# Row 3479

Visit Number: 10302e04bbcdf0f012b8c62808597f56d62668176665a99f16f574cba09307a8

Masked\_PatientID: 3478

Order ID: 7c402b20cee55142eea6049d03fd9a895b041daad6d8b0ad96e65c2bb1bbdf86

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 01/12/2018 15:27

Line Num: 1

Text: HISTORY high suspicion for PE. SOBOE 3-4/7. bedside US RV dilated, hypokientic LV TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Preceding chest radiograph was reviewed. Nil other comparison study available. Technical quality is: Fair. Reflux of contrast into the IVC and hepatic veins is seen. Streak artefacts from contrast bolus in SVC are also noted. There is no discernible filling defect in the main, lobar and segmental pulmonary arteries. The pulmonary trunk and right ventricle are not dilated. The RV/LV ratio is <1. There is however cardiomegaly with reflux of intravenous contrast into the inferior vena cava and hepatic veins. Bilateral pleural effusions are seen, larger on the right. Fluid is seen tracking along bilateral oblique fissures and mediastinal pleura, more on the right side. Associated compression atelectasis/patchy consolidation is seen in the adjacent lungparenchyma of bilateral lower lobes. Diffuse bilateral interstitial and septal thickening is present compatible with interstitial oedema. No suspicious pulmonary mass. Major airways are patent. Within limits of a non-dedicated study, no enlarged thoracic or axillary nodes are identified. Mild bilateral gynecomastia. Imaged thyroid gland is grossly unremarkable. The included appear abdomen appears grossly unremarkable save for a curvilinear calcific density in the left renal pelvicalyceal region (Se 3-99). This is non-specific, possible representing vascular calcification or more likely excreted contrast. No evidence of hydronephrosis in included images. No destructive bony lesion. CONCLUSION 1. No scan evidence of pulmonary embolus in the main, lobar and segmental pulmonary arteries. 2. There is however cardiomegaly with reflux of intravenous contrast into the IVC and hepatic veins, along with scan findings suggestive of congestive cardiac failure/fluid overload. Clinical correlation to exclude cardiomyopathy suggested given patient’s age. Further action or early intervention required Reported by: <DOCTOR>

Accession Number: 64fe11e5a6dbac9f4557ef3582560333932be6c0a71d8f693c5daefe8312f362

Updated Date Time: 01/12/2018 16:55

## Layman Explanation

This radiology report discusses HISTORY high suspicion for PE. SOBOE 3-4/7. bedside US RV dilated, hypokientic LV TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS Preceding chest radiograph was reviewed. Nil other comparison study available. Technical quality is: Fair. Reflux of contrast into the IVC and hepatic veins is seen. Streak artefacts from contrast bolus in SVC are also noted. There is no discernible filling defect in the main, lobar and segmental pulmonary arteries. The pulmonary trunk and right ventricle are not dilated. The RV/LV ratio is <1. There is however cardiomegaly with reflux of intravenous contrast into the inferior vena cava and hepatic veins. Bilateral pleural effusions are seen, larger on the right. Fluid is seen tracking along bilateral oblique fissures and mediastinal pleura, more on the right side. Associated compression atelectasis/patchy consolidation is seen in the adjacent lungparenchyma of bilateral lower lobes. Diffuse bilateral interstitial and septal thickening is present compatible with interstitial oedema. No suspicious pulmonary mass. Major airways are patent. Within limits of a non-dedicated study, no enlarged thoracic or axillary nodes are identified. Mild bilateral gynecomastia. Imaged thyroid gland is grossly unremarkable. The included appear abdomen appears grossly unremarkable save for a curvilinear calcific density in the left renal pelvicalyceal region (Se 3-99). This is non-specific, possible representing vascular calcification or more likely excreted contrast. No evidence of hydronephrosis in included images. No destructive bony lesion. CONCLUSION 1. No scan evidence of pulmonary embolus in the main, lobar and segmental pulmonary arteries. 2. There is however cardiomegaly with reflux of intravenous contrast into the IVC and hepatic veins, along with scan findings suggestive of congestive cardiac failure/fluid overload. Clinical correlation to exclude cardiomyopathy suggested given patient’s age. Further action or early intervention required Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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