# Row 10065

Visit Number: edea1435a374ae7d809bfc7f4084c4c30ccddd5d7b7263fe37f2af0eb8fda03d

Masked\_PatientID: 10065

Order ID: 310fa0fd616210acd3906f9cbef89d7c7e78a8329e7e466dee270ca60e164ee4

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 25/9/2016 18:34

Line Num: 1

Text: HISTORY severe pulmonary hypertension with severe hypoxia --- TRO PE TECHNIQUE Contrast enhanced axial CT scan of the thorax was performed in the pulmonary arterial phase. Coronal reconstruction was also obtained. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 In view of the poor demonstration of the pulmonary arteries on the initial scan of 25 September 2016. A repeat scan was performed on 26 September 2016 utilising a dual energy protocol for pulmonary assessment. FINDINGS No relevant prior imaging study is available for comparison. A repeat examination was performed on 26 September 2016 as the prior study was deemed suboptimal due to the severe pulmonary hypertension and there was poor filling of the pulmonary arteries are occurred during the first examination. Significantly dilated central pulmonary arteries with peripheral pruning are in keeping with pulmonary artery hypertension. There is poor mixing of the contrast and unopacified blood in the pulmonary arteries, resulting in heterogeneous appearance on the initial study. This is in part due to holding of the contrast within the right heart which has severe right atrial and right ventricular dilatation. No filling defect is seen within the markedly enlarged pulmonary arteries to suggest the presence of thrombus. There is however severe diffuse thickening of the pulmonary arteries which show patchy areas of calcification in keeping with severe pulmonary hypertension. There is severe dilatation right ventricle and right atrium as well as significant reflux of contrast into the IVC and hepatic veins. These changes are compatible with severe pulmonary artery hypertension and right heart failure.Scattered consolidation in the middle lobe and centrilobular nodules in the posterior segments of the upper lobes and lung bases may be represent underlying infection or inflammation. Clinical correlation is required. No suspicious pulmonary mass is detected. The major airways are patent. No pleural effusion or pneumothorax is present. No significantly enlarged intra-thoracic node is seen. The heart is enlarged. There is apparent sliver of contrast within the pulmonary artery on the initial scan (Im 4-36) but this is not present on the follow-up scan suggesting that it may be artifactual. Minimal low density pericardial effusion is present. The visualized thyroid is unremarkable. No significant abnormality isdetected in the included upper abdomen. No suspicious osseous lesion is detected. Dual-energy pulmonary perfusion: There is symmetry of the perfusion to both lungs with no overt oligaemic region. CONCLUSION 1. Study was repeated due to poor opacification of the distal pulmonary artery branches secondary to severe pulmonary artery hypertension. 2. Significantly dilated central pulmonary arteries with peripheral pruning are in keeping with severe pulmonary artery hypertension. There is evidence of right heart failure. No obvious thrombus is detected in the pulmonary arteries but there is calcification of the arterial wall in keeping with marked raised pulmonary pressures. 3. Patchy consolidation in the middle lobe and right lower lobe would suggest concurrent lung infection. 4. Minimal low density pericardial effusion is present. Sliver of the contrast within the right pulmonary artery on the earlier study is not confirmed on the follow-up examination suggesting that it is artifactual. There is no evidence of dissection on follow-up study which demonstrates normal smooth lumen of the pulmonary artery. Further action or early intervention required Saravana Kumar Swaminathan , Senior Resident , 16844J Finalised by: <DOCTOR>

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