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Health
South Eastern Sydney
Local Health District

Randwick 2031

MRN:
Proc. ID: **3318408**
Exam Date: **01-MAY-2017**

CT Coronary Angiogram performed on 01-MAY-2017
Indication:
Atypical chest pain with trop rise to 18. Echo suggests HCM. Otherwise fit and well.

Technical parameters:
A CT Coronary Angiogram was performed using a 320 row detector cardiac CT scanner. The images have been evaluated on a 3D work station.

Heart rate: 50 bpm
Radiation dose (DLP): 147 mGycm

Intravenous Beta-blocker: No
Oral Beta-blocker: No
Sublingual GTN: Yes

Technical Quality & technical issues: Good

Coronary arteries:
Dominance: Right

LM:
The left main coronary artery arises from the left coronary sinus and divides into the left anterior descending and left circumflex coronary arteries. There is no haemodynamically significant stenosis.

LAD:
The left anterior descending coronary artery gives rise to a diagonal branch and small septal branches. In the proximal vessel, there is a tiny focus of mural calcification without visible plaque. In the mid-portion, there is a short segment of intra-myocardial bridging. There is no haemodynamically significant stenosis.

Circumflex:
The left circumflex coronary artery gives rise to a large calibre obtuse marginal branch. There is no haemodynamically significant stenosis.

RCA:
The right coronary artery arises from the right coronary sinus and has a markedly tortuous course. It gives rise to three marginal branches before terminating as posterolateral and posterior descending artery branches. There is a focal 25-49% stenosis due to mixed atheroma immediately distal to the ostium of the large calibre third marginal branch. In the proximal vessel, two tiny foci of mural calcification are present without haemodynamically significant stenosis.

Cardiac findings:
The left ventricle demonstrates apparent mild circumferential thickening, measuring up to 15mm at the septum, supportive of the echo finding of HCM. Otherwise, the cardiac chambers, myocardium and pericardium appear normal.

Other findings:
The lungs and pleural spaces are clear. There is no mediastinal lymphadenopathy. The liver is hypodense, consistent with fatty infiltration, with the remainder of the visualised upper abdominal viscera being unremarkable. No destructive osseous lesion is identified.

Conclusion:
Non-obstructive mixed plaque in the distal RCA and several tiny foci of mural calcification in the proximal RCA and LAD.

Coread by Dr Wonder Woman, Dr James Bond

Performing Radiographer:

Dictating Radiologist: **Dr James Bond**
Approving Radiologist: **Dr James Bond**
Report Approval Date: **16-MAY-2017 06:12 PM**