# Row 12359

Visit Number: aa84d67ad0d3e9fea3ca0080b58ed9fc160194355f8acaa34965d8852f264481

Masked\_PatientID: 12342

Order ID: 277e54eb27c4939e7316028bbce26decd9370bcb2d94b7d8b411794dcb37d2d7

Order Name: CT Aortogram with 3D (Chest, Abdomen)

Result Item Code: AORTOCA3D

Performed Date Time: 28/3/2019 11:22

Line Num: 1

Text: HISTORY surgery for Type B dissection and arch aneurysm and MR TECHNIQUE Scans obtained before and after the administration of intravenous contrast. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison made with the CTof 10 August 2018. The patient is status post graft repair of the ascending aorta and aortic arch. No new perigraft collection or active contrast extravasation is detected. The brachiocephalic trunk, left common carotid artery and left subclavian artery demonstrate grossly preserved opacification. The aortic graft is patent. The distal end of the graft has changed in orientation since the prior CT, and now projects obliquely into the false lumen (15-23 vs prior 12-19). There is new partial recanalisation of the false lumen in the descending thoracic aorta (series 15, image 24), at the distal end of the aortic graft. This recanalised false lumen is now 5.1 cm in diameter compared to 3.7 cm previously (5.1 cm) (series 10, image 51). There is resultant increased mass effect on the true lumen. The mural thrombus at the aortic arch is thicker, now 6.3 cm compared to 5.0 cm previously (10-34). The maximum transverse diameter of the aortic arch aneurysm (including both the patent graft and adjacent thrombus) is now 9.1 cm compared to 7.8 cm previously (10-34 vs prior 11-30). The thrombosed false lumen at the level of the hiatus is also thickened, now 3.5 cm compared to 2.4 cm previously (3.5 cm) (series 10, image 82). The rest of the downstream false lumen remains mostly thrombosed, with recanalisation seen in parts of the infrarenal aorta. The celiac axis, superior mesenteric artery, both renal arteries and inferior mesenteric artery demonstrate grossly preserved opacification. No significantly enlarged mediastinal or hilar lymph node is detected. There is stable cardiomegaly. No pericardial effusion is detected. No consolidation or pleural effusion is detected. There is compressive atelectasis of the lung parenchyma adjacent to the dilated aortic arch and descending thoracic aorta. There is a new small low density left pleural effusion. Uncomplicated cholelithiasis noted. No gross lesions seen in the liver, spleen, pancreas, adrenal glands and kidneys. The partially contracted urinary bladder and prostate gland appear grossly unremarkable. No significantly dilated bowel loop is seen. No grossly enlarged para-aortic or pelvic lymph node is identified. No ascites is seen. No destructive bone lesion seen. CONCLUSION Since 10 August 2018, the distal end of the aortic graft has shifted and now projects into the false lumen at the level of the proximal descending thoracic aorta. There is new partial recanalisation of the false lumen, with increased size of both the thrombosed and recanalised segments of the false lumen. This has resulted in overall increased size of the thoracic aortic aneurysm, now up to 9.1 cm at the arch (vs 7.8 cmpreviously). No active contrast extravasation is seen. These findings were discussed with Dr Victor Chao via telephone at the time of reporting. New small low density left pleural effusion. Report Indicator: Further action or early intervention required Finalised by: <DOCTOR>

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