Calcific plaque is noted in several of the coronary arteries.

There is anatomical variation of the coronary artery tree with the left circumflex coronary artery arising from the right coronary artery on its inferior aspect just distal to its origin. The left circumflex coronary artery initially runs between the root of the aorta and right atrium and then hooks below the root of the aorta and runs between the aortic root and left atrium towards the left atrioventricular groove. The vessel is of small calibre but has no significant atherosclerosis within. It gives rise to a small obtuse marginal 1 and obtuse marginal 2 branch, both of which are patent.

The left main coronary artery continues to form the left anterior descending coronary artery. Mixed calcific and soft plaque is noted within the proximal and mid LAD resulting in severe stenosis. However, there is good filling of the LAD distally where this joined by the left internal mammary artery graft. There is also good filling of the first and second diagonal branches of the left coronary artery, and neither of which demonstrate significant disease.

The right coronary artery contains mixed calcific and soft plaque in its origin resulting in mild stenosis. Distal to this however it fills well and gives rise to several patent, non-diseased, acute marginal branches.

The PDA which arises from the RCA also has no significant stenosis.

There are several widely patent posterolateral branches, which continue from the RCA.

The left internal mammary artery graft is patent throughout its course and there is no narrowing demonstrated at its anastomosis with the distal left coronary artery.

The cardiac chambers are within normal limits.

No pericardial effusion is seen.

There is no significant pathology within the visualized mediastinum.

Incidental note however is made of a solitary pulmonary nodule within the lateral basal segment of the left lower lobe. It measures 5 mm in diameter.

There is also an incidental low-density lesion measuring 12mm in diameter in the right lobe of the liver just below the diaphragmatic dome. It cannot be further characterized on this study.

CONCLUSION

There is severe stenosis in the proximal and mid LAD, but there is good filling of the distal LAD as well as the obtuse marginal branches and the LIMA graft to the distal LAD is widely patent with no narrowing of the anastomosis.

The left circumflex coronary artery is of small calibre and has an anomalous course as noted above.

There is mild disease at the origin of the right coronary artery but the rest of the vessel and its branches are widely patent.

The solitary left lower lobe pulmonary nodule is of uncertain significance but requires follow-up imaging, initially in three months to exclude significant pathology.

The low-density focus in the right lobe of the liver cannot be further characterized and should be evaluated further on ultrasound.

Thank you for referring this patient.

Secretary: OFS2

Electronically Signed by: DR OBI WAN KENOBI/DR WONDER WOMAN

General Report #159396: Authorised by Root (Root) at 31/03/2011 06:50

Date Serviced: 31/12/9999 00:00

Requests: 11/OCC/0080315 (Series 0; Requested by: Dr OCCAM; Work Site: OCC)

Services: CT Coronary Angiogram (NR)

Exam Date: 30/03/2011

Report Date:

Report Collection: 6. Pick-Up

Referring Doctor:

Exam: CT CORONARY ANGIOGRAM

CT CORONARY ANGIOGRAM

INDICATION:

Chest pain. Raised cholesterol.

TECHNICAL PARAMETERS:

A CTA Coronary Angiogram was performed using a 64 slice cardiac CT scanner.

The images have been evaluated and re-constructed and manipulated on a 3D

work station.

Heart rate: 70 beats per minute

1 Intravenous BETA-BLOCKER: No

2 Oral BETA-BLOCKER: No