# Row 10914

Visit Number: aa40f5d59724f5ac4fb8d733fa67cbf7e0ec946beb1cd88fe4165e56f141fd3a

Masked\_PatientID: 10912

Order ID: f9b3bb8c9b21bf2cb979d8f3d26f875e946911ec56299d4a5134362b412f5a70

Order Name: CT Aortogram (Chest, Abdomen)

Result Item Code: AORTOCA

Performed Date Time: 01/11/2018 13:30

Line Num: 1

Text: HISTORY Type A dissection extending to left CFA s/p repair. left DP/PT still not present to look at post op changes of false/true lumen as per vascular request TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 100 FINDINGS Previous CT aortogram dated 31 October 1928 was reviewed. VASCULAR FINDINGS The patient is status post replacement of the ascending aorta, aortic valve resuspension and CABG. There is circumferential and linear hyperdense suture material along the ascending aorta. Soft tissue stranding at the retrosternal soft tissue, anterior mediastinum and around the ascending aorta, as well as pneumomediastinum with air pockets tracking into the lower neck and between the strap muscles – likely postsurgical related changes. Tip of the pericardial drain terminates posterior to the right main pulmonary artery. Tip of the chest drain terminates in the right anterior mediastinum in theupper thorax. Two right-sided central lines, one terminating in the proximal SVC and the other in the distal SVC. On the arterial phase, there is a small enhancing focus in the anterior mediastinum at the level of the ascending aortic graft (7/41), which increases in size and appears to communicate with a large right pericardial haematoma which measures 9.2 x 5.3 x 11.0 cm (8/53, 17/49). There is contrast extravasation into this collection, indicating active bleeding. Resultant compression of the distal SVC and right atrium. The SVG graft arising from the right anterolateral aspect of the ascending aortic graft is patent. The right coronary artery is not opacified at its origin, but shows preserved distal opacification. The left anterior descending and left circumflex arteries appear patent. Known extensive aortic dissection, with a small calibre true lumen secondary to mass effect from the false lumen. Main findings: - Propagation of the dissection flap intothe left common carotid artery with thrombosis of the false lumen. - Right brachiocephalic and left subclavian arteries are patent. - Celiac trunk supplied by the true lumen, and shows normal opacification save for the splenic artery which is attenuated. - Superior mesenteric artery supplied by the true lumen, patent. - Left renal artery supplied by the true lumen, patent. - Right renal artery supplied by the false lumen, patent. - Inferior mesenteric artery supplied by the true lumen,slightly attenuated at the origin, but remains patent (there was previous non-opacification of the IMA origin). - Left iliac arteries supplied by the true lumen, patent. - Stable extension of the dissection flap into the right common iliac artery.Pulmonary arterial system shows satisfactory opacification. There is left atrial dilatation. OTHER FINDINGS Tip of the ETT is satisfactorily positioned in the trachea. No discrete intrathoracic or axillary lymphadenopathy. Small highdensity bilateral pleural effusions, likely containing blood products. Resultant compressive atelectasis in both lower lobes. No suspicious pulmonary mass or consolidation in the aerated portions of the lungs. Tiny nonspecific nodule in the left lung apex (8/13). Trachea and central airways are patent. Sliver of right pneumothorax. No suspicious hypervascular hepatic lesion. Two subcentimetre hepatic hypodensities (15/12, 15/25) are too small to accurately characterise. Portal veins opacify normally. Vicarious excretion of contrast into the gallbladder. Biliary tree is not dilated. Pancreas, spleen and adrenals are unremarkable. Interval reperfusion of the left kidney, which shows slight delayed enhancement compared to the right but fairly preserved corticomedullary differentiation. No hydronephrosis. Urinary bladder is contracted around a Foley catheter. Prostate gland is unremarkable. Distal end of the feeding tube is coiled with the tip abutting the gastric fundus. Bowel loops show normal calibre and distribution. There is preserved bowel mural enhancement. No discrete abdominopelvic lymphadenopathy, free air or ascites. Minimal fluid stranding in the pelvis. Soft tissue stranding associated withsmall subcutaneous gas pockets in both groins, possibly related to recent procedures. No large groin haematoma. There is no destructive bony lesion. CONCLUSION Since CT aortogram dated 31 Oct 2018: 1. Status post replacement of ascending aorta, aortic valve resuspension and CABG, with presumed post-surgical changes as described. 2. Large right pericardial/mediastinal haematoma with evidence of active bleed. The bleeding point appears to be in the anterior mediastinum at the levelof the aortic graft. This finding was relayed to Dr Wang Daobo by Dr Elizabeth Cheong on 1 Nov 2018, 2.50 pm. 3. Stable extent of the aortic dissection, with the dissection flap extending proximally into the left common carotid artery and extending inferiorly into the right common iliac artery. 4. Reperfusion of the left renal artery and IMA origin, with satisfactory opacification of the left kidney. 5. Small high density pleural effusions, likely containing blood products. 6. Otherfindings as described. Critical Abnormal Finalised by: <DOCTOR>

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