# Row 12381

Visit Number: c9130a1db035be18506fd64c16c1c0ace1326c5c618cc67022c716eae3546c50

Masked\_PatientID: 12342

Order ID: 2e11167ffb970beab5bab0353eda6978fb26fec0900f0dc525d6223ab8680198

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

Result Item Code: AORTOCA3D

Performed Date Time: 30/12/2020 10:41

Line Num: 1

Text: HISTORY s/p arch replacement FET, and TAA fen TEVAR TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Comparison made to prior study dated 13/07/2020. Vascular findings: Patient is status post ascending aortic arch replacement, frozen elephant trunk and mitral valve annuloplasty on 16/03/2018. - TEVAR on 09/04/2019 - TEVAR on 04/02/2020 - TEVAR and fenestrated thoracoabdominal EVAR on 30/06/2020. The stent graft, fenestrations and iliac limb extensions are stable position and patent. Endoleaks are again seen at the T4-T5 level (9-31; 12-17) and at the T10-T11 level (12-54), largely unchanged. These are at the sites of which the stent grafts are relined, which may represent either a Type II or Type III endoleak. The greatest aneurysm sac measures 8.2 x 9.5 cm (series 12), previously 8.5 x 9.3 cm, largely stable given slight difference in measuring technique. There is persistent perfusion of the false lumen (9-121 to 9-130), which is stable when compare to immediate prior study, and the false lumen continues to reduce in size, now measures approximately 3.1 cm (9-119), previously 3.2 cm. The arch vessels are patent. The coronary arteries are patent with atherosclerotic calcifications. The celiac axis, superior mesenteric artery, and both renal arteries are patent. The inferior mesenteric artery is occluded at its origin with retrograde filling from collaterals. The right internal iliac artery is occluded. Focal dissection flap of the right external iliac artery (9-150). These are unchanged. Patent left external and internal iliac arteries. Patent bilateral common femoral artery, visualized superficial femoral artery and profunda femoris. Non-vascular findings: Chest: Again noted are scattered supraclavicular and mediastinal lymph nodes, normal morphology in size, largely unchanged when compared to prior study, likely reactive in nature. The heart size is enlarged. No pericardial effusion. There is compressive atelectasis in the left lung base. No pleural effusions. There is joint motion within the right lung base limits evaluation. No suspicious masses. Abdomen and pelvis: The liver demonstrate normal parenchymal knee cancer. There is scattered subcentimetre hyperdensities in the right hepatic lobe, which are too small to characterise, likely represents tiny hepatic cysts. Again noted is a gallstone within the gallbladder. No pericholecystic fluid or imaging features of acute cholecystitis. No intrahepatic or extrahepatic biliary ductal dilatation. The adrenal glands, spleen, and pancreas are normal. The kidneys demonstrate normal parenchymal handsand without hydronephrosis or suspicious masses. The stomach, small and large bowel are normal in calibre without bowel wall thickening or obstruction. The bladder is unremarkable. The prostate is enlarged with punctate calcifications. No peritoneal free fluid. No abdominal or pelvic lymphadenopathy. CONCLUSION 1. Status post ascending aortic arch replacement, frozen elephant trunk, mitral valve annuloplasty, TEVAR and fenestrated thoracoabdominal EVAR with persistent endoleaks at T4-T5 and T10-T11 levels, at the segments of the relined stent grafts, representing either a type II or type III endoleak. Largely stable aneurysm sac at the proximal descending thoracic sac. 2. Persistent perfusion of the false lumen inthe infrarenal abdominal aorta, though the size has continued to decrease. Other findings in the body of the report. Report Indicator: May need further action Finalised by: <DOCTOR>

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