# Row 3147

Visit Number: 496156e9e333d2945234cb63356234796f397e81ef29eafd1c3d4ac583c4e632

Masked\_PatientID: 3145

Order ID: 358e3a18a9977962f3c4fb60868afa55bf40d26fc2d0310563ab84392a8a60fc

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 03/7/2016 12:29

Line Num: 1

Text: HISTORY persistent tachycardia HR 130s and breathlessness , fever without obvious source (normal CXR, CTAP NAD), recent spinal surgery 1/12 ago with period of immobility TECHNIQUE Scans of the thorax were acquired in the arterial phase as per protocol for CT pulmonary angiogram after administration of Intravenous contrast: Omnipaque 350 Contrast volume (ml): 60 Suboptimal image quality due to respiratory motion and contrast bolus timing issues. FINDINGS There are no relevant prior scans available for comparison. Multiple small filling defects are noted in the segmental and subsegmental arteries of the bilateral lower lobes, suspicious for pulmonary thrombo-emboli. No constant filling defects are demonstrated in the main pulmonary arteries and segmental branches. No thrombus is seen in the SVC, right atrium or right ventricle. The RV/LV ratio is less than 0.9. The main pulmonary artery is within normal limits. There is no loss of convexity of the interventricular septum. Contrast is seen in the IVC and portal veins due to technical reasons rather than true reflux from right heart strain. Mild cardiomegaly is noted. The mediastinal vessels enhance normally. There are a few, slightly clustered pulmonary nodules located in the periphery of the anterior segment of the left upper lobe, measuring between 0.3 to 0.5 cm (501-33 and 41). The appearance favours an infective/inflammatory etiology rather than neoplasia. A follow-up is advised to ensure resolution. The central airways are clear. No pleural or pericardial effusion is present. There is no significant axillary, supraclavicular, mediastinal or hilaradenopathy. Limited sections through the abdomen acquired in the early arterial phase, are grossly unremarkable. Amorphous hyperdense material is noted in the stomach. No destructive bony lesion is seen. CONCLUSION 1. Multiple filling defects are noted in the segmental and subsegmental arteries of the bilateral lower lobes, suspicious for pulmonary thrombo-emboli. 2. Mild cardiomegaly is seen with no definite evidence of right heart strain. 3. There are a few, slightly clustered pulmonary nodules located in the periphery of theanterior segment of the left upper lobe. The appearance favours an infective/inflammatory etiology rather than neoplasia. A follow-up is advised to ensure resolution. Dr. Edwin Sng was informed of the pertinent findings by Dr. Jaspreet Singh Sangha Brar at 1304 hours on the 3 July 2016. Readback was performed. Critical Abnormal Finalised by: <DOCTOR>

Accession Number: ab296f46a494e12abd6bb702a1e7b2e57bfac284f8cc9aca4634e62c0c41d95e

Updated Date Time: 03/7/2016 13:42

## Layman Explanation

This radiology report discusses HISTORY persistent tachycardia HR 130s and breathlessness , fever without obvious source (normal CXR, CTAP NAD), recent spinal surgery 1/12 ago with period of immobility TECHNIQUE Scans of the thorax were acquired in the arterial phase as per protocol for CT pulmonary angiogram after administration of Intravenous contrast: Omnipaque 350 Contrast volume (ml): 60 Suboptimal image quality due to respiratory motion and contrast bolus timing issues. FINDINGS There are no relevant prior scans available for comparison. Multiple small filling defects are noted in the segmental and subsegmental arteries of the bilateral lower lobes, suspicious for pulmonary thrombo-emboli. No constant filling defects are demonstrated in the main pulmonary arteries and segmental branches. No thrombus is seen in the SVC, right atrium or right ventricle. The RV/LV ratio is less than 0.9. The main pulmonary artery is within normal limits. There is no loss of convexity of the interventricular septum. Contrast is seen in the IVC and portal veins due to technical reasons rather than true reflux from right heart strain. Mild cardiomegaly is noted. The mediastinal vessels enhance normally. There are a few, slightly clustered pulmonary nodules located in the periphery of the anterior segment of the left upper lobe, measuring between 0.3 to 0.5 cm (501-33 and 41). The appearance favours an infective/inflammatory etiology rather than neoplasia. A follow-up is advised to ensure resolution. The central airways are clear. No pleural or pericardial effusion is present. There is no significant axillary, supraclavicular, mediastinal or hilaradenopathy. Limited sections through the abdomen acquired in the early arterial phase, are grossly unremarkable. Amorphous hyperdense material is noted in the stomach. No destructive bony lesion is seen. CONCLUSION 1. Multiple filling defects are noted in the segmental and subsegmental arteries of the bilateral lower lobes, suspicious for pulmonary thrombo-emboli. 2. Mild cardiomegaly is seen with no definite evidence of right heart strain. 3. There are a few, slightly clustered pulmonary nodules located in the periphery of theanterior segment of the left upper lobe. The appearance favours an infective/inflammatory etiology rather than neoplasia. A follow-up is advised to ensure resolution. Dr. Edwin Sng was informed of the pertinent findings by Dr. Jaspreet Singh Sangha Brar at 1304 hours on the 3 July 2016. Readback was performed. Critical Abnormal Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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