All About Your Radiology Report: What to Know

Your healthcare provider (usually a doctor, nurse practitioner, or physician assistant) sometimes uses medical imaging to diagnose and treat diseases they think you may have. A radiologist (http://www.radiologyinfo.org) is a doctor who supervises these exams, reads and interprets the images, and writes a report for your healthcare provider. This report may contain complex words and information. If you have any questions, be sure to talk to your provider or ask to speak to a radiologist.

Electronic Health Records

The radiologist writes the report for your provider who ordered the exam. Typically, the radiologist sends the report to the person who ordered your test, who then delivers the results to you.

Many patients can now access their electronic health records online immediately, including most radiology reports. Online access to your health records may help you make more informed decisions about your healthcare and allow you to share your radiology reports with other doctors or family members more easily. This may increase the safety, quality, and efficiency of your care.

In most radiology practices, the radiologist still writes the report using medical terms that your healthcare provider will understand. These terms may be confusing for you as a patient. Plus, immediate sharing of radiology reports may mean you are reading the report before your healthcare provider has even seen it.

The information below helps explain the typical parts of a radiology report. *RadiologyInfo.org* has also created articles and videos that provide further information on how to better understand your reports for certain radiology tests. These articles can be accessed from the links provided on the How to Read Your Radiology Report (https://www.radiologyinfo.org/en/radiology-reports) page.

Sections of the Radiology Report

Type of exam

This section usually shows the date, time, and type of exam.

Example:

- *Computed tomography (CT) of the abdomen and pelvis with intravenous and oral contrast performed January 10th, 2022.*

History/Reason for exam

This section usually lists the information that your ordering provider has listed for the radiologist when they ordered your exam. It allows your ordering provider to explain what symptoms you are having and why they are ordering the radiology test. This helps the Radiologist accurately interpret your test and focus the report on your symptoms and past medical history. Sometimes the radiologist who reads your exam will also add information that they find in your chart or forms that you fill out before your imaging test.

Example:

- *64-year-old female with a history of breast cancer and new onset abdominal pain.*

Comparison/Priors

Sometimes, the radiologist will compare the new imaging exam with any available previous exams. If so, the doctor will list them here. Comparisons usually involve exams of the same body area and exam type. It is always a good idea to get any prior imaging exams from other hospitals/facilities and provide them to the radiology department where you are having your test. Having these older exams can be very helpful to the radiologist.

Example:

- *Comparison is made to a CT scan of the abdomen and pelvis performed August 24, 2013.*

Technique

This section describes how the exam was done and whether contrast was injected in your vein. Intravenous contrast is often used for CT and MRI scans when your doctor is examining the organs and blood vessels in your body. Contrast is not always required. Certain exams can be done without contrast depending on how the exam is performed and what question your doctor is hoping to answer with the radiology exam. Because it is used for documentation purposes, this section is not typically useful for you or your doctor. However, it can be very helpful to a radiologist for any future exam if needed.

Example:

- *Imaging was performed from the lung bases through the pubic symphysis following the administration of intravenous and oral contrast. Coronal and Sagittal reformatted images were evaluated.*

Findings

This section lists what the radiologist saw in each area of the body in the exam. Your radiologist notes whether they think the area to be normal, abnormal, or potentially abnormal. Sometimes an exam covers an area of the body but does not discuss any findings. This usually means that the radiologist looked but did not find any problems to tell your doctor. Some radiologists will report things in paragraph form, while others use a reporting style where each organ or region of the body is listed as a line with the findings. If the radiologist does not see anything concerning it may say "normal" or "unremarkable."

Below is an example of a report style often used for a CT scan of the abdomen and pelvis. ***This is just an example and NOT an actual report for you:***

- *Lung bases: No pulmonary nodules or evidence of pneumonia.*
- *Liver: There is probable hepatic steatosis (http://www.radiologyinfo.org) .*
- *Gallbladder* is surgically absent.
- *Spleen: Unremarkable (normal).*
- *Pancreas: Normal.*
- *Kidneys and Adrenals: No concerning masses, stones or hydronephrosis. There are bilateral sub-cm hypoattenuating (http://www.radiologyinfo.org) lesions that are too small to characterize but likely reflect benign cysts. No adrenal nodules.*
- *Lymph nodes: No lymphadenopathy (http://www.radiologyinfo.org) .*
- *Bowel: No dilation or wall thickening.*
- *Bladder: Normal.*

- *Pelvis: No masses.*
- *Bones: No aggressive osseous lesions. Degenerative changes are present in the spine.*

Impression

In this section, the radiologist summarizes the findings and reports the most important findings that they see and possible causes (this is called a differential diagnosis) for those findings. This section offers the most important information for decision-making. Therefore, it is the most important part of the radiology report for you and your doctor.

For an abnormal finding, the radiologist may recommend:

- other imaging tests that can help better assess the finding or getting a follow up imaging test to relook at the finding after a period of time.
- biopsy.
- correlating the finding with clinical symptoms or laboratory test results to help better understand if it is likely an incidental finding (http://www.radiologyinfo.org) and likely no issue or if it could explain your clinical symptoms.
    - Many findings that a radiologist sees on your scan are incidental and will cause you no harm.
- comparing the finding with any other imaging studies that the radiologist interpreting your test does not have access to.
    - This is common when you have imaging tests done at different facilities or hospitals.

For a potentially abnormal finding, the radiologist may make any of the above recommendations.

Sometimes the report does not answer the clinical question, and more exams may be needed. More exams may be necessary to follow-up on a suspicious or questionable finding.

Example of an Impression for a CT scan of the abdomen and pelvis. ***This is just an example and not an actual report for you:***

1. *No findings on the current CT to account for the patient's clinical complaint of abdominal pain.*
2. *Small hypoattenuating renal lesions that likely reflect benign cysts. These do not need further work-up.*
3. *Findings suggestive of hepatic steatosis (fatty liver).*

Additional Information

Once the report is complete, the radiologist signs it, and sends the report to your physician. Your doctor will then discuss the results with you.

Sometimes, you may have questions about your report that your physician cannot answer. If so, talk to your facility's imaging staff. Many radiologists are happy to answer your questions.

Disclaimer

Note: Images may be shown for illustrative purposes. Do not attempt to draw conclusions or make diagnoses by comparing these images to

other medical images, particularly your own. Only qualified physicians should interpret images; the radiologist is the physician expert trained in medical imaging.

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