# Row 4046

Visit Number: 33a360cb3071c9bb5dc7865010a40175d9338639ccd6e399b3fb1e3135156ff4

Masked\_PatientID: 4046

Order ID: 455441faca538d9814503ba56bff3ff0b1faa8c2d35688c9628bfd3cdc4206c1

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 30/3/2017 11:06

Line Num: 1

Text: HISTORY TTE showed pumonary hypertension 1. Baseline HR in 80s with episodic tachycardia at 90-100 TRO PE. 2. B/L crepitations on examination TRO ILD (as clarified by Dr Eric Fang with Dr Samantha Koh) TECHNIQUE Scans acquired asper department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS CT pulmonary angiogram: Correlation made with CT coronary angiogram non contrast performed same day. There is a large filling defect involving allof the left sided pulmonary arteries, extending proximally into the pulmonary trunk. The left sided pulmonary arteries are mildly enlarged relative to the right. No definite enhancement of the left pulmonary artery filling defect (HU 41) compared to CT coronary angiogram non contrast scan. There are also right sided lower lobe pulmonary emboli involving the subsegmental lower lobe (10-25) and upper lobe (10-33). The heart is enlarged. Some probable thrombus is present at the right ventricle and possibly the left lower pulmonary veins. Mild coronary artery calcification noted. Small pericardial effusion present. Small volume para-tracheal and subcarinal nodes are present. Patchy upper lobe apical ground glass opacitiespresent. More confluent peripheral areas of patchy consolidation in the left lung may represent infarcts. Ground glass is present in the left lower lobe, may be infective in origin. No overt honeycombing. There is a defect in the right hemidiaphragm, with herniation of a organo-axially rotated stomach through the defect. The gastric fundus lies on the right side. Incidental sclerotic lesion T8 noted, without aggressive features. No bony destruction or soft tissue mass. CONCLUSION Extensive filling defect involving almost all of the left sided pulmonary arteries, with some enlargement of the left main pulmonary artery relative to the right. Whilst may represent emboli, malignancy cannot be altogether excluded. Smaller pulmonary emboli present on the right, along with right ventricular thrombus. Patchy pulmonary ground glass and consolidation mainly in the left lung, non specific. Diaphragmatic hernia with organo-axial rotation of the stomach, suggest clinical correlation for gastrointestinal symptoms. Further action or early intervention required Finalised by: <DOCTOR>

Accession Number: e0dd73cd2d4423e9d3b871133f51be2a6c652e70a881009fc8cb0b654624fae2

Updated Date Time: 30/3/2017 12:12

## Layman Explanation

This radiology report discusses HISTORY TTE showed pumonary hypertension 1. Baseline HR in 80s with episodic tachycardia at 90-100 TRO PE. 2. B/L crepitations on examination TRO ILD (as clarified by Dr Eric Fang with Dr Samantha Koh) TECHNIQUE Scans acquired asper department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 80 FINDINGS CT pulmonary angiogram: Correlation made with CT coronary angiogram non contrast performed same day. There is a large filling defect involving allof the left sided pulmonary arteries, extending proximally into the pulmonary trunk. The left sided pulmonary arteries are mildly enlarged relative to the right. No definite enhancement of the left pulmonary artery filling defect (HU 41) compared to CT coronary angiogram non contrast scan. There are also right sided lower lobe pulmonary emboli involving the subsegmental lower lobe (10-25) and upper lobe (10-33). The heart is enlarged. Some probable thrombus is present at the right ventricle and possibly the left lower pulmonary veins. Mild coronary artery calcification noted. Small pericardial effusion present. Small volume para-tracheal and subcarinal nodes are present. Patchy upper lobe apical ground glass opacitiespresent. More confluent peripheral areas of patchy consolidation in the left lung may represent infarcts. Ground glass is present in the left lower lobe, may be infective in origin. No overt honeycombing. There is a defect in the right hemidiaphragm, with herniation of a organo-axially rotated stomach through the defect. The gastric fundus lies on the right side. Incidental sclerotic lesion T8 noted, without aggressive features. No bony destruction or soft tissue mass. CONCLUSION Extensive filling defect involving almost all of the left sided pulmonary arteries, with some enlargement of the left main pulmonary artery relative to the right. Whilst may represent emboli, malignancy cannot be altogether excluded. Smaller pulmonary emboli present on the right, along with right ventricular thrombus. Patchy pulmonary ground glass and consolidation mainly in the left lung, non specific. Diaphragmatic hernia with organo-axial rotation of the stomach, suggest clinical correlation for gastrointestinal symptoms. Further action or early intervention required Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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