# Row 927

Visit Number: 38d9d5800a36619a44e8f5b262c1462c53dad09a3e738103dc15c29b38ec07e1

Masked\_PatientID: 927

Order ID: f2b88f78112b9c04b671a7d80bc96743448610ffbd09b359c765d1751505b811

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 27/2/2016 12:17

Line Num: 1

Text: HISTORY raised PASP ?PE in view of hx of breast ca and chronic cough also to look for ?mets TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS No comparison CTavailable. The pulmonary arteries are enlarged, in keeping with pulmonary arterial hypertension. No filling defect is noted in the main pulmonary trunk, right and left main pulmonary arteries, and its lobar and segmental arteries. There is cardiomegaly with axis deviation, associated with right atrium and ventricle enlargement, especially of the right atrium. Contrast reflux into enlarged retrohepatic IVC and distended hepatic veins. Overall features are suggestive of right heart dysfunction and tricuspid regurgitation. Status post left mastectomy. No suspicious mass is seen in both chest walls. No enlarged supraclavicular, axillary, mediastinal or hilar nodes seen. There is also no enlarged subpectoral, supradiaphragmatic internal mammary nodes. Pulmonary vasculature is slightly prominent, with no interstitial thickening identified. No pericardial or pleural effusion is evident. The major airways are patent. No lung mass or sinister nodule is seen. Thereis no consolidation. A few sites show mild subpleural opacities likely due to minute scarring from previous inflammation. There is otherwise a 7 x 6mm nodule in the middle lobe (401-47) which is indeterminate. The margins are slightly ill defined and this is possibly post infective or post-inflammatory in nature. No cavitation seen. Sections of the upper abdomen in the arterial phase are unremarkable. No destructive bony lesion is seen. CONCLUSION 1. No pulmonary embolism seen. 2. Pulmonary arterial hypertension may be related to valvular disease and volume overload. Correlation with 2D echo may be useful. 3. Incidental note of an indeterminate middle lobe nodule. Follow-up is prudent in view of known left breast malignancy. Suggest low dose plain CT thorax in 3 months time to follow up on persistence/progression or improvement/resolution. May need further action Finalised by: <DOCTOR>

Accession Number: 4c302af59290bc7117b639cc384ea0a7bdf971cec7808489533a9b236d4de520

Updated Date Time: 27/2/2016 14:56

## Layman Explanation

This radiology report discusses HISTORY raised PASP ?PE in view of hx of breast ca and chronic cough also to look for ?mets TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 FINDINGS No comparison CTavailable. The pulmonary arteries are enlarged, in keeping with pulmonary arterial hypertension. No filling defect is noted in the main pulmonary trunk, right and left main pulmonary arteries, and its lobar and segmental arteries. There is cardiomegaly with axis deviation, associated with right atrium and ventricle enlargement, especially of the right atrium. Contrast reflux into enlarged retrohepatic IVC and distended hepatic veins. Overall features are suggestive of right heart dysfunction and tricuspid regurgitation. Status post left mastectomy. No suspicious mass is seen in both chest walls. No enlarged supraclavicular, axillary, mediastinal or hilar nodes seen. There is also no enlarged subpectoral, supradiaphragmatic internal mammary nodes. Pulmonary vasculature is slightly prominent, with no interstitial thickening identified. No pericardial or pleural effusion is evident. The major airways are patent. No lung mass or sinister nodule is seen. Thereis no consolidation. A few sites show mild subpleural opacities likely due to minute scarring from previous inflammation. There is otherwise a 7 x 6mm nodule in the middle lobe (401-47) which is indeterminate. The margins are slightly ill defined and this is possibly post infective or post-inflammatory in nature. No cavitation seen. Sections of the upper abdomen in the arterial phase are unremarkable. No destructive bony lesion is seen. CONCLUSION 1. No pulmonary embolism seen. 2. Pulmonary arterial hypertension may be related to valvular disease and volume overload. Correlation with 2D echo may be useful. 3. Incidental note of an indeterminate middle lobe nodule. Follow-up is prudent in view of known left breast malignancy. Suggest low dose plain CT thorax in 3 months time to follow up on persistence/progression or improvement/resolution. May need further action Finalised by: <DOCTOR>. In simpler terms, this means...

## Summary

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