# Row 3175

Visit Number: 810c39a0450072b0c8a0da9b3fb843caf398072d0b18ec7cd691006f76eba4da

Masked\_PatientID: 3175

Order ID: 55903b2ed380e43e0c00e62c5f6cc067ad674ca3bc5293712cbfc60acb8383ae

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 16/6/2015 21:10

Line Num: 1

Text: HISTORY Persistent sinus tachycardia, d-dimer 0.77, A-a gradient raised 35.3. Patient admitted for left upper lobe pneumonia and asthma exercabation, improving with antibiotics 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 FINDINGS There are no relevant prior scans available for comparison. The chest radiograph done on12 June 2015 was reviewed. 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. The heart is not enlarged. No pericardial effusion is seen. A patch of consolidation and ground glass change in the apico-posterior segment of the left upper lobe likely corresponds to the left upper zone opacity seen on prior chest radiograph. There is diffuse bronchial wall thickening. Numerous tiny nodules are seen in both lungs, more severely affecting the middle and right lower lobe where there is suggestion “tree-in-bud” appearance, and to a lesser extent in the left lower lobe. These findings are suspicious for airway inflammation. There is no pulmonary mass lesion. Mild atelectasis noted in the inferior lingula. No pleural effusion detected. Mildly prominent bilateral hilar nodes are likely reactive. There is no significantly enlarged mediastinal or axillary lymph node. Diffusely enlarged thyroid gland with multiple non-specific subcentimeter hypodensities, some calcified, suggests multinodular goitre. The limited sections of the upper abdomen in the arterial phase are unremarkable. No destructive bony process is seen. CONCLUSION 1. No pulmonary embolism is noted. 2. There are infective / inflammatory changes affecting the airways with airspace changes in the left upper lobe. Clinical correlation isadvised. May need further action Tham Wei Ping , Senior Resident , 14580G Finalised by: <DOCTOR>

Accession Number: 06fc66678d1470d41bfb25c44cfe9b18ef2b43072b12352918ce8009b872a18d

Updated Date Time: 17/6/2015 9:30

## Layman Explanation

This radiology report discusses HISTORY Persistent sinus tachycardia, d-dimer 0.77, A-a gradient raised 35.3. Patient admitted for left upper lobe pneumonia and asthma exercabation, improving with antibiotics 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 FINDINGS There are no relevant prior scans available for comparison. The chest radiograph done on12 June 2015 was reviewed. 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. The heart is not enlarged. No pericardial effusion is seen. A patch of consolidation and ground glass change in the apico-posterior segment of the left upper lobe likely corresponds to the left upper zone opacity seen on prior chest radiograph. There is diffuse bronchial wall thickening. Numerous tiny nodules are seen in both lungs, more severely affecting the middle and right lower lobe where there is suggestion “tree-in-bud” appearance, and to a lesser extent in the left lower lobe. These findings are suspicious for airway inflammation. There is no pulmonary mass lesion. Mild atelectasis noted in the inferior lingula. No pleural effusion detected. Mildly prominent bilateral hilar nodes are likely reactive. There is no significantly enlarged mediastinal or axillary lymph node. Diffusely enlarged thyroid gland with multiple non-specific subcentimeter hypodensities, some calcified, suggests multinodular goitre. The limited sections of the upper abdomen in the arterial phase are unremarkable. No destructive bony process is seen. CONCLUSION 1. No pulmonary embolism is noted. 2. There are infective / inflammatory changes affecting the airways with airspace changes in the left upper lobe. Clinical correlation isadvised. May need further action Tham Wei Ping , Senior Resident , 14580G Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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