PRP Diagnostic Imaging

North Gosford
Phone 43240006

To: Royal North Shore Cardiology
Referred By:
Dr Peter S Hansen
NORTHERN HEART CENTRE
TWR A, ST 306, 7 WESTBOURNE ST
ST LEONARDS NSW 2065

Ms Wendy Ross
DOB: 11 June 1942
Patient ID: GJE843Y
Visit Number: 17387177
Service Date: 26 June 2025 13:15

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Royal North Shore Cardiology

Visit Description: CT TAVI ANGIOGRAM

CT THORACIC ANGIOGRAM (TAVI)

History: Severe AS. Known aortic root dilatation.

Technique: Arterial phase thoracic angiogram gated study.

Report:
LOWER LIMB ACCESS:
Right common iliac artery: 7 x 8 mm, minimal calcified plaque
Right external iliac artery: 7 x 8 mm, minimal calcified plaque posteriorly
Right common femoral artery: 5 x 6 mm, no significant plaque.
Left common iliac artery: 8 x 9 mm, mild calcified plaque
Left external iliac artery: 7 x 8 mm, minimal calcified plaque.
Left common femoral artery: Mild calcified plaque posteriorly

AORTA:
Aortic measurements are made in the coronal plane, perpendicular to the long axis of the aorta (intraluminal dimensions):
Ascending aorta: 44 x 45 mm
Proximal aortic arch: 32 x 34 mm
Distal aortic arch: 27 x 30 mm
Isthmus: 20 x 22 mm
Descending aorta: 21 x 22 mm
Abdominal aorta: 14 x 17 mm

Measurements derived from reformats using the centreline technique.
All measurements are inside wall to inside wall. Note echo measurements are leading edge to leading edge and thus include on aortic wall. Therefore, echo measurements will be 2 -4mm greater the CT measurements.

There is mild dilatation of the ascending thoracic aorta with a diameter of up to 45 mm.
The proximal portion of the aortic arch is mildly dilated, measuring up to 42 mm just proximal to the innominate artery origin.
The distal arch and descending thoracic aorta are normal in calibre.

The origins of the great vessels demonstrate mild calcified atherosclerotic disease and are otherwise patent.

Other Findings:
No significant pericardial or pleural effusion.
No mediastinal or axillary lymphadenopathy.

Small calcified nodule in the left upper lobe consistent with a granuloma.
Smaller calcified nodules noted within the right mid and upper zones, consistent with granulomas.
Non-specific subpleural nodule in the superior segment of the left lower lobe measuring 4 mm. This can be followed up with CT in 12 months.
Subsegmental atelectasis in the lingular segment.

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Severe uncomplicated diverticular disease is noted, most marked in the sigmoid colon.
The liver, gallbladder, pancreas, adrenals, biliary tree, spleen and kidneys appear unremarkable within the limitations of an arterial phase study.
Low density lesion measuring 7 mm in the lower pole of the right kidney, probably a cyst (density 7 HU).
Low density area within the uterus measuring up to 10 mm in thickness probably represents the endometrial complex.

Moderate lumbar spondylosis with mild to moderate anterolisthesis at L3-L4 and L4-L5 is noted.

Comment:
Dilated ascending thoracic aorta and proximal aortic arch. Please see separate Aortic Root report.
Other findings as described above.
Subpleural nodule left lower lobe which could be follow-up CT in 12 months.
Apparent thickening of the endometrial complex in the uterus. This could be further assessed with a dedicated pelvic ultrasound to assess.

Reported by: Dr Royce Paschkewitz
Co Reported:
Dr Saurabh Khandelwal

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Royal North Shore Cardiology

Visit Description: CT TAVI AORTIC ROOT

TAVI CT ANGIOGRAM

HISTORY: Thank you for referring WENDY PATRICIA ROSS. 83 years Female severe aortic stenosis for transcatheter aortic valve implantation workup.

TECHNIQUE: Gated post-IV contrast single volume 320 slice CT thoracic aortogram (16 cm footprint). 0-60% of the R - R was imaged with 10% reconstructions. 30% recon was associated with the widest annular measurements and was used for reporting purposes. This was followed by a separate spiral CT aortogram with aorta iliac and femoral run-off to assess for catheter delivered vascular access.

REPORT:
Aortic annulus maximum diameter: 24 mm.
Aortic annulus minimal in diameter: 19 mm.
Aortic annulus perimeter: 68 mm.
Aortic annulus area: 3.6 cm2.
Aortic annulus and sub annular calcification: Minimal.
Aortic valve morphology including cine CT assessment: Functionally bicuspid with calcified fused raphe between the left and right coronary cusps.
Aortic valve calcification: Moderate.
Aortic valve Agatston score: 779 Agatston units.

	Men	Women
Severe AS very likely	*>/=3000*	*>/=1600*
Severe AS likely	*>/=2000*	*>/=1200*
Severe AS unlikely	<1600	<800

(European Association of Cardiovascular Imaging and the American Society of Echocardiography, 2017).
Aortic sinus diameter: Functionally bicuspid, commissure-commissure 28 mm, mid sinus to mid sinus 32 mm. Calcified raphe between left and right coronary leaflets Left 32 mm. Right 31 mm. Non 31 mm.
Aortic sinus mean diameter: 31 mm (mean diameter <30 mm connotes an increased risk of coronary occlusion)
LMCA height: annulus to inferior os 11.5mm & annulus to superior os 15mm (considered low if <12mm).
RCA height: annulus to inferior os 10.8 mm & annulus to superior os 15 mm (considered low if <12mm).
Sinotubular junction diameter: 32 x 30 mm.
Sinotubular junction height: 17 mm.
Ascending aorta diameter: 45 x 44 mm (at level of pulmonary bifurcation unless otherwise stated).
Optimal fluoroscopic angulation: LAO 0 degrees CAU 14 degrees, **LAO 10 degrees** CAU 2 degrees, **LAO 30 degrees** CRA 25 degrees.
Other cardiac findings: Systolic acquisition unsuitable for formal coronary evaluation. Motion degraded appearance and calcified coronary vessels. Membranous septum length: 5.2 mm (<8mm increased risk AV conduction injury).

CT AORTOGRAM & ILIOFEMORAL RUN OFF:
Aorta: Moderately dilated ascending aorta. Calcified circumferential plaque abdominal aorta. 11 mm calibre distally prior to iliac bifurcation.
Iliac minimal luminal diameter: Left 6 mm. **Right** 6 mm.
Femoral minimal luminal diameter: Left 6 mm. **Right** 6 mm.
Iliofemoral calcification: Left mild. **Right** mild.

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Iliofemoral tortuosity: Left mild. **Right** mild.
Common femoral puncture site: Mild posterior calcific plaque
CFA bifurcations: High at the level of the upper femoral heads. **Superior acetabular to bifurcation distance** left 15 mm, right 12 mm.
Previous iliofemoral intervention: No visible.

IMPRESSION:
1. Landing zone: Functionally bicuspid aortic valve with calcified raphe between the left and right aortic leaflets. Adequate sinus diameter. Low annulus to inferior left main (11.5 m) and inferior RCA (10.8 mm) height with adequate annulus to superior left main (15mm) and superior RCA (15mm) height. Aortic valve Agatston score 779 Agatston units. CT forwarded on disc to Medtronic representative or referring specialist for review and sizing of transcatheter heart valve.
2. Common femoral access site: High CFA bifurcations bilaterally at the level of the upper femoral heads. 6 mm minimal luminal calibre.
3. Other relevant: Moderately dilated ascending aorta (45 x 44 mm). (see separate radiology CT Aortogram with run-off report).

Reported by: Dr Uday Ahluwalia