# Patient ID: 4964, Performed Date: 20/2/2017 15:35

## Raw Radiology Report Extracted

Visit Number: 56381090c37f73b8cfe3535c2ddd282889b19d3bc6721c74d3b04fe1cf5829bc

Masked\_PatientID: 4964

Order ID: 2e1e682dd4a65e9bae60a3f27445327033b48c4e9c51d153e11b572d0ef2e5fd

Order Name: CT Pulmonary Angiogram

Result Item Code: CTCHEPE

Performed Date Time: 20/2/2017 15:35

Line Num: 1

Text: HISTORY bloody ETT aspirates, has been treated for diffuse alveolar haemorrhage with PLEX and CYC but non-resolving ater 1/52 intubated patient TECHNIQUE Scans of the thorax were acquired in the arterial phase as per protocol forCT pulmonary angiogram after administration of 60 mls of intravenous Omnipaque 350. FINDINGS Prior CT thorax (12 Jan 2017) and recent chest radiograph (19 Feb 2017) were reviewed. Newly diagnosed SLE is noted with its complications. The position of the endotracheal tube is satisfactory, while the NG tube is partially imaged. There is no filling-defect in the pulmonary trunk, main pulmonary arteries and its lobar and segmental branches. Mild cardiomegaly is noted without pericardial effusion. The mediastinal vessels show normal opacification. The extent of scattered ground glass opacity in both lungs has worsened in the interim. In addition, there are now multiple air space opacities in both lungs, worse in the lower lobes where it is confluent in appearance. There is interlobular septal thickening as well. No dominant mass or cavitary lesion is seen. Moderate bilateral pleural effusions are seen Within limits, the imaged upper abdomen is unremarkable, bar small amount of low-density free fluid at perihepatic region. Subcutaneous oedema is likely due to third space fluid loss. No destructive bone lesion is seen. Technical note: Scan was reviewed with Dr Austin Htoo. CONCLUSION 1. There is no pulmonary embolism. 2. Pulmonary changes in both lungs have worsened since prior CT thorax of 12 Jan 2017. The ground glass opacities could be related to pulmonary haemorrhage. The multiple air space opacities with interlobular septal thickening could be due to pulmonary oedema, but superimposed infection cannot be excluded. Clinical correlation is required. May need further action Finalised by: <DOCTOR>

Accession Number: ab7cd7dc88baafce2410fe5cca93ea1f0bd66d92c4230b027588f5de26019915

Updated Date Time: 20/2/2017 16:31

## Layman Explanation

Error generating summary.

## Summary

Error generating summary.