# Patient ID: 1440, Performed Date: 25/11/2016 10:29

## Raw Radiology Report Extracted

Visit Number: eeadd9fe07aa6e8f678d7eb6fd979a86652136856e8cbd7fc846fd3bdc2ee5e7

Masked\_PatientID: 1440

Order ID: 02611c2e2a869bff072e7b82391009bd89d280030150cdb657f14b09ba669933

Order Name: CT Chest, High Resolution

Result Item Code: CTCHEHR

Performed Date Time: 25/11/2016 10:29

Line Num: 1

Text: HISTORY history of systemic sclerosis with worsening SOB TRO ILD TECHNIQUE Non-enhanced CT scan of the point was acquired. FINDINGS Comparison was made with the previous HRCT Chest dated 07/7/2015. Previous Chest radiograph dated 20/11/2016 was reviewed. The heart is mildly enlarged. There are bilateral moderately sized pleural effusions with associated secondary collapse of both lower lobes. Diffuse bilateral ground – glass opacifications are seen in both lungs, sparing the lung apices. In addition there are smooth septal thickening in the lungs bilaterally. These changes most likely represents interstitial and alveolar oedema secondary to cardiac failure. There is no honeycombing to suggestinterstitial lung disease, but the lower lobes cannot be assessed due to collapse secondary to the pleural effusions. There is stable minor scarring in the right apex. The previously noted 4mm pulmonary nodule in the right upper lobe is not identified. There is a silver of pericardial effusion seen in the antero-lateral aspect of the left pericardium. Diffuse atherosclerotic changes are seen along the aorta and the coronary arteries (LAD, LCX and RCA). Calcification of the mitral annulus is also noted. The oesophagus is patulous in keeping with known systemic sclerosis. The right subclavian artery arises from the aorta and courses posteriorly to the oesophagus, a normal anatomical variant. The pulmonary artery trunk measures 2.4 cm, within normal limits. No significantly enlarged hilar, mediastinal or axillary lymph node is seen. The appended upper abdomen appears unremarkable. No destructive bony lesion is seen. Degenerative changes are noted within the thoracic vertebrae. CONCLUSION Mild cardiomegaly with moderately sized pleural effusions. Bilateral mild but extensive ground-glass opacifications and septal thickening. These features are in keeping with cardiac failure. No honeycombing to suggest established fibrosis seen but the lower lobes cannot be assessed due to collapse. May need further action Reported by: <DOCTOR>

Accession Number: fd709b773234c13ebb07c3f709451aeef3f91b9c94f3a6e22f3c37bfadfad0f4

Updated Date Time: 25/11/2016 12:45

## Layman Explanation

The scan shows that your heart is slightly larger than normal. There is fluid buildup around your lungs (pleural effusions) which has caused part of your lower lungs to collapse. There are also changes in your lungs that suggest fluid is building up in the air sacs (ground-glass opacifications) and thickening of the walls between the air sacs (septal thickening). These findings are consistent with heart failure. The scan also shows hardening of the arteries in your chest. Some areas of your lungs can't be examined due to the fluid build-up. The scan does not show any signs of scarring in your lungs, but further investigation may be needed.

## Summary

The text was extracted from a \*\*Computed Tomography (CT) scan\*\* report.  
  
\*\*1. Disease(s):\*\*  
  
\* \*\*Systemic sclerosis:\*\* The patient has a history of systemic sclerosis, a disease that affects the connective tissue.  
\* \*\*Cardiac failure:\*\* The report suggests the ground-glass opacifications and septal thickening are consistent with cardiac failure.  
\* \*\*Atherosclerosis:\*\* Diffuse atherosclerotic changes are seen along the aorta and coronary arteries.  
\* \*\*Interstitial lung disease:\*\* While no honeycombing is seen, the report mentions the possibility of interstitial lung disease, as the lower lobes cannot be assessed due to collapse.  
  
\*\*2. Organ(s):\*\*  
  
\* \*\*Heart:\*\* Mildly enlarged, with a silver of pericardial effusion.  
\* \*\*Lungs:\*\* Bilateral moderate pleural effusions with associated secondary collapse of both lower lobes. Diffuse bilateral ground-glass opacifications, sparing the lung apices. Smooth septal thickening bilaterally.   
\* \*\*Aorta:\*\* Diffuse atherosclerotic changes.  
\* \*\*Coronary arteries:\*\* Diffuse atherosclerotic changes in LAD, LCX and RCA.  
\* \*\*Mitral annulus:\*\* Calcification noted.  
\* \*\*Oesophagus:\*\* Patulous, consistent with known systemic sclerosis.  
\* \*\*Right subclavian artery:\*\* Arises from the aorta and courses posteriorly to the oesophagus, a normal anatomical variant.  
\* \*\*Pulmonary artery trunk:\*\* Measures 2.4 cm, within normal limits.  
\* \*\*Lymph nodes:\*\* No significantly enlarged hilar, mediastinal or axillary lymph nodes.  
\* \*\*Thoracic vertebrae:\*\* Degenerative changes.  
  
\*\*3. Symptoms/Phenomena of Concern:\*\*  
  
\* \*\*Worsening shortness of breath (SOB):\*\* This is mentioned in the patient's history, which may be related to the cardiac failure and/or pleural effusions.  
\* \*\*Pleural effusions:\*\* Moderate in size, causing collapse of both lower lobes, which limits assessment of the lung parenchyma.  
\* \*\*Ground-glass opacifications and septal thickening:\*\* Consistent with cardiac failure.  
\* \*\*Lower lobes cannot be assessed:\*\* Due to collapse secondary to pleural effusions, the possibility of interstitial lung disease cannot be ruled out.  
\* \*\*Possible need for further action:\*\* The report states "May need further action," suggesting the findings require additional investigation or treatment.