# Row 5483

Visit Number: a1d41c683df95ecfcee9c3da2a6b705245a844b8a14d85277a90aa41b60b8ce9

Masked\_PatientID: 5481

Order ID: b82a65e2e5e5adce6e9b18d410b854101597c1b61e664149997ae76d8dc89aeb

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 25/6/2016 23:52

Line Num: 1

Text: HISTORY Asystole collapse with T1RF post op. TRO PE 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): 50 FINDINGS The previous CT dated 02/06/2016 is noted. The tip of endotracheal tube is located well above the carina. No filling-defect is detected in the pulmonary trunk, main pulmonary arteries and its lobar and segmental branches. The cardiac chambers and mediastinal vessels show normal contrast enhancement. No enlarged mediastinal or hilar lymph node is detected. The heart is normal in size. No pericardial effusion is seen. Patchy ground-glass densitiesand mild septal thickening mostly in the peribronchovascular and central distribution are detected in both lungs. Mild centrilobular emphysema in the upper lobes are seen. There are bilateral moderate pleural effusions associated with adjacent subsegmental atelectasis. There are filling defects in the main bronchi as well as several segmental bronchi in both lower lobes most likely due to mucus plugging. Some of these bronchi are occluded and there is mild thickening of the bronchial wall suggesting inflammation. There is stable scarring in the right lung apex with traction bronchiolar dilatation. The nasogastric tube is in situ. Included upper abdomen is unremarkable. No destructive bony process is seen. Generalised mild subcutaneous fat stranding noted indicating fluid overload. CONCLUSION 1. No pulmonary embolism is noted. 2. Patchy ground-glass densities and mild septal thickening mostly in the peribronchovascular and central distribution, favour pulmonary oedema, especially given bilateral small-moderate pleural effusions. Clinical correlation to exclude infection is however suggested. There is likely mucus plugging of segmental bronchi in both lower lobes with associated bronchial wall thickening probably suggesting some inflammation. May need further action Kheok Si Wei , Senior Resident , 15535G Finalised by: <DOCTOR>

Accession Number: b1467efabde68c43e18f506bb26171b74a1b80bb206a94a1b60749d1eafc25ba

Updated Date Time: 26/6/2016 10:48

## Layman Explanation

This radiology report discusses HISTORY Asystole collapse with T1RF post op. TRO PE 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): 50 FINDINGS The previous CT dated 02/06/2016 is noted. The tip of endotracheal tube is located well above the carina. No filling-defect is detected in the pulmonary trunk, main pulmonary arteries and its lobar and segmental branches. The cardiac chambers and mediastinal vessels show normal contrast enhancement. No enlarged mediastinal or hilar lymph node is detected. The heart is normal in size. No pericardial effusion is seen. Patchy ground-glass densitiesand mild septal thickening mostly in the peribronchovascular and central distribution are detected in both lungs. Mild centrilobular emphysema in the upper lobes are seen. There are bilateral moderate pleural effusions associated with adjacent subsegmental atelectasis. There are filling defects in the main bronchi as well as several segmental bronchi in both lower lobes most likely due to mucus plugging. Some of these bronchi are occluded and there is mild thickening of the bronchial wall suggesting inflammation. There is stable scarring in the right lung apex with traction bronchiolar dilatation. The nasogastric tube is in situ. Included upper abdomen is unremarkable. No destructive bony process is seen. Generalised mild subcutaneous fat stranding noted indicating fluid overload. CONCLUSION 1. No pulmonary embolism is noted. 2. Patchy ground-glass densities and mild septal thickening mostly in the peribronchovascular and central distribution, favour pulmonary oedema, especially given bilateral small-moderate pleural effusions. Clinical correlation to exclude infection is however suggested. There is likely mucus plugging of segmental bronchi in both lower lobes with associated bronchial wall thickening probably suggesting some inflammation. May need further action Kheok Si Wei , Senior Resident , 15535G Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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