# Row 1973

Visit Number: c78f3fd912a3643abfd0e30ae1f3f38282ea8e4920b94f8f21d8a9b645f0b572

Masked\_PatientID: 1973

Order ID: ebaec5ba1cb9a0031980ca5ead356009c5ac542bc5be42515507523daa2dca0c

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 02/5/2018 17:18

Line Num: 1

Text: HISTORY CAP with CURB-1 (age) vs viral pneumonitis TRO PE as SPO2 drop on RA TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Comparison is made to previous study of 5 December 2013. Technical quality: Good. Minimal respiratory motion artefacts. There is no evidence of acute pulmonary embolism within the main, lobar and segmental pulmonary arteries. A tiny band-like filling defect in the right interlobar pulmonary artery (402-45 and 405-37) suggests chronic pulmonary embolism – this was not seen in 2013. Areas of scarring are scattered in the right lung, with partial collapse of the right middle lobe. Patchy areas of ground glass consolidative changes and tree in bud nodularity, with associated bronchial wall thickening and mucus plugging, in the right lower lobe are likely infective in nature, showing worsening from before. Small, slightly loculated, right pleural effusion is probably chronic. No pleural enhancement seen to suggest formation of an empyema. Borderline prominence of the pulmonary trunk at around 31 mm is stable (previous 2DE, 9 Oct 2013, shows mild pulmonary hypertension). There is cardiomegaly with biatrial enlargement. No pericardial effusion is seen. No significant intrathoracic lymphadenopathy is seen. An apparent 11 mm nodule is noted in the lateral aspect of the right upper breast (402-55). Imaged sections of the upper abdomen are unremarkable. There is no destructive bony lesion. Chronic T11 and L1 compression fractures again noted. CONCLUSION Since last CT of Dec 2013, 1. A small band like filling defect in right interlobar pulmonary artery likely represents chronic pulmonary embolism (PE). There is no evidence of acute PE. 2. Stable borderline prominence of the pulmonary trunk (previous 2DE, 9 Oct 2013, shows mild pulmonary hypertension). 3. Worsening of infective airway changes in right lower lobe. 4. Probable chronic small right pleural effusion. 5. Apparent nodular focus in right breast may be an island of breast parenchyma or a lesion. Suggest correlation on dedicated breast imaging. 6. Other minor findings as described. Further action or early intervention required Shi Haiyuan , Senior Resident , 15629I Finalised by: <DOCTOR>

Accession Number: c919f176b87f33f0820d7ef92d76c928e40571e52ae9140f7e8f5507dc30a1a7

Updated Date Time: 03/5/2018 7:41

## Layman Explanation

This radiology report discusses HISTORY CAP with CURB-1 (age) vs viral pneumonitis TRO PE as SPO2 drop on RA TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Comparison is made to previous study of 5 December 2013. Technical quality: Good. Minimal respiratory motion artefacts. There is no evidence of acute pulmonary embolism within the main, lobar and segmental pulmonary arteries. A tiny band-like filling defect in the right interlobar pulmonary artery (402-45 and 405-37) suggests chronic pulmonary embolism – this was not seen in 2013. Areas of scarring are scattered in the right lung, with partial collapse of the right middle lobe. Patchy areas of ground glass consolidative changes and tree in bud nodularity, with associated bronchial wall thickening and mucus plugging, in the right lower lobe are likely infective in nature, showing worsening from before. Small, slightly loculated, right pleural effusion is probably chronic. No pleural enhancement seen to suggest formation of an empyema. Borderline prominence of the pulmonary trunk at around 31 mm is stable (previous 2DE, 9 Oct 2013, shows mild pulmonary hypertension). There is cardiomegaly with biatrial enlargement. No pericardial effusion is seen. No significant intrathoracic lymphadenopathy is seen. An apparent 11 mm nodule is noted in the lateral aspect of the right upper breast (402-55). Imaged sections of the upper abdomen are unremarkable. There is no destructive bony lesion. Chronic T11 and L1 compression fractures again noted. CONCLUSION Since last CT of Dec 2013, 1. A small band like filling defect in right interlobar pulmonary artery likely represents chronic pulmonary embolism (PE). There is no evidence of acute PE. 2. Stable borderline prominence of the pulmonary trunk (previous 2DE, 9 Oct 2013, shows mild pulmonary hypertension). 3. Worsening of infective airway changes in right lower lobe. 4. Probable chronic small right pleural effusion. 5. Apparent nodular focus in right breast may be an island of breast parenchyma or a lesion. Suggest correlation on dedicated breast imaging. 6. Other minor findings as described. Further action or early intervention required Shi Haiyuan , Senior Resident , 15629I Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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