# Patient ID: 3261, Performed Date: 05/9/2019 18:31

## Raw Radiology Report Extracted

Visit Number: adae178fa4fae799a9e87bfaa0dacbce4d65f6e90dcbcb7114e3bc5ea7e91a16

Masked\_PatientID: 3261

Order ID: e652fec364b53933600a20665872f8d907f13340375fa8c799aacd59916a16ce

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 05/9/2019 18:31

Line Num: 1

Text: HISTORY MICU patient with severe ARDS, Influenza A positive. Persistently hypoxemic, tachycardic with low grade fever. To look for possible PE and lung parenchyma TECHNIQUE Scans acquired as per department protocol. Intravenous contrast: Omnipaque 350 - Volume (ml): 60 CT study 13 June 2019 was reviewed. Chest X-ray: 3 September 2019 was also reviewed. FINDINGS Findings: Breathing artefacts decreases sensitivity of the study. The patient is intubated. A feeding tube is noted with the tip beyond inferior aspect of the CT study, distal to the stomach. There is a 10mm length of filling defect in the left inferior pulmonary artery ( se 402-43, key image 5001-3, 405-22) associated with distension of the caliber of the artery. However as there are movement artefacts and surrounding peribronchial wall thickening this finding is equivocal. No other filling defect in the main, right and left, or rest of the subsegmental pulmonary arteries to suggest another fociof pulmonary embolism. The main pulmonary artery appears mildly dilated. The left vertebral artery arises from the aortic arch (normal variant). There is ground-glass patchy consolidation throughout both lungs, be related to submitted history of viral pneumonia. Perifissural nodular opacification in the right upper lobe near the horizontal fissure (402-38) newly seen from prior study, probably related to nodular consolidation. There are bilateral small pleural effusions present andfluid in the fissures. Previously noted tiny 2 mm nodule in the anterior basal segment right lower lobe, is not well seen on current study ( prev 5-60 ). The major airways are patent. No significantly enlarged axillary, internal mammary, hilar lymph node is seen. There are small lymph nodes measuring up to 9 mm in the short axis in the aorto pulmonary window. Subcarinal lymph nodes measuring up to 7 mm in short axis are noted. No significant pericardial effusion is evident. Status post right mastectomy with surgical clips noted. No enhancing mass to suggest recurrence. Seroma noted on prior CT study has shown interval resolution. A few calcified nodules are noted in both thyroid lobes. No destructive bony lesion. CONCLUSION Bilateral ground glass consolidation suggestive of viral pneumonia. Small bilateral pleural effusions. The small lymph nodes at the aortopulmonary window and subcarinal regions are probably reactive in nature. A 10mm length of filling defect in the left inferior pulmonary subsegmental artery associated with distension of the calibre of the artery. However as there are movement artefacts and surrounding peribronchial wall thickening due to inflammation this finding is equivocal for subsegmental embolism. No enhancing mass at mastectomy site to suggest recurrence. Report Indicator: Further action or early intervention required Finalised by: <DOCTOR>

Accession Number: b2a22c5b7daf9e62810c8b1a365274421669a5ea51f29704b42828287e283900

Updated Date Time: 05/9/2019 20:20

## Layman Explanation

Error generating summary.

## Summary

Error generating summary.