# Row 12488

Visit Number: 83246c787d793d6e638242843217f8196b9ee19a6918d130e139ecbcf36cc0b3

Masked\_PatientID: 12486

Order ID: 661e796d48a6a147c640c422ef2791ad260eb01b908096c74c6076ecebd9dc46

Order Name: CT Aortogram (Thoracic)

Result Item Code: CTANGAORT

Performed Date Time: 06/3/2015 10:24

Line Num: 1

Text: HISTORY Widen mediastinum on CXR TRO aortic aneurysm; History of rheumatoid arthritis on prednisolone TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Optiray 350 - Volume (ml): 70 FINDINGS No previous CT thorax available for comparison. Reference made to previous CT abdomen and pelvis dated 25/08/2014. Atheromatous changes are seen in the aortic arch and descending thoracic aorta. There is a type B (Stanford) dissection extending from descending thoracic aorta up to the level of the celiac axis origin. There is opacification of the false lumen with a small defect in the flap at the mid descending thoracic aortic level (series 80460, image 41). The celiac axis origin arises from the true lumen, and is patent. A thin linear filling defect within the proximal aspect of celiac axis may represent extension of the dissection flap (series 80460, images 85 and 86). The SMA and both renal artery origins are patent. The aorta at the level of the diaphragmatic hiatus is stable in dimension measuring 3.6 cm maximum AP diameter compared to previous CT abdomen of 25/08/2014. The major arch vessels origins are patent. There are motion artefacts in the ascending thoracic aortic level. The ascending aortic root dimensions are as follows: 2.5 cm at the aortic valve leaflet 3.5 cm at the sinus of Valsalva 3.2 cm at the sino-tubular junction 3.8 cm in the mid ascending aorta at the level of the main pulmonary artery (grossly stable) 3.5 cm at the mid aortic arch. No evidence of periaortic or mediastinal haematoma. The heart is enlarged. No pleural or pericardial effusion is seen. No significantly enlarged mediastinal or hilar nodes seen. Themajor airways are patent. There is a 4 mm nodule in the peripheral right upper lobe (series 80662, image 28) which is nonspecific. A tiny calcified granuloma is noted slightly inferiorly within the same lobe. There are atelectatic changes inboth lower lobes and lingula. The liver shows a few small hypodensities in both lobes which are too small to characterise. The biliary tree is not dilated. The tubular structure is again seen in the gallbladder fossa which may represent a cystic duct stump or collapsed gallbladder. The adrenal glands, pancreas and spleen are unremarkable. There is a 17 x 16 mm septated cyst in the upper pole of the right kidney (also shown on recent ultrasound examination dated 10/02/2015). A few smaller hypodensities in both kidneys are too small to characterise. A small hypodense exophytic lesion in the upper pole of the right kidney may represent hyperdense cyst. The visualised bowels show no gross abnormality. There are multiple healed bilateral rib fractures. No focal destructive bony lesions seen. CONCLUSION Stanford type B aortic dissection extending from the descending thoracic aorta up to the level of the celiac axis origin. Possible dissection extension into the proximal celiac axis which arises from the true lumen. There is opacification of the false lumen. No periaortic haematoma. The aortic dimensions at the mid descending thoracic and diaphragmatic hiatus level are stable compared to theprevious CT of 25/08/2014. A tiny lung nodule in the right upper lobe is nonspecific. Septated cyst in the upper pole of the right kidney. Sister Irene Tan on ward 64 has been informed of the availability of the report and for further action. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: f64c73a623bb2b6eb5b8afd4e8d7d53c2653bc5d1bc6731532ee270ce74afa63

Updated Date Time: 06/3/2015 12:22