# Row 3916

Visit Number: ba3997e07968cdb92c60e3e4e4080ceadfd9067a7bf32c41bdb239cc631263b5

Masked\_PatientID: 3916

Order ID: ed3ff9b166743dfb128477ff8ab8a50bfaa9ec7da863ce78150e616f0658d7ed

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 08/10/2016 15:37

Line Num: 1

Text: HISTORY hx of IgA multiple myeloma now presents with hypotension, dyspnoea; TRO PE b/g L LL proximal DVT on clexane, recently initiated on 30/9/16 TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS No previous CT thorax examination for comparison. No definite filling defect is identified in the pulmonary arteries up to the segmental level. There is cardiomegaly. The main pulmonary artery is notsignificantly dilated. No enlarged mediastinal or hilar node is seen. There are small pleural effusions bilaterally, slightly larger on the right side with adjacent passive atelectatic changes in the dependent lower lobes. Mild to moderatetubular bronchiectatic changes are seen in the middle lobe with surrounding scarring and volume loss. A small 4 mm ground-glass opacity in the right lung apex (image 6-22) is nonspecific. The visualised upper abdomen shows no obvious abnormality. There are extensive lucent changes in the imaged vertebra with coarsening of trabeculae. Associated reduction in the body heights of several vertebrae with kyphosis is also noted. These are noted to be longstanding probably related to known history of myeloma. Background osteopenia is present. The thoracic cage is asymmetric with deformity and crowding of the left sided ribs. CONCLUSION No evidence pulmonary embolism. Bilateral small pleural effusions are likely secondary to cardiac impairment. Mild to moderate bronchiectasis and scarring in the middle lobe with associated volume loss. May need further action Reported by: <DOCTOR>

Accession Number: 0b4d426f5830a9dfa6e7706d25511d1dac3844f4737fb05cee156ee9e2db98a7

Updated Date Time: 08/10/2016 16:10

## Layman Explanation

This radiology report discusses HISTORY hx of IgA multiple myeloma now presents with hypotension, dyspnoea; TRO PE b/g L LL proximal DVT on clexane, recently initiated on 30/9/16 TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS No previous CT thorax examination for comparison. No definite filling defect is identified in the pulmonary arteries up to the segmental level. There is cardiomegaly. The main pulmonary artery is notsignificantly dilated. No enlarged mediastinal or hilar node is seen. There are small pleural effusions bilaterally, slightly larger on the right side with adjacent passive atelectatic changes in the dependent lower lobes. Mild to moderatetubular bronchiectatic changes are seen in the middle lobe with surrounding scarring and volume loss. A small 4 mm ground-glass opacity in the right lung apex (image 6-22) is nonspecific. The visualised upper abdomen shows no obvious abnormality. There are extensive lucent changes in the imaged vertebra with coarsening of trabeculae. Associated reduction in the body heights of several vertebrae with kyphosis is also noted. These are noted to be longstanding probably related to known history of myeloma. Background osteopenia is present. The thoracic cage is asymmetric with deformity and crowding of the left sided ribs. CONCLUSION No evidence pulmonary embolism. Bilateral small pleural effusions are likely secondary to cardiac impairment. Mild to moderate bronchiectasis and scarring in the middle lobe with associated volume loss. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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