Appendix 2: Examples of report changes with corresponding rating of clinical importance and change in severity.

| **Clinical presentation** | **Main imaging finding in preliminary report*** | **Information added to final report** | **Clinical rating** | **Change in severity** |
|---|---|---|---|---|
| Female, 54 years old. Previous abdominal surgery. Severe abdominal pain and vomiting. Ileus? | *Slightly distended small intestine with some air-fluid levels consistent with incomplete ileus.* | Distended loops in the small intestine with air-fluid levels. Distinct transition zone in the pelvis with suspected adhesions, and collapsed distal loops consistent with intestinal obstruction. | Critical | Increased |
| Female, 41 years old. Stoma reversal 3 days ago. CRP[1]: 430 despite antibiotic treatment. Anastomotic leak? | *Small amounts of fluid and a few air bubbles as expected after surgery. No signs of abscess or anastomotic leakage.* | Large fluid collection adjacent to the anastomosis. Air bubbles and contrast enhancing margin consistent with abscess. Due to the proximity to the anastomosis, leakage is suspected. | Critical | Increased |
| | | | | |
| Female, 88 years old. Acute right lower quadrant abdominal pain today. Diarrhoea. Positive faecal occult blood test. Haemorrhage? | *Normal imaging findings.* | Moderate atherosclerotic change in the aorta. Probable origin stenosis in the celiac trunk, and the left renal and superior mesenteric arteries. Contrast filling defect indicating a thrombus in the proximal superior mesenteric artery, but contrast filling in the distal vessel lumen. Mesenteric claudication? | Major | Increased |
| Female, 35 years old. Sub-acute abdominal pain. Ileus? | *Distended ascending and transverse colon with fluid levels. Wall thickening in the descending colon with obscured haustra. In the junction of the descending and sigmoid colon there is a short* | Large bowel obstruction with distended ascending and transverse colon caused by a constricting tumour in the sigmoid colon. Multiple lymph nodes on mesenteric and anti-mesenteric border of the sigmoid colon (assessed as N2-status). Two low-density lesions in the | Major | Increased |

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|---|---|---|---|---|
| | *segment with wall thickening and narrowing of the lumen. Mechanic obstruction is possible, but unlikely.* | liver segments 7 and 8. Metastases cannot be ruled out. MRI[2] is recommended. | | |
| Male, 43 years old. Abdominal discomfort. Right lower quadrant tenderness. Normal rectoscopy (15 cm). | *Normal imaging findings.* | Sharply circumscribed, 3 cm, low-density lesion with a contrast-enhancing margin in the head of the pancreas. No dilation of the pancreatic duct. Cystadenoma? | Intermediate | Increased |
| Female, 78 years old. No previous abdominal disease. Right-sided abdominal pain, nausea and fever today. WBC[3]: 19. Peritonitis. | Appendicitis. *Thickened, hyperaemic caecal wall, but no visible tumour. Malignancy? Inflammation?* | Thickened, hyperaemic caecal wall is probably inflammation secondary to appendicitis. No visible tumour. | Intermediate | Decreased |

*Text in *italics* has been substituted or removed in the final report.
[1]C-reactive protein (mg/L, reference range: < 5)
[2]Magnetic resonance imaging
[3]White blood cell count ($10^9$/L, reference range: 3.5-10.0)