# Row 695

Visit Number: 7f88b4d0b5aa6672311c0f245302c9875e6d91d081d31241e103a795112cdd73

Masked\_PatientID: 681

Order ID: 6a2124b7343617dbc4e3b44046ce7d8a3fda22f694128536fa5e734aefd4d047

Order Name: CT Aortogram (Chest, Abdomen)

Result Item Code: AORTOCA

Performed Date Time: 24/11/2017 13:49

Line Num: 1

Text: HISTORY S/P TEVAR of the Descending Aorta and Arch with special Graft. Underwent replacement of Ascending aorta for Dissection of the Aorta. TECHNIQUE Multiplasic prospective gating CT aortogram of the thoracic aorta was performed with the administration of 100ml of Omnipaque 350. FINDINGS Comparison is made with the previous study of 29/8/2017 (TTSH). VASCULAR The patient is status post replacement of the ascending aorta for Stanford A aortic dissection and TEVAR endograft placement for Stanford B aortic dissection. Surgical sutures are noted at the sinotubular junction which likely represents the site of ascending aorta repair. The aortic stent graft is seen in the aortic arch, the left subclavian arteryand extends to the mid descending thoracic aorta The known dissection flap is extending from the sinotubular junction, involving the origin of the right brochiocephalic artery, origin of left common carotid artery, and extending to the infrarenal abdominal aorta. The dissection involving the left common carotid artery has improved, with the dissection flap seen up to the level of the clavicular heads (previously extending up to the hyoid bone). There is flow of contrast within the true and the false lumen of the thoracic aorta, from the sinotubular junction, representing persistent dissection. There is partial thrombosis of the false lumen. There is more contrast opacification of the false lumen on the current study which may be fed via fenestrations with the true lumen but exact site of this is not certain The overall transverse diameter aorta is largely stable as follows: - aortic annulus, 21 mm (17-59, 15-49 vs prior 8-47), stable; - sinotubular junction 30mm (15-52, 17-59, vs 32mm, prior 8-44), stable - descending thoracic aorta, at level of inferior pulmonary vein 43 mm (14-543, vs prior 7-414). - suprarenal aorta, at level of coeliac trunk, 29mm (14-111, vs prior 7-635); - juxtarenal aorta 25mm (14-114, vs prior 7-662); - infrarenal aorta 22mm (14-39, vs prior 7-761). The origin of the coeliac trunk, the superior mesenteric artery arise from the true lumen and opacify well. The inferior mesenteric artery arises from both the true and false lumen, and is origin is attenuated likely by atherosclerosis. The right renal artery arises from both the true and false lumen and demonstrates reduced opacification. Focal thinning of the medial cortex of the midpole of the right kidney may be due to focal infarction. The left renal artery arises from the true lumen with attenuation of the ostia. Thinning and reduced enhancement of the medial aspect and inferior pole of the left kidney may be due to infarction/ischemia as well. EXTRA-VASCULAR Focal hypodensities in both lobes of the liver are stable and probably cysts (14-93, 14-107, 14-112). The gallbladder is unremarkable. The spleen, pancreas, both adrenal glands, urinary bladder and prostate are unremarkable. The calibre and distribution of bowel loops are within normal limits. Cystic fluid noted superficial to the right common femoral artery and vein measuring 4.0 x 3.3 x 4.7 cm, may represent a lymphocele or a seroma related to previous vascular access. There is mild pleural thickening at the left hemithorax. No pleural effusion is seen. No focal pulmonary nodule, ground-glass opacity or consolidation is noted. The heart size is within normal limits. There is a small amount of pericardial fluid, stable since the previous study. No bony destructive lesion is seen. Degenerative changes noted in the imaged spine. Median sternotomy wires are seen. CONCLUSION Since 29/8/2017: Status post replacement of the ascending aorta and TEVAR endograft placement. The known dissection flap involving the thoracic and abdominal aorta is largely stable, with improvement at the left common carotid artery. There is more contrast opacification of the false lumen but the aortic diameter is largely stable. Bilateral renal arteries are arising from the both true and false lumen with focal narrowing at their ostia. Thinning and hypoenhancement of portions of bilateral kidneys may be due to chronicischemia. May need further action Reported by: <DOCTOR>

Accession Number: 26df4c0a7ea6d6b9b228e349bf7acabb6a926c10915e61c4c6d626cb80e2dbb6

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## Layman Explanation

This radiology report discusses HISTORY S/P TEVAR of the Descending Aorta and Arch with special Graft. Underwent replacement of Ascending aorta for Dissection of the Aorta. TECHNIQUE Multiplasic prospective gating CT aortogram of the thoracic aorta was performed with the administration of 100ml of Omnipaque 350. FINDINGS Comparison is made with the previous study of 29/8/2017 (TTSH). VASCULAR The patient is status post replacement of the ascending aorta for Stanford A aortic dissection and TEVAR endograft placement for Stanford B aortic dissection. Surgical sutures are noted at the sinotubular junction which likely represents the site of ascending aorta repair. The aortic stent graft is seen in the aortic arch, the left subclavian arteryand extends to the mid descending thoracic aorta The known dissection flap is extending from the sinotubular junction, involving the origin of the right brochiocephalic artery, origin of left common carotid artery, and extending to the infrarenal abdominal aorta. The dissection involving the left common carotid artery has improved, with the dissection flap seen up to the level of the clavicular heads (previously extending up to the hyoid bone). There is flow of contrast within the true and the false lumen of the thoracic aorta, from the sinotubular junction, representing persistent dissection. There is partial thrombosis of the false lumen. There is more contrast opacification of the false lumen on the current study which may be fed via fenestrations with the true lumen but exact site of this is not certain The overall transverse diameter aorta is largely stable as follows: - aortic annulus, 21 mm (17-59, 15-49 vs prior 8-47), stable; - sinotubular junction 30mm (15-52, 17-59, vs 32mm, prior 8-44), stable - descending thoracic aorta, at level of inferior pulmonary vein 43 mm (14-543, vs prior 7-414). - suprarenal aorta, at level of coeliac trunk, 29mm (14-111, vs prior 7-635); - juxtarenal aorta 25mm (14-114, vs prior 7-662); - infrarenal aorta 22mm (14-39, vs prior 7-761). The origin of the coeliac trunk, the superior mesenteric artery arise from the true lumen and opacify well. The inferior mesenteric artery arises from both the true and false lumen, and is origin is attenuated likely by atherosclerosis. The right renal artery arises from both the true and false lumen and demonstrates reduced opacification. Focal thinning of the medial cortex of the midpole of the right kidney may be due to focal infarction. The left renal artery arises from the true lumen with attenuation of the ostia. Thinning and reduced enhancement of the medial aspect and inferior pole of the left kidney may be due to infarction/ischemia as well. EXTRA-VASCULAR Focal hypodensities in both lobes of the liver are stable and probably cysts (14-93, 14-107, 14-112). The gallbladder is unremarkable. The spleen, pancreas, both adrenal glands, urinary bladder and prostate are unremarkable. The calibre and distribution of bowel loops are within normal limits. Cystic fluid noted superficial to the right common femoral artery and vein measuring 4.0 x 3.3 x 4.7 cm, may represent a lymphocele or a seroma related to previous vascular access. There is mild pleural thickening at the left hemithorax. No pleural effusion is seen. No focal pulmonary nodule, ground-glass opacity or consolidation is noted. The heart size is within normal limits. There is a small amount of pericardial fluid, stable since the previous study. No bony destructive lesion is seen. Degenerative changes noted in the imaged spine. Median sternotomy wires are seen. CONCLUSION Since 29/8/2017: Status post replacement of the ascending aorta and TEVAR endograft placement. The known dissection flap involving the thoracic and abdominal aorta is largely stable, with improvement at the left common carotid artery. There is more contrast opacification of the false lumen but the aortic diameter is largely stable. Bilateral renal arteries are arising from the both true and false lumen with focal narrowing at their ostia. Thinning and hypoenhancement of portions of bilateral kidneys may be due to chronicischemia. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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