# Row 7069

Visit Number: 22445077a4f7842ee844fc872738abba869ba9300547f9aba23448798107a235

Masked\_PatientID: 7066

Order ID: 90328ae946fa0d7987afdbd14defc4950487faf1bb47a3079b2c716ca8490720

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 10/6/2017 1:35

Line Num: 1

Text: HISTORY Worsening SOB with desaturation and tachycardia BG met breast ca with lung mets andunderlying astham/pul fibrosis recent admission for pneumonia TECHNIQUE Scans of the thorax were acquired in the arterial phase as per protocol for CT pulmonary angiogram, after intravenous administration of 60 ml of Omnipaque 350. FINDINGS Prior CT thorax study of 4 February 2017 was reviewed. There is no filling-defect in the pulmonary trunk, main pulmonary arteries and its lobar and segmental branches. However, note is made of dilated pulmonary trunk, which raises concern for pulmonary arterial hypertension. Extensive and severe bronchiectasis and bullous changes in the left lung with volume long is re-demonstrated. The apex of left lung and inferior lingula are relatively spared. Consolidation in the left lower lobe may reflect infection / inflammation. Interim development of moderate right pleural effusion is seen with passive atelectasis of right lower lobe. There is interim increment in size and number of pulmonary and pleural-based lesions in the right lung. For example, the largest fissural lesion that measures from 1.9 cm (prev 401-36) to current 3.0 cm (7-42). There are suspiciousfor metastases. The mediastinal and bilateral hilar adenopathies are seen. Some are stable while some are larger. For example, the largest right upper paratracheal node is stable and measures 1.4 cm in short axis (6-25 vs prev 402-18), while the right paracardiac adenopathy is larger, from 0.9 cm (prev 402-53) to current 1.6 cm (6-59). The cardiac chambers are unremarkable. There is no pericardial effusion. The patient is status post right simple mastectomy. The imaged upper abdomen is unremarkable on late arterial phase. No aggressive bone lesion is seen. CONCLUSION Since CT of 4 Feb 2017, - There is no pulmonary embolism. - Consolidation in the left lower lobe may be due to infection / inflammation. - Status post right simple mastectomy. There is no local recurrence. - Interim increment in size and number of pulmonary and pleural metastases in the right lungs. New moderate right pleural effusion is seen. - Mediastinal and right hilar adenopathies; some are larger but some are stable. - Dilatation of pulmonary trunk is likely due to pulmonary arterial hypertension. May need further action Finalised by: <DOCTOR>

Accession Number: 8abb705a8da9d624c32b02ea440863a15e16c46208299f9e7ca81357ab30a329

Updated Date Time: 10/6/2017 2:10

## Layman Explanation

This radiology report discusses HISTORY Worsening SOB with desaturation and tachycardia BG met breast ca with lung mets andunderlying astham/pul fibrosis recent admission for pneumonia TECHNIQUE Scans of the thorax were acquired in the arterial phase as per protocol for CT pulmonary angiogram, after intravenous administration of 60 ml of Omnipaque 350. FINDINGS Prior CT thorax study of 4 February 2017 was reviewed. There is no filling-defect in the pulmonary trunk, main pulmonary arteries and its lobar and segmental branches. However, note is made of dilated pulmonary trunk, which raises concern for pulmonary arterial hypertension. Extensive and severe bronchiectasis and bullous changes in the left lung with volume long is re-demonstrated. The apex of left lung and inferior lingula are relatively spared. Consolidation in the left lower lobe may reflect infection / inflammation. Interim development of moderate right pleural effusion is seen with passive atelectasis of right lower lobe. There is interim increment in size and number of pulmonary and pleural-based lesions in the right lung. For example, the largest fissural lesion that measures from 1.9 cm (prev 401-36) to current 3.0 cm (7-42). There are suspiciousfor metastases. The mediastinal and bilateral hilar adenopathies are seen. Some are stable while some are larger. For example, the largest right upper paratracheal node is stable and measures 1.4 cm in short axis (6-25 vs prev 402-18), while the right paracardiac adenopathy is larger, from 0.9 cm (prev 402-53) to current 1.6 cm (6-59). The cardiac chambers are unremarkable. There is no pericardial effusion. The patient is status post right simple mastectomy. The imaged upper abdomen is unremarkable on late arterial phase. No aggressive bone lesion is seen. CONCLUSION Since CT of 4 Feb 2017, - There is no pulmonary embolism. - Consolidation in the left lower lobe may be due to infection / inflammation. - Status post right simple mastectomy. There is no local recurrence. - Interim increment in size and number of pulmonary and pleural metastases in the right lungs. New moderate right pleural effusion is seen. - Mediastinal and right hilar adenopathies; some are larger but some are stable. - Dilatation of pulmonary trunk is likely due to pulmonary arterial hypertension. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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