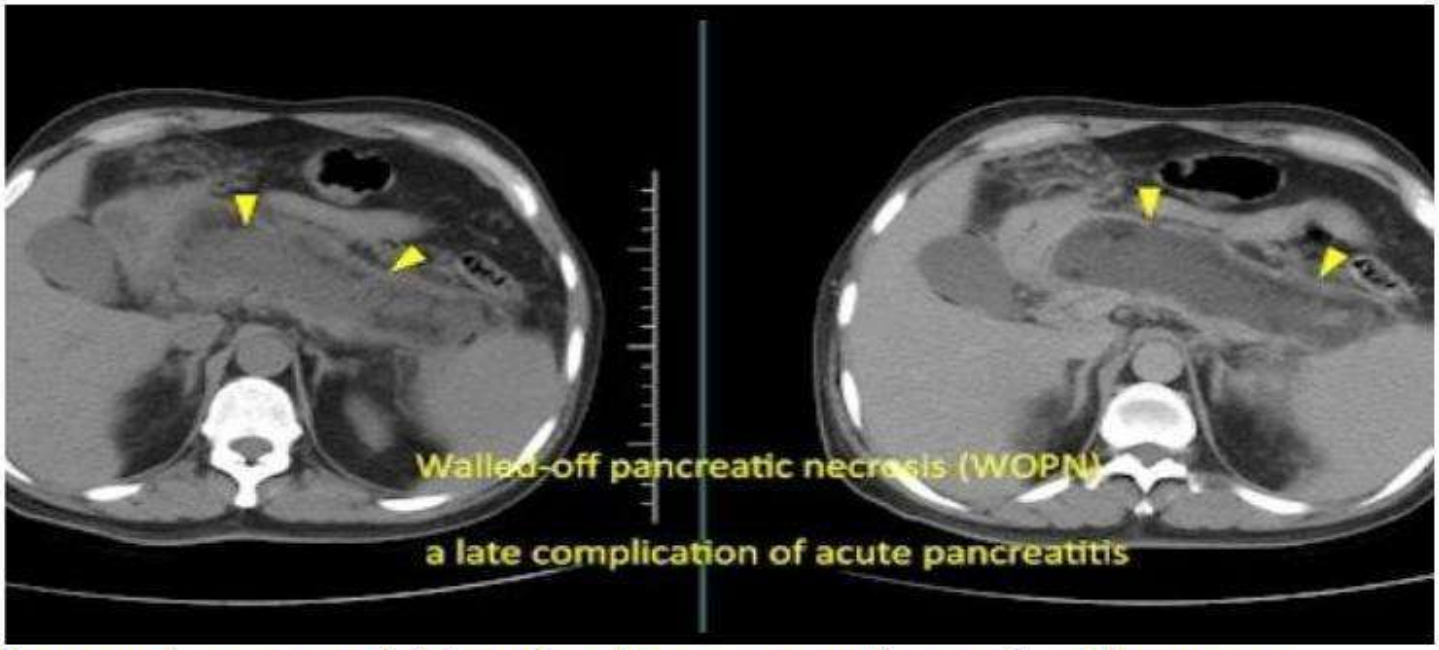
The left lower moiety ureter demonstrates normal caliber, course, opacification and normal anatomic/orthotopic insertion into the bladder.

Prompt CT nephrograms and renal IV contrast excretion bilaterally.
Recommend clinical correlation.



bladder wall tear at left superolateral aspect of bladder wall (bladder dome) .

Marked pelvic retroperitoneal hemorrhage localized to the paravesical, bilateral lateral pelvic spaces and presacral region compressing the urinary bladder. Mild flattening of intrahepatic IVC is noted, likely related to hypovolemia



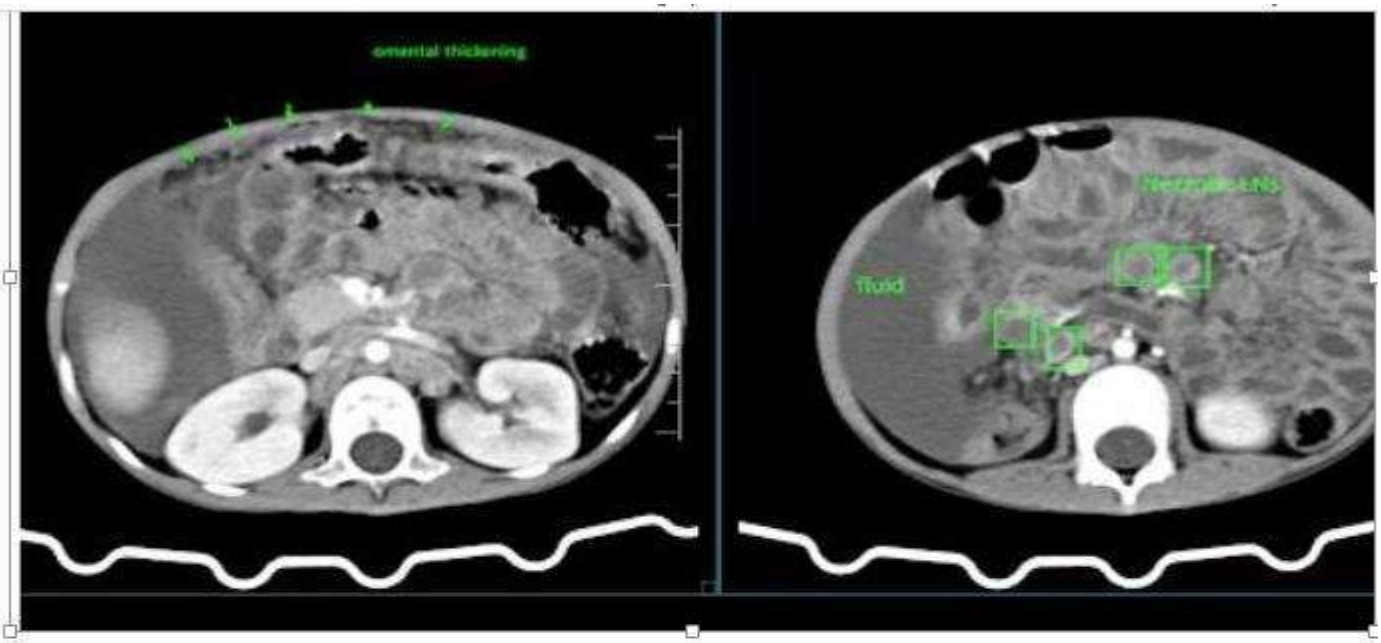
Pancreas is near completely replaced by an expansile necrotic phlegmonous isodense collection demonstrating thin rim enhancement , extensive surrounding mesenteric fat stranding – ***represents Walled-off pancreatic necrosis (WOPN) – late complication of acute necrotizing pancreatitis***

Changes of duodenitis

Extrinsic compression of the splenic vein by the pancreatic phlegmon. No evidence of obvious filling defects in this study.

Trace free fluid in abdomen and pelvis

Recommend clinical correlation, S. amylase, lipase levels, follow up.



Features suggestive of abdominal tuberculosis :-

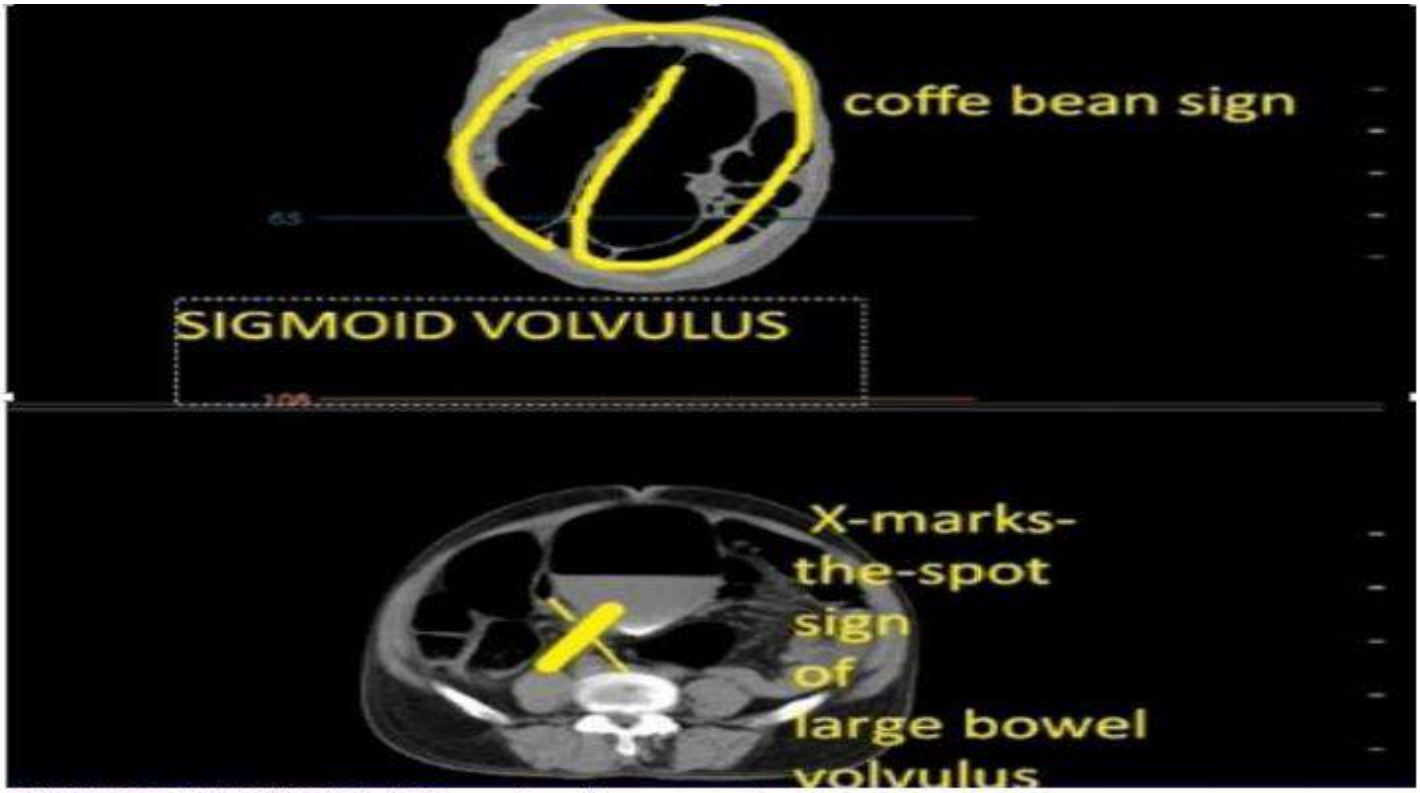
• Mild to moderate amount ascites, predominantly encysted along the right quadrant (15 HU), displacing the small bowel loops, ascending colon to the left

• Irregular thickening of the greater omentum

• Mild long segment mucosal thickening of the jejunal and ileal loops

• Multiple enlarged necrotic lymph nodes predominantly involving the root of mesentery, as well as para-aortic, aortocaval and bilateral iliac compartments of the retroperitoneum.

Recommend clinical correlation, peritoneal fluid

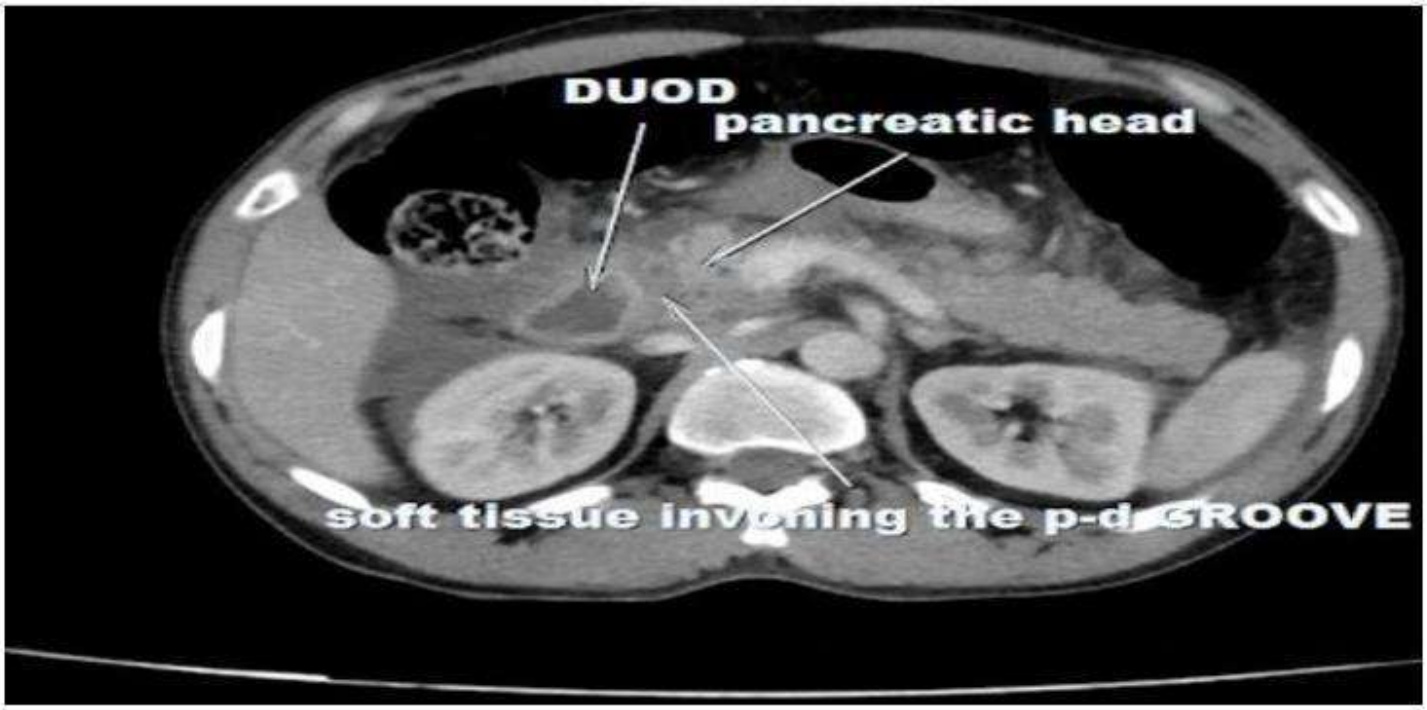


SIGMOID VOLVULUS " X-marks-the-spot sign "

Findings suggestive of large bowel obstruction due to Sigmoid Volvulus :-

Large gas filled bean shaped, closed loop of large bowel with loss of haustral with apex pointing toward the left lower quadrant of the abdomen associated marked twisting of mesenteric vessels (Whirl sign), also demonstrating X-marks-the-spot sign by crossing loops of bowel at the site of the transition.

Trace free fluid in lower abdomen. No evidence of bowel wall necrosis or pneumoperitoneum



Findings represent acute pancreatitis.

Abnormal phlegmonous iso to hypodense soft tissue involving the duodenopancreatic groove with thickening of the proximal duodenal wall – *Acute groove pancreatitis*

Extensive mesenteric fat stranding predominantly around the head, Neck of pancreas associated with isodense non-enhancing soft tissue involving the lesser sac, periduodenal region and the right anterior pararenal space – **suggestive of Acute Peripancreatic Fluid collection (APFC)*.* No

evidence of pancreatic parenchymal necrosis or calcification.

Small amount of free fluid in abdomen and pelvis.

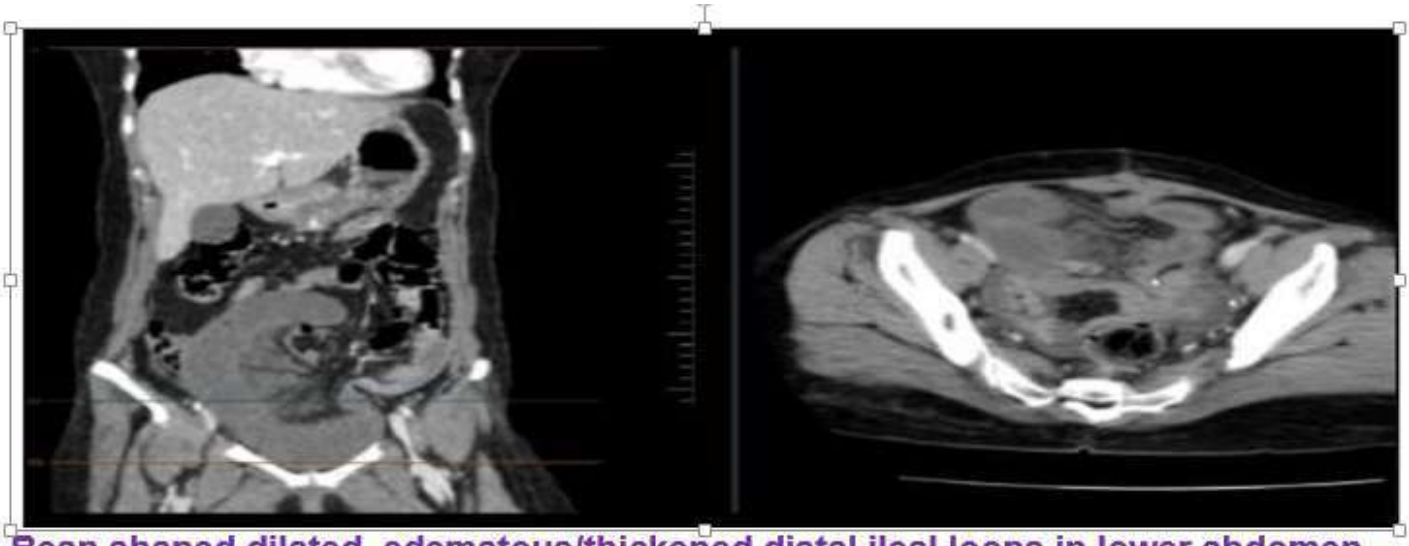
Recommend clinical correlation, S. amylase, lipase levels, follow up



Epiploic appendagitis

A small anterior paracaecal fat attenuation ovoid structure in the right lower quadrant containing a central hyperdense dot with surrounding low attenuation halo and hyperdense rim with focal fat stranding – *suggestive of Epiploic appendagitis*.

Otherwise unremarkable study. Recommend clinical correlation, follow up



Bean shaped dilated, edematous/thickened distal ileal loops in lower abdomen, pelvis demonstrating hypoattenuating mucosal margins on post-contrast study with marked surrounding mesenteric fat stranding, small bowel feces associated with twisted mesenteric vessels in midline infraumbilical region with whirlpool of mesenteric vessels around – *suggestive of internal mesenteric hernia causing closed loop small bowel obstruction.*

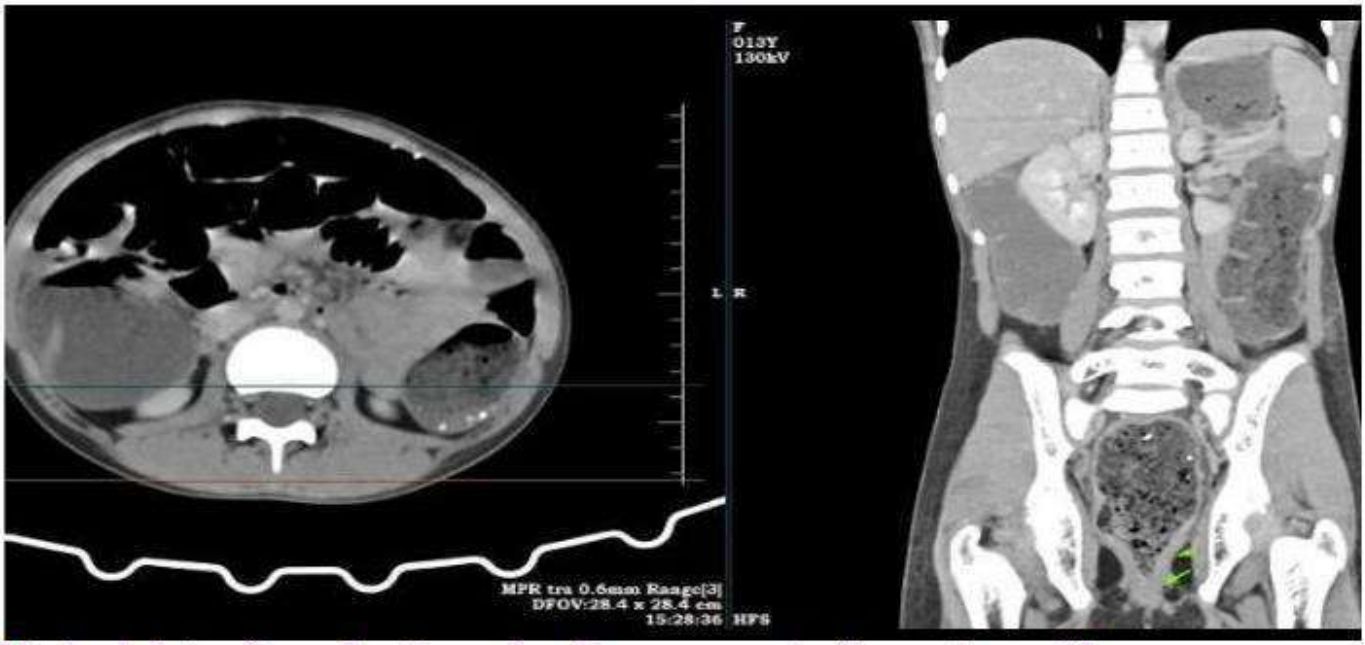
Hypoattenuating mucosal margins of the dilated ileal loops - suggestive of early acute bowel ischemia.

Small free fluid in abdomen and

pelvis. No evidence of

pneumoperitoneum.

Recommend clinical correlation, follow up.



Marked distention of entire colon from cecum to the rectum with abundant fecal material and air fluid levels with tapering of distal rectum as described above –

possibility of aganglionic segment of the distal rectum (Hirschsprung's disease) cannot be ruled out

A few punctate bilateral renal non obstructing calculi /

concretions Recommend clinical correlation, further evaluation

and follow up.



An approximately 5 x 4.8 x 4.7 cm multiloculated complex cystic heterogeneously enhancing mass lesion involving the pancreatic neck with partial exophytic component slightly indenting the posterior wall of gastric antrum without invasion – **represents pancreatic neoplasm**

****Focal nodular thickening at medial wall of D1 segment of duodenum, measuring 2.8 x1.5 cm* demonstrating mild to moderate homogeneous enhancement*** **without transmural infiltration - ? neoplastic**

Normal main pancreatic duct. No evidence of surrounding invasion. No significant lymphadenopathy

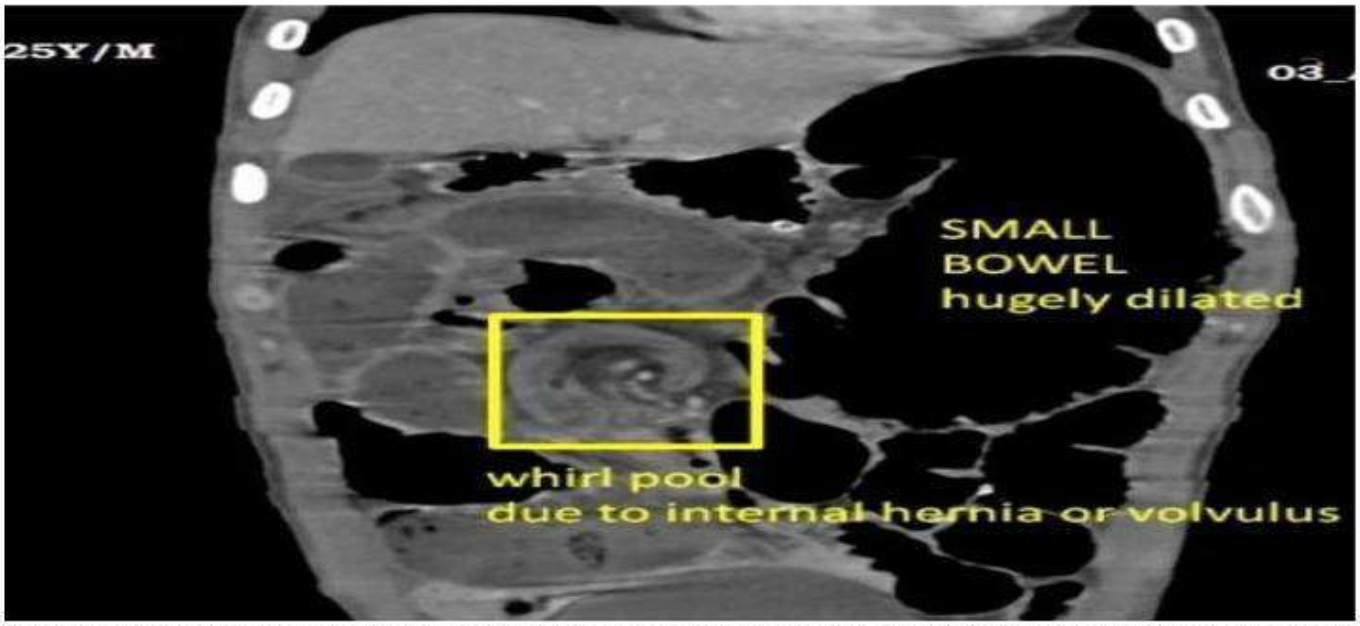
Features of concern for multiple endocrine neoplasia (*MEN)

Recommend HPE correlation, upper GI endoscopy, further evaluation , follow up



Mucocele of the appendix due to luminal obstruction at the base by 1.8 cm appendicolith.

No evidence of periappendiceal collection. No evidence of free fluid or pneumoperitoneum.



High grade small bowel obstruction with apparent transition point at the level of proximal ileal loops demonstrating Whirlpool like twisting of mesenteric vessels in right lumbar quadrant – *likely related to internal mesenteric hernia or volvulus.*

A large dilated small bowel loop in left upper quadrant, likely related to closed loop obstruction demonstrating air fluid level with tiny intramural loculi suggesting early gangreneous changes
SMA, SMV demonstrates normal relationship with normal position of duodeno jejunal

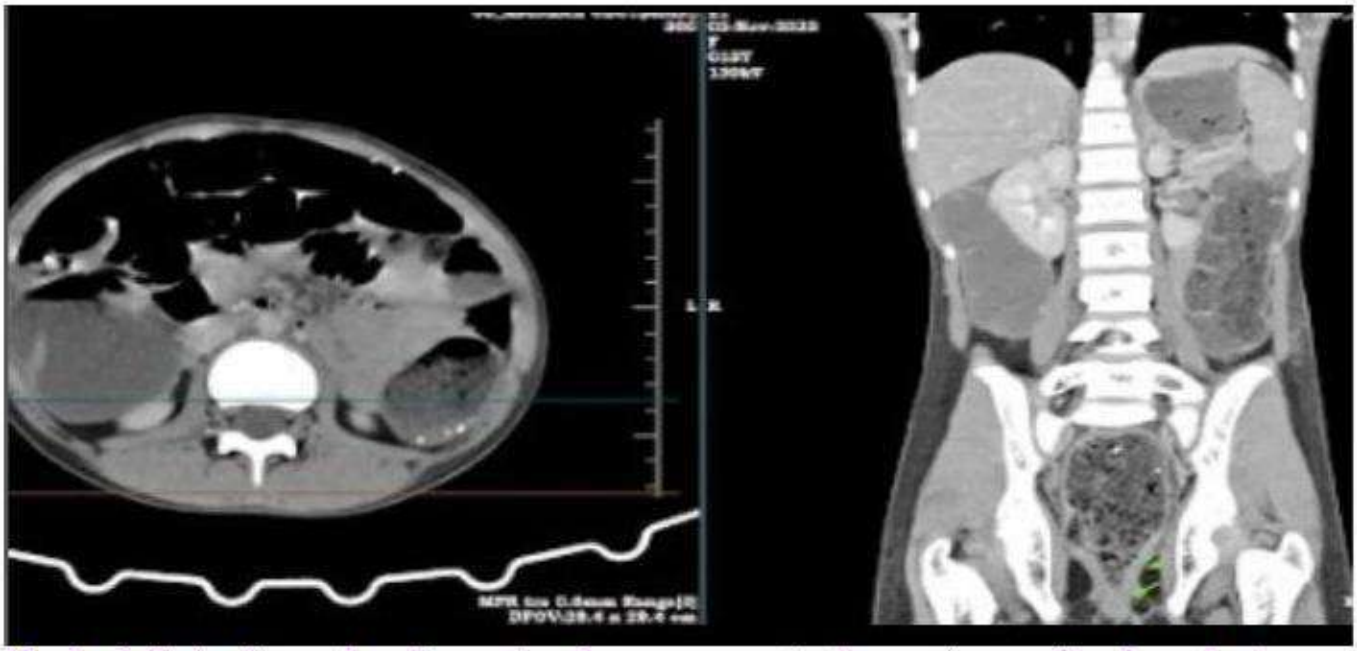
junction to the left Small free fluid in pelvis
Tiny sludge like gall bladder calculi No evidence of pneumoperitoneum
Recommend clinical correlation, further evaluation, follow up.



Clockwise twisting of distal ileal loops in the right lower quadrant, along with mesenteric vessels anteromedial to the common iliac vessels (whirlpool sign) causing resultant upstream dilatation of the small bowel loops with multiple air fluid levels – *represents moderate grade distal ileal obstruction due to internal mesenteric hernia (a congenital defect in mesentery)*

Small free fluid in the pelvis. No evidence of pneumoperitoneum.

The anatomic relationship between SMA - SMV is maintained. No evidence of congenital malrotation

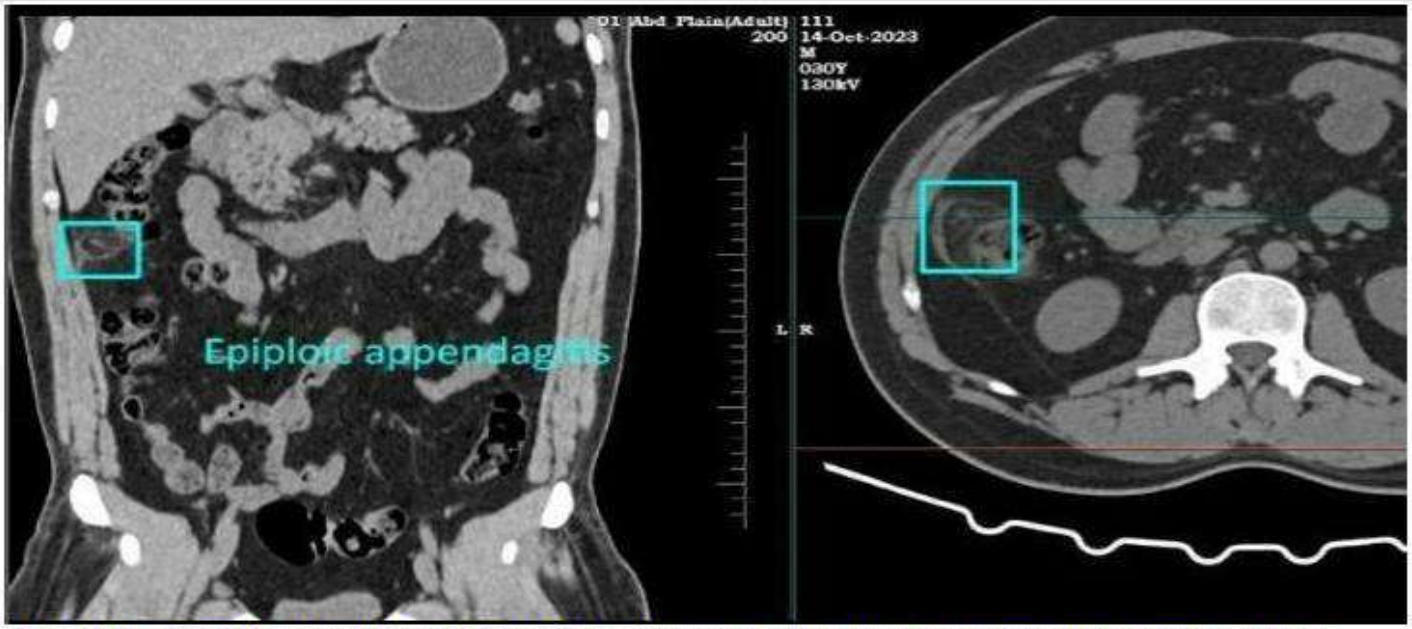


Marked distention of entire colon from cecum to the rectum with abundant fecal material and air fluid levels with tapering of distal rectum as described above –

possibility of aganglionic segment of the distal rectum (Hirschsprung's disease) cannot be ruled out

A few punctate bilateral renal non obstructing calculi / concretions

Recommend clinical correlation, further evaluation and follow up.



A subtle small ovoid fat attenuation lesion in the right paracolic space at the level of proximal ascending colon demonstrating tiny central hyperdense dot with surrounding rim like fat stranding , approximately measuring 2.6 x 1.8 cm – *suggestive of Epiploic appendagitis.*

Recommend clinical correlation



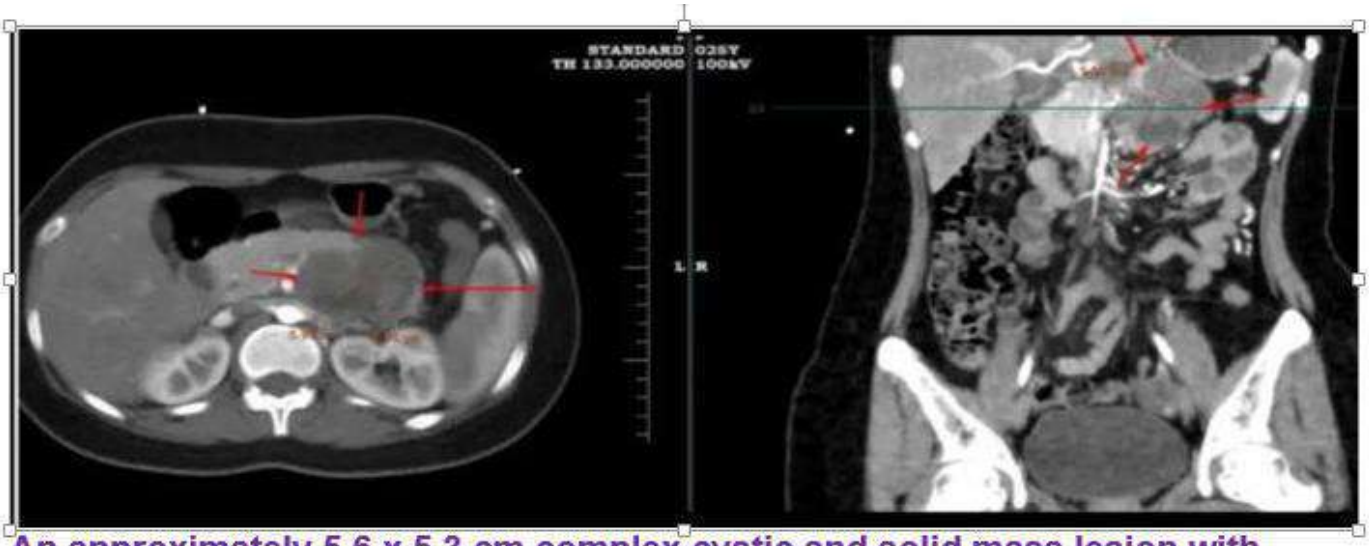
A small, subtle round area of mesenteric fat stranding abutting the anterior wall of distal descending colon with tiny central lucency – *likely suggestive of epiploic appendagitis*

Other possibility of early diverticulitis cannot be ruled out

A few tiny diverticuli along the distal transverse colon, descending colon.

Borderline splenomegaly

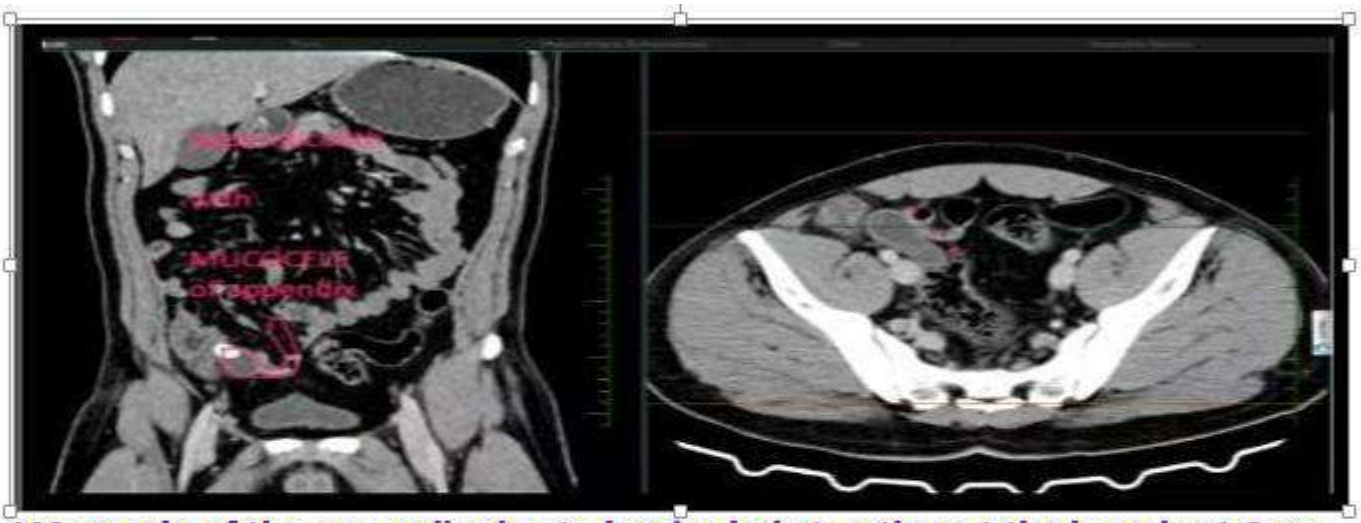
Recommend clinical correlation, follow up.



An approximately 5.6 x 5.3 cm complex cystic and solid mass lesion with heterogeneously enhancing solid component involving the tail of pancreas extending posteriorly into the celiac, para-aortic compartment of the retroperitoneum engulfing the splenic vein as described above – **of concern for neoplastic etiology , likely solid pseudo papillary tumour of pancreas**

The mass is just indenting the left renal vein, left lateral wall of SMA add the celiac artery without invasion .

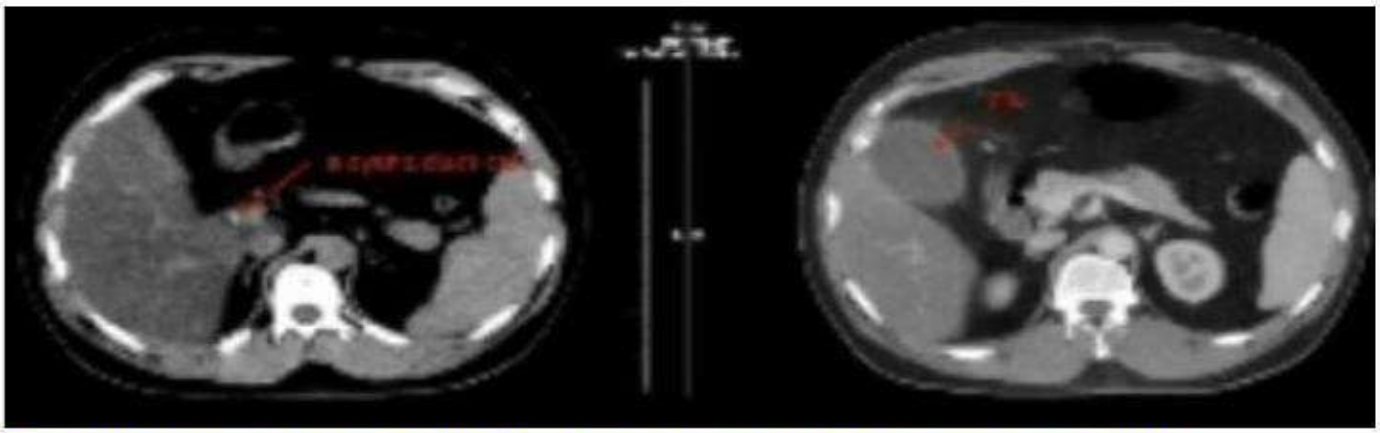
No significant lymphadenopathy. Recommend HPE correlation, follow up.



**Mucocele of the appendix due to luminal obstruction at the base by 1.8 cm appendicolith*.*

No evidence of periappendiceal collection. No evidence of free fluid or pneumoperitoneum.

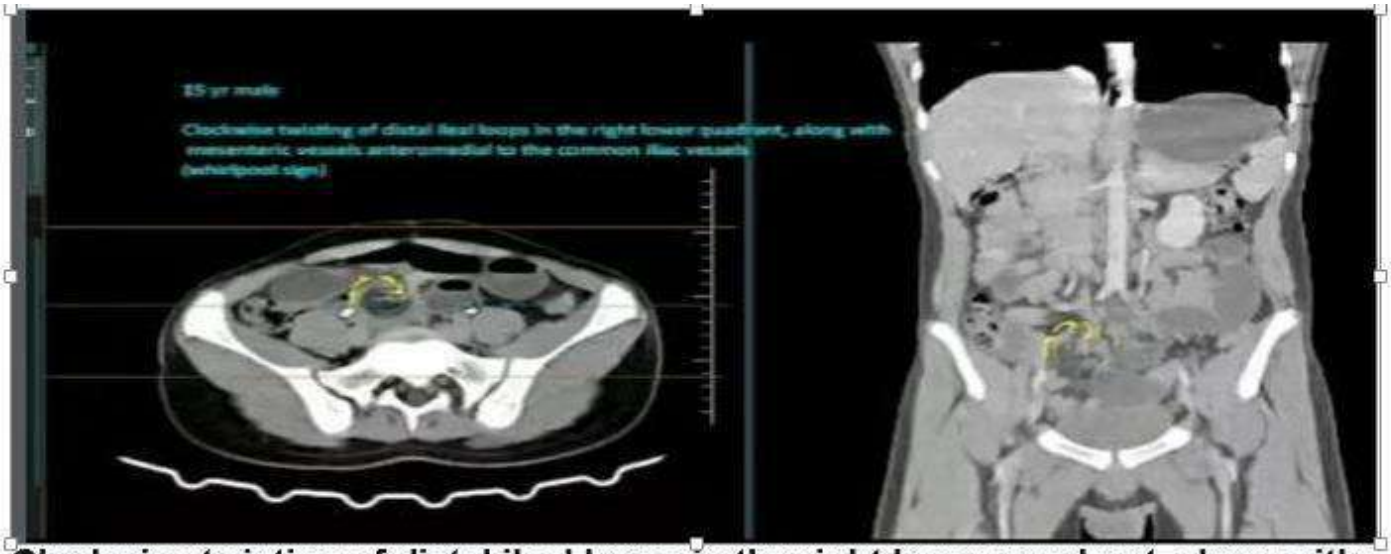
Recommend clinical correlation



Findings suggestive of acute cholecystitis with 0.6 cm impacted cystic duct calculus.

Divarication of anterior abdominal wall recti with right paramedian supraumbilical fat containing anterior abdominal wall hernia.

Fatty liver.
Recommend clinical correlation, follow up.



Clockwise twisting of distal ileal loops in the right lower quadrant, along with mesenteric vessels anteromedial to the common iliac vessels (whirlpool sign) causing resultant upstream dilatation of the small bowel loops with multiple air fluid levels – ***represents moderate grade distal ileal obstruction due to internal mesenteric hernia (a congenital defect in mesentery)***

Small free fluid in the pelvis. No evidence of pneumoperitoneum.

The anatomic relationship between SMA - SMV is maintained. No evidence of congenital malrotation
Recommend clinical correlation, follow up.



Extensive aortic atheromatous changes

Two short segment displaced intimal flaps of the descending abdominal aorta 6 cm distal to origin of right renal artery as described above *– of concern for Penetrating atherosclerotic ulcers (PAU) versus* short segment isolated infrarenal abdominal aortic dissection

The distal flap is close to the IMA osteum, abutting the right lateral wall of IMA. The IMA demonstrates almost normal caliber.

Mild focal ectasia of the aortic lumen at this level without aneurysm. No evidence of periaortic collection or fat stranding. No evidence of extra vasation of the contrast

Recommend clinical correlation, further evaluation, follow up



A small spiculated heterogeneously enhancing mesenteric mass lesion (2.0 x1.8 cm) in the right lower quadrant, apparently adherent to the adjoining ileal loop with surrounding mesenteric fat stranding – **may suggest 'Meckel's diverticulum*'.*

****Other possibilities would be a necrotic mesenteric lymphnode adherent to adjoining ileal loop versus carcinoid tumour*.***

Mild dilatation of small bowel loops.

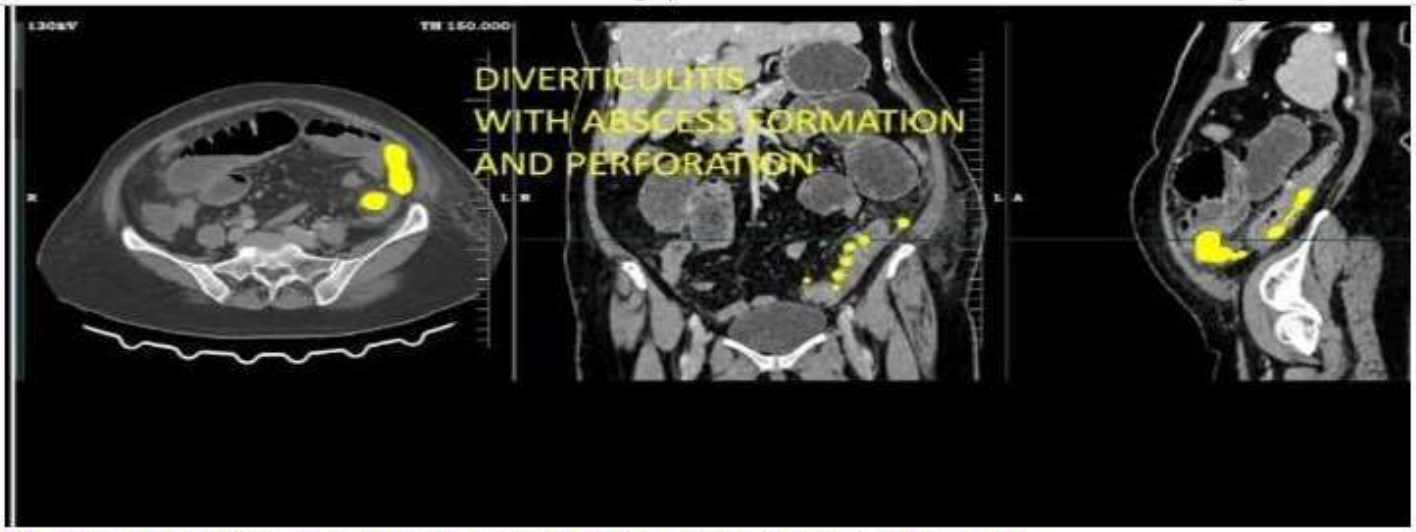
Right renal lower calyceal non-obstructing calculus measuring 0.7 cm (500 HU).



High grade small bowel obstruction :- Marked dilatation of small bowel loops demonstrating multiple air fluid levels with collapsed, stretched distal ileal loop in lower abdomen at the level of common iliac artery with twisting of the vessels around (Whirl pool sign) , *suggesting 'internal mesenteric hernia' versus ? mesenteric adhesions.*

Trace free fluid in abdomen and pelvis. No evidence of pneumoperitoneum.

Recommend clinical correlation, follow up



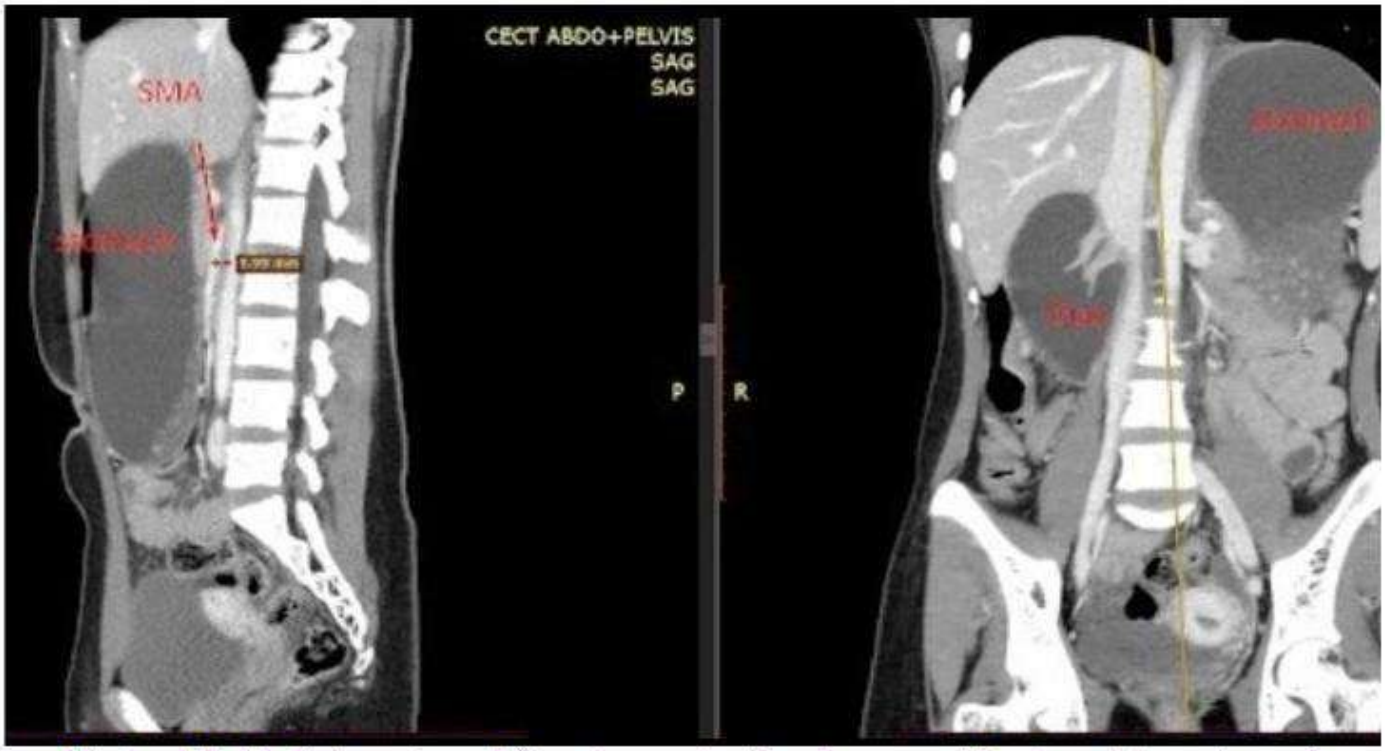
Multiple colonic diverticuli along the entire course of colon.

Mild long segment mural thickening associated with multiple diverticuli and paracolic extramural a rim enhancing , necrotic paracolic collections along the course of distal descending and rectosigmoid colon – *suggestive of diverticulitis with abscess formation*

Small pneumoperitoneum in the periumbilical region, left lower quadrant of abdomen in paracolic spaces - *represents localized perforated diverticulitis along the left distal descending and recto sigmoid colon*

Extensive surrounding mesenteric fat stranding associated with focal thickening of adjoining part of ileal loop in the left lower quadrant of abdomen with resultant small bowel obstruction

Trace free fluid in lower abdomen and pelvis.



Marked fluid distension of the stomach, duodenum with abrupt tapering of the duodenal lumen at the level of superior mesenteric artery with narrow aorta mesenteric angle of 12° and significantly reduced aorta mesenteric distance to 5 mm – **suggestive of Superior mesenteric artery (SMA) syndrome**

The D4 segment of duodenum, jejunum and rest of small bowel loops are collapsed. Small free fluid in pelvis.



Spiculated, heterogeneously enhancing bilateral adnexal pelvic mass lesions measuring
3.5 x 2 cm on the left and 1.8 x 1.2 cm on the right with invasion of the left ureter and left hydroureteronephrosis - *likely suggestive of bilateral ovarian neoplasm, likely 'Krukenberg tumors*'.

Marked diffuse nodular greater omental thickening associated with multiple enhancing peritoneal deposits - *peritoneal metastasis*.

Focal mural thickening of posterior wall of stomach at the body demonstrating posterior transmural invasion into lesser sac indenting the pancreatic tail with obscured peripancreatic fat planes – *of concern for primary gastric carcinoma*.

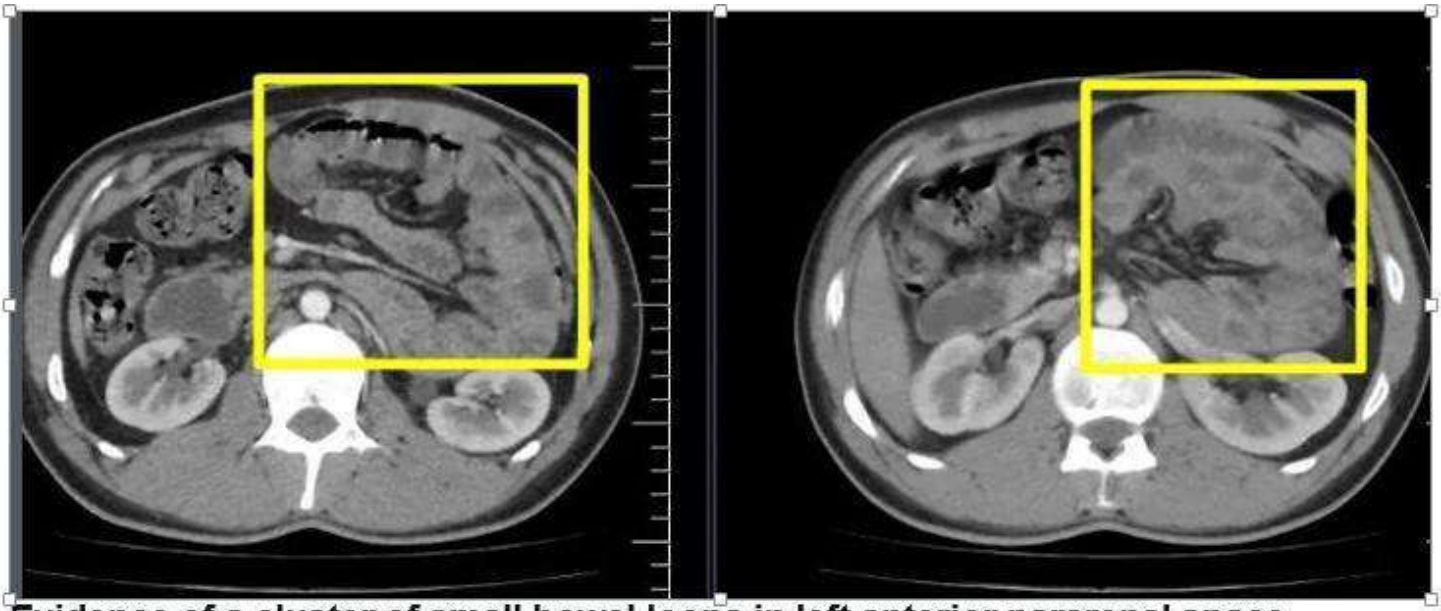


Findings suggestive of acute superior mesenteric vein thrombosis.

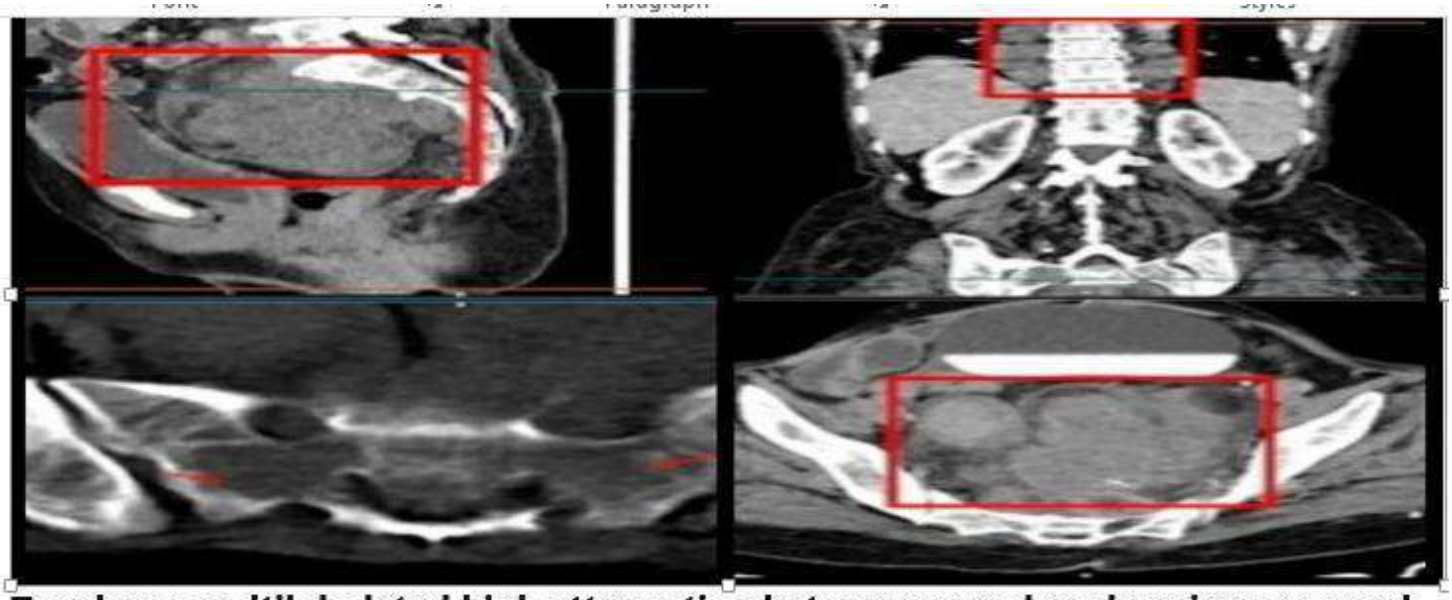
An approximately 5.0 x 3.2 necrotic rim enhancing collection in the right lower quadrant mesentery with surrounding mesenteric fat stranding demonstrating tiny air fluid levels which is apparently communicating with thickened appendix – *suggestive of acute appendicitis with abscesses*

No evidence of bowel wall necrosis in this study.

Recommend further evaluation in view of prothrombotic state , venography , immune status evaluation, follow up



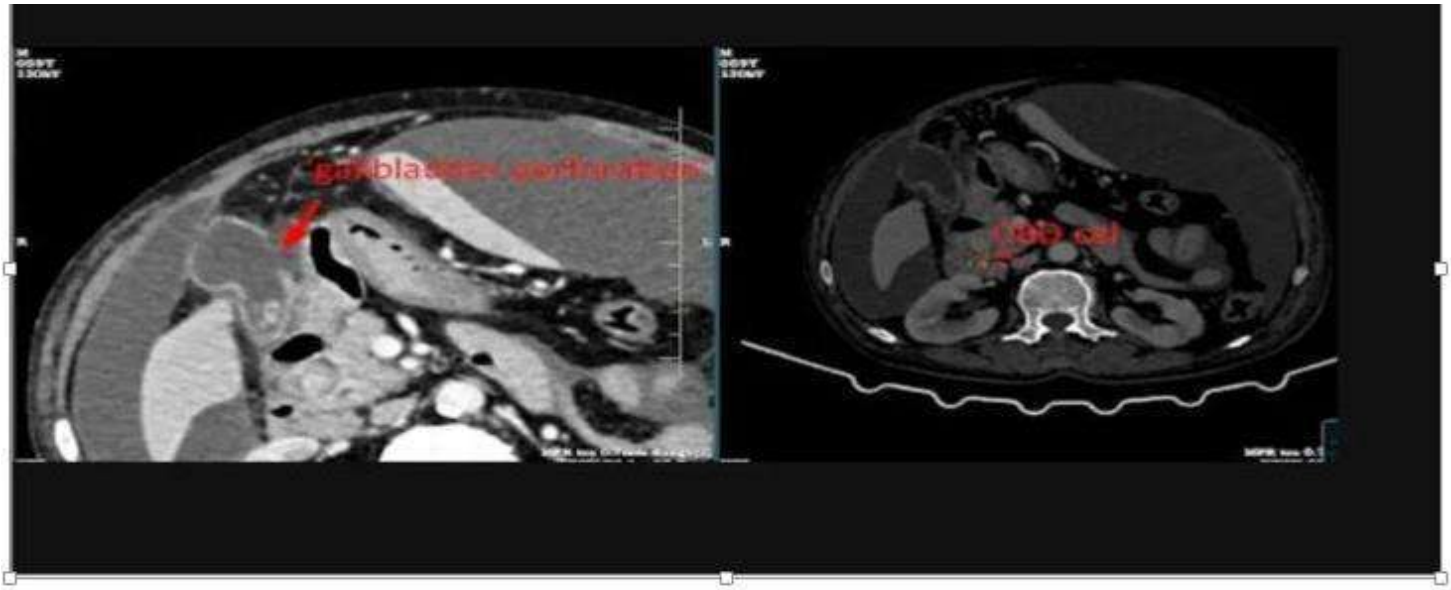
Evidence of a cluster of small bowel loops in left anterior pararenal space, posterior inferior mesenteric vein which are mildly dilated with few air fluid levels stop the duodenum is mildly dilated - **suggestive of 'left paraduodenal internal hernia' causing low-grade small bowel obstruction* .*



Two large multilobulated high attenuation heterogeneously enhancing presacral mass lesions extending into pelvis with lytic changes at the sacral ala associated with another large bilateral paravertebral lobulated high attenuation mass lesion at lower thoracic level extending from D6 to D11 level – *of concern for 'Extramedullary hematopoiesis*'.

***Other possibility of lymphoma cannot be entirely ruled out*.**
Subtle illdefined lyrtic areas involving the sacral vertebral bodies at S2, S3 vertebral bodies, bilateral femoral necks , iliac bones – *of concern for underlying myeloproliferative disorder*

Slightly dysmorphic liver parenchyma with borderline splenomegaly and multiple collateral vessels in periportal region, peripancreatic, perisplenic regions
Benign osteoporotic old anterior wedge compression fracture involving L1 body
No evidence of vertebral metastasis.



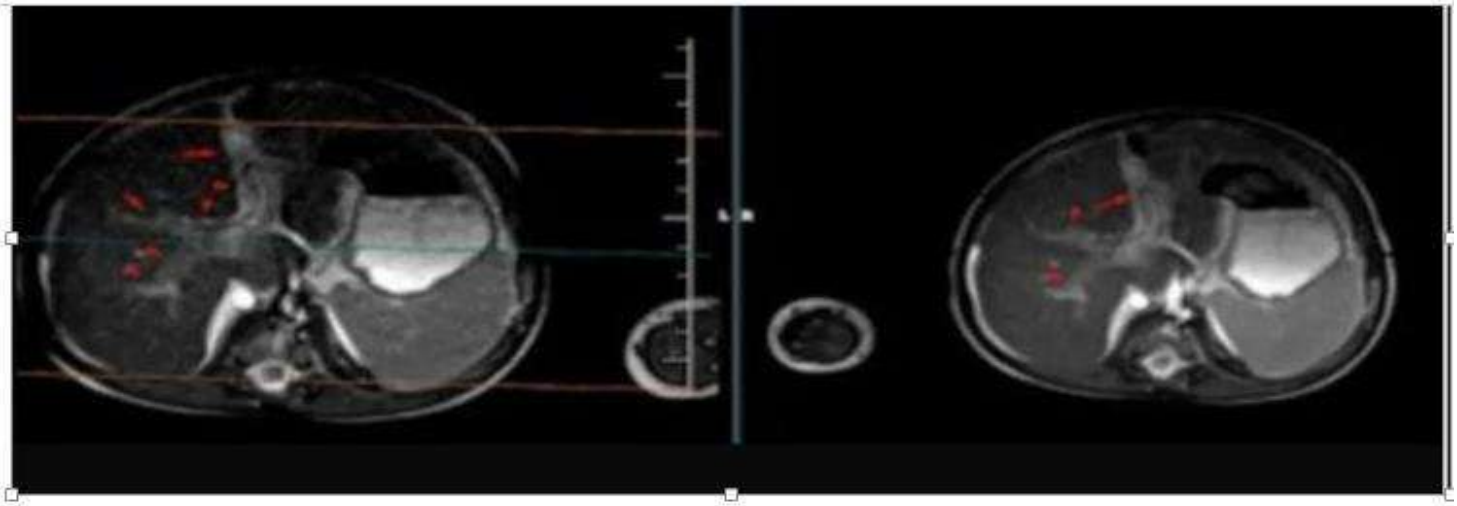
1.1 cm terminal CBD calculus with marked upstream dilatation of the CBD, CHD and bilateral IHBR.

Features suggestive of 'acute calculus cholecystitis' with an impacted gallbladder neck calculus.

Evidence of a small defect at the medial wall of gallbladder - *suggestive of 'gallbladder perforation*'.

Marked free fluid in abdomen and pelvis (15-25 HU) predominantly localised in the right perihepatic, subphrenic spaces causing marked scalloping of the liver margins –
suggestive of bile peritonitis

Slightly dysmorphic liver parenchyma



Umbilical hernia

Slightly dysmorphic liver parenchyma

Marked periportal soft tissue thickening in the right and left lobe (seen as high T2 signals in the periportal region with tiny cystic changes) associated with mild narrowing of intrahepatic portal vein is noted with evidence of minimal beaded dilatation of IHBR –*_likely suggestive of congenital periportal fibrosis_

Mild to moderate free fluid in abdomen and pelvis.

Mild splenomegaly



Cholelithiasis.

Mildly dilated CBD, CHD and central IHBR, likely related to extrinsic obstruction caused by an approximately 2.6x1.3 cm duodenum diverticulum at periampullary region -*suggesting Lemmel Syndrome*



Retrocaval ureter :- Right ureter demonstrates retrocaval course at L4 vertebral level with resultant marked upstream dilatation of proximal ureter with moderate hydronephrosis.



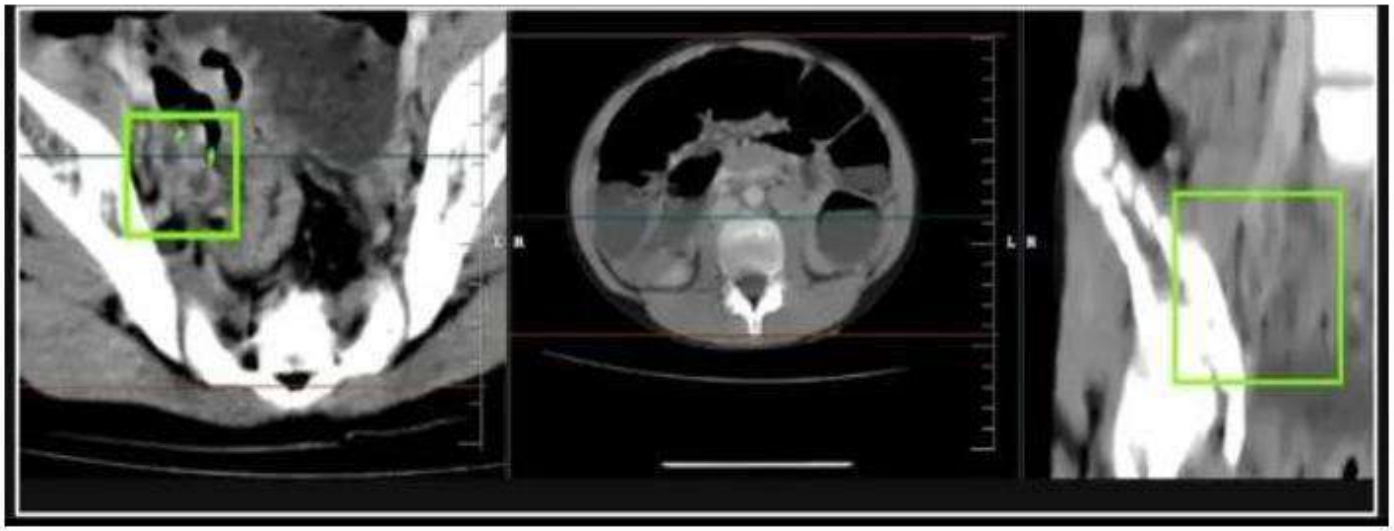
Cholelithiasis.

Mildly dilated CBD, CHD and central IHBR, likely related to extrinsic obstruction caused by an approximately 2.6x1.3 cm duodenum diverticulum at periampullary region -*suggesting Lemmel Syndrome



Massive fluid distention of stomach and the duodenum containing food debris, extending upto the pelvis with abrupt short segment narrowing of the proximal small bowel, apparently at the level of distal duodenum / duodeno jejunal junction, demonstrating focal circumferential mural thickening over an approximate length of 5 cm causing tight stricture – *likely suggestive of neoplastic distal duodenal stricture.*

Massively dilated duodenal loop is extending caudally into the pelvis suggesting long stranding obstruction – *suggesting possibility of underlying congenital duodenal web*



Marked dilatation of small bowel loops with multiple air fluid levels and apparent transition point at the level of distal ileal loops in the right lateral aspect of pelvis demonstrating segmental ileal wall thickening – *represents moderate to high grade distal small bowel obstruction*.

Evidence of hollow blind ending tubular fluid filled structure in the right lateral aspect of pelvis, just posterior to the above-mentioned thickened ileal loop measuring 1 cm in maximum diameter, apparently arising from the distal ileum - *likely suggestive of Meckel's diverticulitis versus ? appendicitis .*

Findings may suggest Meckel's diverticulitis with secondary distal small bowel obstruction.



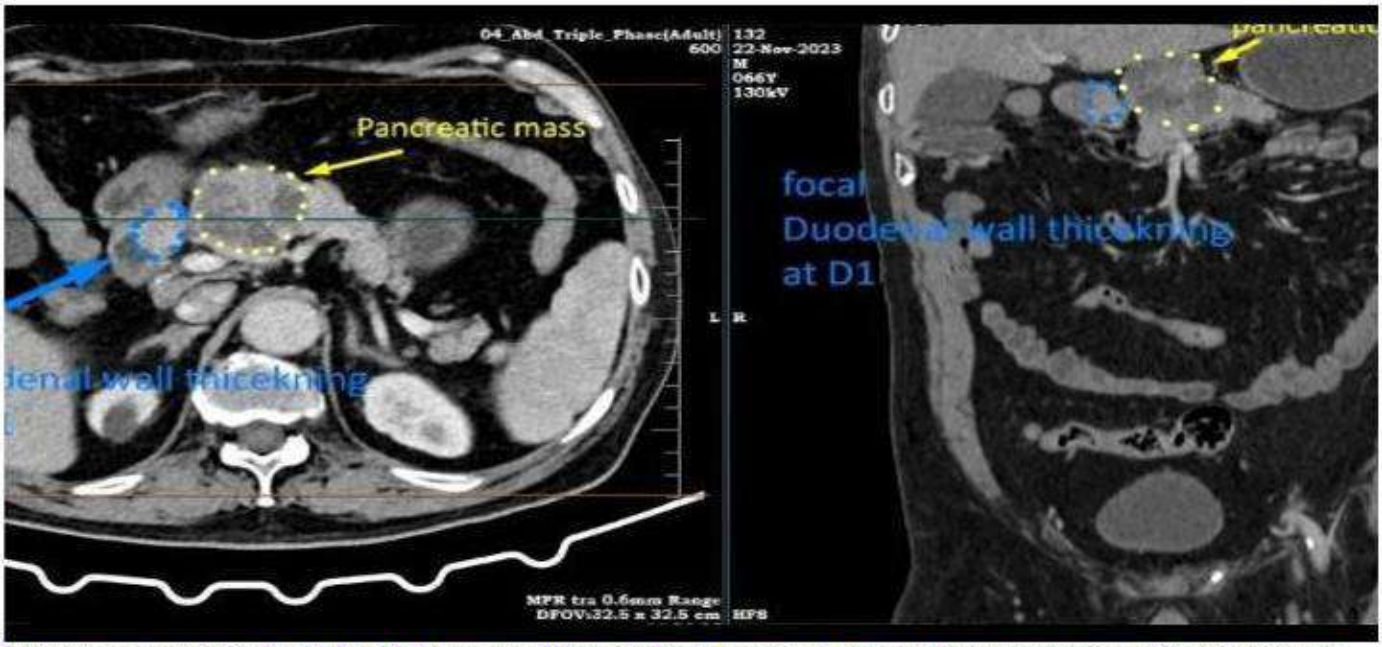
An approximately 7.5 x 7 x 6.8 cm thick walled collection in the right lower quadrant of the abdomen involving subcecal space demonstrating spongiform appearance with mottled gas bubbles demonstrating multiple surgical sutures along the margins of the collection – *needs clinical correlation*

The collection appears adherent to right broad ligament with deviation of uterus to the right.

A tiny intraluminal air loculus within bladder lumen with normal bladder wall

thickness Trace free fluid in lower quadrant

Recommend clinical correlation



An approximately 5 x 4.8 x 4.7 cm multiloculated complex cystic heterogeneously enhancing mass lesion involving the pancreatic neck with partial exophytic component slightly indenting the posterior wall of gastric antrum without invasion – ***represents pancreatic neoplasm***

The posterior margin of the mass is in contact with common hepatic artery over an approximate length of 3.3 cm with slightly obscured fat planes as described above

Focal nodular thickening at medial wall of D1 segment of duodenum, measuring 2.8 x 1.5 cm demonstrating mild to moderate homogeneous enhancement without transmural infiltration - ? neoplastic

Normal main pancreatic duct. No evidence of surrounding invasion. No significant

lymphadenopathy Features of concern for multiple endocrine neoplasia (*MEN)

Other findings as described above
Recommend HPE correlation, upper GI endoscopy, further evaluation , follow up



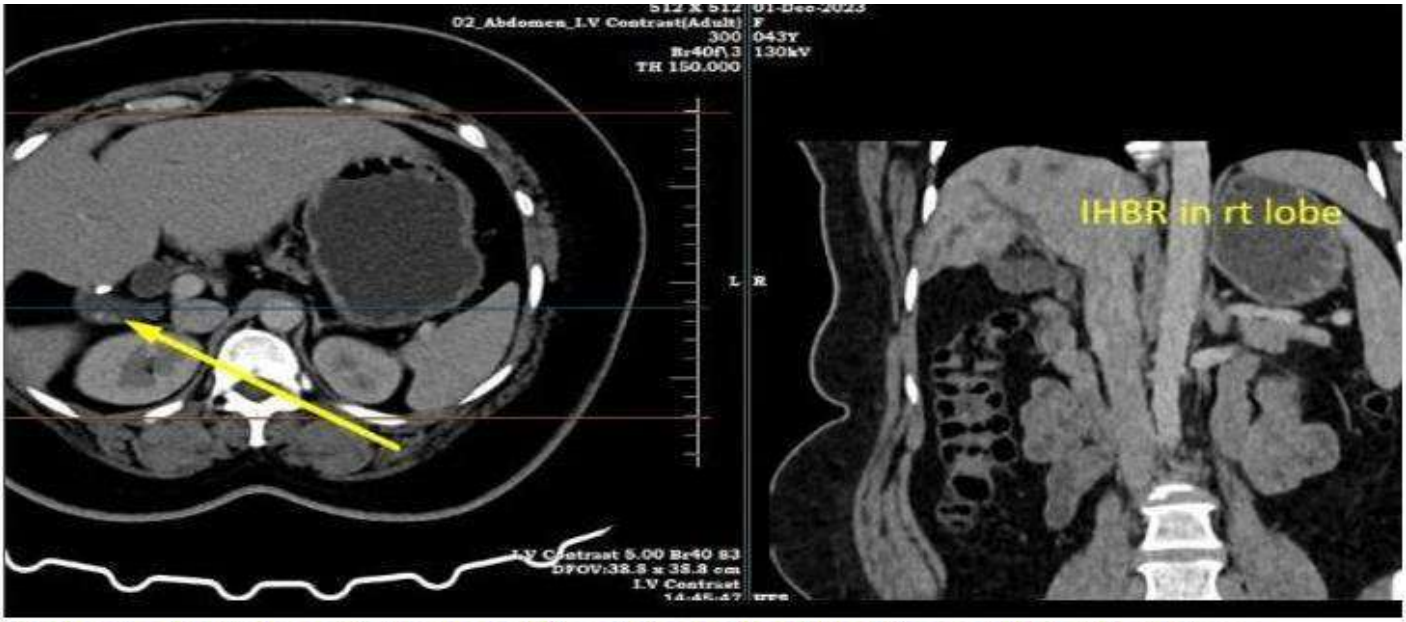
An approximately 5 x 4.8 x 4.7 cm multiloculated complex cystic heterogeneously enhancing mass lesion involving the pancreatic neck with partial exophytic component slightly indenting the posterior wall of gastric antrum without invasion – **represents pancreatic neoplasm**

****Focal nodular thickening at medial wall of D1 segment of duodenum, measuring 2.8 x1.5 cm* demonstrating mild to moderate homogeneous enhancement*** **without transmural infiltration - ? neoplastic**

Normal main pancreatic duct. No evidence of surrounding invasion. No significant lymphadenopathy

Features of concern for multiple endocrine neoplasia (*MEN)

Recommend HPE correlation, upper GI endoscopy, further evaluation , follow up



Status post cholecystectomy with surgical clip involving gall bladder fossa.

An elongated sac like structure within the gall bladder fossa containing tiny multiple calculi which is communicating with CBD via cystic duct –*may suggest residual sac with calculi*.

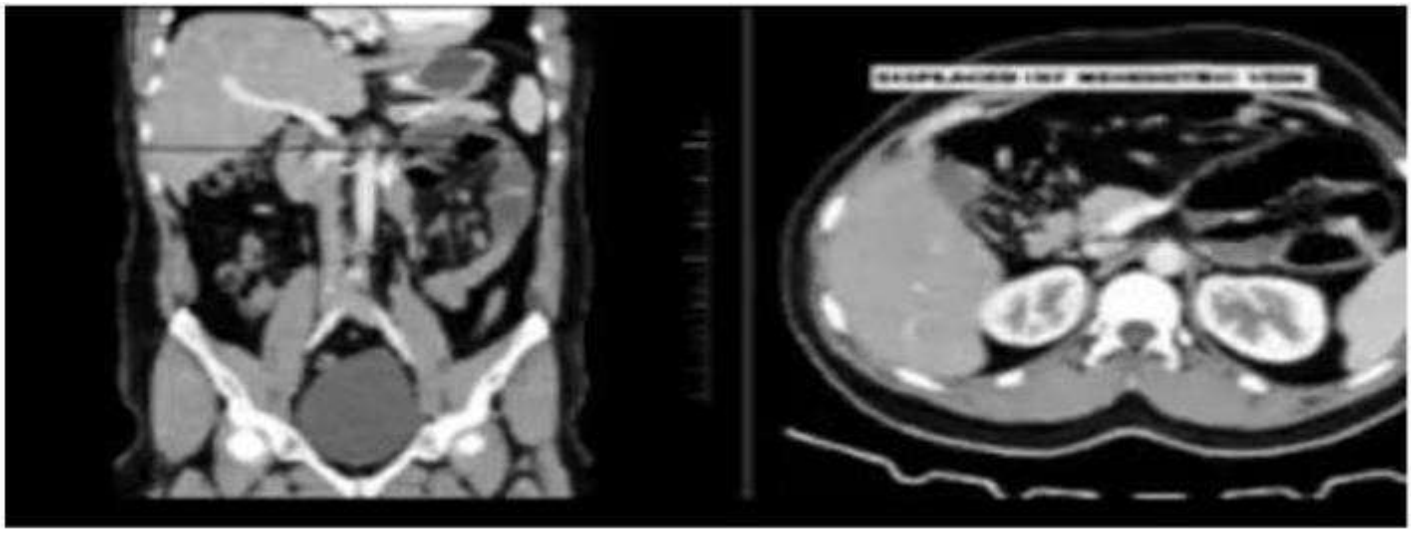
Dilatation of CBD, CHD with asymmetric IHBR dilatation (right >left) and abrupt narrowing of terminal CBD – *a possibility of Primary biliary cholangitis cannot be ruled out*.

No evidence of radio opaque ductal calculus or obvious obstructing lesion in this study.

Mild hypoplasia of right lobe of liver with mild enlargement of left lobe and non-visualization of right hepatic vein.

Mild splenomegaly .

Recommend clinical correlation, MRCP / ERCP, LFT correlation, follow up.



Left paraduodenal hernia causing closed loop low grade small bowel obstruction.

A cluster of dilated small bowel loops (proximal jejunal loops), abnormally positioned in the left anterior pararenal space, demonstrating multiple air fluid levels with surrounding mesenteric fat stranding – *suggestive of Left paraduodenal hernia causing closed loop low grade small bowel obstruction.*

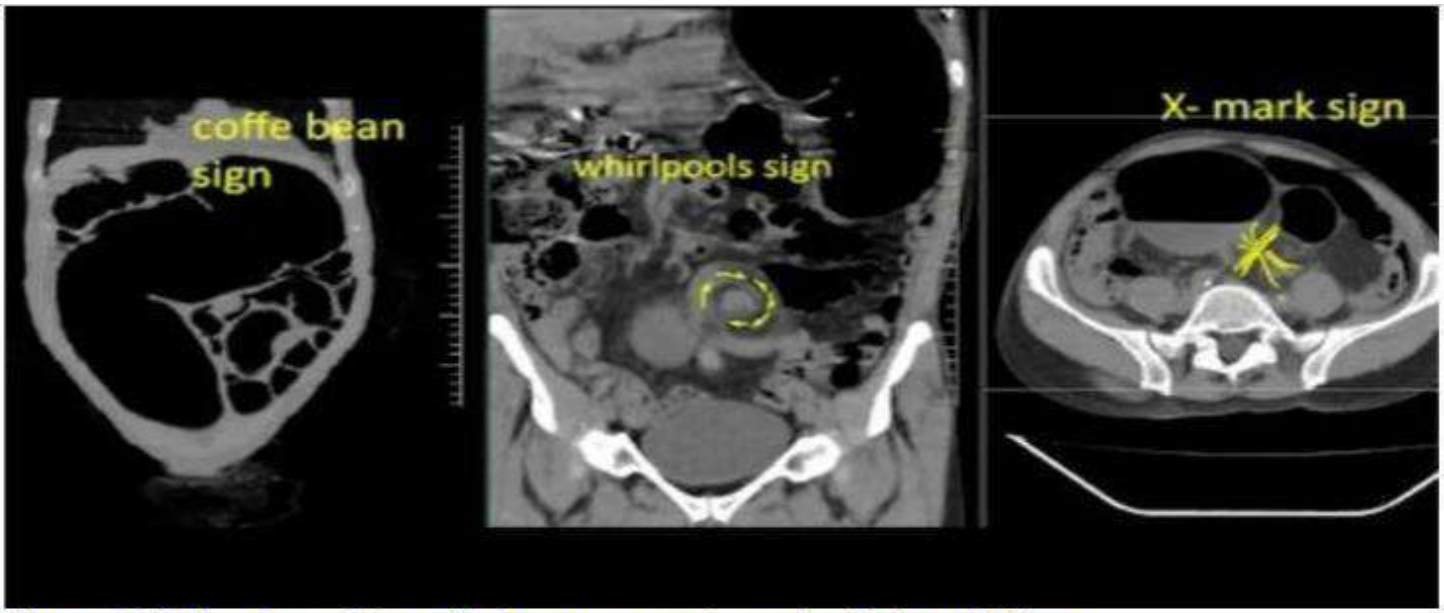
The inferior mesenteric vein is traversing anteromedial to the clustered bowel loops

No evidence of intramural air. No evidence of bowel ischemia

Trace free fluid in bilateral paracolic spaces, lower abdomen. A

solitary gall bladder calculus

Recommend clinical correlation



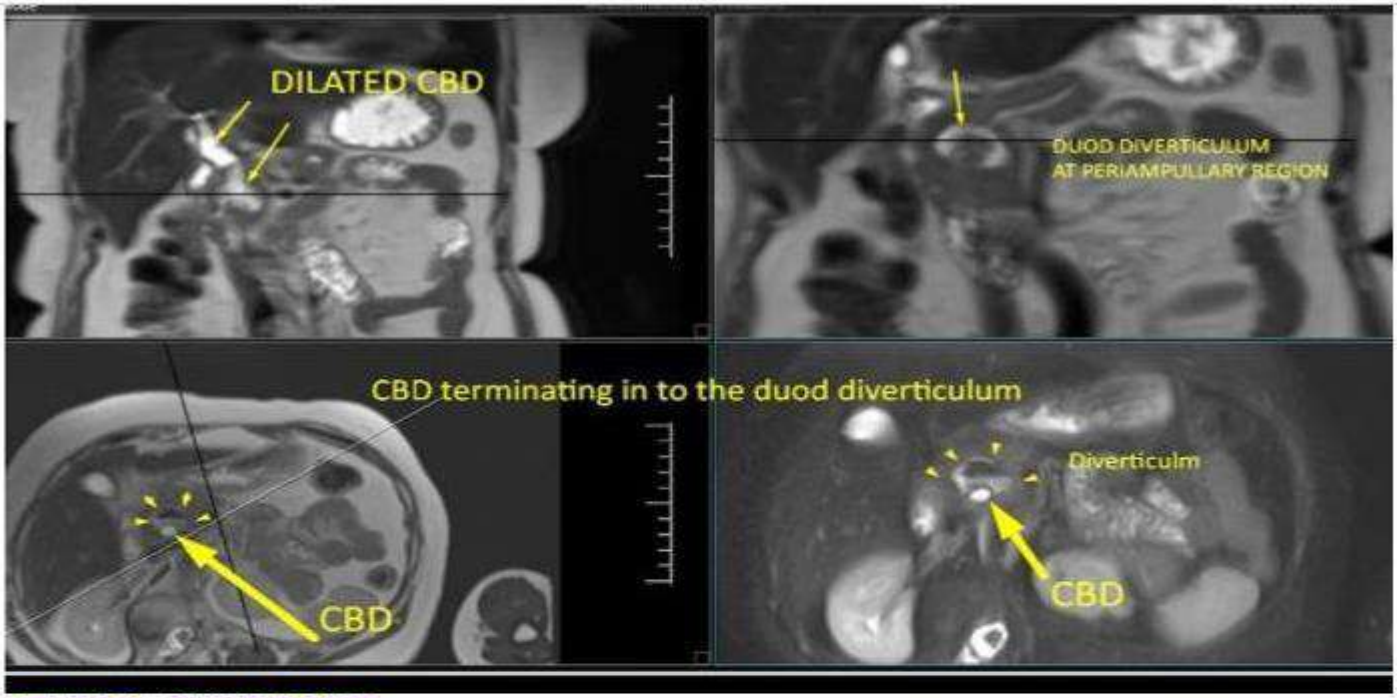
Sigmoid Volvulus with coffe bean, x-mark and whirlpool Signs

Findings suggestive of large bowel obstruction due to Sigmoid Volvulus :-

Large gas filled bean shaped, closed loop of large bowel with loss of haustral with apex pointing toward the left lower quadrant of the abdomen associated marked twisting of mesenteric vessels (Whirl sign), also demonstrating *X-marks-the-spot sign by crossing loops of bowel at the site of the transition*.

Dilated caecum , ascending colon, transverse colon with abundant fecal material. No evidence of small bowel dilatation

Trace free fluid in lower abdomen. No evidence of bowel wall necrosis or pneumoperitoneum in this non-contrast study..
Recommend IV Contrast study for complete evaluation



LEMMEL SYNDROME

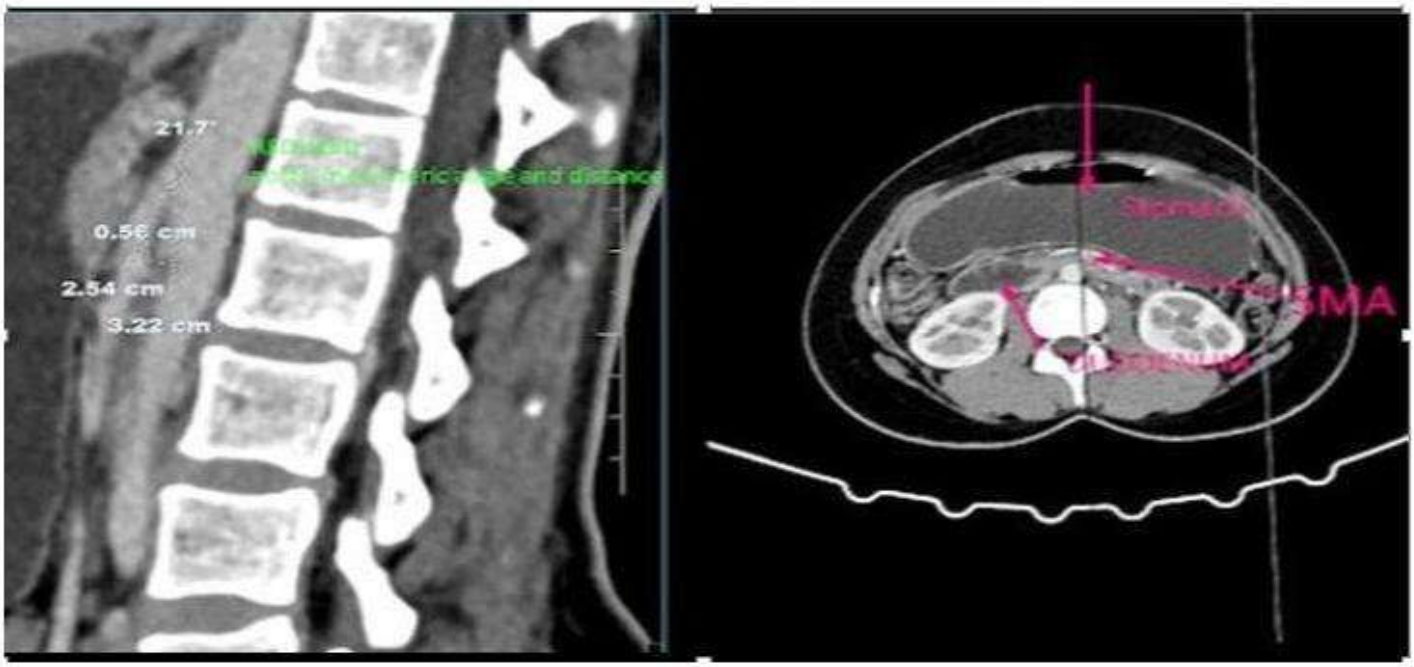
An approximately 3 x 2.2 cm luminal outpouching arising from the D2/D3 segment of duodenum, almost at the periampullary region demonstrating small intraluminal air fluid level with minimal wall thickening - suggestive of a duodenal diverticulum .

Mild dilatation of the CBD, CHD with minimal central IHBR dilatation.

The distal CBD appears to be terminating into the above-mentioned duodenal diverticulum (may suggest Lemmel syndrome).

No evidence of obvious ductal calculus.

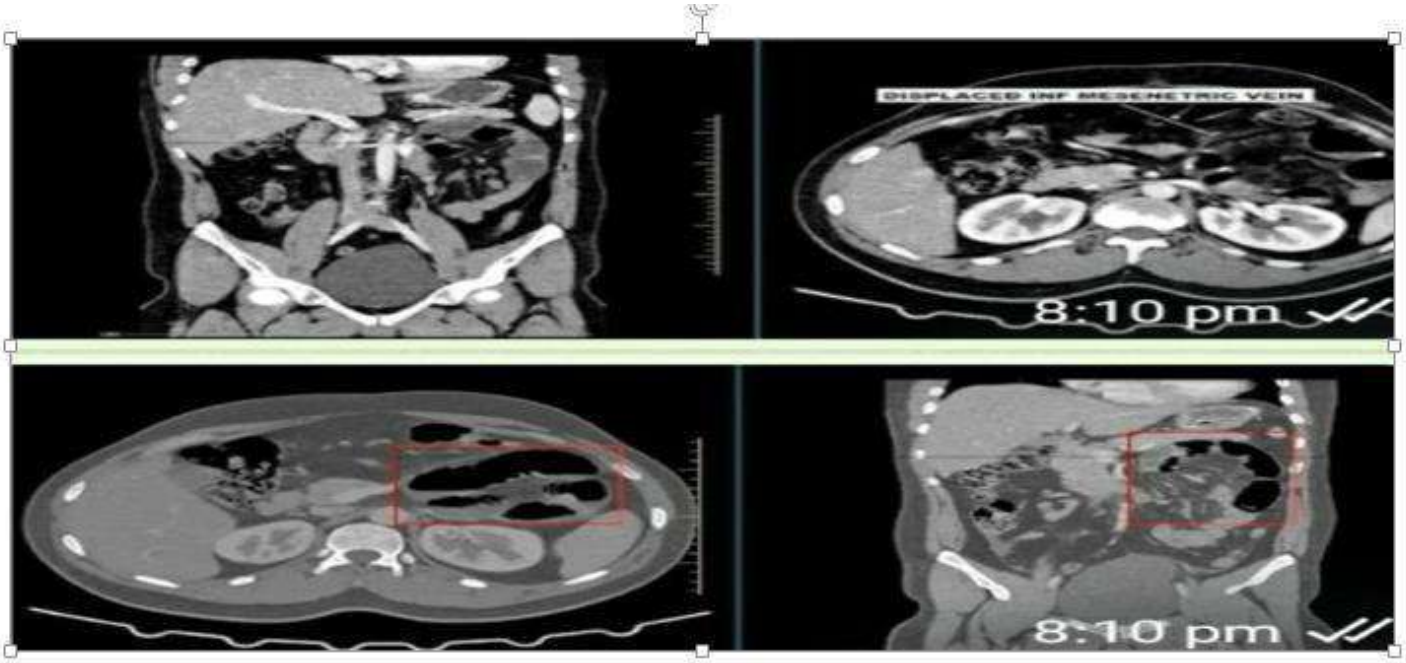
Left renal atrophy



SMA SYNDROME

Fluid distended stomach with dilated D1,D2 segments of duodenum abruptly tapering at the level of SMA, apparently due to vascular compression caused by reduced aorto-mesenteric distance and angle - suggestive of SMA syndrome.

The aorto-mesenteric distance and aorto mesenteric angle measures = 7 mm and 210 respectively



Left paraduodenal hernia causing closed loop low grade small bowel obstruction.

A cluster of dilated small bowel loops (proximal jejunal loops), abnormally positioned in the left anterior pararenal space, demonstrating multiple air fluid levels with surrounding mesenteric fat stranding – *suggestive of Left paraduodenal hernia causing closed loop low grade small bowel obstruction*

The inferior mesenteric vein is traversing anteromedial to the clustered bowel loops

No evidence of intramural air. No evidence of bowel ischemia Trace free fluid in bilateral paracolic spaces, lower abdomen. A solitary gall bladder calculus Recommend clinical correlation.