# Row 2329

Visit Number: e4044e37ebdcd195d00a666bb44f2556baaf432b32d189fef8ae328dff5d2fca

Masked\_PatientID: 2327

Order ID: 8c52f6cd8844d904c4dded4652d42143b2547058690dd62a83dc8a33b8543f3f

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 06/11/2019 18:24

Line Num: 1

Text: HISTORY known L LL DVT 2' underlying malignancy- not on anticoagulation presents with sudden onset SOB today with tachycardia HR 150s TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS The CT study of 28 July 2018 was reviewed. There are tubular filling defects seen at the birfurcation of the left pulmonary artery, extending into the lobar arteries and segmental arteries of the left lung , as well as the lobar, segmental and subsegmental arteries to the right lung, in keeping with bilateral acute pulmonary embolism. There is dilatation of the main pulmonary trunk, measuring up to 3.0 cm, suggestive of pulmonary arterial hypertension. The heart is not enlarged. There is flattening of the interventricular septum and reflux of contrast into the IVC, suggestive of mild right heart strain. No pericardial effusion. Background bronchiectasis in the right upper and middle lobe, and lingula. Grossly stable centrilobular nodules with surrounding ground-glass opacities are present in the right lung and left lower lobe basal segments, which may be inflammatory/post-inflammatory. New wedge-shaped ground-glass opacity at the subpleuralregion of the left upper lobe apicoposterior segment (2.1 cm) (series 4, image 16) is indeterminate, but could represent a pulmonary infarct in the given clinical context or can be inflammatory. Stable subcentimetre mediastinal and bilateral hilar lymph nodes, measuring up to (0.9 cm) (series 3, image 41) are probably reactive. Included upper abdomen shows no gross abnormality. Stable L1 vertebral compression fracture. No overt bony destruction is identified. CONCLUSION 1. Findings are in keeping with acute bilateral pulmonary embolism. 2. Mild dilatation of the main pulmonary trunk is suggestive of pulmonary arterial hypertension. There is also flattening of the interventricular septum and reflux of contrast into the IVC, suggestive of mild right heart strain. 3. New wedge-shaped opacity at the left upper lobe is indeterminate, but could represent a pulmonary infarct in the given clinical context or can be inflammatory. Attention on follow-up suggested. Pertinent finding 1 and 2 conveyed to Dr Sarah Too Jiayu by Dr Felicia Teo on 06/11/2019 at 6.40 pm. Report Indicator: Critical Abnormal Reported by: <DOCTOR>

Accession Number: 5d484f5f49f33eae1fa7c9ba8ceb1ca2a3b619023f261e14853e4ca4b3ec54a9

Updated Date Time: 06/11/2019 20:05

## Layman Explanation

This radiology report discusses HISTORY known L LL DVT 2' underlying malignancy- not on anticoagulation presents with sudden onset SOB today with tachycardia HR 150s TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS The CT study of 28 July 2018 was reviewed. There are tubular filling defects seen at the birfurcation of the left pulmonary artery, extending into the lobar arteries and segmental arteries of the left lung , as well as the lobar, segmental and subsegmental arteries to the right lung, in keeping with bilateral acute pulmonary embolism. There is dilatation of the main pulmonary trunk, measuring up to 3.0 cm, suggestive of pulmonary arterial hypertension. The heart is not enlarged. There is flattening of the interventricular septum and reflux of contrast into the IVC, suggestive of mild right heart strain. No pericardial effusion. Background bronchiectasis in the right upper and middle lobe, and lingula. Grossly stable centrilobular nodules with surrounding ground-glass opacities are present in the right lung and left lower lobe basal segments, which may be inflammatory/post-inflammatory. New wedge-shaped ground-glass opacity at the subpleuralregion of the left upper lobe apicoposterior segment (2.1 cm) (series 4, image 16) is indeterminate, but could represent a pulmonary infarct in the given clinical context or can be inflammatory. Stable subcentimetre mediastinal and bilateral hilar lymph nodes, measuring up to (0.9 cm) (series 3, image 41) are probably reactive. Included upper abdomen shows no gross abnormality. Stable L1 vertebral compression fracture. No overt bony destruction is identified. CONCLUSION 1. Findings are in keeping with acute bilateral pulmonary embolism. 2. Mild dilatation of the main pulmonary trunk is suggestive of pulmonary arterial hypertension. There is also flattening of the interventricular septum and reflux of contrast into the IVC, suggestive of mild right heart strain. 3. New wedge-shaped opacity at the left upper lobe is indeterminate, but could represent a pulmonary infarct in the given clinical context or can be inflammatory. Attention on follow-up suggested. Pertinent finding 1 and 2 conveyed to Dr Sarah Too Jiayu by Dr Felicia Teo on 06/11/2019 at 6.40 pm. Report Indicator: Critical Abnormal Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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