# Row 558

Visit Number: 4f626639b027c1fcc79d454b50d1432374684ed245c6a97348c708d663c87571

Masked\_PatientID: 538

Order ID: 65612ed78a1df0606cb6bfc6ac73eecf3002a47680a2fbbf3c1e7765c078568f

Order Name: CT Aortogram (Chest, Abdomen)

Result Item Code: AORTOCA

Performed Date Time: 12/9/2019 15:40

Line Num: 1

Text: HISTORY TRO aortic dissection. Sudden onset of severe pain back radiating to chest at 2pm, cold sweat and clammy, hypertensive TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 105 FINDINGS No prior comparison study. The chest radiograph performed on this same day was reviewed. VASCULAR FINDINGS There is a crescenteric hyperdensity extending from the aortic root along the ascending aorta (measuring up to 0.6 cm in depth), compatible with an intramural haematoma. The intramural haematoma extends close to the origin of the right coronary artery (RCA) which is grossly uninvolved. The coronary arteries show normal opacification. A dissection flap is seen extending from the proximal aortic arch into the descending thoracic aorta and abdominal aorta. It further continues into the right iliac arteries and imaged right common femoral/superficial femoral arteries. The distal extent of the dissection flap is not visualised. Extension of the dissection flap into the left subclavian artery is also noted which shows normal opacification (14-48). There is delayed opacification of the false lumen. There is an accessory right renal artery. Apart from the inferior mesenteric artery (IMA) which appears to arise from the false lumen (13/131), the celiac trunk, superior mesenteric artery, both right renal arteries and left renal artery appear to arise from the true lumen (refer to key image for the right renal arteries). Aorta and its major branches show satisfactory opacification. OTHER FINDINGS No focal consolidation or suspicious pulmonary lesion is detected. No pleural effusion is seen. Subsegmental atelectasis is seen in bothlungs, predominantly in the basal segments. There are small subpleural blebs in the lung apices. The central airways are patent. The heart size is normal. No thoracic adenopathy is detected. No pericardial effusion is seen. Hepatic steatosis. No suspicious hypervascular hepatic lesion is detected. No radiodense gallstone is detected. No biliary dilatation is seen. The spleen, pancreas and adrenal glands are unremarkable. Both kidneys show symmetric enhancement. Tiny left renalupper pole hypodensity is too small to be accurately characterise. No hydronephrosis. The urinary bladder is moderately distended and grossly unremarkable. The prostate is not enlarged. Bowel loops show preserved mural enhancement and calibre. Appendix is not inflamed. Scattered colonic diverticula are seen, larger ones arising from the transverse colon. Incidental small umbilical and bilateral fat containing inguinal herniae. No ascites or pneumoperitoneum is detected. No abdominal or pelvic adenopathy. No destructive bony lesion is identified. CONCLUSION 1. Stanford type A dissection with intramural haematoma (IMH) extending from the aortic root along the ascending aorta. Dissection flap is seen extending from the aortic arch across the length of the entire aorta, and into the right iliac/femoral arteries as described. The distal extent is not imaged in this study. 2. Coronary arteries are grossly uninvolved, although the IMH extends close to the RCA origin. 3. Accessory right renal artery. Apart from the IMA, the major branches of the abdominal aorta appear to arise from the true lumen. 4. No CT evidence of ischaemic complications in the abdominal viscera. 5. Other findings as detailed above. Pertinent finding (1) was conveyed to Dr. Ramos Tracy Rex Cruz by Dr. Tan Zehao at approximately 16:15 & further updates given at 17:30 hrs on 12 September 2019. Report Indicator: Critical Abnormal Reported by: <DOCTOR>

Accession Number: bdcb5f29ee84a218f8c5604cca75ca54543c34278f7dcaa9139931d187338b16

Updated Date Time: 12/9/2019 19:14

## Layman Explanation

This radiology report discusses HISTORY TRO aortic dissection. Sudden onset of severe pain back radiating to chest at 2pm, cold sweat and clammy, hypertensive TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 105 FINDINGS No prior comparison study. The chest radiograph performed on this same day was reviewed. VASCULAR FINDINGS There is a crescenteric hyperdensity extending from the aortic root along the ascending aorta (measuring up to 0.6 cm in depth), compatible with an intramural haematoma. The intramural haematoma extends close to the origin of the right coronary artery (RCA) which is grossly uninvolved. The coronary arteries show normal opacification. A dissection flap is seen extending from the proximal aortic arch into the descending thoracic aorta and abdominal aorta. It further continues into the right iliac arteries and imaged right common femoral/superficial femoral arteries. The distal extent of the dissection flap is not visualised. Extension of the dissection flap into the left subclavian artery is also noted which shows normal opacification (14-48). There is delayed opacification of the false lumen. There is an accessory right renal artery. Apart from the inferior mesenteric artery (IMA) which appears to arise from the false lumen (13/131), the celiac trunk, superior mesenteric artery, both right renal arteries and left renal artery appear to arise from the true lumen (refer to key image for the right renal arteries). Aorta and its major branches show satisfactory opacification. OTHER FINDINGS No focal consolidation or suspicious pulmonary lesion is detected. No pleural effusion is seen. Subsegmental atelectasis is seen in bothlungs, predominantly in the basal segments. There are small subpleural blebs in the lung apices. The central airways are patent. The heart size is normal. No thoracic adenopathy is detected. No pericardial effusion is seen. Hepatic steatosis. No suspicious hypervascular hepatic lesion is detected. No radiodense gallstone is detected. No biliary dilatation is seen. The spleen, pancreas and adrenal glands are unremarkable. Both kidneys show symmetric enhancement. Tiny left renalupper pole hypodensity is too small to be accurately characterise. No hydronephrosis. The urinary bladder is moderately distended and grossly unremarkable. The prostate is not enlarged. Bowel loops show preserved mural enhancement and calibre. Appendix is not inflamed. Scattered colonic diverticula are seen, larger ones arising from the transverse colon. Incidental small umbilical and bilateral fat containing inguinal herniae. No ascites or pneumoperitoneum is detected. No abdominal or pelvic adenopathy. No destructive bony lesion is identified. CONCLUSION 1. Stanford type A dissection with intramural haematoma (IMH) extending from the aortic root along the ascending aorta. Dissection flap is seen extending from the aortic arch across the length of the entire aorta, and into the right iliac/femoral arteries as described. The distal extent is not imaged in this study. 2. Coronary arteries are grossly uninvolved, although the IMH extends close to the RCA origin. 3. Accessory right renal artery. Apart from the IMA, the major branches of the abdominal aorta appear to arise from the true lumen. 4. No CT evidence of ischaemic complications in the abdominal viscera. 5. Other findings as detailed above. Pertinent finding (1) was conveyed to Dr. Ramos Tracy Rex Cruz by Dr. Tan Zehao at approximately 16:15 & further updates given at 17:30 hrs on 12 September 2019. Report Indicator: Critical Abnormal Reported by: <DOCTOR>. In simpler terms, this means...

## Summary

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