# Row 690

Visit Number: 9823cd298fadd1113473e5d8dec43dbc294671fec88ea0a5d1db8296c6441daa

Masked\_PatientID: 681

Order ID: 78c3e47fdc9d23ad91a84a13c7801bb41d36573544ef03c04c087f3d6e1a2553

Order Name: CT Aortogram with 3D (Thoracic)

Result Item Code: CTANGAORT3D

Performed Date Time: 31/10/2018 22:06

Line Num: 1

Text: HISTORY hx of dissestion now CP and giddiness BP >20 diff both arms TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS The prior CT aortogram study dated 24November 2017 was reviewed. 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 clips at the site of the sinotubularjunction likely represent the site of ascending aorta repair. The aortic stent graft extends from the aortic arch to the proximal aspect of the left subclavian artery as well as to the mid-point of the descending thoracic aorta. There is interval resolution of the dissection flap in the left common carotid artery. There is persistent opacification of the false lumen, which is again seen extending from the sinotubular junction into the infrarenal abdominal aorta, in keeping with persistent dissection. Further interval partial thrombosis of the false lumen is again noted and it now terminates at the L2 vertebral level (was L3 previously). There is normal opacification of the true lumen. Small interval new penetrating atherosclerotic ulcers are seen at the anterior and posterior aspects of the infrarenal abdominal aorta (se 6-124). No evidence of haematoma or periaortic stranding is seen. The overall transverse diameter of the aorta is largely stable, as follows: - aortic annulus, 21 mm (11-66 vs prior 17-59); - sinotubular junction 30mm (11-63 vs prior 17-59) ; - descending thoracic aorta, at level of inferior pulmonary vein 43 mm (6-46 vs prev 14-53); - suprarenal aorta, at level of coeliac trunk, 29mm (6-99 vs prior 14-106); - juxtarenal aorta 25mm (14-114 vs prior 7-662); - infrarenal aorta 26mm (6-110 vs prior 14-118). The origin of the coeliac trunk, the superior mesenteric artery and the inferior mesenteric artery arise from the true lumen and opacify well. The right renal artery arises from both the true and false lumens. The left renal artery arises from the true lumen and shows focal thinning at the ostium. EXTRA-VASCULAR Mild subsegmental atelectasis is noted in the left lower lobe. No consolidation or pleural effusion is detected. No enlarged supraclavicular, mediastinal or hilar node is detected. The heart is not enlarged. No pericardial effusion is detected. The imaged thyroid is unremarkable. Stable hypodensities in both hepatic lobes are too small to characterise but probably represent cysts. The gallbladder, biliary tree, pancreas, spleen and adrenal glands are unremarkable, save for a small splenunculus. The right kidney is atrophic compared to left. Stable scarring at the interpolar region and lower poles of the left kidney may represent sequelae of ischaemia/infarction. Stable scarring at the posterior interpolar region of the right kidney is also noted. No free fluid, free gas or abdominal lymphadenopathy is seen. The imaged bowel loops show normal calibre and distribution. No destructive bony lesion is detected. Mild lumbar spondylotic change is noted. Median sternotomy wires are seen. CONCLUSION 1. Status post replacement of the ascending aorta and TEVAR endograft placement. 2. Stable dissection flap from sinotubular junction to infrarenal abdominal aorta with interval partial thrombosis of the false lumen. The aortic diameter is otherwise stable in the interim. Interval resolution of the dissection flap at the left common carotid artery. 3. New penetrating atherosclerotic ulcers at the abdominal aorta without evidence of haematoma or periaortic stranding. 4. Other minor findings as detailed above. May need further action Reported by: <DOCTOR>

Accession Number: 27b28387cb1fb2f36a594a8e8a2ceaf79c5c351011e11e4c7cfb9b4697489326

Updated Date Time: 01/11/2018 1:39

## Layman Explanation

This radiology report discusses HISTORY hx of dissestion now CP and giddiness BP >20 diff both arms TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS The prior CT aortogram study dated 24November 2017 was reviewed. 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 clips at the site of the sinotubularjunction likely represent the site of ascending aorta repair. The aortic stent graft extends from the aortic arch to the proximal aspect of the left subclavian artery as well as to the mid-point of the descending thoracic aorta. There is interval resolution of the dissection flap in the left common carotid artery. There is persistent opacification of the false lumen, which is again seen extending from the sinotubular junction into the infrarenal abdominal aorta, in keeping with persistent dissection. Further interval partial thrombosis of the false lumen is again noted and it now terminates at the L2 vertebral level (was L3 previously). There is normal opacification of the true lumen. Small interval new penetrating atherosclerotic ulcers are seen at the anterior and posterior aspects of the infrarenal abdominal aorta (se 6-124). No evidence of haematoma or periaortic stranding is seen. The overall transverse diameter of the aorta is largely stable, as follows: - aortic annulus, 21 mm (11-66 vs prior 17-59); - sinotubular junction 30mm (11-63 vs prior 17-59) ; - descending thoracic aorta, at level of inferior pulmonary vein 43 mm (6-46 vs prev 14-53); - suprarenal aorta, at level of coeliac trunk, 29mm (6-99 vs prior 14-106); - juxtarenal aorta 25mm (14-114 vs prior 7-662); - infrarenal aorta 26mm (6-110 vs prior 14-118). The origin of the coeliac trunk, the superior mesenteric artery and the inferior mesenteric artery arise from the true lumen and opacify well. The right renal artery arises from both the true and false lumens. The left renal artery arises from the true lumen and shows focal thinning at the ostium. EXTRA-VASCULAR Mild subsegmental atelectasis is noted in the left lower lobe. No consolidation or pleural effusion is detected. No enlarged supraclavicular, mediastinal or hilar node is detected. The heart is not enlarged. No pericardial effusion is detected. The imaged thyroid is unremarkable. Stable hypodensities in both hepatic lobes are too small to characterise but probably represent cysts. The gallbladder, biliary tree, pancreas, spleen and adrenal glands are unremarkable, save for a small splenunculus. The right kidney is atrophic compared to left. Stable scarring at the interpolar region and lower poles of the left kidney may represent sequelae of ischaemia/infarction. Stable scarring at the posterior interpolar region of the right kidney is also noted. No free fluid, free gas or abdominal lymphadenopathy is seen. The imaged bowel loops show normal calibre and distribution. No destructive bony lesion is detected. Mild lumbar spondylotic change is noted. Median sternotomy wires are seen. CONCLUSION 1. Status post replacement of the ascending aorta and TEVAR endograft placement. 2. Stable dissection flap from sinotubular junction to infrarenal abdominal aorta with interval partial thrombosis of the false lumen. The aortic diameter is otherwise stable in the interim. Interval resolution of the dissection flap at the left common carotid artery. 3. New penetrating atherosclerotic ulcers at the abdominal aorta without evidence of haematoma or periaortic stranding. 4. Other minor findings as detailed above. May need further action Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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