# Row 12342

Visit Number: 6bcbc78024d1306cc8194f9408e2f7d64bcdb45bb3eedac129cede0f8899dece

Masked\_PatientID: 12342

Order ID: 956435bc2716f71eac57e01f3002bfb053f5747de3a8d65cd289a990fc065251

Order Name: CT Aortogram (Chest, Abdomen)

Result Item Code: AORTOCA

Performed Date Time: 17/2/2018 19:51

Line Num: 1

Text: HISTORY 1. Symptomatic Aortic Regurgitation with Dilated aortic arch 2. Hypertension TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Previous chest radiograph done earlier in the day was reviewed. VASCULAR FINDINGS No active contrast extravasation, haemothorax or haemoperitoneum. There is a small low density right pleural effusion which is probably unrelated to the vascular findings of concern. The ascending aorta is not significantly dilated (3.8 cm). Small amount of low density fluid around the aortic root and descending aorta (15-20 HU) is likely to represent fluid within the superior pericardial recess rather than acute blood. Aneurysmal dilatation of the aortic arch, descending thoracic aorta and suprarenal abdominal aorta, associated with a dissection flap which extends from the aortic arch (distal to the left subclavian artery origin) inferiorly to the thoracic and abdominal aorta. There is also dissection of the right common iliac artery extending into the proximal right external iliac artery. There is eccentric heterogeneously hyperdense intramural haematoma/thrombus around the aortic arch, descendingthoracic aorta and suprarenal abdominal aorta. The transverse dimensions of the aorta are as follows: a. 9.4 cm, aortic arch (se 501/29) b. 5.4 x 5.8 cm, level of the pulmonary trunk (se 501/44) c. 6.3 x 6.0 cm, level of the left inferior pulmonary vein (se 501/58) d. 4.5 x 4.6 cm, suprarenal abdominal aorta (se 501/96) The aortic arch aneurysm causes mass effect with displacement of the trachea and oesophagus to the right side of the midline and mild compression of these structures. There is delayed filling of the false lumen in the venous phase. The celiac trunk, superior mesenteric artery, left renal artery and inferior mesenteric artery arise from the true lumen. The right renal artery arises from the false lumen. Resultant delayed perfusion of the right kidney (slightly reduced enhancement compared to the left kidney in the portal venous phase), which otherwise shows preserved corticomedullary differentiation. OTHER FINDINGS No suspicious pulmonary nodule, mass or consolidation. Diffuse mosaic attenuation in the lower lobes is non-specific and may be related to inspiratory effort. Small thin-walled pulmonary cysts are seen. There is compressive atelectasis at the left lower lobe adjacent tothe enlarged descending thoracic aorta. Trachea and central airways are patent. There is cardiomegaly and coronary arterial disease. No significant supraclavicular, mediastinal, hilar or axillary adenopathy. No significant pericardial effusion or left pleural effusion. No suspicious focal hepatic lesion. A few tiny bilobar hepatic hypodensities are too small to accurately characterise. There is a gallstone; no CT features of acute cholecystitis or biliary dilatation. The pancreas, spleen, left kidney and adrenals are unremarkable. Partially distended urinary bladder cannot be accurately assessed. There is mild prostatomegaly. Visualised bowel loops show no abnormal dilatation. There is hyperdense fluid layering in the small bowel loops particularly in the pelvis – these are already hyperdense on the precontrast phase and do not show suspicious contrast blush or pooling on the postcontrast phases, possibly representing ingested material. No significant abdominopelvic adenopathy, free air or ascites. There is no destructive bony lesion. CONCLUSION 1. Stanford type B aortic dissection with extents as described, on background aneurysmal dilatation of the aortic arch, descending thoracic aortaand suprarenal abdominal aorta. The maximum dilatation of the aneurysmal segment is at the distal arch measuring up to 9.4 cm which is considered as an independent risk factor for adverse events. There are no overt CT features to suggest frankaortic rupture or leakage. 2. Hyperattenuating areas along the aortic wall and false lumen are possibly due to underlying intramural haematoma/thrombus. This finding is strictly non-specific and should be assessed in conjunction with the clinical symptoms of the patient. 3. Right renal artery arises from the false lumen, with resultant delayed perfusion of the right kidney. Rest of the major branches of the abdominal aorta arise from the true lumen. 4. Hyperdense fluid layering in the distal small bowel loops may possibly be due to ingested material but further correlation is suggested. No overt contrast blush or suspicious enhancing lesion is detected. 5. Other findings as described above. Findings 1-3 were relayed toDr Sharon Harvinder Kaur Dhillo by Dr E Cheong on 17 Feb 2018, 8.20 pm, and subsequent discussed with Dr Sivaraj Pillai Govindasamy (CTVS Registrar). Critical Abnormal Cheong Hui Ting Elizabeth , Senior Resident , 17485H Finalised by: <DOCTOR>

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