# Row 1969

Visit Number: fd2dae5ac988c3b485c70a03ac8177a2afc0212ff42929a4a08f58150d84565c

Masked\_PatientID: 1967

Order ID: a8aa1f50b1c37189a8ad3ed76792a601e46da43e74e298423f8bb1e0a60f7aff

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 10/3/2017 20:06

Line Num: 1

Text: HISTORY pt tachycardiac, maintaining saturation on 15L NRM, bedbound TRO PE TECHNIQUE Contrast enhanced scans of the thorax during the pulmonary angiogram phase. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Note is made of the chest radiograph of 10 March 2017 (10:51 a.m.). No filling defect is seen in the right ventricular outflow tract, main pulmonary trunk, right to left pulmonary arteries, including lobar and segmental branches, to suggest pulmonary embolism. There is interval development of left lower lobe collapse with ipsilateral mediastinal shift. There is also volume loss in the left upper lobe with patchy consolidation and ground-glass opacities in the aerated portions of the left upper lobe. The airways distal to the left main bronchus are opacified and appear to contain low density material which may be retained secretions or aspirated fluid. Apart from mild linear atelectasis, the right lung appears unremarkable. No grossly enlarged mediastinal, hilar lymph node is detected. The heart is top normal in size with prominent mitral annulus calcification. No pericardial effusion is seen. There is a small left pleural effusion. There is mild enlargement of the thyroid gland with compression of the trachea (502-20). The limited sections of the upper abdomen appear grossly unremarkable. Posterior spinal implants are partially visualised. There appears to be fusion of several costovertebral joints with syndesmophytes, suspicious for an underlying spondyloarthropathy. CONCLUSION 1. Since the chest radiograph of 10 Mar 2017 at 10.51 am, there is acute left lung atelectasis (worst in the left lower lobe) with airway opacification distal to the left main bronchus (suspicious for retained secretions or aspirated fluid). This finding was discussed with Dr Marcus Sim via telephone at the time of reporting. 2. No pulmonary embolism detected. May need further action Finalised by: <DOCTOR>

Accession Number: 9a0a4c81ef4e4e14060d15733fc37ca75af7bc954f96201bf59b1bf684f26603

Updated Date Time: 10/3/2017 20:47

## Layman Explanation

This radiology report discusses HISTORY pt tachycardiac, maintaining saturation on 15L NRM, bedbound TRO PE TECHNIQUE Contrast enhanced scans of the thorax during the pulmonary angiogram phase. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Note is made of the chest radiograph of 10 March 2017 (10:51 a.m.). No filling defect is seen in the right ventricular outflow tract, main pulmonary trunk, right to left pulmonary arteries, including lobar and segmental branches, to suggest pulmonary embolism. There is interval development of left lower lobe collapse with ipsilateral mediastinal shift. There is also volume loss in the left upper lobe with patchy consolidation and ground-glass opacities in the aerated portions of the left upper lobe. The airways distal to the left main bronchus are opacified and appear to contain low density material which may be retained secretions or aspirated fluid. Apart from mild linear atelectasis, the right lung appears unremarkable. No grossly enlarged mediastinal, hilar lymph node is detected. The heart is top normal in size with prominent mitral annulus calcification. No pericardial effusion is seen. There is a small left pleural effusion. There is mild enlargement of the thyroid gland with compression of the trachea (502-20). The limited sections of the upper abdomen appear grossly unremarkable. Posterior spinal implants are partially visualised. There appears to be fusion of several costovertebral joints with syndesmophytes, suspicious for an underlying spondyloarthropathy. CONCLUSION 1. Since the chest radiograph of 10 Mar 2017 at 10.51 am, there is acute left lung atelectasis (worst in the left lower lobe) with airway opacification distal to the left main bronchus (suspicious for retained secretions or aspirated fluid). This finding was discussed with Dr Marcus Sim via telephone at the time of reporting. 2. No pulmonary embolism detected. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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