# Row 4311

Visit Number: c6451b63df4f2245ca835eab965f5a76b5bdb4debae60474329dbab878107dd8

Masked\_PatientID: 4295

Order ID: 1b63577f8ae64ff659e5ad9552d263e489912cbb3dff7c6ba931c00e6c8cbbf9

Order Name: CT Chest or Thorax

Result Item Code: CTCHE

Performed Date Time: 23/9/2018 15:56

Line Num: 1

Text: HISTORY collapse T2RF, haemoptysis +++ reintubated TRO lung bleeding and worse pneumonia also CT brain TRO stroke and bleed for seizures; redo mvr tva on 5/9 TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS The recent chest radiographs were reviewed. Status post re-do sternotomy, mitral valve replacement and tricuspid annuloplasty 05/09/2018. Midline sternotomy wires and mediastinal clips areseen. Tip of the endotracheal tube is 2.6 cm above the carina. Tip of the right internal jugular venous line is in the superior vena cava. The feeding tube passes into the stomach and is incompletely imaged in this study. No active contrast extravasation is seen to suggest active bleeding during the time of scanning. Background emphysematous changes are noted in the lungs. Extensive air space consolidation and patchy ground-glass changes are noted, particularly involving the left upper lobe, right upper lobe and middle lobe. Septal thickening is noted throughout both lungs, most prominent in the dependent aspects. There are bilateral moderate hypodense pleural effusions. Some of these show loculated components, such as in the lateral aspect of the right lower hemithorax and along the medial aspect of the along the superior medial aspect of the left hemithorax. There is enlargement of the right heart chambers. The pulmonary trunk is dilated, in keepingwith pulmonary arterial hypertension. A small pericardial effusion is present. The partially imaged in the liver appears enlarged with a nodular surface, likely representing cardiac cirrhosis. The rest of the imaged upper abdomen is unremarkable. No destructive bone lesion is seen. CONCLUSION 1. No active contrast extravasation is seen to suggest active bleeding during the time of scanning. 2. Extensive consolidation and ground-glass changes are seen in both lungs. There is septal thickening and bilateral moderate pleural effusions are present. These findings may represent ongoing infection. Fluid overload secondary to cardiac decompensation may also be a contributing factor. May need further action Finalised by: <DOCTOR>

Accession Number: b9bb3cb164831b93818d8729ce22faebdd72820ea528db174d52944fdd27381a

Updated Date Time: 23/9/2018 17:28

## Layman Explanation

This radiology report discusses HISTORY collapse T2RF, haemoptysis +++ reintubated TRO lung bleeding and worse pneumonia also CT brain TRO stroke and bleed for seizures; redo mvr tva on 5/9 TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 50 FINDINGS The recent chest radiographs were reviewed. Status post re-do sternotomy, mitral valve replacement and tricuspid annuloplasty 05/09/2018. Midline sternotomy wires and mediastinal clips areseen. Tip of the endotracheal tube is 2.6 cm above the carina. Tip of the right internal jugular venous line is in the superior vena cava. The feeding tube passes into the stomach and is incompletely imaged in this study. No active contrast extravasation is seen to suggest active bleeding during the time of scanning. Background emphysematous changes are noted in the lungs. Extensive air space consolidation and patchy ground-glass changes are noted, particularly involving the left upper lobe, right upper lobe and middle lobe. Septal thickening is noted throughout both lungs, most prominent in the dependent aspects. There are bilateral moderate hypodense pleural effusions. Some of these show loculated components, such as in the lateral aspect of the right lower hemithorax and along the medial aspect of the along the superior medial aspect of the left hemithorax. There is enlargement of the right heart chambers. The pulmonary trunk is dilated, in keepingwith pulmonary arterial hypertension. A small pericardial effusion is present. The partially imaged in the liver appears enlarged with a nodular surface, likely representing cardiac cirrhosis. The rest of the imaged upper abdomen is unremarkable. No destructive bone lesion is seen. CONCLUSION 1. No active contrast extravasation is seen to suggest active bleeding during the time of scanning. 2. Extensive consolidation and ground-glass changes are seen in both lungs. There is septal thickening and bilateral moderate pleural effusions are present. These findings may represent ongoing infection. Fluid overload secondary to cardiac decompensation may also be a contributing factor. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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