Lung ca Synoptic Reporting CT -NCG

PROTOCOL :

Patient Instructions *:*

- *4 hours fasting, but water intake is encouraged prior to the scan.*
- *Patient is asked to void 30 minutes prior to the scan.*
- *Serum Creatinine to be in check, ideally <1.2 mg/dl, above which, the eGFR is calculated. Contrast enhanced scan can be performed for eGFR>30mL/min.*

- ***Contrast Agent*** *:*
- *Intravenous : At the time of scan, approximately 50 to 70 ml of non-ionic contrast is injected at the rate of 2 ml/sec. Iso-osmolar contrast agent used if eGFR is on the lower side. Post contrast imaging between 60 to 70 seconds.*
- ***Scan area*** *:supraclavicular fossa to upper abdomen.*
- *Section thickness : 5mm. Isotropic multiplanar post processing reconstruction at 1.5 mm interval.*

Lung CancerStaging CT Scan:

CT SCAN OF CHEST AND ABDOMEN

Contrast Enhanced CT scan performed on a multislice MDCT.

Indication:

Primary - -size

- -bronchopulmonary segment/ Involved lobe
- -collapse
- -Involvement of parietal/ visceral pleura, extrapleural space, ribs, chest wall
- -Mediastinal structures-main bronchus, carina, trachea, mediastinal vessels, phrenic and recurrent laryngeal nerve involvement
- -pericardium involvement/ pericardial effusion

Other lung nodules- same lobe, ipsilateral lung and contra lateral lung lesions

- Solid/Part solid/ground glass opacity

Lymph node-Hilar, mediastinal N2/N3, Supraclavicular (station according IASLC mapping)
Non regional adenopathy- axillary, retroperitoneal, internal mammary.
Node characteristics- Size> 1cm, round/oval, necrosis, calcification, perinodal fat stranding, fatty hilum, enhancement patterns.

Metastatic disease–pleural nodules, pleural effusion
Lung, liver, adrenal, skeletal metastatic lesions.

Cardiac- size, chamber enlargement, thrombus, coronary calcification or pulmonary arteries.

Other info required -
-Condition of the lung - COPD, Emphysema, Infective changes, ILD

-Anomalous vessel or bronchi
-Any other anomaly