# Row 3288

Visit Number: e66a3ec5909bbacf4dc1e8e509caf6963812c0984319844c5aeb89923c291ad7

Masked\_PatientID: 3288

Order ID: 5d655c513bdc02c80a551609a9bbd51d29ab04d769fcc7d5e79e0c779e6fae8f

Order Name: CT Aortogram (Chest, Abdomen)

Result Item Code: AORTOCA

Performed Date Time: 14/12/2018 11:33

Line Num: 1

Text: HISTORY Severe AR with dissection flap noted on TTE likely Stanfod A dissection. For urgent CT aortogram TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Prior CT dated 13 December 2018 was reviewed. VASCULAR FINDINGS A dissection flap is seen terminating at the proximal aortic arch distal to the right brachiocephalic trunk and proximal to the left common carotid artery. Its proximal extent cannot be clearly identified, although there is suggestion of extension towards the dilated aortic root. The true and false lumens cannot be clearly delineated, but there is equal contrast opacification. No extension of the dissection flap into the major branches of the arch. There is aneurysmal dilatation of the aortic root and ascending aorta, measuring 7.1 cm in maximal diameter. The distal aortic arch, descending thoracic aorta, abdominal aorta and the major branches in the abdomenare of normal calibre and show normal contrast opacification. No significant mural calcification is seen. Cardiomegaly with gross dilatation of the left ventricle is noted. No large pericardial effusion or mediastinal haematoma. Reflux of contrast into the inferior vena cava, indicating cardiac dysfunction. OTHER FINDINGS Diffuse smooth interlobular septal thickening in both lungs, as well as patchy ground-glass changes most prominently in the lower lobes. Moderate bilateral pleural effusions are present. Trachea and central airways are patent. No supraclavicular, mediastinal, hilar or axillary lymphadenopathy. Imaged thyroid gland is unremarkable. There is vicarious contrast excretion in the gallbladder. Interval insertion of a Foley catheter with a small intravesical air pocket, possibly procedural related. Contrast excretion is also noted in the urinary bladder. Small amount of low density free fluid in the pelvis. Rest of the intra-abdominal findings are stable from the CT done on 13 Dec 2018. No destructive bony lesion is seen. CONCLUSION 1. Stanford type A aortic dissection, the distal end of the dissection flap terminates proximal to the left common carotid artery origin. Theproximal extent of the dissection flap is better documented on TTE report (SCM, 14 Dec 2018). Significant dilatation of the aortic root and ascending aorta. 2. There are features of congestive cardiac failure. 3. Other findings as described above. It is noted that the primary team was aware of pertinent findings at the time of reporting. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: 7ffd43c725d53316dae00ff5c0264061bac448322d2e922a10c82811d81fcd73

Updated Date Time: 14/12/2018 14:15

## Layman Explanation

This radiology report discusses HISTORY Severe AR with dissection flap noted on TTE likely Stanfod A dissection. For urgent CT aortogram TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS Prior CT dated 13 December 2018 was reviewed. VASCULAR FINDINGS A dissection flap is seen terminating at the proximal aortic arch distal to the right brachiocephalic trunk and proximal to the left common carotid artery. Its proximal extent cannot be clearly identified, although there is suggestion of extension towards the dilated aortic root. The true and false lumens cannot be clearly delineated, but there is equal contrast opacification. No extension of the dissection flap into the major branches of the arch. There is aneurysmal dilatation of the aortic root and ascending aorta, measuring 7.1 cm in maximal diameter. The distal aortic arch, descending thoracic aorta, abdominal aorta and the major branches in the abdomenare of normal calibre and show normal contrast opacification. No significant mural calcification is seen. Cardiomegaly with gross dilatation of the left ventricle is noted. No large pericardial effusion or mediastinal haematoma. Reflux of contrast into the inferior vena cava, indicating cardiac dysfunction. OTHER FINDINGS Diffuse smooth interlobular septal thickening in both lungs, as well as patchy ground-glass changes most prominently in the lower lobes. Moderate bilateral pleural effusions are present. Trachea and central airways are patent. No supraclavicular, mediastinal, hilar or axillary lymphadenopathy. Imaged thyroid gland is unremarkable. There is vicarious contrast excretion in the gallbladder. Interval insertion of a Foley catheter with a small intravesical air pocket, possibly procedural related. Contrast excretion is also noted in the urinary bladder. Small amount of low density free fluid in the pelvis. Rest of the intra-abdominal findings are stable from the CT done on 13 Dec 2018. No destructive bony lesion is seen. CONCLUSION 1. Stanford type A aortic dissection, the distal end of the dissection flap terminates proximal to the left common carotid artery origin. Theproximal extent of the dissection flap is better documented on TTE report (SCM, 14 Dec 2018). Significant dilatation of the aortic root and ascending aorta. 2. There are features of congestive cardiac failure. 3. Other findings as described above. It is noted that the primary team was aware of pertinent findings at the time of reporting. Further action or early intervention required Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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