# Row 1514

Visit Number: 15b186db7b661a4c62dd41f5cb25c7b05e58b9724eede8dffef2d9c086e55fea

Masked\_PatientID: 1513

Order ID: cf3a4a7f47898de7448f4ea94c9eea01da865682537e42ffaeef6294b0ca0cd6

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 29/1/2019 20:12

Line Num: 1

Text: HISTORY T1RF with widened A-a gradient. CXR however appears clear - does not explain hypoxemia In view of immobility over last few days + underlying cancer TRO PE TECHNIQUE Scans of the thorax were acquired in the arterial phase asper protocol for CT pulmonary angiogram after administration of Intravenous contrast: Omnipaque 350 Contrast volume (ml): 60 FINDINGS Comparison made with the CT chest study dated 7 December 2018. There is no filling-defect in the pulmonary trunk, main pulmonary arteries and its lobar and segmental branches. The cardiac chambers and mediastinal vessels show normal contrast enhancement. Cardiomegaly noted. No evidence of right heart strain. Coronary atherosclerotic calcifications are present. No pericardial effusion is seen. There is interval pneumomediastinum as well as slivers of pneumothorax bilaterally. No clustering of gas locules is seen around the trachea or oesophagus. No pleural effusion. There is extensive ground-glass change on a background of smooth interlobular septal thickening in bilateral upper lobes and lower lobes, and to lesser extent the middle lobe, with some areas reminiscent of the crazy-paving appearance. There are subpleural cysts in the right lung base as well few scattered thin walled pulmonary cysts in both lungs, more on the right. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. Mostly sclerotic bone lesions in the ribs, right scapula and the thoracic and lumbar spine in keeping with metastases. CONCLUSION 1. No pulmonary embolism is detected. 2. There is extensive ground-glass change on a background of smooth interlobular septal thickening in bilateral upper lobes and lower lobes, with some areas reminiscent of the crazy-paving appearance. Appearances favour infection, possibly by atypical agents. The other consideration will be that of a drug induced pneumonitis should there be a relevant prior drug exposure. 3. There is interval pneumomediastinum as well as slivers of pneumothorax bilaterally, the cause of which is indeterminate. The following has been communicated to Dr. Tham Sai Leong on the 29/01/2019 by Dr. Lee Shuhui Melissa. Read back was performed. Critical Abnormal Lee Shuhui Melissa (Li Shuhui) , Senior Resident , 17008I Finalised by: <DOCTOR>

Accession Number: a1699817f2e7b9657844b8ed6aebc3a740fe324209fbc6cdd8c202f41f9cf200

Updated Date Time: 30/1/2019 8:25

## Layman Explanation

This radiology report discusses HISTORY T1RF with widened A-a gradient. CXR however appears clear - does not explain hypoxemia In view of immobility over last few days + underlying cancer TRO PE TECHNIQUE Scans of the thorax were acquired in the arterial phase asper protocol for CT pulmonary angiogram after administration of Intravenous contrast: Omnipaque 350 Contrast volume (ml): 60 FINDINGS Comparison made with the CT chest study dated 7 December 2018. There is no filling-defect in the pulmonary trunk, main pulmonary arteries and its lobar and segmental branches. The cardiac chambers and mediastinal vessels show normal contrast enhancement. Cardiomegaly noted. No evidence of right heart strain. Coronary atherosclerotic calcifications are present. No pericardial effusion is seen. There is interval pneumomediastinum as well as slivers of pneumothorax bilaterally. No clustering of gas locules is seen around the trachea or oesophagus. No pleural effusion. There is extensive ground-glass change on a background of smooth interlobular septal thickening in bilateral upper lobes and lower lobes, and to lesser extent the middle lobe, with some areas reminiscent of the crazy-paving appearance. There are subpleural cysts in the right lung base as well few scattered thin walled pulmonary cysts in both lungs, more on the right. No significantly enlarged mediastinal, hilar, axillary or supraclavicular lymph node is detected. Mostly sclerotic bone lesions in the ribs, right scapula and the thoracic and lumbar spine in keeping with metastases. CONCLUSION 1. No pulmonary embolism is detected. 2. There is extensive ground-glass change on a background of smooth interlobular septal thickening in bilateral upper lobes and lower lobes, with some areas reminiscent of the crazy-paving appearance. Appearances favour infection, possibly by atypical agents. The other consideration will be that of a drug induced pneumonitis should there be a relevant prior drug exposure. 3. There is interval pneumomediastinum as well as slivers of pneumothorax bilaterally, the cause of which is indeterminate. The following has been communicated to Dr. Tham Sai Leong on the 29/01/2019 by Dr. Lee Shuhui Melissa. Read back was performed. Critical Abnormal Lee Shuhui Melissa (Li Shuhui) , Senior Resident , 17008I Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

No diseases detected.  
No specific organs mentioned.  
No symptoms mentioned.