# Row 10928

Visit Number: aa40f5d59724f5ac4fb8d733fa67cbf7e0ec946beb1cd88fe4165e56f141fd3a

Masked\_PatientID: 10912

Order ID: 2499bd173bd37a241708c3170b7f8fa5f2f44827c63d9071d76c7efb132b3077

Order Name: CT Aortogram (Thoracic)

Result Item Code: CTANGAORT

Performed Date Time: 18/11/2018 12:33

Line Num: 1

Text: HISTORY Type A aortic dissection s/p ascending aorta replacement, aortic valve resuspension, and CABG of one vessel on 1/11/18 TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: given FINDINGS Comparison made with CT of 1/11/2018. The patient is status post replacement of ascending aorta, aortic valve resuspension and SVG-RPDA coronary bypass on 1/11/2018. There is no change of the configuration of the ascending aortic graft (11-50). Thecourse of the SVG-RPDA graft shows normal enhancement and patency throughout the length with a few adjacent clips and no adjacent hematoma. There is no active extravasation. In close vicinity, the native right coronary artery also enhance normally and better seen than before at its proximal aspect but appears to show a short segment of severe narrowing near the origin. The contralateral left coronary arteries also enhance normally as before. Distal to the graft, there is no change of the configuration and size of the type A aortic dissection imaged till the upper abdomen. The false lumen is larger than the true lumen. The true lumen is narrowest at the distal descending thoracic aorta and upper abdominal aorta measuring5-6 mm and 3-4mm respectively. The false lumen of the left common carotid artery is again thrombosed. There is a patent true lumen supplying the rest of the visualised left common carotid artery. The innominate artery and left subclavian artery are supplied by the true lumen. There is a 25mm thick right pericardial effusion adjacent to the surgical site. There is mild pericardial thickening and enhancement but this may be reactive to the prior hemopericardium seen on 1/11/2018. There is interval decrease in size/thickness from prior 55mm with resolution of previous mass effect indenting into the right atrium. Most of the pericardial effusion is now of fluid attenuation or only mildly hyperdense, in keeping with partial resolution of blood products. A small 25 x 15mm area of slight hyperdensity (40-50HU) measuring 16 x 25mm at the lateral basal aspect (5-69) likely represents residual haemorrhage. No internal gas pocket is noted to suggest gas forming infection. The post-surgical air locules in the anterior mediastinum have resolved. The scan is not dedicated for the pulmonary angiogram, nevertheless rest of the pulmonary and mediastinal vasculature enhances normally. The heart size is enlarged. The thoracic esophagus is unremarkable. Mediastinal fat is relatively clear with no overt features of mediastinitis. No mediastinal abscess or collection seen. There is interval elevation of the left hemidiaphragm with segmental collapse-consolidation in the left lower lobe. Air bronchograms are noted with no obstructing mass. Rest of the aerated lungs shows no consolidation or ground-glass changes. There is prominence of the pulmonary venous vasculature likely due to congestion. No enlarged supraclavicular, axillary, mediastinal or hilar nodes seen. Interval removal of ETT, surgical drains and NG tube. Sliver of left pleural effusion is noted. Prior minimal pneumothorax and subcutaneous emphysema has resolved. Limited sections of the upper abdomen in the arterial phase are unremarkable apart from a small hepatic cyst. No destructive bony lesion is seen. CONCLUSION Since last CT of 1/11/2018, 1. Status post ascending aorta graft and right coronarybypass. 2. Interval improvement of postsurgical changes. No mediastinitis or abscess. 3. Mild thickening of the pericardial lining may be due to prior hemopericardium rather than due to infection. No gas pockets noted. There is significant improvement of the hemopericardium, now mostly fluid attenuation. 4. Stable extent and configuration of residual Type A dissection as described. 5. Small area of consolidation in left lower lobe may be due to focal infection or atelectasis,the latter being favoured due to volume loss. Rest of the aerated lungs otherwise shows no infective changes. 6. Sliver of left pleural effusion. No empyema. 7. Other minor findings as described. May need further action Finalised by: <DOCTOR>

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