# Row 6293

Visit Number: 737b70f946b5802f7e31faca2fd5bd203936bba26c1e7cc2a9fe4b92200edc0a

Masked\_PatientID: 6287

Order ID: d513e0c159e560f60cc44b1e14e4fce0ff8f2b2759ef902f8feae78e939147cd

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 22/4/2015 21:42

Line Num: 1

Text: HISTORY SOB - came in in T2RF + left LL swelling bedside 2DE: large RA/RV compressing on LV TECHNIQUE Axial images of the thorax with coronal reconstruction in the arterial phase as per PE protocol. The technical quality of thestudy is good. Intravenous contrast: Optiray 350 - Volume (ml): 60 FINDINGS No previous study is available for reference. There is no filling defect in the main pulmonary trunk, left and right main, lobar, segmental, and the adequately opacified subsegmental branches of the pulmonary arteries to suggest pulmonary embolus. Main pulmonary trunk is 2.6cm in diameter which is within normal limits. The right ventricle to left ventricle ratio is normal; interventricular septum is not straightened. However, there is isolated dilation of the right atrium with some reflux of contrast into the intrahepatic inferior vena cava and hepatic veins, suggestive of an element of right heart strain / dysfunction. Echocardiographic correlation may be considered, if clinical warranted. There is no pericardial effusion. The thoracic aorta is of normal calibre. There is no significantly enlarged mediastinal or hilar lymph node. Prominent right hilar lymph nodes are non-specific. Small bilateral pleural effusions are present, left larger than right. There is no confluent consolidation. Patchy mosaic attenuation is seen throughout both lungs, remaining nonspecific. Peripheral scarring is seen in the lung apices, middle lobe, lingula as well as to a lesser extent in the lower lobes. Some associated traction bronchiectasis is noted. These are likely sequelae of prior infection. A few tiny nodules with possibly a calcified granuloma are seen in the rightlower lobe (Se 7/33-34, 48), also non-specific but possibly post-inflammatory. There is dilation of the oesophagus but no definite transition point or oesophageal mass is detected. The imaged upper abdomen is grossly unremarkable save forascites. No suspicious bony abnormality is evident. CONCLUSION 1.No CT evidence of pulmonary embolism. 2.Isolated dilation of the right atrium with some reflux of contrast into the intrahepatic inferior vena cava and hepatic veins, suggestive of an element of right heart strain / dysfunction. Echocardiographic correlation may be considered, if clinical warranted. No secondary findings to suggest pulmonary hypertension. 3. Non-specific patchy mosaic attenuation in both lungs. Bilateral lung scarring likely sequalae of prior infection. A few tiny nodules in the right lower lobe are non-specific. 4. Ascites and bilateral small pleural effusions. May need further action Tan Jingxian Colin , Senior Resident , 14814H Finalised by: <DOCTOR>

Accession Number: 94dda0a17a1faff26dfdc458f761def725510d6ab74b8a8b2e684082ae1a5c8e

Updated Date Time: 22/4/2015 23:49

## Layman Explanation

This radiology report discusses HISTORY SOB - came in in T2RF + left LL swelling bedside 2DE: large RA/RV compressing on LV TECHNIQUE Axial images of the thorax with coronal reconstruction in the arterial phase as per PE protocol. The technical quality of thestudy is good. Intravenous contrast: Optiray 350 - Volume (ml): 60 FINDINGS No previous study is available for reference. There is no filling defect in the main pulmonary trunk, left and right main, lobar, segmental, and the adequately opacified subsegmental branches of the pulmonary arteries to suggest pulmonary embolus. Main pulmonary trunk is 2.6cm in diameter which is within normal limits. The right ventricle to left ventricle ratio is normal; interventricular septum is not straightened. However, there is isolated dilation of the right atrium with some reflux of contrast into the intrahepatic inferior vena cava and hepatic veins, suggestive of an element of right heart strain / dysfunction. Echocardiographic correlation may be considered, if clinical warranted. There is no pericardial effusion. The thoracic aorta is of normal calibre. There is no significantly enlarged mediastinal or hilar lymph node. Prominent right hilar lymph nodes are non-specific. Small bilateral pleural effusions are present, left larger than right. There is no confluent consolidation. Patchy mosaic attenuation is seen throughout both lungs, remaining nonspecific. Peripheral scarring is seen in the lung apices, middle lobe, lingula as well as to a lesser extent in the lower lobes. Some associated traction bronchiectasis is noted. These are likely sequelae of prior infection. A few tiny nodules with possibly a calcified granuloma are seen in the rightlower lobe (Se 7/33-34, 48), also non-specific but possibly post-inflammatory. There is dilation of the oesophagus but no definite transition point or oesophageal mass is detected. The imaged upper abdomen is grossly unremarkable save forascites. No suspicious bony abnormality is evident. CONCLUSION 1.No CT evidence of pulmonary embolism. 2.Isolated dilation of the right atrium with some reflux of contrast into the intrahepatic inferior vena cava and hepatic veins, suggestive of an element of right heart strain / dysfunction. Echocardiographic correlation may be considered, if clinical warranted. No secondary findings to suggest pulmonary hypertension. 3. Non-specific patchy mosaic attenuation in both lungs. Bilateral lung scarring likely sequalae of prior infection. A few tiny nodules in the right lower lobe are non-specific. 4. Ascites and bilateral small pleural effusions. May need further action Tan Jingxian Colin , Senior Resident , 14814H Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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