Encounter #: 10070038020

Report Date/Time: 8/30/2013 12:42:00 AM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

NEAR SYNCOPE

History and Indication

NEAR SYNCOPE

Technique

Contiguous axial slices were obtained from the skull base to the

vertex. Sagittal and coronal reformatted images were also obtained.

Comparison

Prior head CT dated 07/20/2013

Findings

Again noted is evidence of chronic microangiopathy. There are old

lacunar infarcts involving the bilateral basal ganglia and thalamus

again demonstrated. There is no mass effect, midline shift or current

CT evidence for acute infarct. There is no intracranial hemorrhage

or extra-axial collection. There is no hydrocephalus. A retention

cyst or polyp is noted in the left sphenoid sinus. The remainder of

the visualized paranasal sinuses and mastoid air cells are clear.

There is no acute osseous abnormality.

Impression

No intracranial hemorrhage and no CT evidence for acute infarct.

If clinical index of suspicion persists for acute infarct, recommend

further evaluation with an MRI if no contraindications exist.

Attending Radiologist: OLIVIERI-FITT, ROSEMARIE

Ordered By: KIM, JUNG

Order Date: August 29, 2013 11:35 PM

Completion Date: August 30, 2013 12:42 AM

Encounter Number: 010070038020

Accession Number: 5494842

Images were reviewed and interpreted by Attending Radiologist: Dr. OLIVIERI-FITT, ROSEMARIE

Electronically Signed On: August 30, 2013 6:29 AM by Dr. OLIVIERI-FITT, ROSEMARIE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 8/29/2013 11:49:00 PM

Report Name: CHEST,AP PORTABLE

Clinical History

Chest pain.

Technique

Single frontal portable view of the chest.

Comparison

07/22/2013

Findings

There is no cardiomegaly. The mediastinal contours are unremarkable.

There is no airspace consolidation, pleural effusion, pulmonary

vascular congestion, or pneumothorax. Degenerative changes of the

left shoulder joint are noted. Persistent small osteophyte arising

from the right clavicle along the inferior aspect is noted.

Impression

No acute cardiopulmonary disease.

Attending Radiologist: ABBASI, ALMAS

Ordered By: KIM, JUNG

Order Date: August 29, 2013 11:30 PM

Completion Date: August 29, 2013 11:49 PM

Encounter Number: 010070038020

Accession Number: 5494841

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: August 30, 2013 9:11 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 11/9/2013 7:51:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

R/O INTRACRANIAL BLEED

History and Indication

VASCULITIS, H/O INFARCTS INCREASED LETHARGY/

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

No images available for comparison.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There are old lacunar infarcts involving the bilateral basal ganglia

and thalamus again demonstrated.

The ventricles, cisterns and sulci are age-appropriate in size.

There is no mass effect, midline shift or focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

Overall, no change compared to the prior study. No evidence of

intracranial hemorrhage.

Moderate small vessel disease.

Several lacunar infarctions involving the basal ganglia and thalamus.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: HOTMER-PAGONIS, DARLENE

Order Date: November 9, 2013 7:00 PM

Completion Date: November 9, 2013 7:51 PM

Encounter Number: 010070038020

Accession Number: 5580481

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: November 9, 2013 8:53 PM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 1/30/2014 12:57:00 PM

Report Name: CHEST,ROUTINE(PA/AP/LAT)

Examination

CHEST,ROUTINE(PA/AP/LAT)/URGENT

Clinical History

PATIENT IS A 59 YEAR OLD W/ CNS VASCULITIS ON IMMUNOSUPPRESSANTS WHO

HAS COUGH, CHILLS. PLEASE EVALUATE FOR PNA.

Presenting Diagnosis

POSSIBLE INFILTRATE

Technique

Two views of the chest are presented.

Comparison

Compared to a prior study of 08/29/2013.

Findings

Minimal atelectasis at both bases is noted. The lungs are otherwise

clear of active consolidation, pleural effusion or congestion.

Pulmonary vascularity is within normal limits. The heart is normal in

size and configuration. Extra thoracic osseous structures and soft

tissues are remarkable only for degenerative changes about the right

acromioclavicular joint.

Impression

Bibasilar atelectasis mild.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: BHASHYAM, SANDEEP

Order Date: January 29, 2014 12:40 PM

Completion Date: January 30, 2014 12:57 PM

Encounter Number: 010070038020

Accession Number: 5669849

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: January 30, 2014 2:03 PM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 9/9/2014 8:42:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

DIZZINESS

History and Indication

CNS VASCULITIS S/P R THALAMIC INFARCT

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

Previous CT head performed 11/09/2013.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There are old lacunar infarcts involving the bilateral basal ganglia

and right thalamus. There are bilateral cerebral white matter

hypodensities consistent with moderate chronic small vessel disease.

The ventricles, cisterns and sulci are age-appropriate in size.

There is no mass effect or midline shift. There are extensive

atherosclerotic calcifications in the visualized intracranial carotid

and vertebral arteries.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is a polyp versus retention cyst in the left sphenoid sinus.

Impression

No interval change.

Bilateral old lacunar infarcts involving the basal ganglia and

thalamus.

Moderate chronic microvascular disease.

Attending Radiologist: BANGIYEV, LEV

Ordered By: HUNTE, FREDERICK

Order Date: September 9, 2014 7:00 PM

Completion Date: September 9, 2014 8:42 PM

Encounter Number: 010070038020

Accession Number: 5935466

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: September 10, 2014 6:40 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 9/10/2014 3:58:00 PM

Report Name: MRA HEAD WO CONTRAST

Examination

MRA Head without contrast

Clinical History

EVALUATE VASCULITIS/STROKE

History and Indication

CNS VASCULITIS NOW WITH DIZZINESS

Technique

3D TOF

Comparison

Correlation is made with cerebral angiogram dated 07/05/2013

Findings

Evaluation of intracranial internal carotid arteries demonstrate

contour irregularities in the right petrous segment without

hemodynamically significant stenosis.

Small contour irregularities are noted in the bilateral A1 segments

without hemodynamically significant stenosis. The A2 and visualized

distal ACA branches are unremarkable.

Evaluation of middle cerebral artery demonstrates mild contour

irregularities in the bilateral M1 segments. There are bilateral

foci of stenosis with poststenotic dilatation in the M2 and distal

MCA branches consistent with known history of CNS vasculitis.

Evaluation of vertebrobasilar circulation demonstrate dominant left

and slightly hypoplastic right intracranial vertebral arteries. There

are normal-appearing basilar, superior cerebellar, and posterior

cerebral arteries bilaterally.

There is no evidence of intracranial aneurysm or vascular

malformation.

Impression

Multiple bilateral areas of vascular stenosis with poststenotic

dilatation in the MCA territory is consistent with known history of

vasculitis.

No evidence of intracranial aneurysm or vascular malformation.

Attending Radiologist: BANGIYEV, LEV

Ordered By: HUNTE, FREDERICK

Order Date: September 10, 2014 1:30 PM

Completion Date: September 10, 2014 3:58 PM

Encounter Number: 010070038020

Accession Number: 5936417

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: September 10, 2014 4:33 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 9/10/2014 3:12:00 PM

Report Name: MRA NECK WO CONTRAST

Examination

MRA NECK WITHOUT CONTRAST

Clinical History

EVALUATE VASCULITIS/STROKE

History and Indication

CNS VASCULITIS NOW WITH DIZZINESS

Technique

3D time-of-flight for the arteries in the neck. Following this MIP

images were created. NASCET methodology was employed to evaluate the

degree of stenosis.

Comparison

No images available for comparison.

Findings

Evaluation of the aortic arch in major branches demonstrates common

origin of the brachiocephalic and left common carotid artery, a

normal anatomic variant. There is otherwise normal flow signal,

contour and caliber without stenosis or evidence for dissection.

Evaluation of common carotid arteries demonstrate normal flow signal,

contour, and caliber without stenosis or evidence for dissection.

Evaluation of the cervical internal carotid arteries demonstrate

slight narrowing at the carotid bulbs bilaterally without

hemodynamically significant stenosis. There is no evidence for

dissection.

Evaluation of the vertebral arteries demonstrate normal flow signal,

contour, and caliber without stenosis or evidence for dissection.

Impression

No evidence for hemodynamically significant stenosis or dissection.

Attending Radiologist: BANGIYEV, LEV

Ordered By: HUNTE, FREDERICK

Order Date: September 10, 2014 1:30 PM

Completion Date: September 10, 2014 3:12 PM

Encounter Number: 010070038020

Accession Number: 5936416

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: September 10, 2014 5:59 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 9/11/2014 12:00:00 PM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: ROBERT LEUNER Exam Date: 9/11/2014 at 10:42:05 AM Heart

Rate:

MR #: 30659729 Report Date: 9/11/2014 Rhythm:

ACC #: 5936848 Height: 177.80 cm BP:

145/87

DOB: 10/13/1954 Weight: 92.99 kg

Location: 13N

Age/Sex: 59 years / M BSA: 2.11 m²

Ref. Physician: AINUL ASIF, cc:

Sonographer: JP

Fellow: MM

Indications: R/O Cardiac source of Emboli.

History: HTN, CVA, HLD, depression, BPH.

Procedure: Comp. Echo w/contrast - C8929 and Definity Contrast -

Q9957. The use

of contrast was indicated for enhancement of endocardial

border

definition. There were no contraindications for the use of

contrast

in this patient. Verbal consent was given by the patient

who is aware

of the possible adverse reactions associated with the use

of

contrast. No adverse reactions or hemodynamic compromise

identified.

Study Quality: This was a technically difficult study.

Measurements and Calculations

Diast Nl Syst Nl

RV 2.05 cm 2.0 - 3.8 LA Diam 3.41 cm 3.0-4.0

IVS 1.32 cm 0.6 - 1.0 LA Area cm² <=20

LVID 5.17 cm 4.2 - 5.9 4.14 cm LA Vol ml 18-58

LVPW 1.23 cm 0.6 - 1.0 LA Vol/BSA ml/m² 22+ / -6

RA Diam cm 2.9-4.5

Ao at the sinuses 3.46 cm

Ao Ascending 3.02 cm

LVEF % (visual estimation)

LV FS 20.0

LV SV 27.4 ml

LV SI 13.0 ml/m²

Aov Cusp Sep 2.70 cm

(Systole)

Aov VTI 0.174 m LVOT VTI 0.146 m LVOT diameter

Aov VMax 1.08 m/s LVOT Vmax 0.85 m/s Dimensionless

Index 0.78

Aov Pk Pressure 4.7 mmHg Aov Mn Pressure 2.4 mmHg

Gradient Gradient

MV Pk Gradient mmHg MV Mn Gradient 1.0

MV VTI 0.248 m MV DT 179 msec

MV E Vmax 0.66 m/s MV A Vmax 0.63 m/s E/A 1.05

MV Area press 1/2 Time 4.23

IVRT E/E ' 9.45

Septal E ' 0.080 m/s Prop Velocity

Lateral E ' 0.07 m/s LA Pressure 12.83 mmHg

Average E' 0.075 m/s

MV Average E/E' 8.82

TV E Max TV Mn Grad PHT 52.03 msec TV VTI

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

mildly increased. Global systolic function is probably normal based

on limited images. No evidence of a clot with the use of contrast.

Even with Definity, global and regional LV assessment was limited.

Left Ventricle - Diastole:The Doppler derived transmitral left

ventricular inflow velocity pattern is E wave dominant. The Doppler

derived early diastolic deceleration time is normal at 179 msec.

Left Atrium: The left atrium is not well seen.

Right Atrium: The right atrium is not well seen.

Atrial Septum: Atrial septum is not well visualized.

Right Ventricle: The right ventricle is not well seen.

Aortic Valve: The aortic valve was not well seen.

Mitral Valve: The mitral valve is not well seen.

Tricuspid Valve: The tricuspid valve is not well seen.

Pulmonic Valve: The pulmonic valve is not well visualized. Trace

pulmonary regurgitation is seen.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.46 cm. The ascending aorta is normal at 3.02 cm.

Pericardium: No pericardial effusion seen.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Normal left ventricular cavity size.

2. Mildly increased left ventricular wall thickness.

3. Probably normal left ventricular systolic function.

4. No evidence of a clot with the use of contrast.

5. No pericardial effusion.

6. Normal aortic root diameter for body size.

7. The aortic valve was not well seen.

012480 Howard Novotny MD, FACC

Electronically signed by 012480 Howard Novotny MD, FACC on 9/11/2014

at 3:34:33 PM

\*\*\* Final \*\*\*

Attending Cardiologist: NOVOTNY, HOWARD

Ordered By: HUNTE, FREDERICK

Order Date: September 10, 2014 5:00 PM

Completion Date: September 11, 2014 12:00 PM

Encounter Number: 010070038020

Accession Number: 5936848

Images were reviewed and interpreted by Attending Cardiologist: Dr. NOVOTNY, HOWARD

Electronically Signed On: September 11, 2014 3:34 PM by Dr. NOVOTNY, HOWARD

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 9/12/2014 5:14:00 PM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

CNS VASCULITIS

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 01/ 30/14

Findings

The lung fields are clear there are no congestive changes, pleural

effusions or airspace consolidation. The cardiomediastinal silhouette

is within normal limits.

Degenerative changes of the right AC joint are noted.

Impression

1. No acute intrathoracic disease.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: HUNTE, FREDERICK

Order Date: September 12, 2014 4:15 PM

Completion Date: September 12, 2014 5:14 PM

Encounter Number: 010070038020

Accession Number: 5939764

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: September 15, 2014 7:59 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 9/22/2014 1:16:00 PM

Report Name: CVC ANG CAROTID CEREBRAL BILATERAL

Report

Pre-operative Diagnosis: Vasculitis

Post-operative Diagnosis: Same

Procedure: Cerebral angiography

Op: Fiorella

Assistant: None

Contrast: Visipaque 240, 80cc

Fluoro: 5.6 Min; 491.0 mGy

History: 59 year-old male with a history of vasculitis. The

recommendation was made for diagnostic cerebral angiography for

further evaluation. The risks, benefits, alternatives, complications

and personnel associated with the procedure were discussed with the

patients family in detail. They provided informed consent to proceed.

Protocol: Informed consent. Conscious sedation managed by the

anesthesia staff. Sterile fields prepped and draped over the right

inguinal region. Local anesthesia with lidocaine. Access into the

right common femoral artery with a 5F micropuncture kit. 5F sheath

placed and attached to a heparinized saline side flush.

Catheterizations of the both internal carotids and the left vertebral

arteries was achieved with a 5F Vertebral catheter over a 0.035

glidewire under fluoroscopic control. Following angiography, the

catheter was removed. A right common femoral artery angiogram was

performed through the sheath. Hemostasis was achieved with a

Starclose device. No complications were evident.

FINDINGS:

RIGHT INTERNAL CAROTID ARTERY: No evidence of aneurysm. Multi focal

regions of irregular stenosis primarily involving distal branches of

the middle cerebral artery are again noted and not significantly

changed in comparison to the previous angiogram from July 2013. No

large capillary phase defects. The venous phase is unremarkable.

LEFT INTERNAL CAROTID ARTERY: No evidence of aneurysm. Multi focal

regions of irregular stenosis primarily involving distal branches of

the middle cerebral artery are again noted and not significantly

changed in comparison to the previous angiogram from July 2013. No

large capillary phase defects. The venous phase is unremarkable.

LEFT VERTEBRAL ARTERY: No evidence of aneurysm. Mild serial stenoses

of the PCAs bilaterally, involving the distal PCA segments primarily.

The capillary and venous phases of the angiogram are normal. No

significant change in comparison to the prior angiogram.

RIGHT COMMON FEMORAL ARTERY: No evidence of dissection or spasm

involving the right common femoral or right common iliac artery.

IMPRESSION:

STABLE FINDINGS OF MULTIPLE DISTAL SERIAL STENOSIS, AS DESCRIBED

ABOVE.

Attending Radiologist: FIORELLA, DAVID

Ordered By: FIORELLA, DAVID

Order Date: September 22, 2014 11:00 AM

Completion Date: September 22, 2014 1:16 PM

Encounter Number: 010070038020

Accession Number: 5950821

Images were reviewed and interpreted by Attending Radiologist: Dr. FIORELLA, DAVID

Electronically Signed On: September 26, 2014 3:07 PM by Dr. FIORELLA, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 9/27/2014 2:39:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

59M WITH PMH OF CNS VASCULITIS P/W FEVER

Indication

EVALUATE FOR PNEUMONIA

Technique

CHEST AP PORTABLE/ROUT

Comparison

09/12/2014.

Findings

The trachea is midline. The osseous structures are unremarkable. The

cardiomediastinal silhouette is unchanged. The diaphragm is normal in

position and smooth in contour. There is no pleural effusion,

pulmonary vascular congestion, focal airspace consolidation, or

pneumothorax.

Impression

No acute cardiopulmonary process.

Attending Radiologist: FREIBERG, EVAN

Ordered By: CHAKRAVARTY, RAMANUJ

Order Date: September 27, 2014 9:40 AM

Completion Date: September 27, 2014 2:39 PM

Encounter Number: 010070038020

Accession Number: 5958129

Images were reviewed and interpreted by Attending Radiologist: Dr. FREIBERG, EVAN

Electronically Signed On: September 27, 2014 3:32 PM by Dr. FREIBERG, EVAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 10/11/2014 2:13:00 PM

Report Name: MRA HEAD WO CONTRAST

Examination

MRA Head without contrast

Clinical History

EVALUATE FOR INTRACRANIAL HEMORRHAGE

History and Indication

HX OF CNS VASCULITIS AND ACURE CVA 9/9/14 NOW WITH WORSENING

DIZZINESS

Technique

3D TOF

Comparison

Prior study dated 09/10/2014.

Findings

Evaluation of intracranial internal carotid arteries demonstrate

luminal irregularities in the right petrous segment without

hemodynamically significant stenosis.

Mild luminal irregularities are noted in the bilateral A1 segments

without hemodynamically significant stenosis. There is a patent

anterior communicating artery with normal trifurcation. The A2 and

visualized more distal ACA branches are unremarkable.

Evaluation of middle cerebral artery demonstrates mild contour

irregularities in the bilateral M1 segments. There are bilateral

foci of stenosis with poststenotic dilatation in the M2 and more

distal MCA branches, unchanged from prior study, consistent with

known history of CNS vasculitis.

Evaluation of vertebrobasilar circulation demonstrate dominant left

and slightly hypoplastic right intracranial distal vertebral

arteries. There is normal-appearing flow in basilar with mild luminal

irregularity and stenosis at the origins of the bilateral superior

cerebellar, and posterior cerebral arteries. There is focal stenosis

at the origin of the right anterior inferior cerebellar artery. The

left anterior inferior cerebral artery demonstrate normal flow

related enhancement.

There is no evidence of intracranial aneurysm or vascular

malformation.

Impression

Again seen are multiple bilateral areas of vascular stenosis with

poststenotic dilatation in the middle cerebral artery territory

distributions consistent with known history of vasculitis. Luminal

irregularity in the bilateral A1 segments and at the origins of the

posterior cerebral and superior cerebellar arteries as described. No

evidence of intracranial aneurysm or vascular malformation.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: KHIANI, KOMAL

Order Date: October 10, 2014 11:50 AM

Completion Date: October 11, 2014 2:13 PM

Encounter Number: 010070038020

Accession Number: 5975316

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: October 12, 2014 5:48 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 10/11/2014 2:13:00 PM

Report Name: MRI BRAIN WO CONTRAST

Clinical History

EVALUATION OF STROKE

History and Indication

HX OF CEREBRA VASCULITIS AND RECENT CVA 9/9/14

Technique

Multiple sequences were performed through the brain in multiple

planes.

Comparison

MR of the brain dated 09/10/2014.

Findings

There is no evidence of restricted diffusion to suggest acute

infarction.

Again seen are multiple round foci of FLAIR hyperintensity with T2

shine through on diffusion-weighted sequences in the left frontal and

parietal lobes, and to a lesser extent in the right parietal lobe

compatible with evolving subacute infarctions primarily in the

watershed territories. There is subacute to chronic infarction in the

left precentral gyrus with T1 hyperintensity compatible with cortical

laminar necrosis. There is subcortical FLAIR hypointensity and

gradient echo blooming in the right superior temporal lobe (coronal

image 128, axial image 22), unchanged from prior study. Findings may

represent chronic hemorrhage or microcalcification. There are

punctate and round foci of gradient echo blooming in the left

cerebellum and bilateral cerebral hemispheres with a peripheral

distribution. Findings raise the possibility of amyloid angiopathy.

Ventricles, cisterns and sulci are stable in size and in

configuration. There is moderate periventricular and subcortical

FLAIR hyperintensity most compatible with microvascular ischemic

disease. Chronic lacunar infarcts are again noted in the right medial

thalamus and right greater the left corona radiata which are

unchanged from prior exam. There is no evidence of intracranial

hemorrhage, mass, or extra-axial collection. There is no mass effect

or midline shift.

See dedicated MRA.

The pituitary gland is normal in size.

Evaluation of the paranasal sinuses demonstrates a mucous retention

cyst in the left sphenoid sinus and mild mucosal thickening in the

paranasal sinuses.

No gross abnormality is noted within the orbits.

Impression

No evidence of acute infarction. Evolving subacute infarctions in the

left frontoparietal and right posterior parietal watershed

territories as described. Small area of subacute to chronic

infarction in the left precentral gyrus with cortical laminar

necrosis.

Chronic lacunar infarcts in the right thalamus and bilateral corona

radiata, unchanged.

Subcortical FLAIR hypointensity and gradient echo blooming in the

right superior temporal lobe (coronal image 128, axial image 22),

unchanged from prior study. Findings may represent chronic hemorrhage

or microcalcification.

Punctate and round foci of gradient echo blooming in the left

cerebellum and bilateral cerebral hemispheres with a peripheral

distribution. Findings raise the possibility of amyloid angiopathy.

Moderate microvascular ischemic disease and involutional change.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: KHIANI, KOMAL

Order Date: October 10, 2014 11:45 AM

Completion Date: October 11, 2014 2:13 PM

Encounter Number: 010070038020

Accession Number: 5975315

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: October 12, 2014 4:08 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 10/11/2014 2:37:00 PM

Report Name: MRA NECK WO CONTRAST

Examination

MRA NECK WITHOUT CONTRAST

Clinical History

EVALUATE FOR OCCULSION/STENOSIS

History and Indication

HX OF CNS VASCULITIS AND ACUTE CVA 9/9/14 NOW WITH WORSENING

DIZZINESS

Technique

3D time-of-flight for the arteries in the neck. Following this MIP

images were created. NASCET methodology was employed to evaluate the

degree of stenosis.

Comparison

No images available for comparison.

Findings

There is luminal irregularity at the origin of the proximal left

internal carotid artery extending approximately 1.5 centimeters with

approximately 30 percent stenosis and apparent crescent of T1

hyperintensity on the fat saturated axial sequences. Findings raise

the possibility of a focal dissection.

There is no evidence of greater than 30% stenosis of the right

carotid artery and right and left vertebral arteries.

Impression

Luminal irregularity at the origin of the proximal left internal

carotid artery with approximately 30 percent stenosis and apparent

crescent of T1 hyperintensity on the fat saturated axial sequences.

Findings raise the possibility of a focal dissection. Recommend

ultrasound correlation as this is at the level of the bifurcation and

should be well visualized sonographically.

PA Hoelzer informed at time of dictation with read back.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: KHIANI, KOMAL

Order Date: October 10, 2014 11:50 AM

Completion Date: October 11, 2014 2:37 PM

Encounter Number: 010070038020

Accession Number: 5975317

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: October 12, 2014 4:35 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 10/23/2014 4:00:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

Dizziness, altered mental status

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

CT head from 09/09/2014. Correlation is made to MRI brain from

10/11/2014.

Findings

There are evolving areas of hypoattenuation within the left

frontoparietal centrum semiovale, compatible with subacute infarcts

seen on the recent MRI. Redemonstrated are chronic infarctions within

the right thalamus and bilateral corona radiata.

Confluent areas of hypoattenuation within the periventricular and

subcortical white matter without mass effect are most compatible with

moderate to advanced microvascular ischemic changes given presence of

atherosclerotic calcifications at the skullbase.

There is moderate age-related cerebral and cerebellar volume loss ex

vacuo ventricular prominence. There is no midline shift or herniation

pattern.

There is no CT evidence of intracranial hemorrhage or extra-axial

collection.

The calvarium is intact.

The mastoid air cells are clear. There is a mucous retention cyst or

polyp within the left sphenoid sinus. The visualized orbits are

unremarkable.

Impression

Evolving subacute infarctions, as above. Otherwise, no significant

change from the prior examination.

Attending Radiologist: FILATOV, ALEXANDER

Ordered By: MASSASATI, LAMAH

Order Date: October 23, 2014 1:15 PM

Completion Date: October 23, 2014 4:00 PM

Encounter Number: 010070038020

Accession Number: 5991436

Images were reviewed and interpreted by Attending Radiologist: Dr. FILATOV, ALEXANDER

Electronically Signed On: October 23, 2014 4:44 PM by Dr. FILATOV, ALEXANDER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 1/3/2015 2:39:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

60 YO MALE WITH FEVER, CHILLS ON CHRONIC STEROIDS FOR VASCULITIS

Indication

EVALUATE FOR PNEUMONIA

Technique

CHEST AP PORTABLE/URGENT

Comparison

Chest radiograph from 09/27/2014

Findings

The trachea is midline. The osseous structures are unremarkable. The

cardiomediastinal silhouette is unchanged. The diaphragm is normal

in position and smooth in contour. There is no free air beneath the

diaphragm. There is no pleural effusion, pulmonary vascular

congestion, focal airspace consolidation, or pneumothorax.

Impression

No acute cardiopulmonary process.

No free air beneath the diaphragm.

Attending Radiologist: FREIBERG, EVAN

Ordered By: MOURAD, MERVAT

Order Date: January 3, 2015 12:50 PM

Completion Date: January 3, 2015 2:39 PM

Encounter Number: 010070038020

Accession Number: 6074854

Images were reviewed and interpreted by Attending Radiologist: Dr. FREIBERG, EVAN

Electronically Signed On: January 3, 2015 3:37 PM by Dr. FREIBERG, EVAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 1/3/2015 2:39:00 PM

Report Name: ABDOMEN SERIES PORTABLE (FLAT/ERECT)

Clinical History

60 YO MALE WITH NAUSEA, VOMITING, FEVER, DIARRHEA

Indication

EVALUATE FOR BOWEL OBSTRUCTION, EVALUATE FOR FREE AIR

Technique

Portable upright and supine views of the abdomen.

Comparison

None.

Findings

There are multiple gas distended loops of bowel. Within the mid

abdomen there is a dilated loop of small bowel measuring 3.9 cm in

diameter. However gas is seen more distally within the bowel and in

the region of the rectum. Limited evaluation for free air given the

poor quality of the Upright view; however, on a concurrently

available upright chest radiograph there is no evidence for free air

beneath the diaphragm. Phleboliths are noted within the pelvis.

Impression

Multiple gas distended loops of bowel. Within the mid abdomen there

is a dilated loop of small bowel measuring 3.9 cm. Gas is seen more

distally and within the region of the rectum. Therefore there is low

concern for small bowel obstruction at this time. However serial

abdominal radiographs are recommended.

The upright view on this abdominal series is limited. However, on the

concurrently available chest radiograph which was obtained at the

same time, there is no free air beneath the diaphragm.

Dr. E. Freiberg discussed the findings, with read back, over the

telephone with Dr. M. Mourad At 3:30 p.m. on 01/03/2015.

Attending Radiologist: FREIBERG, EVAN

Ordered By: MOURAD, MERVAT

Order Date: January 3, 2015 1:10 PM

Completion Date: January 3, 2015 2:39 PM

Encounter Number: 010070038020

Accession Number: 6074865

Images were reviewed and interpreted by Attending Radiologist: Dr. FREIBERG, EVAN

Electronically Signed On: January 3, 2015 3:35 PM by Dr. FREIBERG, EVAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 1/4/2015 7:08:00 AM

Report Name: ABDOMEN SERIES PORTABLE (FLAT/ERECT)

Examination

ABDOMEN SERIES PORTABLE (FLAT/ERECT)/URGENT

Clinical History

60 YO MALE WITH ABD DISTENSION, VOMITING, DIARRHEA, FEVER

Technique

Portable supine and erect views of the abdomen.

Comparison

Abdominal radiographs performed on 01/03/2015

Findings

There is a nonobstructive bowel gas pattern.There is interval

decrease in gaseous distention of multiple loops of small bowel. Air

is seen within the descending colon and rectum. There is no free

intraperitoneal air seen on the upright view. Phleboliths are again

noted within the pelvis.

Impression

Nonobstructive bowel gas pattern as described above.

Attending Radiologist: FREIBERG, EVAN

Ordered By: MOURAD, MERVAT

Order Date: January 4, 2015 6:05 AM

Completion Date: January 4, 2015 7:08 AM

Encounter Number: 010070038020

Accession Number: 6075367

Images were reviewed and interpreted by Attending Radiologist: Dr. FREIBERG, EVAN

Electronically Signed On: January 4, 2015 7:34 PM by Dr. FREIBERG, EVAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 1/4/2015 1:24:00 PM

Report Name: CT ABD AND PELVIS W/O CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

60 YO MALE WITH VOMITING/ABD DISTENSION/FEVER/DIARRHEA/STOOL OCCULT

BLOOD POSITIVE

Technique

Routine study. Post Processed reconstructions included.

Contrast

Oral contrast

Comparison

No prior CT.

Findings

LUNG BASES: Clear. No pleural effusion. Mildly enlarged heart.

Diminished attenuation of the blood pool relative ventricular wall

compatible with anemia.

Abdomen: Limited assessment in the absence of intravenous contrast

particularly in evaluation of visceral and vascular structures.

LIVER: Mildly prominent with hepatic steatosis. Areas of focal fatty

sparing adjacent to the gallbladder.

BILIARY TRACT: No dilatation.

PANCREAS: Unremarkable.

SPLEEN: Normal size.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No calculus or hydronephrosis. Minimal

nonspecific perirenal fat stranding. Tiny exophytic subcentimeter low

density left renal lesion too small for definitive characterization

likely tiny cyst.

BOWEL: Oral contrast reaches the rectum and there is no evidence for

obstruction. Normal caliber. Mild uncomplicated colonic

diverticulosis. No pericolonic fat stranding is noted. There is no

definitive wall thickening. The appendix is normal. .

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta with mild atherosclerotic change. .

Pelvis:

REPRODUCTIVE ORGANS: Normal size. Coarse prostate calcifications.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Mild degenerative changes. . No focal lesion.

Impression

No evidence for obstruction. Minimal uncomplicated colonic

diverticulosis. No evidence for colitis. Normal appendix.

Mildly prominent liver with hepatic steatosis.

Mild cardiomegaly. Evidence to suggest anemia.

Case discussed with Dr. Moured at 4:30 PM on 1/4/14.

Attending Radiologist: CUNNINGHAM, ROBIN

Ordered By: MOURAD, MERVAT

Order Date: January 3, 2015 3:40 PM

Completion Date: January 4, 2015 1:24 PM

Encounter Number: 010070038020

Accession Number: 6074949

Images were reviewed and interpreted by Attending Radiologist: Dr. CUNNINGHAM, ROBIN

Electronically Signed On: January 4, 2015 4:30 PM by Dr. CUNNINGHAM, ROBIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 6/24/2015 7:28:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

FEVER/CHILLS/ HYPOXIA

Technique

Portable AP view of the Chest

Comparison

Comparison is made with chest radiograph dated01/03/2015

Findings

The cardiomediastinal silhouette is within normal limits.There is no

evidence of significant pulmonary vascular congestion. There is no

pleural effusion. There is no pneumothorax. There is no focal

consolidation. Visualized vertebral bodies appear grossly within

normal limits.

Impression

No acute cardiopulmonary process.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: LINGAM, VEENA

Order Date/Time: June 24, 2015 6:35 PM

Scan Initiation Date/Time: June 24, 2015 7:12 PM

Completion Date/Time: June 24, 2015 7:28 PM

Encounter Number: 010070038020

Accession Number: 6294203

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: June 24, 2015 8:30 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10070038020

Report Date/Time: 1/8/2016 6:07:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Persistent cough.

Technique

AP portable view of the chest.

Comparison

06/24/2015.

Findings

There is no evidence of pneumothorax, vascular congestion, pleural

effusion, or focal consolidation. The cardiomediastinal silhouette is

unchanged compared to prior study. The osseous structures are grossly

unremarkable.

Impression

No evidence of focal consolidation.

Attending Radiologist: FISHER, PAUL

Ordered By: SIVADAS, REKHA

Order Date/Time: January 8, 2016 5:25 PM

Scan Initiation Date/Time: January 8, 2016 6:00 PM

Completion Date/Time: January 8, 2016 6:07 PM

Encounter Number: 010070038020

Accession Number: 6543287

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: January 9, 2016 12:29 PM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/19/2014 9:11:00 PM

Report Name: CHEST,AP PORTABLE

Clinical History

Altered mental status

Technique

Portable AP chest

Comparison

Chest radiograph dated 12/11/2013

Findings

The cardiac silhouette cannot be adequately assessed due to portable

technique. The pulmonary vascularity is prominent. There is improved

aeration of the right middle and lower lobes with resolution of the

right pleural effusion -there is no new airspace consolidation or

effusion.

Impression

Mild pulmonary vascular congestion.

Interval improvement of right pleural effusion with improved aeration

of the right lower and middle lobes.

Attending Radiologist: BANGIYEV, LEV

Ordered By: WILKERSON, JEROME

Order Date: February 19, 2014 8:05 PM

Completion Date: February 19, 2014 9:11 PM

Encounter Number: 010074070771

Accession Number: 5693866

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: February 20, 2014 2:52 AM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/19/2014 10:50:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

AMS

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

No images available for comparison.

Findings

Ventricles, sulci, and fissures are mildly prominent consistent with

age. There is periventricular patchy deep white matter low

attenuation consistent with chronic microvascular changes.

Atherosclerotic calcifications are noted in the visualized

intracranial arteries. There is no compelling CT evidence for acute

infarct, intracranial hemorrhage, mass, or extra-axial collection.

The patient is status post cataract surgery. Otherwise the orbits

and visualized soft tissues are normal.

The visualized paranasal sinuses are clear. The visualized mastoid

air cells are underdeveloped.

Impression

No acute intracranial finding.

Attending Radiologist: BANGIYEV, LEV

Ordered By: WILKERSON, JEROME

Order Date: February 19, 2014 8:05 PM

Completion Date: February 19, 2014 10:50 PM

Encounter Number: 010074070771

Accession Number: 5693867

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: February 20, 2014 12:30 AM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/20/2014 6:46:00 PM

Report Name: CHEST,AP PORTABLE

Clinical History

NG TUBE PLACEMENT

Indication

LINE OR TUBE PLACEMENT

Technique

Single portable AP view of the chest optimized for NG tube placement

Comparison

Chest radiograph 02/19/2014

Findings

There has been interval placement of a nasogastric tube extending

below the left hemidiaphragm with distal tip overlying the region of

the gastric body.

TIPS catheter in situ.

Limited evaluation of the chest and upper abdomen as this study is

optimized for NG tube placement.

Impression

Interval placement of a nasogastric tube with tip overlying the

region of the gastric body.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: LINGAM, VEENA

Order Date: February 20, 2014 6:10 PM

Completion Date: February 20, 2014 6:46 PM

Encounter Number: 010074070771

Accession Number: 5695187

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: February 20, 2014 7:24 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/21/2014 5:05:00 PM

Report Name: CHEST,AP PORTABLE

Clinical History

POSSIBLE ASPIRATION, NG TUBE PLACEMENT.

History and Indication

NG tube placement.

Technique

AP view of the chest and upper abdomen is presented optimized for

tube placement.

Comparison

Study from the previous day.

Findings

The NG tube is poorly visualized on this study secondary to

technique. I believe I see part of the tube below the diaphragm,

however if placement is in question, a repeat study would be

recommended. Motion artifact significantly limits evaluation of the

lungs.

Impression

Significantly limited study.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: LINGAM, VEENA

Order Date: February 21, 2014 3:35 PM

Completion Date: February 21, 2014 5:05 PM

Encounter Number: 010074070771

Accession Number: 5696218

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: February 21, 2014 5:34 PM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/23/2014 9:43:00 AM

Report Name: CHEST,AP PORTABLE

Clinical History

HEPATIC ENCEPHALOPATHY NOW WITH HYPOTHERMIA

Additional History

EVALUATE FOR PNEUMONIA

Technique

Single portable semi upright AP view of the chest.

Comparison

Single portable frontal supine view of the chest dated 02/21/2014 at

5 p.m..

Findings

The enteric tube distal tip is not well visualized due to overlying

soft tissues.

There is a moderate right-sided pleural effusion with subjacent

compressive subsegmental right lower lobe atelectasis. There is mild

pulmonary vascular congestion. There is no pneumothorax.

The cardiomediastinal silhouette is enlarged and globular in

appearance, stable from prior examination. A metallic TIPS stent is

redemonstrated overlying the right upper quadrant.

Visualized osseous structures stable.

Impression

1. Moderate right-sided pleural effusion with adjacent

compressive right lower lobe atelectasis.

2. Superimposed right lower lobe pneumonia cannot be excluded.

3. Cardiomegaly with mild pulmonary vascular congestion.

4. Enteric tube distal tip not well visualized. Dedicated

examination may be obtained if clinically indicated to confirm proper

positioning.

Attending Radiologist: BALSAM, DVORAH

Ordered By: HUNTE, FREDERICK

Order Date: February 23, 2014 8:30 AM

Completion Date: February 23, 2014 9:43 AM

Encounter Number: 010074070771

Accession Number: 5697242

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: February 23, 2014 7:07 PM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/26/2014 2:31:00 PM

Report Name: CHEST,AP PORTABLE

Clinical History

CIRRHOSIS S/P TIPS, SARCOIDOSIS, HX OF CHF, NOW W/ AMS

Indication

EVALUATE FOR CHF, PNA

Technique

CHEST,AP PORTABLE/STAT

Comparison

02/22/2014

Findings

Interval placement of NG tube is noted with the tip is below

diaphragm. The cardiomediastinal silhouette is enlarged. No

significant change noted in the right-sided pleural effusion. There

is mild pulmonary vascular congestion. No pneumothorax is seen.

Impression

Persistent right-sided pleural effusion.

Mild pulmonary vascular congestion.

Attending Radiologist: ABBASI, ALMAS

Ordered By: WICHTENDAHL, NANCY

Order Date: February 26, 2014 2:10 PM

Completion Date: February 26, 2014 2:31 PM

Encounter Number: 010074070771

Accession Number: 5701286

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: February 26, 2014 2:34 PM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/26/2014 2:50:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATION FOR STROKE

History and Indication

CIRRHOSIS W/ HEPATIC ENCEPHALOPATHY, HYPERNATREMIC TO 153, NOW AMS

Technique

Contiguous axial slices were obtained from the skull base to the

vertex. 2 dimensional coronal sagittal post processing reconstruction

was performed and interpreted.

Comparison

Head CT dated 02/19/2014

Findings

No acute territorial infarct, intracranial hemorrhage or extra-axial

collection. The cortical sulci, ventricles and cisterns are again

prominent for age, which should be correlated with the medical and

social history, such as history of alcoholism. No midline shift or

mass effect is appreciated. In the absence of trauma, the

hyperdensity along the falx likely represents calcification. There is

patchy hypodensity in the bilateral cerebral white matters likely

represents chronic small vessel disease.

The pituitary appears slightly prominent for patient age within the

sella without extension to the suprasellar region. Although this may

be a normal variation, clinical correlation with the endocrinologic

status is recommended. The calvaria are intact. There is no

significant disease in the paranasal sinuses cord immediate cavities.

The right mastoid air cells are underdeveloped.

Impression

No acute intracranial pathology.

Prominent ventricles, cisterns and sulci for a patient's given age

which likely represents brain atrophy, given the history of

alcoholism.

No significant interval change.

Attending Radiologist: ROQUE, CLEMENTE

Ordered By: WICHTENDAHL, NANCY

Order Date: February 26, 2014 1:55 PM

Completion Date: February 26, 2014 2:50 PM

Encounter Number: 010074070771

Accession Number: 5701254

Images were reviewed and interpreted by Attending Radiologist: Dr. ROQUE, CLEMENTE

Electronically Signed On: February 26, 2014 4:51 PM by Dr. ROQUE, CLEMENTE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/28/2014 11:14:00 AM

Report Name: PARACENTESIS W/IMAGE INC ALL

Clinical History

64-year-old femalewith history ofaltered mental status. Suspicion

for SBP. Plan is to perform a paracentesis for diagnostic purposes.

Please note the attending radiologist Dr. Ferretti was present for

the entire procedure.

Technique

Ultrasound was used to image the abdomen. A pocket of ascites was

identified. A hard copy image was still in the patient's records.

Following sterile preparation and draping and using standard aseptic

technique and following local lidocaine effusion under ultrasound

guidance a5 French Yueh needle was inserted into the ascitic fluid of

the abdomen via a right lower quadrant approach. Yellow serous fluid

was seen in the aspirate. Approximately 60 cc was sent for analysis.

Removal of a total of60 cc of ascitic fluid was removed. The needle

was removed.

The patient tolerated the procedure well with no immediate post

paracentesis complications observed.

Moderate sedation was not used.

Comparison

None

Findings

Small amount of ascites

Impression

60ccs of serous ascitic fluid removed from the abdomen via right

lowerquadrant approach.

Sent for analysis.

No complications.

Attending Radiologist: FERRETTI, JOHN

Ordered By: SHORTELL, ELIZABETH

Order Date: February 27, 2014 8:35 AM

Completion Date: February 28, 2014 11:14 AM

Encounter Number: 010074070771

Accession Number: 5702024

Images were reviewed and interpreted by Attending Radiologist: Dr. FERRETTI, JOHN

Electronically Signed On: March 1, 2014 11:56 AM by Dr. FERRETTI, JOHN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/28/2014 7:43:00 PM

Report Name: MRA:HEAD W/O CONTRAST

Examination

MRA Head without contrast

Clinical History

EVALUATE FOR VASCILITIS,

History and Indication

64 YO F WITH SARCOIDOSIS AND AMS

Technique

3D TOF

Comparison

No prior studies are available for comparison.

Findings

Study limited by motion artifact.

There appears to be moderate (34 percent) stenosis of the cavernous

segment of the left internal carotid artery. The left a 1 segment is

congenitally hypoplastic.

There is no other occlusive disease, aneurysm or AVM noted.

Impression

Study limited by motion. Stenosis of the proximal left cavernous

carotid artery as described.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: KRUTOSHINSKAYA, YANA

Order Date: February 28, 2014 3:30 PM

Completion Date: February 28, 2014 7:43 PM

Encounter Number: 010074070771

Accession Number: 5704244

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: March 1, 2014 11:29 AM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/28/2014 7:44:00 PM

Report Name: MRA:NECK W/O CONTRAST

Examination

MRA NECK WITHOUT CONTRAST

Clinical History

EVALUATE FOR ARTERIAL INJURY

History and Indication

64 YO F WITH SARCOIDOSIS AND AMS

Technique

3D time-of-flight for the arteries in the neck. Following this MIP

images were created. NASCET methodology was employed to evaluate the

degree of stenosis.

Comparison

No images available for comparison.

Findings

The study is severely limited due to patient motion artifact. The

vertebral arteries are grossly unremarkable. Both common carotid

arteries appear to be of good caliber. The proximal internal carotid

arteries cannot be evaluated due to artifact. The more distal

internal carotid arteries appear to be of adequate caliber except for

a small segment of the absent flow signal in the right internal

carotid artery which is likely artifactual.

Impression

Markedly limited examination. The proximal internal carotid arteries

cannot be evaluated. No definite abnormality elsewhere in. If

clinically important, consider repeating if and when the patient

can't fully cooperate.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: KRUTOSHINSKAYA, YANA

Order Date: February 28, 2014 3:30 PM

Completion Date: February 28, 2014 7:44 PM

Encounter Number: 010074070771

Accession Number: 5704245

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: March 1, 2014 11:19 AM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 2/28/2014 7:46:00 PM

Report Name: MRI:BRAIN W/O CONTRAST

Clinical History

EVALUATE FOR AMS (NEUROSARCOID/ENCEPHALIITIS)

History and Indication

4 YO F WITH PMH SARCOIDOSIS, LIVER CIRRHOSIS S/P TIPS WITH H/O

HEPATIC ENCEPHALOPATHY, DVT S/P IVC FILTER, GERD, DM, HTN, CKD,

ADMITTED FOR AMS, FOUND TO HAVE UTI, HYPERAMMONEMIA, AND UREMIA, ARF

W/ AMS

Technique

Multiple sequences were performed through the brain in multiple

planes.

Comparison

CT 02/26/2014

Findings

There is no evidence of restricted diffusion to suggest acute

infarction.

Was study is markedly limited by patient motion artifact.

There are foci of FLAIR hyperintensity in the bilateral cerebral

white matter consistent with small vessel disease.

There is mild central and moderate cortical cerebral atrophy. There

is mild cerebellar atrophy. There is no hydrocephalus.

There is no mass, mass effect, midline shift or focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

There is normal flow voids in the major arteries of the circle of

Willis.

The pituitary gland is normal in size.

There is no significant disease in the paranasal sinuses.

No gross abnormality is noted within the orbits except for bilateral

cataract surgery. .

Impression

Atrophy and small vessel disease. The absence of contrast enhancement

would limit evaluation for active sarcoid. Study is significantly

limited by motion artifact.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: BHASHYAM, SANDEEP

Order Date: February 28, 2014 5:15 PM

Completion Date: February 28, 2014 7:46 PM

Encounter Number: 010074070771

Accession Number: 5704413

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: March 1, 2014 11:24 AM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/3/2014 6:57:00 PM

Report Name: LUMBAR PUNCTURE UNDER FLUOROSC

Examination

FAILED BEDSIDE ATTEMPT

LUMBAR PUNCTURE UNDER FLUOROSCOPY

Clinical History

ALTERED MENTAL STATUS

History and Indication

Technique

After obtaining informed consent and performing time out procedure,

lumbar puncture was attempted using oblique fluoroscopic guided

approach at the L2-L3 level.

Findings

Multiple attempts were performed to axis thecal sac at L2-3 level

without success.

Impression

Status post unsuccessful lumbar puncture without complication noted.

Attending Radiologist: BANGIYEV, LEV

Ordered By: GLANTZ, GLENN

Order Date: March 2, 2014 11:55 AM

Completion Date: March 3, 2014 6:57 PM

Encounter Number: 010074070771

Accession Number: 5705338

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: March 4, 2014 8:51 AM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/3/2014 7:58:00 PM

Report Name: CHEST,AP PORTABLE

Examination

Chest

Clinical History

R/O INFILTRATE

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 01/02/26/14.

Findings

There is persistent but decreased central pulmonary congestion. There

is persistent pleural effusion on the right. The heart is the upper

limit of normal to slightly enlarged. Nasogastric tube is noted to be

extending below the diaphragm and likely within the stomach.

Impression

Decreased central congestion with persistent right-sided pleural

effusion. Cardiomegaly is likely.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: SHORTELL, ELIZABETH

Order Date: March 3, 2014 10:50 AM

Completion Date: March 3, 2014 7:58 PM

Encounter Number: 010074070771

Accession Number: 5705995

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: March 4, 2014 8:19 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/4/2014 12:04:00 PM

Report Name: CT:ABD AND PELVIS W/O CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

S/P LUMBAR PUNCTURE ATTEMPT YESTEDAY WITH ACUTE ANEMIA

Technique

Routine study. Post Processed reconstructions included.

Contrast

No oral or intravenous contrast administered.

Comparison

12/07/2013.

Findings

LUNG BASES: Since the previous examination, there is no change in the

larger right pleural effusion and slight increase in the left pleural

effusion, now moderate in size with adjacent atelectasis/

consolidation, left side greater than right. The heart is enlarged

and there are coronary calcifications /stones. There is no

pericardial effusion.

Abdomen: A nasogastric tube extends to the stomach.

LIVER: The liver remains cirrhotic in appearance and there is a TIPS

shunt in place.

BILIARY TRACT: No obvious dilatation. The gallbladder appears

contracted.

PANCREAS: Limited evaluation with no focal or diffuse pathology.

SPLEEN: Enlarged at 17 cm in length.

ADRENALS: Inadequately visualized due to streak artifact from the

arms within the gantry and the and motion.

KIDNEYS: No obvious hydronephrosis.

BOWEL: Normal caliber. No wall thickening. Limited evaluation without

oral contrast. There is a rectal balloon in place.

PERITONEUM: Moderate ascites, approximately unchanged from the prior

exam. The internal density of the ascites is now 34 HU and was

previously 8, question proteinaceous or hemorrhagic component. There

is no obvious layering hematoma within the ascites.

RETROPERITONEUM: Limited evaluation for adenopathy due to streak

artifact and diffuse infiltration of the fatty tissues.

VESSELS: Calcific atherosclerotic changes of the abdominal arteries

without obvious aneurysmal dilatation.

Pelvis:

REPRODUCTIVE ORGANS: Neither the uterus nor the ovaries are

identified with certainty, likely removed.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Decompressed by a Foley catheter.

BONES: There is loss of height of multiple thoracic and lumbar

vertebral bodies involving L1, T9 to T12, L4 and L5, most severe at

L1.

Impression

No definite hemorrhagic collection. Unchanged quantity of ascites

since the previous examination with slightly increased density,

question partial proteinaceous or hemorrhagic component. There is no

obvious layering hematoma. Unchanged right pleural effusion,

increased left pleural effusion, unchanged bibasilar atelectasis /

consolidation, cirrhotic appearing liver with a TIPS shunt in place,

multiple vertebral compression deformities as described above,

unchanged from the prior exam.

Attending Radiologist: BUDORICK, NANCY

Ordered By: PETER, RENNY

Order Date: March 4, 2014 10:30 AM

Completion Date: March 4, 2014 12:04 PM

Encounter Number: 010074070771

Accession Number: 5707411

Images were reviewed and interpreted by Attending Radiologist: Dr. BUDORICK, NANCY

Electronically Signed On: March 5, 2014 10:58 AM by Dr. BUDORICK, NANCY

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/4/2014 12:06:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR CHANGE IN CONSCIOUSNESS

History and Indication

PATIENT ADMITTED WITH SUSPECTED ENCEPHALOPATHY, NOW NOT WITHDRAWING

TO PAIN BILATERALLY

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

MRI of the brain dated 02/28/2014 and CT of the head dated

02/26/2014.

Findings

Study is limited by patient motion with resultant streak artifact.

There is no loss of gray-white matter distinction or other sign of

acute infarction. There is moderate periventricular and subcortical

white matter hypodensity most compatible with with microvascular

ischemic disease.

The ventricles, cisterns and sulci are prominent in size and normal

in configuration compatible with age-appropriate involutional change.

There is no mass effect, midline shift or focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact. Bilateral cataract surgery.

Mild mucosal thickening in the right maxillary sinus. There is no

other significant disease in the visualized paranasal sinuses and

mastoids.

Impression

Limited study without gross CT evidence of acute lobar infarction,

intracerebral hemorrhage, or extra-axial hematoma. Follow up is

advised.

Microvascular ischemic disease and age appropriate involutional

change.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: PETER, RENNY

Order Date: March 3, 2014 9:00 AM

Completion Date: March 4, 2014 12:06 PM

Encounter Number: 010074070771

Accession Number: 5705765

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: March 4, 2014 1:08 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/4/2014 5:31:00 PM

Report Name: LUMBAR PUNCTURE UNDER FLUOROSC

Examination

OBTAIN CSF

LUMBAR PUNCTURE UNDER FLUOROSCOPY

Clinical History

AMS, R/O NEURO SARCOID

History and Indication

Technique

After obtaining informed consent and performing time out procedure,

lumbar puncture was performed using oblique fluoroscopic guided

approach at the L2-L3 level.

Findings

Clear fluid was encountered. 6 cc of fluid was collected and sent to

the laboratory for requested analysis.

Impression

Status post successful lumbar puncture without complication noted.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: SHORTELL, ELIZABETH

Order Date: March 4, 2014 3:20 PM

Completion Date: March 4, 2014 5:31 PM

Encounter Number: 010074070771

Accession Number: 5708093

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: March 10, 2014 4:28 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/6/2014 3:57:00 PM

Report Name: QUINTON CATHETER (NON-TUNNELED)

Clinical History

Oliguria, elevated BUN / creatinine. Presenting for dialysis

catheter.

Technique

RIGHT QUINTON

PROVIDER PERFORMING PROCEDURE: C. Kim. K. Ramirez.

PROCEDURE:

1. Placement of a duel lumen 12 French x 15 cm Quinton catheter via

the right internal jugular vein approach.

Procedure and possible complications and the use of conscious

sedation was explained to the patient and informed consent was

obtained. The patient was brought into the radiology suite and was

placed supine on the fluoroscopic table. The patients clinical status

is ASA 3. The right neck and chest were prepped with 2 percent

chlorhexidine solution and draped in usual sterile fashion. Maximum

sterile barrier technique was used during CVC insertion

Cap/mask/sterile gown/gloves 1% lidocaine was used for local

anesthetic. A patent vessel could not be visualized; ultrasound

evaluation of a potential access site was performed. After

successfully identifying a patent vessel, with the use of the

ultrasound guidance, the internal jugular vein was accessed with a

micropuncture needle. A permanent recording was created for the

patient's record. Under fluoroscopic guidance, a guidewire was

advanced into the superior vena cava. The micropuncture needle was

then exchanged for a 4 French dilator, through which the guidewire

was removed and exchanged for an Amplatz wire which was advanced into

the IVC. Following a series of exchanges the track was dilated and a

12 French x 15 cm dual-lumen Quinton catheter was advanced over the

Amplatz. The inner stiffener and Amplatz were removed. The tip of the

catheter is at the level of the SVC/right atrial junction. Both

lumens aspirated and flushed easily. Catheter was secured in place,

and loaded with an appropriate amount of heparin, and sterile

dressing was applied. The patient was transferred to the floor in

stable condition. There were no immediate complications associated

with the procedure.

FLUORO TIME: 1.5 min

Impression

SUCCESSFUL PLACEMENT OF A 12 FRENCH X 15 CM DUAL-LUMEN QUINTON

CATHETER VIA THE RIGHT INTERNAL JUGULAR VEIN APPROACH.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: SHORTELL, ELIZABETH

Order Date: March 6, 2014 3:05 PM

Completion Date: March 6, 2014 3:57 PM

Encounter Number: 010074070771

Accession Number: 5709792

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: April 11, 2014 7:50 PM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/8/2014 10:07:00 AM

Report Name: CHEST,AP PORTABLE

Clinical History

Fluid overload

Technique

Portable AP chest

Comparison

Chest radiograph dated 03/03/2014

Findings

There are bilateral posterior layering pleural effusions, right

greater than left, slightly increased from prior study. Persistent

mild pulmonary vascular congestion is seen. No focal airspace

consolidation or pneumothorax. The cardiac silhouette is enlarged.

Osseous structures are unchanged. A new right IJ catheter is seen,

reportedly a Quentin catheter, with no evidence of pneumothorax seen.

Impression

Slight interval increase of bilateral pleural effusions, right

greater than left.

Persistent mild pulmonary vascular congestion.

Stable cardiomegaly.

Attending Radiologist: FISHER, PAUL

Ordered By: RAMESH, NADIA

Order Date: March 8, 2014 9:05 AM

Completion Date: March 8, 2014 10:07 AM

Encounter Number: 010074070771

Accession Number: 5713100

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: March 8, 2014 3:23 PM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/11/2014 1:56:00 PM

Report Name: CHEST,AP PORTABLE

Clinical History

KAO FEED TUBE PLACEMENT

Additional History

LINE OR TUBE PLACEMENT

Technique

Single portable upright AP view of the chest.

Comparison

Prior radiograph dated 03/08/2014

Findings

The right IJ introducer sheath is unchanged in position with distal

tip overlying the SVC. The enteric feeding tube is noted with distal

tip well positioned. A TIPS shunt is noted overlying the right upper

abdominal quadrant.

There has been interval improvement in right greater than left

pleural effusions and subjacent atelectasis. Dense retrocardiac

opacity is favored to represent a posterior segment left lower lobe

pneumonia. Obscuration of the right lateral cardiac silhouette is

favored to represent medial segment right middle lobe pneumonia.

There is residual right basilar subsegmental linear atelectasis.

There is no pneumothorax or pulmonary vascular congestion.

The cardiomediastinal silhouette is enlarged, stable from prior

examinations.

Visualized osseous structures are stable from prior examination.

Impression

1. New feeding tube well positioned.

2. Interval improvement in right greater than left right greater

than left pleural effusions. Residual right basilar linear

atelectasis.

3. Posterior segment left lower lobe and medial segment right

middle lobe multifocal pneumonia versus atelectasis.

4. Stable cardiomegaly.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: SHORTELL, ELIZABETH

Order Date: March 11, 2014 11:40 AM

Completion Date: March 11, 2014 1:56 PM

Encounter Number: 010074070771

Accession Number: 5716390

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: March 11, 2014 2:32 PM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/21/2014 1:38:00 PM

Report Name: FLUORO GUID CVC RE/PLACE ADD

PICC line insertion, right upper extremity.

Clinical History

Poor IV access.

Technique

Maximal sterile barium technique was used during CVC insertion.

Ultrasound was used to locate the right basilic vein. The skin was

marked, prepped and draped in the usual fashion. Under continuous

ultrasound guidance, a 21 gauge needle was used to enter the right

basilic vein. Under fluoroscopic guidance, a guidewire was advanced

into the superior vena cava. After a series of guidewire and

catheter exchanges, a 5 French, dual-lumen, 38 cm in length PICC line

was inserted into the superior vena cava. There is no immediate

complication. Fluoro time was 0.6 min.

Impression:

Successful PICC line insertion, right upper extremity, as described

above.

Attending Radiologist: TACK, CARL

Ordered By: MUKHI, PREETI

Order Date: March 21, 2014 1:11 PM

Completion Date: March 21, 2014 1:38 PM

Encounter Number: 010074070771

Accession Number: 5726675

Images were reviewed and interpreted by Attending Radiologist: Dr. TACK, CARL

Electronically Signed On: March 23, 2014 10:49 AM by Dr. TACK, CARL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/21/2014 1:39:00 PM

Report Name: PERMACATH PLACEMENT (TUNNELED)

Perm-A-Cath placement of a right internal jugular vein.

Clinical History

End-stage renal failure.

Technique

Maximal sterile barrier technique was used during CVC insertion.

Intravenous conscious sedation was administered. A Quentin catheter

had been previously placed through the right internal jugular vein. A

guidewire was advanced through the Quentin catheter into the inferior

vena cava.

1 percent lidocaine was used to infiltrate the soft tissues below the

right clavicle. A short horizontal incision was made. Using blunt

dissection, a tunnel was created from the incision to the entrance in

the right internal jugular vein. The Perma-Cath was brought through

the tunnel.

The Quinton catheter was removed over the wire. A peel-away sheath

was advanced into the right atrium. The Perma-Cath was advanced into

the right atrium and the peel-away sheath was removed. The catheter

was appropriately flushed. A sterile dressing was applied. There

was no immediate complication.

Impression:

Successful Perma-Cath insertion through previous tract as described

above.

Attending Radiologist: TACK, CARL

Ordered By: TOMY, RITTY

Order Date: March 21, 2014 1:13 PM

Completion Date: March 21, 2014 1:39 PM

Encounter Number: 010074070771

Accession Number: 5728283

Images were reviewed and interpreted by Attending Radiologist: Dr. TACK, CARL

Electronically Signed On: March 23, 2014 10:46 AM by Dr. TACK, CARL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/26/2014 2:19:00 PM

Report Name: CHEST AP(PORT) CENTRAL LINE PL

Clinical History

S/P LUE PICC

Indication

CENTRAL LINE PLACEMENT

Technique

PA chest is not included left upper extremity for PICC line

placement.

Comparison

Compared to a prior study of 03/11/2014. .

Findings

A PICC line is noted from the left upper extremity with the tip in

the superior vena cava. Entrance site shows no evidence of abnormal

foreign bodies or other abnormalities. There is increased central

congestion with questionable of pleural effusion on the right.

Right-sided IJ Quentin catheter with the tip in the superior vena

cava and a nasogastric feeding tube for noted in place.

Impression

Successful PICC line placement from the left tip in the SVC. Central

congestion with right-sided pleural effusion. Remaining tubes and

lines are in good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: ACQUAVIVA, MELISSA

Order Date: March 26, 2014 12:20 PM

Completion Date: March 26, 2014 2:19 PM

Encounter Number: 010074070771

Accession Number: 5734632

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: March 26, 2014 2:38 PM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/28/2014 2:28:00 PM

Report Name: CHEST AP(PORT) CENTRAL LINE PL

Examination

CHEST AP(PORT) CENTRAL LINE PL/STAT

Clinical History

PICC LINE PLACEMENT NOW BLEEDING FROM SITE

Presenting Diagnosis

CENTRAL LINE PLACEMENT

Technique

PA and Lateral views of the chest are presented.

Comparison

Compared to March 26, 2014

Findings

There is a PICC line noted in place the tip is in the SVC there is no

unintentional radiopaque foreign body. The dialysis catheter is

unchanged. There is a feeding tube in place. The lungs are clear,

there is no consolidation, congestive changes or pleural effusions.

The cardiac size is mildly enlarged. .

Impression

Tubes and lines as above.

Cardiomegaly.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: HUNTE, FREDERICK

Order Date: March 28, 2014 12:40 PM

Completion Date: March 28, 2014 2:28 PM

Encounter Number: 010074070771

Accession Number: 5737513

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: March 28, 2014 3:17 PM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/28/2014 3:08:00 PM

Report Name: ULTRASOUND SUBPHREN SP/ASCITE

Examination

Sonographic ascites survey.

Clinical History

DIASTOLIC CHF(EF 62 %), HTN, HL, DMII, CKD III, SARCOIDOSIS WITH

LIVER CIRRHOSIS S/P TIPS, PREVIOUS HEPATIC ENCEPHALOPATHY (NONCOMPL C

LACTULOSE), THROMBOCYTOPENIA, DVT S/P IVC,NOW ENCEPHALOPATHIC W/U FOR

PEG

History and Indication

COMPLETE ABDOMINAL SURVEY TO EVALUATE FOR ASCITES

Technique

Gray scale real-time ultrasoundwas utilized to evaluate the right and

left upper and lower abdominal quadrants as well as pelvis to assess

volume of ascites.

Comparison

No prior sonograms.

Findings

There is evidence for mild ascites, mostly in the upper abdominal

quadrants, perihepatic and perisplenic locations. Largest volume of

fluid noted in the right upper quadrant. No significant pelvic free

fluid is seen.

Please note that abdominal viscera were not assessed on this

dedicated study to evaluate ascites. Incidentally noted coarsened and

heterogeneous liver.

Impression

Relatively small volume of ascites is seen. Mostly within the upper

abdomen perihepatic and perisplenic region, the largest pocket of

fluid in the right upper quadrant.

Preliminary report was provided via PACs shortly following exam

completion on 3/28/2014.

Attending Radiologist: VAN DE VEGTE, G LUCY

Ordered By: REILLY, PETER

Order Date: March 27, 2014 5:05 PM

Completion Date: March 28, 2014 3:08 PM

Encounter Number: 010074070771

Accession Number: 5736567

Images were reviewed and interpreted by Attending Radiologist: Dr. VAN DE VEGTE, G LUCY

Electronically Signed On: March 28, 2014 4:05 PM by Dr. VAN DE VEGTE, G LUCY

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/31/2014 10:26:00 PM

Report Name: CHEST,AP PORTABLE

Examination

Portable chest

Clinical History

NGT POSITIONING

Technique

Single frontal view the chest.

Comparison

Prior study from 03/28/2014.

Findings

No nasogastric tube is visualized. Correlate clinically to determine

whether the nasogastric tube is coiled within the nasopharynx.

Redemonstrated is a right IJ double-lumen central venous catheter

with the tip overlying the cavoatrial junction. Left upper extremity

PICC line is again seen with tip overlying the distal SVC.

There is no evidence for focal consolidation, pulmonary vascular

congestion, or sizable pleural effusion. Evaluation for right

pleural effusion is somewhat limited due to exclusion of the right

costophrenic angle.

Trachea is midline. Cardiac silhouette again appears enlarged

although evaluation is somewhat limited due to rotation.

Bony structures demonstrate no significant interval change.

Impression

1. No nasogastric tube visualized. Correlate clinically to determine

whether the nasogastric tube is coiled within the nasopharynx.

2. Other lines as described above.

3. No acute pleural or parenchymal process.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: ABRAHAM, ALBIN

Order Date: March 31, 2014 3:05 PM

Completion Date: March 31, 2014 10:26 PM

Encounter Number: 010074070771

Accession Number: 5740297

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: April 4, 2014 2:09 PM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 4/5/2014 10:29:00 AM

Report Name: CHEST,AP PORTABLE

Clinical History

PULLED PICC LINE, CHECK POSITION

Additional History

CHECK LINE PLACEMENT

Technique

Single portable semi upright AP view of the chest.

Comparison

Prior radiograph dated 03/31/2014.

Findings

Slight interval retraction of the left upper extremity PICC line is

noted with distal tip now overlying the proximal left brachiocephalic

vein. The tunneled right internal jugular approach hemodialysis

intravenous catheter is seen with distal tips overlying the right

atrium. The tips stent is partially visualized.

There has been interval development of moderate asymmetrical

right-sided pulmonary vascular congestion and a moderate right

layering pleural effusion with subjacent atelectasis obscuring the

right hemidiaphragmatic silhouette. There is no pneumothorax. The

cardiomediastinal silhouette is enlarged.

Visualized osseous structures are stable from prior examination.

Impression

1. Interval retraction of left upper extremity PICC line noted,

with distal tip now overlying the left proximal brachiocephalic vein.

2. Cardiomegaly with interval development of moderate asymmetric

right-sided pulmonary vascular congestion and an associated moderate

right-sided pleural effusion with subjacent atelectasis.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: MUKHI, PREETI

Order Date: April 5, 2014 8:50 AM

Completion Date: April 5, 2014 10:29 AM

Encounter Number: 010074070771

Accession Number: 5746473

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: April 5, 2014 2:02 PM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 5/10/2014 9:18:00 AM

Report Name: CHEST,AP PORTABLE

Clinical History

Evaluate for pneumonia.

Technique

Single AP view of the chest.

Comparison

Chest radiograph dated 4/5/2014.

Findings

Lines and tubes: There is a right IJ multi lumen venous catheter in

place, with the distal tip within the cavoatrial junction / right

atrium.

Heart and Mediastinum: Cardiomediastinal silhouette is enlarged,

unchanged..

Lungs and Pleura: There is bibasilar atelectasis. There is elevation

of the left hemidiaphragm.

There are no large pleural effusions, pulmonary vascular congestion,

or pneumothoraces.

Osseous structures and soft tissues: Unremarkable.

Impression

Bibasilar atelectasis.

Stable cardiomegaly.

Attending Radiologist: FISHER, PAUL

Ordered By: YEUNG, POMIN

Order Date: May 10, 2014 6:45 AM

Completion Date: May 10, 2014 9:18 AM

Encounter Number: 010074070771

Accession Number: 5787568

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: May 10, 2014 11:45 AM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 5/22/2014 2:19:00 PM

Report Name: ULTRASOUND RT UPPER QUAD

Given history is a 64-year-old female with hepatic encephalopathy

status post TIPS now with worsening mental status please evaluate

TIPS velocities.

Ultrasonography of the right upper quadrant and special attention to

the TIPS was performed using grayscale, color flow and pulsed

Doppler technique. Images were obtained in the sagittal and

transverse planes. .

The study is compared to prior exam dated 03/18/2014.

The study is limited due to patient body habitus, inability of

patient to fully cooperate with respiratory maneuvers and

positioning.

The study demonstrates the liver to measures 14.5 cm. It demonstrates

marked coarsened increased echotexture with nodular contour . This is

consistent with patient's known cirrhosis. . This may obscure subtle

small lesions due to poor beam penetration however none are

visualized. The gallbladder is thick walled. This can be seen with

hypoproteinemic states, adjacent ascites ,acalculous cholecystitis in

the appropriate setting. It is without sludge or discrete calculi..

There is no evidence of pericholecystic fluid. The intrahepatic and

extrahepatic biliary ducts are normal in caliber. The common bile

duct measures 0.3 cm at the porta hepatis. The pancreas is limited in

visualization due to bowel gas. It appears echogenic which can be

seen with fatty replacement. . The right kidney measures 11.2 x 5.6 x

5 point cm. It is normal in contour and echotexture and without

hydronephrosis, intrarenal calculus or perinephric fluid collection.

The proximal abdominal aorta is normal in caliber. Ascites is noted

within the abdomen however appear somewhat diminished from prior

exam. The spleen measures 11.1 cm in longitudinal dimension. It is

Normal in contour and echotexture.

TIPS shunt was evaluated demonstrating color flow indicating

patency. Peak systolic Velocities were obtained at the proximal

extent of the TIPS with a value of 75.7 centimeters/second, at its

mid extent with a peak systolic velocity of 66 cm/sec and at its

distal extent with a value of 77 cm /sec.

The portal vein is patent and demonstrates normal directional flow.

Peak systolic velocity in the main portal vein is 50

centimeters/second. The right portal vein demonstrates a peak

systolic velocity of 50 centimeters/second. The left portal vein is

not visualized.

Hepatic veins are somewhat limited in visualization and appear

somewhat attenuated however patent with peak systolic velocity of 36

centimeters/second in the mid hepatic vein, and 31 centimeters/second

in the left hepatic vein.

No recannulized umbilical vein is appreciated. Hepatic artery

demonstrates normal color flow direction with the peak systolic

velocity of 94.9 centimeters/second

Impression :

Limited study.

Marked coarsened heterogeneous liver compatible with patient's known

cirrhosis. No focal lesion noted.

Patent hepatopetal portal flow. TIPS shunt demonstrates patent flow

without evidence of stenosis.

Thick-walled gallbladder. This may be secondary to mildly contracted

state, adjacent ascites, hypoproteinemic states. no evidence of

cholelithiasis.

Ascites slightly improved from prior exam.

No biliary dilatation.

Attending Radiologist: MASON, MARYANNA

Ordered By: ASIF, AINUL

Order Date: May 21, 2014 9:50 AM

Completion Date: May 22, 2014 2:19 PM

Encounter Number: 010074070771

Accession Number: 5800162

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: May 22, 2014 5:22 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 5/22/2014 2:19:00 PM

Report Name: US:DUPLEX COLOR/SPECTRAL COMP

Given history is a 64-year-old female with hepatic encephalopathy

status post TIPS now with worsening mental status please evaluate

TIPS velocities.

Ultrasonography of the right upper quadrant and special attention to

the TIPS was performed using grayscale, color flow and pulsed

Doppler technique. Images were obtained in the sagittal and

transverse planes. .

The study is compared to prior exam dated 03/18/2014.

The study is limited due to patient body habitus, inability of

patient to fully cooperate with respiratory maneuvers and

positioning.

The study demonstrates the liver to measures 14.5 cm. It demonstrates

marked coarsened increased echotexture with nodular contour . This is

consistent with patient's known cirrhosis. . This may obscure subtle

small lesions due to poor beam penetration however none are

visualized. The gallbladder is thick walled. This can be seen with

hypoproteinemic states, adjacent ascites ,acalculous cholecystitis in

the appropriate setting. It is without sludge or discrete calculi..

There is no evidence of pericholecystic fluid. The intrahepatic and

extrahepatic biliary ducts are normal in caliber. The common bile

duct measures 0.3 cm at the porta hepatis. The pancreas is limited in

visualization due to bowel gas. It appears echogenic which can be

seen with fatty replacement. . The right kidney measures 11.2 x 5.6 x

5 point cm. It is normal in contour and echotexture and without

hydronephrosis, intrarenal calculus or perinephric fluid collection.

The proximal abdominal aorta is normal in caliber. Ascites is noted

within the abdomen however appear somewhat diminished from prior

exam. The spleen measures 11.1 cm in longitudinal dimension. It is

Normal in contour and echotexture.

TIPS shunt was evaluated demonstrating color flow indicating

patency. Peak systolic Velocities were obtained at the proximal

extent of the TIPS with a value of 75.7 centimeters/second, at its

mid extent with a peak systolic velocity of 66 cm/sec and at its

distal extent with a value of 77 cm /sec.

The portal vein is patent and demonstrates normal directional flow.

Peak systolic velocity in the main portal vein is 50

centimeters/second. The right portal vein demonstrates a peak

systolic velocity of 50 centimeters/second. The left portal vein is

not visualized.

Hepatic veins are somewhat limited in visualization and appear

somewhat attenuated however patent with peak systolic velocity of 36

centimeters/second in the mid hepatic vein, and 31 centimeters/second

in the left hepatic vein.

No recannulized umbilical vein is appreciated. Hepatic artery

demonstrates normal color flow direction with the peak systolic

velocity of 94.9 centimeters/second

Impression :

Limited study.

Marked coarsened heterogeneous liver compatible with patient's known

cirrhosis. No focal lesion noted.

Patent hepatopetal portal flow. TIPS shunt demonstrates patent flow

without evidence of stenosis.

Thick-walled gallbladder. This may be secondary to mildly contracted

state, adjacent ascites, hypoproteinemic states. no evidence of

cholelithiasis.

Ascites slightly improved from prior exam.

No biliary dilatation.

Attending Radiologist: MASON, MARYANNA

Ordered By: ASIF, AINUL

Order Date: May 22, 2014 2:20 PM

Completion Date: May 22, 2014 2:19 PM

Encounter Number: 010074070771

Accession Number: 5802102

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: May 22, 2014 5:22 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 5/21/2014 5:11:00 PM

Report Name: PORT ABDOMEN FLAT/ERECT

Clinical History

64 FEMALE WITH HEPATIC ENCEPAHLOPATHY WITH DIFFUSE ABDOMINAL PAIN AND

DISTENSION

Indication

EVALUATE FOR BOWEL OBSTRUCTION, EVALUATE FOR FREE AIR

Technique

Supine and upright views of the abdomen.

Comparison

No images available for comparison.

Findings

There is a non-obstructive bowel gas pattern with no evidence of

pneumoperitoneum. A gastrostomy tube is identified. A focus of

calcification is identified in the mid abdomen of unknown

significance. A metal stent is identified in the right upper

quadrant. There is multilevel degenerative change of the lumbosacral

spine. The lung bases are grossly clear.

Impression

Nonobstructive bowel gas pattern.

Attending Radiologist: ABBASI, ALMAS

Ordered By: ASIF, AINUL

Order Date: May 21, 2014 11:20 AM

Completion Date: May 21, 2014 5:11 PM

Encounter Number: 010074070771

Accession Number: 5800391

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: May 23, 2014 11:21 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 6/19/2014 8:38:00 PM

Report Name: CT:ABD AND PELVIS W/O CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

64F WITH H/O HEPATIC ENCEPHALOPATHY S/P PEG WITH BLEED FROM PEG WITH

NO LESION SEEN ON EGD

GI bleed bleeding.

Cirrhosis secondary to sarcoidosis with esophageal varices status

post TIPS in 1994.

Hemodialysis dependent.

Technique

Routine study. Post Processed reconstructions included.

Contrast

None administered.

Comparison

CT abdomen 03/04/2014.

Findings

LUNG BASES: There has been interval resolution of the previously seen

right-sided pleural effusion. There is bibasilar atelectasis. The

heart is enlarged.

Abdomen:

BOWEL AND PERITONEUM: There has been interval placement of a

gastrostomy tube, which courses adjacent to and questionably

perforates the transverse colon. Complex soft tissue with gas density

is noted along the course of the percutaneous gastrostomy tube within

the abdomen. Additionally, there is pneumoperitoneum as well as

hemorrhagic fluid within the abdomen and pelvis with a hematocrit

level the pelvis (series 2 image 65). These findings are highly

concerning for bowel injury and intraperitoneal bleeding. No evidence

of bowel obstruction.

LIVER: Cirrhosis with a mass like component at the inferior right

hepatic lobe measuring 3.00 x 2.8 see them (series 2 image 30).

Recommend liver CT or MRI for further evaluation. TIPS shunt again

noted.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Enlarged. No focal lesion.

ADRENALS: No nodule or mass.

KIDNEYS: No mass, calculus or hydronephrosis. Linear scar at the left

lower pole.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta. Diffuse atherosclerotic calcification

of the aorta and its branches.

Subcutaneous air is noted at the site of the gastrostomy tube entry.

Pelvis:

REPRODUCTIVE ORGANS: Status post hysterectomy.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Multilevel degenerative changes, with loss of vertebral body

height throughout the visualized lower thoracic spine, as well as at

L4, L5, and most severe with vertebral plana at L1.

Impression

Gastrostomy tube courses in close proximity to, and questionably

perforates, the transverse colon. Given the presence of

pneumoperitoneum and hemorrhage, findings are highly concerning for

bowel injury. Recommend further evaluation with rectal Gastrografin

CT.

This was discussed via telephone by Dr. Uzair Sarmast with Dr. A

Guillaume At 11:20 a.m. on 06/20/2014.

Hepatic cirrhosis with 3.0 cm mass-like component of the inferior

right hepatic lobe. Recommend further evaluation with this liver CT

or MR.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: CANTAVE, INGRID

Order Date: June 19, 2014 7:10 PM

Completion Date: June 19, 2014 8:38 PM

Encounter Number: 010074070771

Accession Number: 5835894

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: June 20, 2014 11:34 AM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 6/20/2014 6:45:00 AM

Report Name: ABDOMEN,SUPINE(KUB)

Clinical History

Evaluate for obstruction

Technique

2 veiws of the abdomen

Comparison

5/21/2014

Findings

Non-obstructive gas pattern. No free air. Gastrostomy tube in place.

TIPS stent in place. Embolization coil at midline.

Impression

No obstruction.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: AHUJA, ANKUR

Order Date: June 20, 2014 4:10 AM

Completion Date: June 20, 2014 6:45 AM

Encounter Number: 010074070771

Accession Number: 5836100

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: June 20, 2014 7:06 PM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 6/20/2014 3:49:00 PM

Report Name: FLAT PLATE OF ABDOMEN/PORT

Clinical History

Evaluate nasogastric tube placement.

Technique

Supine and erect views of the abdomen.

Comparison

Abdominal x-ray from 06/20/2014.

Findings

There has been interval placement of a nasogastric tube which

terminates within the gastric antrum. Again seen is a gastrostomy

tube overlying the midbody of the stomach. Again seen is a stent

within the right upper quadrant overlying the hepatic shadow likely

reflecting the TIPSS. Embolization coils are noted to the left of

midline in the upper abdomen. There is a nonobstructive gas pattern.

There is no evidence of gross free air.

Impression

Interval placement of a nasogastric tube terminating in the gastric

antrum.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: CANTAVE, INGRID

Order Date: June 20, 2014 1:35 PM

Completion Date: June 20, 2014 3:49 PM

Encounter Number: 010074070771

Accession Number: 5836868

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: June 20, 2014 7:08 PM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 6/24/2014 8:31:00 PM

Report Name: PORT ABDOMEN FLAT/ERECT

Clinical History

Patient with a gastric tube complaining of abdominal pain.

Technique

Supine and erect views of the abdomen.

Comparison

06/20/2014

Findings

There is a nonspecific bowel gas pattern without evidence of

obstruction or free intraperitoneal air.No organomegaly or abnormal

calcifications are seen within the abdomen or pelvis.

Again seen is a gastric tube with the balloon located in the left

upper quadrant. Its external position is slightly different from the

prior study. There has been interval removal of an NG tube. There is

a TIPSS stent in the right upper quadrant.

The osseous structures are grossly unremarkable.

Impression

Non-obstructive bowel gas pattern. Stable position of a gastric tube.

Interval removal of a nasogastric tube.

Attending Radiologist: ABBASI, ALMAS

Ordered By: SAVLA, GEETA

Order Date: June 24, 2014 7:20 PM

Completion Date: June 24, 2014 8:31 PM

Encounter Number: 010074070771

Accession Number: 5841628

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: June 25, 2014 2:05 PM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 6/30/2014 4:22:00 PM

Report Name: FLAT PLATE OF ABDOMEN/PORT

Clinical History

RECENT G TUBE PLACEMENT

Indication

EVALUATE FOR BOWEL OBSTRUCTION, EVALUATE FOR FREE AIR

Technique

Supine and upright views of the abdomen.

Comparison

06/24/2014

Findings

This study is limited by partial exclusion of the abdomen and pelvis.

There is a non-obstructive bowel gas pattern with no evidence of

pneumoperitoneum.No organomegaly or pathologic calcifications are

identified. A gastrostomy tube is identified although its position

cannot be confirmed in reference to the bowel. A stent is again

identified. They have ring-like coil structure is seen to the left of

the lower thoracic spine without change. There may be a small

left-sided pleural effusion or left lower lobe atelectasis. Osseous

structures are unchanged. Right-sided catheter is overlying the

region of the spine/right atrium.

Impression

Limited study by partial exclusion of the abdomen and pelvis.

Gastrostomy tube is visualized overlying the left quadrant, exact

location to the GI system cannot be confirmed on this study. Could

performed contrast study for exact localization.

Rounded coil like structure overlying the left upper quadrant of

indeterminate etiology without change.

Possible atelectasis versus mild left pleural fluid.

Attending Radiologist: GOULD, ELAINE

Ordered By: KANAGALA, NEELIMA

Order Date: June 30, 2014 3:55 PM

Completion Date: June 30, 2014 4:22 PM

Encounter Number: 010074070771

Accession Number: 5848484

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: June 30, 2014 6:26 PM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 6/30/2014 5:53:00 PM

Report Name: PORT ABDOMEN FLAT/ERECT

Clinical History

RECENT G TUBE PLACEMENT

Indication

EVALUATE FOR BOWEL OBSTRUCTION, EVALUATE FOR FREE AIR

Technique

Supine and upright views of the abdomen.

Comparison

06/24/2014

Findings

This study is limited by partial exclusion of the abdomen and pelvis.

There is a non-obstructive bowel gas pattern with no evidence of

pneumoperitoneum.No organomegaly or pathologic calcifications are

identified. A gastrostomy tube is identified although its position

cannot be confirmed in reference to the bowel. A stent is again

identified. They have ring-like coil structure is seen to the left of

the lower thoracic spine without change. There may be a small

left-sided pleural effusion or left lower lobe atelectasis. Osseous

structures are unchanged. Right-sided catheter is overlying the

region of the spine/right atrium.

Impression

Limited study by partial exclusion of the abdomen and pelvis.

Gastrostomy tube is visualized overlying the left quadrant, exact

location to the GI system cannot be confirmed on this study. Could

performed contrast study for exact localization.

Rounded coil like structure overlying the left upper quadrant of

indeterminate etiology without change.

Possible atelectasis versus mild left pleural fluid.

Attending Radiologist: GOULD, ELAINE

Ordered By: KANAGALA, NEELIMA

Order Date: June 30, 2014 4:45 PM

Completion Date: June 30, 2014 5:53 PM

Encounter Number: 010074070771

Accession Number: 5848564

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: June 30, 2014 6:26 PM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 7/23/2014 8:59:00 PM

Report Name: FLAT PLATE OF ABDOMEN/PORT

Clinical History

Abdominal pain. Evaluate for bowel obstruction.

Technique

Supine and erect views of the abdomen.

Comparison

Abdominal radiograph from 06/30/2014.

Findings

Stent is seen in the position of the common bile duct. No evidence

for bowel obstruction.

Embolization coils are seen in the left upper quadrant.

Impression

Non-obstructive bowel gas pattern.

Attending Radiologist: BARISH, MATTHEW

Ordered By: PAUL, ARUNAVA

Order Date: July 23, 2014 7:45 AM

Completion Date: July 23, 2014 8:59 PM

Encounter Number: 010074070771

Accession Number: 5875535

Images were reviewed and interpreted by Attending Radiologist: Dr. BARISH, MATTHEW

Electronically Signed On: July 25, 2014 2:46 PM by Dr. BARISH, MATTHEW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 7/26/2014 8:56:00 AM

Report Name: ULTRASOUND OF ABDOMEN LIMITED

Clinical History

Ascites for further evaluation. Cirrhosis

Technique

Limited grayscale ultrasonographic evaluation of the ascites in the

abdomen.

Comparison

None

Findings

Moderate ascites is seen with multiple internal septations suggestive

of loculations.

Impression

Multiple septations in the ascites. Peritonitis cannot be excluded.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: PAUL, ARUNAVA

Order Date: July 25, 2014 5:15 PM

Completion Date: July 26, 2014 8:56 AM

Encounter Number: 010074070771

Accession Number: 5879437

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: July 26, 2014 10:30 AM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 7/27/2014 9:13:00 PM

Report Name: CHEST,AP PORTABLE

Examination

Chest

Clinical History

LEUCOCYTOSIS

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 05/10/2014.

Findings

There is central vascular congestion with perihilar edema. There is

obscuration of the left hemidiaphragm and shift of the mediastinum to

the left Consistent with atelectasis. The heart size is within normal

limits. A right IJ dialysis catheter is noted in position with the

tip at the cavoatrial junction. A vascular shunt is noted at the

level of the right hemidiaphragm

Impression

Central vascular congestion with right hilar edema. Atelectasis left

lung base. Heart size within normal limits. Tubes and lines in good

position unchanged.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: PAUL, ARUNAVA

Order Date: July 27, 2014 12:05 PM

Completion Date: July 27, 2014 9:13 PM

Encounter Number: 010074070771

Accession Number: 5880514

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: July 28, 2014 8:31 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 7/29/2014 9:16:00 AM

Report Name: PARACENTESIS W/IMAGE INC ALL

Clinical History

Request for diagnostic paracentesis. Possibly infected abdominal

collection.

Description:

Risks, benefits, and alternatives to diagnostic paracentesis were

discussed with the patient's brother and informed written consent was

obtained. She was brought to the examination room supine in her

stretcher. A loculated pocket of complex fluid was identified in the

left abdomen. Overlying skin was prepped for 2 percent cortex and

solution draped. 1 percent lidocaine was given subcutaneously. A 21

gauge needle was advanced into the collection and fluid was

aspirated. Sample was sent to the laboratory for analysis. The

needle was removed and a sterile dressing was applied. The patient

was brought back to her hospital room having tolerated this procedure

well.

Comparison

Abdominal ultrasound from 07/26/2014

Findings

Loculated fluid collection in the left abdomen as seen on diagnostic

ultrasound contains multiple internal septations. 15 cc clear yellow

fluid aspirated.

Impression

Technically successful diagnostic paracentesis. No immediate

postprocedure complications.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: PAUL, ARUNAVA

Order Date: July 29, 2014 8:00 AM

Completion Date: July 29, 2014 9:16 AM

Encounter Number: 010074070771

Accession Number: 5878740

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: July 31, 2014 8:51 AM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 10/13/2014 9:32:00 PM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

PREOP FOR FISULOGRAM AND POSSIBLE AVG PLACEMENT

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 07/27/2014.

Findings

There is mild central vascular congestion with cardiomegaly. Dialysis

catheter via right IJ approach is again noted. Catheter tip is in the

superior vena cava. Degenerative changes are noted in both shoulders

There is elevation of the left hemidiaphragm with atelectasis left

lung base.

Impression

Mild central congestion. Cardiomegaly. Atelectasis left lung base.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: PYKE, OWEN

Order Date: October 13, 2014 7:45 PM

Completion Date: October 13, 2014 9:32 PM

Encounter Number: 010074070771

Accession Number: 5978518

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: October 14, 2014 8:28 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 12/4/2014 3:26:00 PM

Report Name: REMOVAL IMPLANT VEN AC DEV

Clinical History

64year-old female with history ofend stage renal disease. Patient has

a right IJ Perma-Cath in place which isno longer needed as patient is

using AV fistula. Plan is to remove right IJ Perma-Cath.

Please note the attending radiologist Dr. Ferretti was present for

the entire procedure.

Technique

Chest scout demonstratesright IJ Perma-Cath in place with distal tip

overlying the right atrium.

Following sterile preparation and draping using standard aseptic

technique local lidocaine infusion was then carried out at the

insertion site of thePerma-Cath. The catheter was then removed under

fluoroscopic guidance.

The patient tolerated the procedure well and no immediate

postPerma-Cath removal complications. No radiopaque foreign bodies

identified post removal.

Moderate sedation was not used. The patient was sent to the floor in

stable condition.

Total of0.1 min of fluoroscopy time was used.

Comparison

None

Findings

No radiopaque foreign bodies remain.

Impression

Successful removal of right IJ Perma-Cath.

No complications.

Attending Radiologist: FERRETTI, JOHN

Ordered By: MASSASATI, LAMAH

Order Date: December 4, 2014 3:04 PM

Completion Date: December 4, 2014 3:26 PM

Encounter Number: 010074070771

Accession Number: 6038045

Images were reviewed and interpreted by Attending Radiologist: Dr. FERRETTI, JOHN

Electronically Signed On: December 4, 2014 3:59 PM by Dr. FERRETTI, JOHN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 1/26/2015 5:47:00 PM

Report Name: CT ABD AND PELVIS W/O CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

SARCOIDOSIS LIVER CIRROHIS S/P TIPS, PEG TUBE PLACMENT NOW WITH

DIARRHEA

Technique

Routine study. Post Processed reconstructions included.

Contrast

None.

Comparison

Unenhanced abdominal pelvic CT dated 06/19/2014 and a right upper

quadrant ultrasound dated 07/26/2014 .

Findings

LUNG BASES: Bilateral pleural effusions. Right hilar and subcarinal

calcified lymph nodes compatible with the patient's history of

sarcoidosis. Bibasilar parenchymal opacities which may represent

subsegmental atelectasis. Cardiomegaly. Coronary arterial

calcifications.

Abdomen:

LIVER: Lobular liver compatible with patient's history of cirrhosis.

Tips. Evaluation for liver masses is limited on this unenhanced

examination. Punctate hepatic granulomas. No definite focal hepatic

masses.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Splenomegaly. Calcified splenic granulomata. No focal

lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: Peg tube. Evaluation of the bowel is limited secondary to

under opacification and under distention. Normal caliber. No wall

thickening.

PERITONEUM: No ascites, free air, or fluid collection. Calcified

upper abdominal lymph nodes compatible with the patient's history of

sarcoidosis.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta. Diffuse arterial calcifications.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Collapsed L1 vertebral body unchanged from the 06/19/2000 14 .

this is currently seen on image 72 of the sagittal series and

previously was present on image 71 . There are additional stable

vertebral bodies which demonstrate loss of height. Vertebral bodies

are again appreciated and are unchanged. No focal lesions or acute

fractures.

Impression

Bilateral pleural effusions and subsegmental atelectasis.

Cardiomegaly.

Calcified mediastinal, right hilar, and upper abdominal lymph nodes

compatible with patient's history of sarcoidosis. Punctate calcified

hepatic and splenic granulomata.

Cirrhotic liver.

Splenomegaly.

TIPS.

G-tube in stomach.

Evaluation of bowel is limited secondary to under distention and

opacifications. However there are no dilated loops of bowel, free

intraperitoneal air or pneumatosis.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: HUNTE, FREDERICK

Order Date: January 26, 2015 5:10 PM

Completion Date: January 26, 2015 5:47 PM

Encounter Number: 010074070771

Accession Number: 6102432

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 26, 2015 6:03 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 3/2/2015 7:12:00 PM

Report Name: KNEE RIGHT 1 OR 2 VIEWS

Clinical History

Possible arthritic changes

Technique

RIGHT KNEE 2 views

Comparison

No images available for comparison.

Findings

The lateral radiograph is inadequate for the determination of joint

effusion. There is moderate to severe joint space narrowing and

osteophyte formation along the medial and lateral compartments of the

knee. The patellofemoral component has osteophyte formation along the

superior and inferior aspects. There is chondrocalcinosis of the

medial and lateral compartments. Multiple vascular calcifications are

noted. The bones are diffusely osteopenic.

Impression

Moderate severe tricompartmental osteoarthrosis of the right knee.

Chondrocalcinosis.

Attending Radiologist: EISENBERG, JASON

Ordered By: TERESSA, GETU

Order Date: March 2, 2015 1:55 PM

Completion Date: March 2, 2015 7:12 PM

Encounter Number: 010074070771

Accession Number: 6146191

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: March 2, 2015 10:20 PM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 5/4/2015 11:11:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

PRE-OP FOR AV FISTULOGRAM/PLASTY

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 10/13/2014.

Findings

There is central vascular congestion with bilateral pleural effusions

greater on the left than the right. Bibasilar atelectasis. There is

cardiomegaly unchanged. Shunt noted in the right upper quadrant.

Impression

Central vascular congestion and effusion left lung base. Bibasilar

atelectasis. Left worse than right. Cardiomegaly.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: JOHNSON, CHENARA

Order Date: May 4, 2015 9:45 AM

Completion Date: May 4, 2015 11:11 AM

Encounter Number: 010074070771

Accession Number: 6225732

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: May 4, 2015 11:34 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 6/1/2015 12:04:00 PM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

65F ESRD AWAITING PLACEMENT NOW WITH COUGH.

History and Indication

EVALUATE FOR PNEUMONIA

Technique

A single AP view the chest.

Comparison

5/4/2015

Findings

There is a moderate left pleural effusion with adjacent atelectasis.

Mild pulmonary congestion is noted. The cardiomediastinal silhouette

is within normal limits.

A portosystemic shunt is noted.

Impression

Moderate left pleural effusion perhaps increased.

Mild august congestion.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: THARAKAN, MATHEW

Order Date: June 1, 2015 8:40 AM

Completion Date: June 1, 2015 12:04 PM

Encounter Number: 010074070771

Accession Number: 6261960

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: June 1, 2015 1:51 PM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 6/2/2015 3:48:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATION FOR STROKE

History and Indication

65F H/O ESRD ON HD MWF, DM, SARCOIDOSIS WITH CIRRHOSIS S/P TIPS, DVT

S/P IVC FILTER NOW FAMILY QUESTIONING CVA DUE TO SLURRED SPEECH.

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

Prior study dated 03/04/2014.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There are involutional changes without hydrocephalus. There is small

vessel disease.

There is no mass effect, midline shift or focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No acute intracranial hemorrhage or CT evidence of acute territorial

infarct. Correlate clinically and with MR imaging as long as the

patient is compatible.

Attending Radiologist: DUNKIN, JARED

Ordered By: THARAKAN, MATHEW

Order Date: June 2, 2015 1:50 PM

Completion Date: June 2, 2015 3:48 PM

Encounter Number: 010074070771

Accession Number: 6264322

Images were reviewed and interpreted by Attending Radiologist: Dr. DUNKIN, JARED

Electronically Signed On: June 2, 2015 3:55 PM by Dr. DUNKIN, JARED

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 7/14/2015 8:55:00 AM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Female Adult Echocardiography Report

Name: ROCHELLE RILEY Exam Date/Time: 7/14/2015 8:00:36 AM Heart

Rate:

MR #: 30660651 Report Date: 7/14/2015 Heart

Rhythm:

ACC #: 6316657 Ht: 165.10 cm BP:

166/74 mmHg

DOB: 2/7/1950 Wt: 62.60 kg

Location: 15S

Age/Sex: 65 yearsF BSA: 1.69 m²

Ref. Physician: GETU TERESSA, cc:

Sonographer: JP

Indications: SOB

History: CHF, SOB, edema CP, HTN, elevated cholesterol, Sarcoidosis,

anemia,

ESRD, diabetes, carotid artery stenosis, altered mental

status.

Procedure: Complete Echocardiogram - 93306 and Patient was getting

restless.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 2.27 cm 2.0 - 3.8 LA Diam 4.64 cm 3.0-4.0

IVS 2.28 cm 0.6 - 0.9 LA Area 30.18cm² <=20

LVID 3.24 cm 3.9 - 5.3 2.35 cm LA Vol 97.70 ml 18-58

LVPW 1.77 cm 0.6 - 1.0 LA Vol/BSA 57.83ml/m² 22+ / -6

RA Diam 3.88cm 2.9-4.5

Ao at the sinuses 3.30

LVEF >75 % (visual estimation)

LV FS 27.6

LV SV 22.1 ml

LV SI 13.1 ml/m²

Aov Cusp Sep 1.49 cm

(Systole)

Aov VTI 0.383 m LVOT VTI 0.259 m LVOT diameter

1.98

cm

Aov VMax 1.55 m/s LVOT Vmax 1.15 m/s Dimensionless

Index 0.74

Aov Pk Pressure 9.6 mmHg Aov Mn 4.4 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 2.08 cm² Aov Area Index 1.23 cm²/m²

(VTI)

MV Pk Gradient mmHg MV Mn Gradient 4.7

MV VTI 0.380 MV DT 243 msec

MV E Vmax 0.98 m/s MV A Vmax 1.45 m/s E/A 0.68

MV Area press 1/2 Time 3.13

IVRT E/E ' 19.61

Lateral E ' 0.05 m/s LA Pressure 26.22 mmHg

TR Vmax 2.80 m/s TR Pk Grad 31.4 mmHg RA Pressure 3 mmHg RVSP

34.4 mmHg

TV E Max TV Mn Grad mmHg PHT 70.39 msec TV VTI

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is decreased. Ventricular wall thickness is

severely increased. The relative wall thickness is severely increased

(1.25). Is mid cavity obliteration with a peak pressure gradient of

13.7mmHg. Global left ventricular systolic function is hyperdynamic.

The ejection fraction is >75% by visual estimation.

Left Ventricle - Diastole:The overall diastolic function is mildly

impaired (grade I, impaired relaxation pattern) with normal left

ventricular filling pressures.

Left Atrium: The left atrium is severely dilated in size.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal. The right ventricular

systolic pressure, as estimated using the tricuspid regurgitation

velocity, is 34.4 mmHg.

Aortic Valve: The aortic valve is trileaflet and is calcified with

normal excursion.

Mitral Valve: There is moderate mitral annular calcification. The

mitral valve leaflets are thickened and calcified. No evidence of

mitral insufficiency is seen.

Tricuspid Valve: Mild tricuspid regurgitation is present.

Pulmonic Valve: Trace pulmonary regurgitation is seen.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.30 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.80 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is normal at 34.4 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 11/5/13. There is a mild improvement in the parameters of left

ventricular diastolic filling as compared to the prior study.

Summary:

1. Small left ventricular cavity size.

2. Severely dilated left atrial size.

3. Severely increased left ventricular wall thickness.

4. Hyperdynamic global left ventricular systolic function.

5. Mid cavity obliteration.

6. Mild diastolic dysfunction with normal left ventricular filling

pressures.

7. Normal right ventricular systolic function.

8. Trileaflet aortic valve and aortic sclerosis.

9. Thickened and calcified mitral valve leaflets.

10. Mild tricuspid regurgitation.

11. No pericardial effusion.

12. Normal aortic root diameter for body size.

13. Severely increased relative wall thickness.

14. Mild improvement in left ventricular diastolic filling since the

prior study.

012480 Howard Novotny MD, FACC

Electronically signed by 012480 Howard Novotny MD, FACC on 7/14/2015

at 11:22:10 AM

\*\*\* Final \*\*\*

Attending Cardiologist: NOVOTNY, HOWARD

Ordered By: SULTANA, REBEKA

Order Date/Time: July 13, 2015 3:25 PM

Scan Initiation Date/Time:

Completion Date/Time: July 14, 2015 8:55 AM

Encounter Number: 010074070771

Accession Number: 6316657

Images were reviewed and interpreted by Attending Cardiologist: Dr. NOVOTNY, HOWARD

Electronically Signed On: July 14, 2015 11:22 AM by Dr. NOVOTNY, HOWARD

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 7/22/2015 2:04:00 AM

Report Name: ABDOMEN TUBE INJ JEJUNOSTOMY

Examination

ABDOMEN TUBE INJ JEJUNOSTOMY/STAT

Clinical History

PEG TUBE PLACEMENT

Indication

PEG TUBE

Technique

Oral contrast has been introduced via the PEG tube by the clinician

at a portable frontal abdominal radiograph was obtained

Technologist Comments

Comparison

Unenhanced abdominal radiograph dated 07/23/2014

Findings

The PEG tube tip is in the stomach. Contrast of partially opacifies

the stomach. There is no contrast extravasation. A metallic

radiopacity is seen medial to the stomach of uncertain etiology.

Motion artifact limits evaluation. The patient is post TIPS

placement. A nonspecific gas pattern is identified

No acute fracture are present

Impression

The distal portion of the PEG tube is in the stomach. No contrast

extravasation

Attending Radiologist: ZAWIN, MARLENE

Ordered By: SAM, STANLEY

Order Date/Time: July 21, 2015 11:55 PM

Scan Initiation Date/Time: July 22, 2015 1:03 AM

Completion Date/Time: July 22, 2015 2:04 AM

Encounter Number: 010074070771

Accession Number: 6327938

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: July 22, 2015 8:14 AM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 10/1/2015 2:19:00 PM

Report Name: HAND LEFT PORTABLE

Clinical History

Left hand contracture, evaluate for fracture /dislocation

Technique

Two-views of the left hand

Comparison

None

Findings

There is persistent flexion at the 2nd through 5th

metacarpophalangeal and proximal interphalangeal joints, correlate

clinically for contracture. There is mild to moderate osteoarthritis

of the carpometacarpal joints. There is also arthritis of the

triscaphe and scapholunate joints spaces. There is mild arthritic

changes of the 1st metacarpophalangeal joint. Noted is radial artery

calcifications. The soft tissues are unremarkable.

Impression

1. Flexion at the 2nd through 5th metacarpophalangeal and

proximal interphalangeal joints, correlate for contracture.

Degenerative changes of the left wrist involving the triscaphe and

basal joint.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: MALIK, ADEN

Order Date/Time: October 1, 2015 12:55 PM

Scan Initiation Date/Time: October 1, 2015 2:09 PM

Completion Date/Time: October 1, 2015 2:19 PM

Encounter Number: 010074070771

Accession Number: 6419761

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: October 1, 2015 3:50 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 10/22/2015 8:15:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Evaluate for pneumonia

Technique

Portable AP view of the chest

Comparison

Comparison is made to 06/01/2015

Findings

Cardiomediastinal silhouette is enlarged, unchanged from the prior

study. Patient status post TIPS. There is a radiopaque opacity in the

epigastric region just to the left of midline, unchanged.

Layering moderate to large left-sided pleural effusion, unchanged

from the prior study. Moderate pulmonary vascular congestion. No

pneumothorax.

Impression

Layering moderate to large sized left-sided pleural effusion,

unchanged from June. Moderate pulmonary vascular congestion.

Underlying pneumonia cannot be ruled out.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: BHASHYAM, SANDEEP

Order Date/Time: October 22, 2015 7:50 PM

Scan Initiation Date/Time: October 22, 2015 8:05 PM

Completion Date/Time: October 22, 2015 8:15 PM

Encounter Number: 010074070771

Accession Number: 6448281

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: October 22, 2015 9:33 PM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 10/25/2015 3:03:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/ROUT

Clinical History

65M ESRD, CIRROHOSIS FOUND TO HAVE LETHARGY. LAST CXR SHOWED VOLUME

OVERLOAD. NOW S/P HD. CHECK FOR PNA

Indication

EVALUATE FOR PNEUMONIA

Technique

Technologist Comments

BEST IMAGES POSSIBLE

Comparison

10/22/2020

Findings

The heart is markedly enlarged, unchanged. There is marked pulmonary

vascular congestion, also unchanged. Large left pleural effusion

partially obscures the lower left lung. The remainder of the lungs

show no definite consolidation.

TIPS stent is noted in the right upper quadrant of the abdomen.

Impression

Cardiomegaly, vascular congestion, and left pleural effusion are all

unchanged. No definite consolidation.

Attending Radiologist: BALSAM, DVORAH

Ordered By: THARAKAN, MATHEW

Order Date/Time: October 25, 2015 6:00 AM

Scan Initiation Date/Time: October 25, 2015 2:01 AM

Completion Date/Time: October 25, 2015 3:03 AM

Encounter Number: 010074070771

Accession Number: 6450429

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: October 25, 2015 4:48 PM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 10/31/2015 3:29:00 AM

Report Name: SHOULDER LEFT PORTABLE

Examination

SHOULDER LEFT PORTABLE/ROUT

Clinical History

65FH/O HEPATIC ENCEPHAL, SARCOIDOSIS WITH CIRRHOSIS S/P TIPS, DM, HTN

RETINOPATHY, OA, L1 COMPRESSION FRACTURE

Indication

NOW WITH NEW ONSET LEFT SHOULDER PAIN

Technique

Single frontal view of the left shoulder

Technologist Comments

BEST IMAGES POSSIBLE, PT UNABLE TO COOPERATE FOR EXAM.

Comparison

None.

Findings

There is no evidence of acute fracture on limited single view. There

is narrowing of the acromioclavicular and glenohumeral joints, most

consistent with degenerative change. The bone density of the

visualized humerus has a mottled appearance, which could be secondary

to patient's underlying metabolic disorder, but consideration for

additional imaging is recommended if there is continued clinical

concern. .

Impression

Only a single view was provided. No evidence of acute fracture on

limited view. Degenerative arthrosis. Bone density of the visualized

humerus has a mottled appearance, which could be secondary to

patient's underlying metabolic disorder, but consideration for

additional imaging is recommended if there is continued clinical

concern.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: THARAKAN, MATHEW

Order Date/Time: October 30, 2015 9:05 PM

Scan Initiation Date/Time: October 31, 2015 3:24 AM

Completion Date/Time: October 31, 2015 3:29 AM

Encounter Number: 010074070771

Accession Number: 6458975

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: October 31, 2015 11:59 AM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10074070771

Report Date/Time: 12/23/2015 2:33:00 PM

Report Name: REPOSITIONING G/J TUBE

Clinical History

Broken feeding tube ( cap), which needs to be exchanged.

Technique

G-TUBE EXCHANGE

PROCEDURE:The procedure, and possible complications were explained to

the patient's brother and informed consent was obtained. The patient

was brought to the Radiology suite and placed supine on the table.

The patient presented with an existing G-tube. Nurse monitoring was

performed throughout the entire procedure. Fluoroscopic images

revealed a patent and properly placed G-tube through which contrast

material easily passed and opacified the gastric rugal folds. The

patient's upper abdomen and G-tube were prepped and draped in usual

sterile fashion. A Bentson wire was then advanced through the G-tube

and into the stomach. The G-tube was then removed and replaced with a

new 16 French G-tube over the wire until its tip was present in the

stomach. Contrast material was injected and confirmed its position

under fluoroscopy with opacification of the gastric rugal folds. The

G-tube was then secured and a sterile dressing was applied.

There were no immediate complications associated with the procedure.

The patient was transported back to the floor in stable condition.

The attending radiologist, Dr. Ferretti, was present and supervised

the entire procedure.

A total of 4.2 min of fluoroscopy time was used.

Impression

Successful exchange of a gastric tube as described above.

Attending Radiologist: FERRETTI, JOHN

Ordered By: SARWAR, CHAUDHRY

Order Date/Time: December 23, 2015 1:13 PM

Scan Initiation Date/Time:

Completion Date/Time: December 23, 2015 2:33 PM

Encounter Number: 010074070771

Accession Number: 6524500

Images were reviewed and interpreted by Attending Radiologist: Dr. FERRETTI, JOHN

Electronically Signed On: December 24, 2015 8:33 AM by Dr. FERRETTI, JOHN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 5/6/2014 4:42:00 PM

Report Name: CHEST,AP PORTABLE

Examination

CHEST,AP PORTABLE/ER

Clinical History

AMS

Assessment

EVALUATE FOR PNEUMONIA

Technique

Single AP view of the chest, portable

Comparison

None

Findings

The trachea is midline. Cardiomediastinal silhouette is within normal

limits. No focal consolidation, pleural effusion, or pneumothorax

identified. The visualized osseous structures are grossly

unremarkable.

Impression

No focal consolidation nor large pleural effusion

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: LU, CHRISTINA

Order Date: May 6, 2014 12:45 PM

Completion Date: May 6, 2014 4:42 PM

Encounter Number: 010076021947

Accession Number: 5782572

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: May 6, 2014 7:27 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 5/6/2014 4:48:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT head without contrast

Clinical History

Trauma

Technique

Multiple contiguous axial images were obtained from the skull base to

the vertex without administration of intravenous contrast. Images

were reviewed in soft tissue, subdural and bone windows. Post

processing reformatted images were produced and reviewed.

Comparison

None

Findings

No acute intracranial hemorrhage or acute transcortical infarction.

No focal parenchymal abnormality is evident, although evaluation for

subtle mass is limited without intravenous contrast. No extra-axial

collection or midline shift. Involutional changes are noted. No

hydrocephalus. No acute depressed skull fracture. A 6 mm subcutaneous

nodule is present at the vertex within the anterior left frontal

scalp near midline (coronal image 32). There is complete

opacification of right frontal sinus and partial opacification of the

right ethmoid sinus anteriorly, and near complete opacification of

the right maxillary sinus secondary to mucosal thickening. Areas of

hyperdensity within the opacified right maxillary sinus may reflect

inspissated secretions. In addition, there is questionable bony

erosion of the medial wall of the right maxillary sinus posteriorly,

with extension of soft tissue into the right nasal passageway. A

small retention cyst or polyp is present in the left maxillary sinus.

Imaged portions of the orbits and mastoid air cells appear

unremarkable. Intracranial calcified arteriosclerotic vascular

plaques are present.

Impression

1. No acute traumatic intracranial injury

2. Severe paranasal sinus disease involving the right frontal,

anterior ethmoid and maxillary sinuses; hyperdense areas within

opacified right maxillary sinus, may reflect inspissated secretions.

In addition, there is questionable bony erosion of posteromedial wall

of right maxillary sinus with extension of soft tissue into right

nasal passageway. Consider followup CT sinus for further evaluation.

3. 6 mm subcutaneous nodule within left frontal scalp; possibly

a sebaceous cyst however correlate with direct inspection

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: LU, CHRISTINA

Order Date: May 6, 2014 4:25 PM

Completion Date: May 6, 2014 4:48 PM

Encounter Number: 010076021947

Accession Number: 5783079

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: May 6, 2014 5:23 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 5/12/2014 3:38:00 PM

Report Name: MRI:BRAIN W/O CONTRAST

Clinical History

R/O CVA, ENCEPHALITIS

History and Indication

ACUTE ENCEPHALOPATHY, AGGRESSIVE BEHAVIOR, HALLUCINATION

Technique

Multiple sequences were performed through the brain in multiple

planes.

Comparison

No images available for comparison.

Findings

There is no evidence of restricted diffusion to suggest acute

infarction.

There are a few tiny foci of FLAIR hyperintensity in the bilateral

frontal white matter which are of doubtful clinical significance

which could represent minimal small vessel disease.

There is slight prominence of the lateral and 3rd ventricles and 4th

ventricle consistent with central atrophy. There is moderate

cerebral cortical atrophy and mild cerebellar atrophy, advanced for

the patient's stated age. Correlate with medical and social history.

There is no mass, mass effect, midline shift or other focal

parenchymal abnormality.

There is no intracranial hemorrhage or extra-axial collection.

There is normal flow voids in the major arteries of the circle of

Willis.

The pituitary gland is normal in size.

The right maxillary sinus is completely filled with heterogeneous

material all likely including inspissated mucus. There is also

essentially complete opacification of the anterior right ethmoid

sinus. This suggests blockage of the right ostiomeatal unit. There is

a small mucous retention cyst in the left maxillary sinus.

No gross abnormality is noted within the orbits.

Impression

Atrophy advanced for age.

Severe Sinus disease as described.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: CHEN, CHUN

Order Date: May 8, 2014 5:45 PM

Completion Date: May 12, 2014 3:38 PM

Encounter Number: 010076021947

Accession Number: 5785886

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: May 12, 2014 4:41 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 5/18/2014 10:34:00 AM

Report Name: CT:ABD AND PELVIS W/O CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

50 MALE WITH UNCONTROLLED FINGERSTICKS, HISTORY OF ALCOHOLISM, PLEASE

RULE OUT CHRONIC PANCREATITIS, R/O MASS

Technique

Routine study. Post Processed reconstructions included.

Contrast

None.

Comparison

None.

Findings

The study is limited due to excessive of noise and lack of contrast,

especially for evaluation of the pancreas and mass.

LUNG BASES: No focal opacity. No pleural effusion.

Abdomen:

LIVER: There is mild hepatomegaly. Evaluation of focal lesion is

limited by lack of intravenous contrast.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology. Evaluation is limited by

lack of intravenous contrast.

SPLEEN: Normal size. No focal lesions.

ADRENALS: Not well seen.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: No obstruction. Abundant fecal material is noted in the colon.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta. Vascular calcifications are noted.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Distended.

BONES: No acute fracture. No focal lesion.

Impression

Study limited by excessive noise and lack of intravenous contrast,

especially for evaluation of pancreas or mass.

Mild hepatomegaly.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: ASIF, AINUL

Order Date: May 18, 2014 9:35 AM

Completion Date: May 18, 2014 10:34 AM

Encounter Number: 010076021947

Accession Number: 5796183

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: May 18, 2014 11:14 AM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 6/19/2014 8:48:00 AM

Report Name: ULTRASOUND RT UPPER QUAD

Examination

Right upper quadrant ultrasound.

Clinical History

EVALUATE FOR BILIARY DISEASE

History and Indication

ETOH ABUSE

Technique

Gray scale real time ultrasound was performed to evaluate the right

upper quadrant in transverse and sagittal planes, also utilizing

color Doppler exam.

Comparison

No prior sonograms. Comparison made selected images prior abdominal

pelvic CT 05/18/2014.

Findings

Ultrasound evaluation is somewhat limited related to unfavorable

patient body habitus as well as extensive shadowing from overlying

bowel gas.

The liver is enlarged in size at 21 cm in length. The liver

parenchyma is increased in echogenicity with poor penetration of the

acoustic beam which may be due to diffuse fatty infiltration and/or

fibrosis. Note this does further limit ultrasound evaluation for

superimposed focal lesion. Visualized liver parenchyma demonstrates

no definite focal liver mass. The portal vein is patent with normal

direction of flow. The hepatic vein and IVC confluence is patent.

There is no intrahepatic ductal dilatation. There is no extrahepatic

ductal dilatation. The visualized proximal common bile duct is seen,

maximum caliber 4 mm. Remaining duct and pancreas are largely

obscured by overlying bowel gas.

The gallbladder is physiologically distended and demonstrates foci of

ring down artifact emanating from the anterior gallbladder wall

suggesting possible adenomyomatosis. Specifically, there is no

evidence for contained gallstones or sludge. There is no evidence for

gallbladder wall thickening or pericholecystic fluid. Negative

sonographic Murphy's sign is reported.

Incidental views of the right kidney shows normal size and contour

measuring12.3 x 5.1 x 4.9cm. There is no evidence for hydronephrosis

or renal calculi visualized by strict ultrasound criteria.

There is no evidence for significant ascites.

The visualized upper abdominal aorta and IVC are grossly unremarkable

where seen.

Impression

Hepatomegaly and findings of hepatic steatosis /fibrosis. No gross

focal lesion demonstrated. Hepatopetal portal flow.

No evidence for cholelithiasis, gallbladder wall thickening and no

sonographic Murphy sign. Incidentally noted foci of ring down

artifact emanating from the anterior gallbladder wall suggesting

possible adenomyomatosis.

Otherwise, negative right Upper quadrant sonogram. Specifically no

evidence for biliary dilatation.

Preliminary report was provided via PACs shortly following exam

completion on 6/18/2014.

Attending Radiologist: VAN DE VEGTE, G LUCY

Ordered By: KRIEGSFELD, TERESA

Order Date: June 18, 2014 6:50 PM

Completion Date: June 19, 2014 8:48 AM

Encounter Number: 010076021947

Accession Number: 5834567

Images were reviewed and interpreted by Attending Radiologist: Dr. VAN DE VEGTE, G LUCY

Electronically Signed On: June 19, 2014 9:14 AM by Dr. VAN DE VEGTE, G LUCY

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 2/26/2015 12:54:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR STROKE

History and Indication

51 M UNCONTROLLED DM, PROLONGED HOSPITALIZATION PENDING PLACEMENT,

NOW C/O SUDDEN ONSET LEFT SIDED BLURRY VISION

Technique

Contiguous axial slices were obtained from the sku toenail ll base to

the vertex. Sagittal and coronal reformatted images were also

obtained.

Comparison

MRI 05/12/2014 and head CT 05/06/2014

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

Again noted is mild dilatation of the lateral and 3rd ventricles

representing central atrophy. The 4th ventricle is also slightly

prominent. There is mild to moderate cerebral cortical atrophy and

mild cerebellar atrophy advanced for the patient's stated age.

Correlate with clinical and surgical history.

There is no mass effect, midline shift or focal parenchymal

abnormality. The minimal small vessel disease noted on the MRI is not

visible on CT.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is complete opacification of the superior right maxillary sinus

with mucoperiosteal thickening of its anterior and posterior walls.

He the tissue in the sinuses continuous with the tissue in the

adjacent nasal cavity and the status of the medial wall of the sinus

is uncertain. Extensive disease again noted in the right ethmoid

sinus. The right frontal sinus is not developed. There is disease in

the right fronto ethmoidal recess however.

Impression

No acute intracranial pathology noted. No interval change. Atrophy

advanced for age. Correlate with medical and social history. Sinus

disease.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: LIN, JUAN

Order Date: February 26, 2015 11:40 AM

Completion Date: February 26, 2015 12:54 PM

Encounter Number: 010076021947

Accession Number: 6141561

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: February 26, 2015 1:15 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 2/27/2015 12:14:00 PM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: STEPHAN SCARPATI Exam Date: 2/27/2015 at Heart

Rate: 110

11:00:55 AM

MR #: 30113414 Report Date: 2/27/2015 Rhythm:

Sinus

Tachycardia

ACC #: 6142645 Height: 165.10 cm BP: 134/78

DOB: 8/26/1963 Weight: 75.30 kg Location:

16N

Age/Sex: 51 years / M BSA: 1.83 m²

Ref. Physician: Teressa, Getu, cc:

Sonographer: TS

Indications: R/O Cardiac Source of Emboli

History: AMS, DM, Polysubstance abuse, Etoh abuse, Hepatitis C,

Encephalopathy,

Severe agitation

Procedure: Comp. Echo w/contrast - C8929, Agitated Saline Injection -

96374,

Definity Contrast - Q9957 and Patient Supine. The use of

contrast was

indicated for enhancement of endocardial border

definition. There

were no contraindications for the use of contrast in this

patient.

Verbal consent was given by the patient who is aware of

the possible

adverse reactions associated with the use of contrast. No

adverse

reactions or hemodynamic compromise identified.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.06 cm 2.0 - 3.8 LA Diam 3.44 cm 3.0-4.0

IVS 0.95 cm 0.6 - 1.0 LA Area 11.81cm² <=20

LVID 5.72 cm 4.2 - 5.9 4.92 cm LA Vol 31.56 ml 18-58

LVPW 0.99 cm 0.6 - 1.0 LA Vol/BSA 17.27ml/m² 22+ / -6

RA Diam 3.21cm 2.9-4.5

Ao at the sinuses 3.37 cm

Ao Ascending 3.31 cm

Ao Arch 2.38 cm

Ao Descending 2.66cm

LVEF 35 % (visual estimation)

LV FS 13.9

LV SV 78.7 ml

LV SI 43.1 ml/m²

Aov Cusp Sep 1.72 cm

(Systole)

Aov VTI 0.182 m LVOT VTI 0.099 m LVOT diameter

2.04

cm

Aov VMax 1.21 m/s LVOT Vmax 0.64 m/s Dimensionless

Index 0.53

Aov Pk Pressure 5.8 mmHg Aov Mn 3.7 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 1.78 cm² Aov Area Index 0.98 cm²/m²

(VTI)

MV VTI MV DT 118 msec

MV E Vmax 0.59 m/s MV A Vmax 0.79 m/s E/A 0.75

MV Area press 1/2 Time 6.44

IVRT 125 E/E ' 13.21

Septal E ' 0.045 m/s Prop Velocity

Lateral E ' 0.04 m/s LA Pressure 18.28 mmHg

Average E' 0.045 m/s

MV Average E/E' 13.21

TR Vmax 2.13 m/s TR Pk Grad 18.1 mmHg RA Pressure 3 mmHg RVSP

21.1 mmHg

TV E Max TV Mn Grad mmHg PHT 34.15 msec TV VTI

PV Vmax 0.73 m/s PV Pk Grad 2.1 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

normal. The relative wall thickness is normal (0.34). Global left

ventricular systolic function is moderately reduced. The ejection

fraction is 35% by visual estimation. Left ventricular basal

fractional shortening is decreased.

Left Ventricle - Diastole:The left ventricular isovolumetric

relaxation time is prolonged at 125 msec. The Doppler derived

transmitral left ventricular inflow velocity pattern is A wave

dominant. The Doppler derived early diastolic deceleration time is

short at 118 msec. The flow in the pulmonary vein is systolic

dominant. The velocity of the early diastolic septal mitral annular

movement, as determined by tissue Doppler imaging is reduced at 0.045

m/s. The velocity of the early diastolic lateral mitral annular

movement, as determined by tissue Doppler imaging is reduced at 0.04

m/s. The overall diastolic function is mildly impaired (grade I,

impaired relaxation pattern) with normal left ventricular filling

pressures.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is normal in size.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation. There is lipomatous hypertrophy of

the atrial septum. No bubbles seen in the left heart with agitated

saline injection.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal. The right ventricular

fractional area change is 33.15% which is normal.

Aortic Valve: The aortic valve is trileaflet and is calcified with

normal excursion.

Mitral Valve: The mitral valve is structurally normal. Trace mitral

regurgitation is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Trace

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is normal.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.37 cm. The ascending aorta is normal at 3.31 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.13 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is normal at 21.1 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Normal left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Moderately reduced global left ventricular systolic function.

4. Mild diastolic dysfunction with normal left ventricular filling

pressures.

5. Normal right ventricular systolic function.

6. Trileaflet aortic valve and aortic sclerosis.

7. Trace mitral regurgitation.

8. Trace tricuspid regurgitation.

9. No pericardial effusion.

10. Normal aortic root diameter for body size.

11. Normal atrial septum by 2D and color Doppler.

12. No agitated saline bubbles seen in the left heart.

014300 Noelle Mann MD, FACC

Electronically signed by 014300 Noelle Mann MD, FACC on 2/27/2015 at

12:33:02 PM

\*\*\* Final \*\*\*

Attending Cardiologist: MANN, NOELLE

Ordered By: LIN, JUAN

Order Date: February 27, 2015 8:30 AM

Completion Date: February 27, 2015 12:14 PM

Encounter Number: 010076021947

Accession Number: 6142645

Images were reviewed and interpreted by Attending Cardiologist: Dr. MANN, NOELLE

Electronically Signed On: February 27, 2015 12:33 PM by Dr. MANN, NOELLE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 2/27/2015 6:49:00 PM

Report Name: CT ANGIO HEAD W/WO INCL PST PR

Examination

CT HEAD WITHOUT CONTRAST

CT HEAD ANGIOGRAM

CT NECK ANGIOGRAM

Clinical History

Sudden onset left visual deficit.

History and Indication

SUSPECTED WERNICKE'S ENCEPHALOPATHY, WITH SUDDEN ONSET LEFT EYE

BLURRINESS

Technique

Noncontrast CT head: Contiguous axial slices were obtained from the

skull base to the vertex without contrast.

CT angio of the neck: Following rapid IV bolus of contrast material,

rapid helical imaging with very thin slices from the aortic arch to

the lower cranial level was performed. Following this, 3-D

workstation was utilized to create 3-D rendered MIP images. NASCET

methodology was employed to evaluate the degree of stenosis.

CT angiography of the head: Following rapid injection of intravenous

contrast material after an appropriate delay, very thin helical axial

slices were obtained through the entire head. Following this, 3-D

workstation was employed to create 3-D rendered and MIP images.

Contrast

Contrast Agent OMNIPAQUE 350 105 mg/dl 02/27/2015 INTRAVENOUS

Comparison

CT head without contrast 02/26/2015

Findings

Noncontrast CT head: There is no evidence of acute intracranial

hemorrhage, acute territorial infarction or focal extra-axial

collection. There is volume loss, more than expected for patient's

age. Please correlate with medical and social history. Vascular

calcifications are present in both ICA siphons. Bony calvarium is

intact.

There is diffuse opacification of the right frontal, right maxillary

and anterior right ethmoids. There is chronic osteitis of the right

maxillary sinus wall. Hyperdense components in the right maxillary

sinus may represent inspissated secretions and/or superimposed fungal

colonization.

The mastoid air cells are clear. There is a nonspecific 0.5 x 0.5 cm

round, well-defined slightly hyperdense lesion within the

subcutaneous fat overlying the frontal calvarium at the vertex,

possibly a sebaceous cyst with proteinaceous contents. Please

correlate with physical exam findings.

CT angio of the neck: There is a bovine aortic arch with minimal

calcification at the takeoff of the great vessels.

Right common carotid artery: Normal course and caliber with no

hemodynamically significant stenosis. There is mild calcification at

the bifurcation.

Right internal carotid artery: Mild calcification at the origin.

Normal course and caliber with no hemodynamically significant

stenosis through the cervical segment.

Right external carotid artery: Origin is patent, otherwise

unremarkable.

Left common carotid artery: Normal course and caliber with no

significant stenosis. Intimal hyperplasia suggested along the mid to

distal left CCA with mild calcification at the bifurcation.

Left internal carotid artery: Normal course and caliber with no

hemodynamically significant stenosis.

Left external carotid artery: the origin is patent, otherwise

unremarkable.

Vertebral arteries: The left vertebral artery is dominant. There is

calcification at the origins of both vertebral arteries with moderate

narrowing of the right vertebral artery origin. There is mild

calcification along the distal right V1 segment with mild to moderate

narrowing of the lumen. There is mild calcification present along the

V2 segments of both vertebral arteries without significant luminal

narrowing. There is also mild calcification along the V4 segment of

the right vertebral artery without significant luminal narrowing.

There is diffuse soft tissue fullness throughout Waldeyer's ring.

This may be on the basis of tonsillar/ adenoidal hypertrophy. Please

correlate with direct visualization and patient's immune status.

There is minimal biapical scarring. Cervical spondylosis is noted.

CT angiography of the head:

Anterior circulation: Central arteries are patent. There is moderate

calcification along the cavernous segments of both internal carotid

arteries with mild luminal narrowing. There is a 1 x 2 MM

outpouching along the cavernous segment of the left internal carotid

artery, which points laterally (image 194 of series 6). The left A1

segment is dominant. The anterior and middle cerebral arteries are

patent with no significant stenosis. The anterior communicating

artery is patent.

Posterior circulation: There is no occlusion or significant stenosis

in the central arteries. There is a patent left PICA, bilateral AICAs

and SCAs. There are no definite patent posterior communicating

arteries.

There is no gross AVM in the circle of Willis.

Impression

Noncontrast CT head: No evidence of acute intracranial hemorrhage or

acute territorial infarct.

Right maxillary, frontal and anterior ethmoid sinus disease, as

above.

CT angio of the neck: Moderate narrowing at the origin of the

hypoplastic right vertebral artery. No evidence of hemodynamically

significant stenosis of the extracranial carotid arteries or the

dominant left vertebral artery.

CT angiography of the head: No significant stenosis in the anterior

posterior circulation. Mild narrowing of the cavernous internal

carotid arteries, bilaterally.

1 x 2 MM, laterally oriented outpouching of the cavernous left ICA,

as described above. Although this may be atherosclerotic outpouching,

an aneurysm cannot be entirely excluded. Continued follow-up is

recommended.

Attending Radiologist: WOROCH, LUBOSLAV

Ordered By: LIN, JUAN

Order Date: February 27, 2015 1:50 PM

Completion Date: February 27, 2015 6:49 PM

Encounter Number: 010076021947

Accession Number: 6143380

Images were reviewed and interpreted by Attending Radiologist: Dr. WOROCH, LUBOSLAV

Electronically Signed On: February 28, 2015 8:31 AM by Dr. WOROCH, LUBOSLAV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 2/27/2015 6:50:00 PM

Report Name: CT ANGIO NECK W/WO INC POSTPRO

Examination

CT HEAD WITHOUT CONTRAST

CT HEAD ANGIOGRAM

CT NECK ANGIOGRAM

Clinical History

Sudden onset left visual deficit.

History and Indication

SUSPECTED WERNICKE'S ENCEPHALOPATHY, WITH SUDDEN ONSET LEFT EYE

BLURRINESS

Technique

Noncontrast CT head: Contiguous axial slices were obtained from the

skull base to the vertex without contrast.

CT angio of the neck: Following rapid IV bolus of contrast material,

rapid helical imaging with very thin slices from the aortic arch to

the lower cranial level was performed. Following this, 3-D

workstation was utilized to create 3-D rendered MIP images. NASCET

methodology was employed to evaluate the degree of stenosis.

CT angiography of the head: Following rapid injection of intravenous

contrast material after an appropriate delay, very thin helical axial

slices were obtained through the entire head. Following this, 3-D

workstation was employed to create 3-D rendered and MIP images.

Contrast

Contrast Agent OMNIPAQUE 350 105 mg/dl 02/27/2015 INTRAVENOUS

Comparison

CT head without contrast 02/26/2015

Findings

Noncontrast CT head: There is no evidence of acute intracranial

hemorrhage, acute territorial infarction or focal extra-axial

collection. There is volume loss, more than expected for patient's

age. Please correlate with medical and social history. Vascular

calcifications are present in both ICA siphons. Bony calvarium is

intact.

There is diffuse opacification of the right frontal, right maxillary

and anterior right ethmoids. There is chronic osteitis of the right

maxillary sinus wall. Hyperdense components in the right maxillary

sinus may represent inspissated secretions and/or superimposed fungal

colonization.

The mastoid air cells are clear. There is a nonspecific 0.5 x 0.5 cm

round, well-defined slightly hyperdense lesion within the

subcutaneous fat overlying the frontal calvarium at the vertex,

possibly a sebaceous cyst with proteinaceous contents. Please

correlate with physical exam findings.

CT angio of the neck: There is a bovine aortic arch with minimal

calcification at the takeoff of the great vessels.

Right common carotid artery: Normal course and caliber with no

hemodynamically significant stenosis. There is mild calcification at

the bifurcation.

Right internal carotid artery: Mild calcification at the origin.

Normal course and caliber with no hemodynamically significant

stenosis through the cervical segment.

Right external carotid artery: Origin is patent, otherwise

unremarkable.

Left common carotid artery: Normal course and caliber with no

significant stenosis. Intimal hyperplasia suggested along the mid to

distal left CCA with mild calcification at the bifurcation.

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hemodynamically significant stenosis.

Left external carotid artery: the origin is patent, otherwise

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Vertebral arteries: The left vertebral artery is dominant. There is

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calcification along the distal right V1 segment with mild to moderate

narrowing of the lumen. There is mild calcification present along the

V2 segments of both vertebral arteries without significant luminal

narrowing. There is also mild calcification along the V4 segment of

the right vertebral artery without significant luminal narrowing.

There is diffuse soft tissue fullness throughout Waldeyer's ring.

This may be on the basis of tonsillar/ adenoidal hypertrophy. Please

correlate with direct visualization and patient's immune status.

There is minimal biapical scarring. Cervical spondylosis is noted.

CT angiography of the head:

Anterior circulation: Central arteries are patent. There is moderate

calcification along the cavernous segments of both internal carotid

arteries with mild luminal narrowing. There is a 1 x 2 MM

outpouching along the cavernous segment of the left internal carotid

artery, which points laterally (image 194 of series 6). The left A1

segment is dominant. The anterior and middle cerebral arteries are

patent with no significant stenosis. The anterior communicating

artery is patent.

Posterior circulation: There is no occlusion or significant stenosis

in the central arteries. There is a patent left PICA, bilateral AICAs

and SCAs. There are no definite patent posterior communicating

arteries.

There is no gross AVM in the circle of Willis.

Impression

Noncontrast CT head: No evidence of acute intracranial hemorrhage or

acute territorial infarct.

Right maxillary, frontal and anterior ethmoid sinus disease, as

above.

CT angio of the neck: Moderate narrowing at the origin of the

hypoplastic right vertebral artery. No evidence of hemodynamically

significant stenosis of the extracranial carotid arteries or the

dominant left vertebral artery.

CT angiography of the head: No significant stenosis in the anterior

posterior circulation. Mild narrowing of the cavernous internal

carotid arteries, bilaterally.

1 x 2 MM, laterally oriented outpouching of the cavernous left ICA,

as described above. Although this may be atherosclerotic outpouching,

an aneurysm cannot be entirely excluded. Continued follow-up is

recommended.

Attending Radiologist: WOROCH, LUBOSLAV

Ordered By: LIN, JUAN

Order Date: February 27, 2015 2:00 PM

Completion Date: February 27, 2015 6:50 PM

Encounter Number: 010076021947

Accession Number: 6143381

Images were reviewed and interpreted by Attending Radiologist: Dr. WOROCH, LUBOSLAV

Electronically Signed On: February 28, 2015 8:31 AM by Dr. WOROCH, LUBOSLAV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 3/3/2015 2:52:00 PM

Report Name: MRA NECK WO CONTRAST

Examination

MRA NECK WITHOUT CONTRAST

Clinical History

EVALUATE FOR OCCULSION/STENOSIS

History and Indication

51 MALE WITH DM, WITH SUDDEN ONSET LEFT SIDED BLURRED VISION, PLEASE

EVALUATE

Technique

3D time-of-flight for the arteries in the neck. Following this MIP

images were created. NASCET methodology was employed to evaluate the

degree of stenosis.

Comparison

No images available for comparison.

Findings

There is no evidence of any stenosis of the right and left carotid

arteries and right and left vertebral arteries. The right vertebral

artery is hypoplastic.

There is no evidence of dissection.

Impression

No significant abnormality noted.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: LIN, JUAN

Order Date: February 26, 2015 10:15 PM

Completion Date: March 3, 2015 2:52 PM

Encounter Number: 010076021947

Accession Number: 6142419

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: March 3, 2015 2:56 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 3/3/2015 2:57:00 PM

Report Name: MRA HEAD WO CONTRAST

Examination

MRA Head without contrast

Clinical History

EVALUATE FOR ARTERIAL DISEASE

History and Indication

51 MALE WITH DM, WITH SUDDEN ONSET LEFT SIDED BLURRED VISION, PLEASE

EVALUATE

Technique

3D TOF

Comparison

No prior studies are available for comparison.

Findings

The visualized vessels of the anterior and posterior cerebral

vascular territories demonstrates normal flow signal, contour, and

caliber without evidence for stenosis, intracranial aneurysm, or

vascular malformation.

There is complete opacification within the right maxillary sinus with

near complete opacification of the right frontal sinus and right

ethmoid air cells.

Impression

Normal intracranial MRA.

Extensive paranasal sinus mucosal changes.

Attending Radiologist: BANGIYEV, LEV

Ordered By: LIN, JUAN

Order Date: February 26, 2015 10:15 PM

Completion Date: March 3, 2015 2:57 PM

Encounter Number: 010076021947

Accession Number: 6142418

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: March 3, 2015 4:03 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10076021947

Report Date/Time: 12/6/2015 3:12:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Hypotension

Technique

Portable AP film of the chest

Comparison

Comparison is made to 05/06/2014

Findings

Cardiomediastinal silhouette is within normal limits.

No focal consolidation. No large pleural effusion. No pneumothorax.

No pulmonary vascular congestion.

Visualized osseous structures are unremarkable.

Impression

No evidence of active cardiopulmonary disease.

Attending Radiologist: BALSAM, DVORAH

Ordered By: CHAKRAVARTY, RAJARSHI

Order Date/Time: December 5, 2015 11:15 PM

Scan Initiation Date/Time: December 6, 2015 2:30 AM

Completion Date/Time: December 6, 2015 3:12 AM

Encounter Number: 010076021947

Accession Number: 6502943

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: December 6, 2015 1:48 PM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 6/12/2014 1:21:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT head without contrast

Clinical History

Trauma

Technique

Multiple contiguous axial images were obtained from the skull base to

the vertex without administration of intravenous contrast. Images

were reviewed in soft tissue, subdural and bone windows. Post

processing reformatted images were produced and reviewed.

Comparison

CT head 11/26/2013

Findings

No acute intracranial hemorrhage or compelling evidence for acute

transcortical infarction. Again noted are areas of

encephalomalacia/gliosis medially in the right cerebellum and

anterolaterally in the left frontal lobe. Interval development of

hypodensity in the left parieto-occipital lobe, likely chronic given

the ex vacuo dilatation of the occipital horn of the left lateral

ventricle. Interval resolution of previously present left

parieto-occipital subdural hematoma. There are areas of low

attenuation in the periventricular and subcortical white matter, a

nonspecific finding however most likely secondary to chronic small

vessel ischemic disease. No extra-axial collection or midline shift.

Involutional changes are noted. No hydrocephalus. No acute depressed

skull fracture. Again noted is a retention cyst or polyp in the left

sphenoid sinus. Mucosal thickening is noted in the left maxillary

sinus. The imaged portions of the orbits, remaining paranasal sinuses

and mastoid air cells appear unremarkable. Intracranial calcified

arteriosclerotic vascular plaques are present.

Impression

1. No acute traumatic intracranial injury

2. Interval development of encephalomalacia/gliosis in left

parieto-occipital lobe, likely sequela of chronic infarction or

trauma given ex vacuo dilatation of left lateral ventricle occipital

horn

3. Again noted, areas of encephalomalacia/gliosis in right

cerebellum and left frontal lobe

4. Chronic small vessel disease

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: TAIT, ROBERT

Order Date: June 12, 2014 12:40 PM

Completion Date: June 12, 2014 1:21 PM

Encounter Number: 010077163326

Accession Number: 5826940

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: June 12, 2014 2:05 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 6/12/2014 3:00:00 PM

Report Name: CHEST,AP PORTABLE

Clinical History

POSSIBLE PNEUMONIA

Technique

Single portable upright AP view of the chest

Comparison

Radiographs dated 11/15/2013

Findings

Status post interval extubation.

There is no focal consolidation, large pleural effusion,

pneumothorax, or pulmonary vascular congestion. The cardiomediastinal

silhouette is within normal limits.

Visualized osseous structures are within normal limits.

Impression

No focal consolidation or large pleural effusion

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: TAIT, ROBERT

Order Date: June 12, 2014 2:35 PM

Completion Date: June 12, 2014 3:00 PM

Encounter Number: 010077163326

Accession Number: 5827151

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: June 12, 2014 3:42 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 7/15/2014 7:02:00 PM

Report Name: SHOULDER/LEFT/PORTABLE

Clinical History

58 MALE WITH LEFT SHOULDER PAIN, R/O FRACTURE

Indication

POSSIBLE FRACTURE

Technique

Left shoulder 3 views portable.

Comparison

None.

Findings

There is no evidence of fracture or dislocation. The visualized soft

tissues have a normal radiographic appearance.

Impression

No fracture or dislocation.

Attending Radiologist: BALSAM, DVORAH

Ordered By: ASIF, AINUL

Order Date: July 15, 2014 8:35 AM

Completion Date: July 15, 2014 7:02 PM

Encounter Number: 010077163326

Accession Number: 5865043

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: July 15, 2014 8:24 PM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 9/30/2014 7:12:00 PM

Report Name: ABDOMEN SERIES (FLAT/ERECT)

Clinical History

58M WITH PMH OF HX OF TBI P/W ABDOMINAL BLOATING AND NO BOWEL

MOVEMENT IN OVER 24 HOURS.

Technique

Supine and upright views of the abdomen.

Comparison

None.

Findings

There is a nonobstructive bowel gas pattern. Stool is seen in the

right colon. There is no evidence of intraperitoneal free air.

The visualized osseous structures appear intact.

Impression

No radiographic evidence of bowel obstruction.

Attending Radiologist: ABBASI, ALMAS

Ordered By: CHAKRAVARTY, RAMANUJ

Order Date: September 30, 2014 4:20 PM

Completion Date: September 30, 2014 7:12 PM

Encounter Number: 010077163326

Accession Number: 5962030

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: October 1, 2014 2:37 PM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 3/2/2015 11:38:00 AM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

CVA SYMPTOMS

History and Indication

NEW LEFT ARM MOTOR WEAKNESS AND NUMBNESS

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

Comparison is made with the study from 06/12 /2014.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

Again there is chronic infarct in the left anterior frontal lobe and

left medial parietal lobe in the watershed distribution and also

another small focus of old infarct in the medial inferior right

hemisphere. Again noted is a small focus of old infarct in the left

pre and post central gyrus, respectively.

The ventricles, cisterns and sulci are age-appropriate in size.

There is no mass effect, midline shift.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids other than a small retention cyst in left maxillary and

sphenoid sinuses respectively. .

Impression

No acute hemorrhage or acute infarct. Multiple old infarctions are

again seen.

Attending Radiologist: YAN, ZENGMIN

Ordered By: KHIANI, KOMAL

Order Date: March 2, 2015 11:00 AM

Completion Date: March 2, 2015 11:38 AM

Encounter Number: 010077163326

Accession Number: 6145781

Images were reviewed and interpreted by Attending Radiologist: Dr. YAN, ZENGMIN

Electronically Signed On: March 2, 2015 12:45 PM by Dr. YAN, ZENGMIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 3/2/2015 8:00:00 PM

Report Name: MRI BRAIN WO CONTRAST

Clinical History

EVALUATION OF STROKE

History and Indication

NEW LEFTARM NUMBNESS AND MOTOR WEAKNESS

Technique

Multiple sequences were performed through the brain in multiple

planes.

Comparison

No prior brain MRIs available for comparison.

Findings

There is no evidence of restricted diffusion to suggest acute

infarction.

Again seen are areas of encephalomalacia and chronic FLAIR

hyperintensity likely related to prior traumatic brain injury and /

or prior infarction in the left anterior frontal lobe, left medial

parietal lobe and right cerebral hemisphere as well as multiple

additional smaller foci of FLAIR hyperintensity representing chronic

small vessel disease. There is associated ex vacuo dilatation of the

the ventricles, especially the left lateral ventricle. The

There is no mass, mass effect, midline shift or acute appearing focal

parenchymal abnormality.

There is no intracranial hemorrhage or extra-axial collection.

There is normal flow voids in the major arteries of the circle of

Willis.

No gross abnormality is noted within the orbits.

Impression

No evidence of acute infarct or other acute intracranial pathology.

Chronic changes as above related to prior traumatic brain injury and

prior infarcts.

Attending Radiologist: EISENBERG, JASON

Ordered By: KHIANI, KOMAL

Order Date: March 2, 2015 1:00 PM

Completion Date: March 2, 2015 8:00 PM

Encounter Number: 010077163326

Accession Number: 6146057

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: March 3, 2015 12:11 AM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 3/2/2015 8:01:00 PM

Report Name: MRA NECK WO CONTRAST

Examination

MRA NECK WITHOUT CONTRAST

Clinical History

EVALUATE FOR ARTERIAL INJURY

History and Indication

NEW RT ARM NUMBNESS/WEAKNESS

Technique

3D time-of-flight for the arteries in the neck. Following this MIP

images were created. NASCET methodology was employed to evaluate the

degree of stenosis.

Comparison

No images available for comparison.

Findings

There is no evidence of greater than 30% stenosis of the right and

left carotid arteries and right and left vertebral arteries.

There is no evidence of dissection. Portions of the distal right

vertebral artery not well seen, likely related to hyperplasia and

slow flow.

Impression

No significant abnormality noted.

Attending Radiologist: EISENBERG, JASON

Ordered By: KHIANI, KOMAL

Order Date: March 2, 2015 5:25 PM

Completion Date: March 2, 2015 8:01 PM

Encounter Number: 010077163326

Accession Number: 6146629

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: March 3, 2015 12:13 AM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 3/2/2015 8:01:00 PM

Report Name: MRA HEAD WO CONTRAST

Examination

MRA Head without contrast

Clinical History

EVALUATE FOR ARTERIAL DISEASE

History and Indication

NEW RT ARM WEAKNESS/NUMBNESS

Technique

3D TOF

Comparison

No prior studies are available for comparison.

Findings

There are foci of intermittent narrowing of the left internal carotid

artery in the cavernous and clinoid segments with what appears to be

up to 70 percent stenosis.

There is otherwise no significant occlusive disease, aneurysm or AVM

noted.

Impression

There appears to be intermittent narrowing of the left internal

carotid artery especially in the cavernous and clinoid segments with

up to 70 percent stenosis.

Attending Radiologist: EISENBERG, JASON

Ordered By: KHIANI, KOMAL

Order Date: March 2, 2015 5:25 PM

Completion Date: March 2, 2015 8:01 PM

Encounter Number: 010077163326

Accession Number: 6146627

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: March 3, 2015 12:17 AM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 4/27/2015 7:01:00 PM

Report Name: FOOT RIGHT 2 VIEWS

Clinical History

Pain on ambulation

Technique

3 views of the right foot.

Comparison

None.

Findings

No fracture or dislocation is identified. The joint spaces are

unremarkable. No significant soft tissue swelling is seen. There are

no areas of bony rarefaction to suggest osteomyelitis.

Impression

No acute fracture or dislocation. No evidence of osteomyelitis.

Attending Radiologist: AREMAN, DAVID

Ordered By: ABBENE, DEA

Order Date: April 27, 2015 5:10 PM

Completion Date: April 27, 2015 7:01 PM

Encounter Number: 010077163326

Accession Number: 6217721

Images were reviewed and interpreted by Attending Radiologist: Dr. AREMAN, DAVID

Electronically Signed On: May 1, 2015 1:15 PM by Dr. AREMAN, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10077163326

Report Date/Time: 4/27/2015 7:01:00 PM

Report Name: HIPS BILATERAL AND AP PELVIS

Clinical History

POSSIBLE ARTHRITIC CHANGES

History and Indication

PAIN ON LEG FLEXION

Technique

Single frontal view of the pelvis and frog leg views of both hips (3

views altogether) submitted.

Comparison

None

Findings

No visualized acute fracture/dislocation. The sacroiliac joints are

unremarkable. No significant degenerative change is seen in the hips.

Impression

No visualized acute fracture or dislocation. No degenerative disease.

Attending Radiologist: AREMAN, DAVID

Ordered By: ABBENE, DEA

Order Date: April 27, 2015 5:10 PM

Completion Date: April 27, 2015 7:01 PM

Encounter Number: 010077163326

Accession Number: 6217722

Images were reviewed and interpreted by Attending Radiologist: Dr. AREMAN, DAVID

Electronically Signed On: May 1, 2015 1:20 PM by Dr. AREMAN, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 9/10/2014 6:38:00 PM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

AGGITATION

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 09/04/2014.

Findings

The lung fields are clear there are no congestive changes, pleural

effusions or airspace consolidation. The cardiomediastinal silhouette

is within normal limits.

Bony structures appear grossly normal.

Impression

1. No acute intrathoracic disease.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: FISCHL, ADRIAN

Order Date: September 10, 2014 3:00 PM

Completion Date: September 10, 2014 6:38 PM

Encounter Number: 010079900790

Accession Number: 5936636

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: September 10, 2014 7:01 PM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 9/13/2014 10:08:00 PM

Report Name: CHEST AP PORTABLE

REPORT

AP chest.

Comparison: 09/10/2014, most recent prior.

History: Possible effusion.

Findings: There is no sizeable effusion. Very subtle increased

markings are noted in the right lung base relatively stable compared

to prior study which may be related to mild atelectasis. Correlate

clinically to exclude evolving subtle pneumonia.

The remainder of the study is unchanged. There is stable mild

cardiomegaly.

Impression:

No sizeable effusions noted.

Very mild increased markings in the right lung base possibly

atelectatic. No significant change. Recommend close followup to

exclude developing infiltrate.

Attending Radiologist: GOULD, ELAINE

Ordered By: SOLIS-COHEN, ADAM

Order Date: September 13, 2014 9:55 PM

Completion Date: September 13, 2014 10:08 PM

Encounter Number: 010079900790

Accession Number: 5940638

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: September 14, 2014 4:15 AM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 9/18/2014 7:20:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SEIZURE

Indication

POSSIBLE EFFUSION

Technique

CHEST AP PORTABLE/STAT

Comparison

09/13/2014

Findings

The cardiomediastinal silhouette is within normal limits. There is no

focal consolidation, pulmonary vascular congestion or pleural

effusion.

Impression

No acute cardiopulmonary process.

Attending Radiologist: ABBASI, ALMAS

Ordered By: KIM, ETHAN

Order Date: September 18, 2014 6:50 AM

Completion Date: September 18, 2014 7:20 AM

Encounter Number: 010079900790

Accession Number: 5946239

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: September 18, 2014 8:39 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 9/18/2014 11:37:00 AM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR SEIZURE

History and Indication

SEIZURE

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

09/03/2014

Findings

The study is limited secondary to patient's motion and suboptimal

head positioning.

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There is mild to moderate dilatation of the lateral and 3rd

ventricles within normal size 4th ventricle. There is no

hydrocephalus. There is moderate cerebral cortical atrophy and mild

cerebellar vermian atrophy is advanced for the patient's stated age.

Correlate with medical and social history. This is unchanged from

the prior study.

There is no mass effect, midline shift or focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No acute intracranial pathology.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: KIM, ETHAN

Order Date: September 18, 2014 7:00 AM

Completion Date: September 18, 2014 11:37 AM

Encounter Number: 010079900790

Accession Number: 5946241

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: September 18, 2014 11:50 AM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 9/24/2014 1:33:00 PM

Report Name: MRI BRAIN WO CONTRAST

MRI of the brain without contrast.

Clinical History

Dementia.

History and Indication

Dementia.

Technique

A multisequential, multiplanar MRI of the brain was performed without

intravenous contrast.

Comparison

No prior MRI available for comparison.

Correlation is made with the head CT dated 09/18/2014 and 05/03/2012.

Findings

This examination is somewhat limited by motion on multiple sequences.

There is no evidence of restricted diffusion to suggest an acute

infarct.

There is generalized loss of volume of the parenchyma with secondary

prominence of the cortical sulci, cerebellar folia and ventricular

system. This is more than expected for the patient's age. Please

correlate with medical and social history.

There is hyperintense T2/FLAIR signal in the periventricular white

matter in and scattered foci of punctate FLAIR signal within the deep

and subcortical white matter of the frontal lobes. This is

nonspecific, but may be the sequela of chronic small vessel ischemia.

There is no mass effect or midline shift. There is no focal

extra-axial collection.

There is no evidence of hydrocephalus. Asymmetric size of the lateral

ventricles, larger on the left, is noted, and are unchanged when

correlated with 05/03/2012 CT. This may be developmental.

There is no evidence of intraparenchymal susceptibility artifact to

suggest hemosiderin.

The flow voids of the central arteries and the circle of Willis and

major dural venous sinuses are present.

The basal cisterns are intact. There is no evidence of tonsillar

herniation.

There are no fluid levels in the visualized paranasal sinuses or

mastoid air cells. Visualized intraorbital contents are unremarkable.

Impression

No evidence of acute infarct, intracranial hemorrhage, mass effect or

midline shift.

Generalized loss of volume of the parenchyma, more than expected for

the patient's age. Please correlate with medical social history.

Mild chronic small vessel ischemic changes.

Attending Radiologist: WOROCH, LUBOSLAV

Ordered By: PAVELING, JACKIE

Order Date: September 21, 2014 4:25 PM

Completion Date: September 24, 2014 1:33 PM

Encounter Number: 010079900790

Accession Number: 5950088

Images were reviewed and interpreted by Attending Radiologist: Dr. WOROCH, LUBOSLAV

Electronically Signed On: September 24, 2014 1:48 PM by Dr. WOROCH, LUBOSLAV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/3/2014 5:41:00 PM

Report Name: CT CHEST WITH CONTRAST

Examination

CT ABD AND PELVIS WITH CONTRAST/URGENT

CT of the chest with contrast

Clinical History

58 FEMALE WITH WORSENING PSYCHOSIS, FOUND TO HAVE ELEVATED AB FOR

LIMBIC ENCEPHALITIS; R/O MALIGNANCY

Technique

Postcontrast CT of the chest abdomen pelvis were obtained

Contrast

Contrast Agent OMNIPAQUE 300 95 mg/dl 11/03/2014 INTRAVENOUS

Comparison

None

Findings

Chest: There is a solitary 1.4 centimeter nodule in the left lobe of

the thyroid which could benefit from ultrasonographic evaluation. No

significant lymphadenopathy is seen in the supraclavicular region,

axilla or mediastinum. Mild dilatation of the thoracic esophagus is

noted with partial opacification with fluid. Mediastinotomy

vasculature is grossly unremarkable.

Some of the lung images are degraded by moment artifact. The trachea

and its bronchial branches are grossly patent. Suggestion of

bronchial wall thickening is noted in the lower lobes. No sign of

bronchiectasis. Patchy subsegmental atelectatic changes in the lung

bases which could be from aspiration in the presence of residual

fluid in the thoracic esophagus described above. No sign of lobar

consolidations seen. Patchy consolidation is also seen in the

dependent portions of the right lung upper lobe.

Abdomen and pelvis: Multiple images are degraded by the patient's

movement artifact. Within these limitations no suspicious focal

lesion is identified in the liver, spleen, pancreas. Hypoplastic

thickening of the adrenal is noted bilaterally. No suspicious

exophytic lesions or hydronephrosis is seen in the kidneys on either

side. No significant retroperitoneal lymphadenopathy. Mild calcific

atherosclerotic change is seen in the normal caliber aorta and its

branches.

No sign of abnormal small bowel dilatation. No fluid collection mass

lesion or lymphadenopathy is seen in the pelvis. No signs of

destructive bone lesion seen within these limitations of image

degradation from movement artifacts.

Impression

No convincing evidence of malignancy seen in the chest abdomen or

pelvis. Solitary nodule in the left lobe of the thyroid, which could

benefit from further evaluation with ultrasound.

Possible mild aspiration in the lung bases. Slightly dilated thoracic

esophagus associated with small volume of intraluminal fluid probably

from reflux.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: ASIF, AINUL

Order Date: November 2, 2014 11:45 AM

Completion Date: November 3, 2014 5:41 PM

Encounter Number: 010079900790

Accession Number: 6003120

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: November 4, 2014 7:26 AM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/3/2014 5:41:00 PM

Report Name: CT ABD AND PELVIS WITH CONTRAST

Examination

CT ABD AND PELVIS WITH CONTRAST/URGENT

CT of the chest with contrast

Clinical History

58 FEMALE WITH WORSENING PSYCHOSIS, FOUND TO HAVE ELEVATED AB FOR

LIMBIC ENCEPHALITIS; R/O MALIGNANCY

Technique

Postcontrast CT of the chest abdomen pelvis were obtained

Contrast

Contrast Agent OMNIPAQUE 300 95 mg/dl 11/03/2014 INTRAVENOUS

Comparison

None

Findings

Chest: There is a solitary 1.4 centimeter nodule in the left lobe of

the thyroid which could benefit from ultrasonographic evaluation. No

significant lymphadenopathy is seen in the supraclavicular region,

axilla or mediastinum. Mild dilatation of the thoracic esophagus is

noted with partial opacification with fluid. Mediastinotomy

vasculature is grossly unremarkable.

Some of the lung images are degraded by moment artifact. The trachea

and its bronchial branches are grossly patent. Suggestion of

bronchial wall thickening is noted in the lower lobes. No sign of

bronchiectasis. Patchy subsegmental atelectatic changes in the lung

bases which could be from aspiration in the presence of residual

fluid in the thoracic esophagus described above. No sign of lobar

consolidations seen. Patchy consolidation is also seen in the

dependent portions of the right lung upper lobe.

Abdomen and pelvis: Multiple images are degraded by the patient's

movement artifact. Within these limitations no suspicious focal

lesion is identified in the liver, spleen, pancreas. Hypoplastic

thickening of the adrenal is noted bilaterally. No suspicious

exophytic lesions or hydronephrosis is seen in the kidneys on either

side. No significant retroperitoneal lymphadenopathy. Mild calcific

atherosclerotic change is seen in the normal caliber aorta and its

branches.

No sign of abnormal small bowel dilatation. No fluid collection mass

lesion or lymphadenopathy is seen in the pelvis. No signs of

destructive bone lesion seen within these limitations of image

degradation from movement artifacts.

Impression

No convincing evidence of malignancy seen in the chest abdomen or

pelvis. Solitary nodule in the left lobe of the thyroid, which could

benefit from further evaluation with ultrasound.

Possible mild aspiration in the lung bases. Slightly dilated thoracic

esophagus associated with small volume of intraluminal fluid probably

from reflux.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: ASIF, AINUL

Order Date: November 2, 2014 11:45 AM

Completion Date: November 3, 2014 5:41 PM

Encounter Number: 010079900790

Accession Number: 6003121

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: November 4, 2014 7:26 AM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/8/2014 9:15:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

FEVER, SEPSIS

Indication

EVALUATE FOR PNEUMONIA

Technique

Portable chest

Comparison

Comparison is made to exam dated September 18, 2014.

Findings

The lungs are essentially clear, with no focal infiltrates,

effusions, or pulmonary vascular congestion seen. Small density at

the right base probably represents a small pulmonary scar, given its

stability. The heart is normal in size and shape.

Impression

Clear lungs, no evidence of infiltrate.

Attending Radiologist: FISHER, PAUL

Ordered By: CHAKRAVARTY, RAJARSHI

Order Date: November 8, 2014 7:10 PM

Completion Date: November 8, 2014 9:15 PM

Encounter Number: 010079900790

Accession Number: 6011353

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: November 9, 2014 9:37 AM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/9/2014 11:46:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

FEVER

History and Indication

EVALUATE FOR PNEUMONIA

Technique

AP portable view of the chest

Comparison

11/08/2014

Findings

Cardiomediastinal silhouette is within normal limits.

No focal pulmonary parenchymal process identified. The left

costophrenic angle is not included in the view of the chest. No large

pneumothorax. No pleural effusion on the right side..

Impression

No acute cardiopulmonary disease.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: CHAKRAVARTY, RAJARSHI

Order Date: November 9, 2014 10:55 PM

Completion Date: November 9, 2014 11:46 PM

Encounter Number: 010079900790

Accession Number: 6012020

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: November 10, 2014 1:56 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/11/2014 3:08:00 PM

Report Name: ULTRASOUND THYROID/NECK

Clinical History

Evaluate thyroid mass.

Technique

Thyroid sonogram was performed with high frequency linear transducer

and color Doppler.

Comparison

Chest abdomen and pelvis CT 11/03/2014.

Findings

This study is limited due to marked patient motion and combativeness

during the exam.

The right lobe of the thyroid measures 1.6 x 1.6 x 4.2 cm and

demonstrates heterogeneous echotexture. A distinct nodule is not

visualized in the right lobe.

The isthmus is mildly thickened at 4 mm.

The left lobe is also heterogeneous measuring 1.5 x 1.2 x 4.3 cm. At

the lower pole there is a heterogeneous mixed predominantly solid

nodule measuring 1.3 x 1.3 x 2.1 cm with internal and peripheral

vascularity. The nodule is smoothly marginated. No definitive

microcalcifications can be seen.

Overall thyroid vascularity of the left lobe is within normal limits.

Unable to complete the examination to evaluate for right lobe

vascularity. Evaluation of the anterior and lateral neck for

adenopathy was also not performed.

Impression

Limited exam as discussed above.

Heterogeneous thyroid glands with solitary predominantly solid left

lobe thyroid nodule. Followup is advised. In the absence of prior

studies to document stability needle aspiration biopsy could be

considered for definitive diagnosis however may not be feasible due

to patient's inability to cooperate. Nuclear thyroid imaging is also

a consideration for further assessment as warranted.

Attending Radiologist: CUNNINGHAM, ROBIN

Ordered By: HOELZER, MAUREEN

Order Date: November 8, 2014 5:35 PM

Completion Date: November 11, 2014 3:08 PM

Encounter Number: 010079900790

Accession Number: 6011292

Images were reviewed and interpreted by Attending Radiologist: Dr. CUNNINGHAM, ROBIN

Electronically Signed On: November 11, 2014 4:47 PM by Dr. CUNNINGHAM, ROBIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/12/2014 3:22:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

AGITATION

Indication

EVALUATE FOR PNEUMONIA

Technique

CHEST AP PORTABLE/STAT

Comparison

11/09/2014

Findings

The cardiomediastinal silhouette is within normal limits. There is no

focal consolidation, pulmonary vascular congestion or pleural

effusion.

Impression

No acute cardiopulmonary process.

Attending Radiologist: ABBASI, ALMAS

Ordered By: CHAKRAVARTY, RAJARSHI

Order Date: November 12, 2014 1:25 AM

Completion Date: November 12, 2014 3:22 AM

Encounter Number: 010079900790

Accession Number: 6015076

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: November 12, 2014 9:28 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/12/2014 5:50:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

58F WITH PMH OF SEVERE AGITATION AND PSYCHOSIS P/W AMS AND FEVER

Indication

EVALUATE FOR PNEUMOTHORAX

Technique

Portable AP view of the chest.

Comparison

Earlier same date. 11/12/2014

Findings

The patient is slight rotated in position. Cardiomediastinal

silhouette is within normal limits and unchanged. There is no

pulmonary vascular congestion. There is a small opacity within right

lung base which is probably related to atelectasis, not present on

the prior. There is definite focal airspace consolidation, sizable

pleural effusion or pneumothorax.

Bony structures are unremarkable.

Impression

No definite acute pulmonary process. Small opacity within the right

lung base, most suggestive of atelectasis, not present on prior of

the same date.

Attending Radiologist: BALSAM, DVORAH

Ordered By: CHAKRAVARTY, RAMANUJ

Order Date: November 12, 2014 4:30 PM

Completion Date: November 12, 2014 5:50 PM

Encounter Number: 010079900790

Accession Number: 6016236

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: November 12, 2014 6:11 PM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/13/2014 1:22:00 PM

Report Name: PERCUTANEOUS BIOPSY RAD

Clinical History

Examination: Ultrasound guided thyroid biopsy.

Clinical History: 58-year-old female with a left thyroid lobe nodule

of undetermined etiology, image guided fine needle aspiration of this

nodule was requested for further evaluation.

Procedure:

The patient was unable to consent ; therefore emergency consent was

obtained by the primary service. A time out was called confirming

patients name,procedure, side and site. FNA from the left thyroid

nodule was performed using sterile technique under ultrasound

guidance. A total of four needle passes were made, three using 22

gauge needle and 1 pass was made using a 24 gauge needle. Cytology

was present to confirm adequacy. The patient tolerated procedure well

and there were no complication during the procedure.

Amit Gupta, Attending IR performed the entire procedure.

Impression:

Ultrasound guided fine needle biopsy of nodule in left lobe of

thyroid without complication.

Attending Radiologist: GUPTA, AMIT

Ordered By: MUKHI, PREETI

Order Date: November 13, 2014 11:27 AM

Completion Date: November 13, 2014 1:22 PM

Encounter Number: 010079900790

Accession Number: 6016087

Images were reviewed and interpreted by Attending Radiologist: Dr. GUPTA, AMIT

Electronically Signed On: November 13, 2014 2:12 PM by Dr. GUPTA, AMIT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/13/2014 1:50:00 PM

Report Name: PERCUTANEOUS BIOPSY RAD

Clinical History

Examination: Ultrasound guided thyroid biopsy.

Clinical History: 58-year-old female with a left thyroid lobe nodule

of undetermined etiology, image guided fine needle aspiration of this

nodule was requested for further evaluation.

Procedure:

The patient was unable to consent ; therefore emergency consent was

obtained by the primary service. A time out was called confirming

patients name,procedure, side and site. FNA from the left thyroid

nodule was performed using sterile technique under ultrasound

guidance. A total of four needle passes were made, three using 22

gauge needle and 1 pass was made using a 24 gauge needle. Cytology

was present to confirm adequacy. The patient tolerated procedure well

and there were no complication during the procedure.

Amit Gupta, Attending IR performed the entire procedure.

Impression:

Ultrasound guided fine needle biopsy of nodule in left lobe of

thyroid without complication.

Attending Radiologist: GUPTA, AMIT

Ordered By: MUKHI, PREETI

Order Date: November 13, 2014 1:45 PM

Completion Date: November 13, 2014 1:50 PM

Encounter Number: 010079900790

Accession Number: 6017446

Images were reviewed and interpreted by Attending Radiologist: Dr. GUPTA, AMIT

Electronically Signed On: November 13, 2014 2:12 PM by Dr. GUPTA, AMIT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/13/2014 3:40:00 PM

Report Name: MRI BRAIN WO AND WITH CONTRAST

Examination

MRI BRAIN WO AND WITH CONTRAST/ROUT

Clinical History

R/O INFECTIOUS PROCESS, ABSCESS

History and Indication

FUO

Technique

Multiple sequences were obtained through the brain without and with

intravenous gadolinium.

Contrast

7 cc of intravenous Gadavist contrast.

Comparison

09/24/2014.

Findings

There is no area of restricted diffusion to suggest acute infarction.

There are scattered foci of FLAIR hyperintensity within the bilateral

cerebral white matter, likely sequelae of small vessel disease. There

is prominence of the cerebral and cerebellar sulci, cisterns and the

ventricles which is greater than expected for patient's stated age

age. Again noted is asymmetry of the lateral ventricles, larger on

the left, which is unchanged and may be developmental. There is no

hydrocephalus.

There is no mass effect, midline shift or other focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection. No

abnormal contrast enhancement is noted in the brain or leptomeninges.

The pituitary gland is normal in size.

Normal flow void is noted in the major arteries of the circle of

Willis.

There is moderate mucosal thickening of the left frontal sinuses,

bilateral ethmoid air cells, bilateral sphenoid and maxillary

sinuses. There is a large mucous retention cyst in the right sphenoid

sinus and a moderately sized mucous retention cyst in the right

maxillary sinus.

The orbits are grossly unremarkable.

Impression

1. No evidence of intracranial abscess or other acute

intracranial process.

2. Cerebral and cerebellar atrophy greater than expected for

patient's stated age. Please correlate with medical and social

history.

3. Moderate paranasal sinus inflammation and mucosal disease as

described. Correlate clinically.

4. No other significant interval change.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: MUKHI, PREETI

Order Date: November 12, 2014 4:35 PM

Completion Date: November 13, 2014 3:40 PM

Encounter Number: 010079900790

Accession Number: 6016243

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: November 13, 2014 4:33 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/21/2014 1:53:00 PM

Report Name: ULTRASOUND OF ABDOMEN

Clinical History

Transaminitis. Evaluate for biliary disease. Acute kidney injury.

Also evaluate kidneys.

Technique

An abdominal sonogram is performed with color and spectral Doppler

interrogation.

Comparison

CT 11/03/2014 and ultrasound 05/07/2014.

Findings

The liver is again enlarged measuring 22 cm craniocaudal and

demonstrates no focal abnormality. The echotexture of the liver is

within normal limits. Multiple shadowing gallstones are identified.

There is mild gallbladder wall thickening and small percholecystic

fluid are nonspecific in the presence of ascites. No intrahepatic

ductal dilatation is identified. The proximal common duct measures up

to 8 mm in diameter which is slightly prominent for stated age and

increased from 6 mm previously. Portions of the distal duct are

obscured. The sonographic Murphy' sign is negative.

The spleen is borderline in size measuring 12.7 cm in craniocaudal

dimension, previously 11.3 cm in length.

The visualized portions of the pancreas are unremarkable. The tail is

obscured by overlying bowel gas.

Mild abdominal ascites is identified which accumulates mostly in the

right lower quadrant.

The visualized proximal intraabdominal aorta is unremarkable. The

visualized portions of the upper IVC are unremarkable.There is normal

hepatopetal flow and waveform in the main portal vein.

The right kidney measures 14.3 cm in length and the left kidney

measures 13.9 Cm in length. There is no evidence for hydronephrosis,

shadowing calculus, or contour deforming mass of either kidney. Renal

cortical echogenicity is within normal limits. Poles of the left

kidney are partly obscured by bowel gas Bladder not fully distended

but grossly unremarkable.

Bilateral pleural effusions are demonstrated.

Impression

Mild ascites and bilateral pleural effusions, new from prior CT.

Cholelithiasis. Gallbladder wall thickening is nonspecific in the

presence of ascites. If there is concern for cholecystitis consider

HIDA scan.

Mild extrahepatic duct dilatation, increased size from prior study.

Correlate with biliary function tests and follow up. No definite

choledocholithiasis though portions of the duct are obscured.

Redemonstration of a hepatomegaly with normal echotexture.

Borderline prominent spleen.

Normal renal cortical echogenicity without hydronephrosis.

Attending Radiologist: CUNNINGHAM, ROBIN

Ordered By: JAGLALL, NEIL

Order Date: November 21, 2014 11:20 AM

Completion Date: November 21, 2014 1:53 PM

Encounter Number: 010079900790

Accession Number: 6027494

Images were reviewed and interpreted by Attending Radiologist: Dr. CUNNINGHAM, ROBIN

Electronically Signed On: November 21, 2014 2:15 PM by Dr. CUNNINGHAM, ROBIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/21/2014 9:34:00 AM

Report Name: ABDOMEN SUPINE (KUB)

Clinical History

ETOH HX W/ UNEXPLAINED ENCEPHALOPATHY

Technique

Single supine portable view of the abdomen

Comparison

No prior CT's are available for direct comparison. Scout from CT of

the chest, abdomen, and pelvis from 11/03/2014 was reviewed.

Findings

Lines and tubes: None

Bowel gas pattern: No evidence of focal bowel dilatation to suggest

obstruction.

Free air: Given the limitations of the supine portable technique, no

gross pneumoperitoneum is noted.

Osseous and soft tissue: The right hepatic lobe appears elongated,

possibly a Riedel's lobe, unchanged from prior. Mild degenerative

changes of the lower lumbar spine.

Impression

Nonobstructive bowel gas pattern.

Attending Radiologist: MANKES, SETH

Ordered By: WNEK, JESSICA

Order Date: November 21, 2014 7:50 AM

Completion Date: November 21, 2014 9:34 AM

Encounter Number: 010079900790

Accession Number: 6027083

Images were reviewed and interpreted by Attending Radiologist: Dr. MANKES, SETH

Electronically Signed On: November 21, 2014 3:36 PM by Dr. MANKES, SETH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/22/2014 10:57:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

H/O AMS / FEVER

Indication

EVALUATE FOR ASPIRA PNA

Technique

CHEST AP PORTABLE/URGENT

Comparison

Chest radiograph from 11/12/2014.

Findings

The trachea is midline. The osseous structures are unchanged. The

cardiomediastinal silhouette is within normal limits in size. There

is no pleural effusion. There is no pneumothorax. There is no

pulmonary vascular congestion. There is opacification within the

right mid to lower lung most compatible with subsegmental

atelectasis. The previously seen small opacity within the right lung

base appears to have resolved.

Impression

Opacification in the right mid to lower lung most compatible with

subsegmental atelectasis; however, pneumonia cannot be excluded and

clinical correlation and follow up is recommended.

Attending Radiologist: FREIBERG, EVAN

Ordered By: MATHEW, ALEX

Order Date: November 22, 2014 10:00 AM

Completion Date: November 22, 2014 10:57 AM

Encounter Number: 010079900790

Accession Number: 6028608

Images were reviewed and interpreted by Attending Radiologist: Dr. FREIBERG, EVAN

Electronically Signed On: November 22, 2014 12:52 PM by Dr. FREIBERG, EVAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/22/2014 5:19:00 PM

Report Name: ULTRASOUND PORTAL VEIN

Clinical History

Given history is a 58-year-old female with unexplained jaundice.

Evaluate for portal hypertension or thrombosis.

Technique

Ultrasonography of the portal vein was performed using grayscale,

color flow Doppler and pulse Doppler technique. Hepatic vein and

splenic vein were also interrogated. Images were obtained in sagittal

and transverse planes.

Comparison

Abdominal ultrasound dated 11/21/2014

Findings

The IVC is patent and demonstrates normal color flow direction. The

hepatic veins demonstrate normal color flow direction with normal

Doppler waveforms with signature peak systolic velocity of the right

hepatic vein 24.6 cm/s, middle hepatic vein 26.4 centimeters/second

and left hepatic vein 26.4 centimeter/second. The portal veins are

patent and demonstrate normal color flow direction and Doppler

waveforms signature. Left portal vein peak systolic velocity 18.2

centimeters/second, main portal vein 26.9 cm , right portal vein 25.1

centimeters/second. The splenic vein demonstrates normal flow

direction, Doppler waveforms signature and is patent with peak

systolic velocity is 17.3 centimeter/second. The abdominal aorta is

normal in caliber with normal flow direction.

Impression

No evidence of portal hypertension.

Attending Radiologist: MASON, MARYANNA

Ordered By: MATHEW, ALEX

Order Date: November 22, 2014 10:00 AM

Completion Date: November 22, 2014 5:19 PM

Encounter Number: 010079900790

Accession Number: 6028609

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: November 23, 2014 10:46 AM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 11/24/2014 7:05:00 PM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

FEVER ?PNA

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 11/22/2014.

Findings

There is increasing central vascular congestion. Heart size is normal

to upper limit of normal. Linear atelectasis is noted in the right

mid lung field. Bony thorax of extra thoracic osseous structures and

soft tissues are unremarkable.

Impression

No clear evidence of pneumonia. Increasing central vascular

congestion. Linear atelectasis right mid lung field. Heart size upper

limits of normal.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: MATHEW, ALEX

Order Date: November 24, 2014 5:20 PM

Completion Date: November 24, 2014 7:05 PM

Encounter Number: 010079900790

Accession Number: 6031188

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: November 25, 2014 7:43 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 12/18/2014 6:52:00 PM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/ROUT

Clinical History

FEVER

Additional History

EVALUATE FOR PNEUMONIA

Technique

Frontal view of the chest.

Comparison

11/24/2014

Findings

The airway is patent and midline. There is right basilar

atelectasis.There is no focal consolidation, large pleural effusions,

pneumothorax, or pulmonary vascular congestion. The cardiomediastinal

silhouette is within normal limits. There are changes noted of the

acromioclavicular and glenohumeral joints.

Impression

Left basilar atelectasis without evidence of focal consolidation.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: MASSASATI, LAMAH

Order Date: December 18, 2014 5:45 PM

Completion Date: December 18, 2014 6:52 PM

Encounter Number: 010079900790

Accession Number: 6059947

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: December 18, 2014 6:55 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 12/19/2014 2:43:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR INTERVAL CHANGE

History and Indication

PATIENT WITH BREAKTHROUGH SEIZURE.

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

CT head: 09/18/2014. MRI with contrast 11/13/2014

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There is mild to moderate dilatation of the left lateral ventricle

and 3rd ventricle as seen on prior CT examination. There is no

hydrocephalus.

There is moderate cerebral cortical atrophy and mild vermian atrophy

again noted.

Mild small vessel disease.

There is no mass effect, midline shift or no focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No interval change. No evidence of intracranial pathology.

Mild small vessel disease.

Attending Radiologist: YAN, ZENGMIN

Ordered By: YEUNG, POMIN

Order Date: December 18, 2014 8:30 PM

Completion Date: December 19, 2014 2:43 PM

Encounter Number: 010079900790

Accession Number: 6060083

Images were reviewed and interpreted by Attending Radiologist: Dr. YAN, ZENGMIN

Electronically Signed On: December 19, 2014 4:56 PM by Dr. YAN, ZENGMIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 8/9/2015 5:39:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Rule out infection.

Technique

Chest 2 views.

Comparison

Not relevant.

Findings

The heart is not enlarged. The pulmonary vasculature is normal and

the lungs are clear. There is no evidence of pneumonia or pleural

effusion.

Impression

No evidence of pneumonia or pleural effusion.

Attending Radiologist: BALSAM, DVORAH

Ordered By: CAFONE, JOSEPH

Order Date/Time: August 9, 2015 9:50 AM

Scan Initiation Date/Time: August 9, 2015 4:59 PM

Completion Date/Time: August 9, 2015 5:39 PM

Encounter Number: 010079900790

Accession Number: 6351625

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: August 9, 2015 7:17 PM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 8/9/2015 5:39:00 PM

Report Name: SPINE CERVICAL (AP/ LATERAL/ ODONTOID) PORTABLE

Examination

SPINE CERVICAL (AP/ LATERAL/ ODONTOID) PORTABLE/URGENT

Clinical History

S/P SEIZURE AND HEAD TRAUMA

Indication

EVALUATE FOR TRAUMA

Technique

Single lateral view.

Technologist Comments

pt unable to cooperate. best images possable

Comparison

None.

Findings

Only a single lateral view was submitted. This study is

nondiagnostic.

Impression

Nondiagnostic cervical spine x-ray.

Attending Radiologist: WEST, STEVEN

Ordered By: HOELZER, MAUREEN

Order Date/Time: August 9, 2015 4:10 PM

Scan Initiation Date/Time: August 9, 2015 5:01 PM

Completion Date/Time: August 9, 2015 5:39 PM

Encounter Number: 010079900790

Accession Number: 6351821

Images were reviewed and interpreted by Attending Radiologist: Dr. WEST, STEVEN

Electronically Signed On: August 14, 2015 2:54 PM by Dr. WEST, STEVEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 10/15/2015 2:40:00 PM

Report Name: PARTIAL ECHO

Stony Brook University Hospital

Stony Brook, New York

Female Adult Echocardiography Report

Name: PATRICIA MCNAMARA Exam 10/15/2015 2:17:17 Heart

Rate: 78

Date/Time: PM

MR #: 00217479 Report Date: 10/15/2015 Heart

Rhythm:

Sinus

Rhythm

ACC #: 6436517 Ht: 165.10 cm BP:

111/76 mmHg

DOB: 3/24/1956 Wt: 57.15 kg

Location: 15N

Age/Sex: 59 yearsF BSA: 1.63 m²

Ref. Physician: MATHEW THARAKAN, cc:

Sonographer: JP

Fellow: AL

Indications: palpitations

History: depression, dementia, seizures.

Procedure: Color Flow Imaging - 93325, Limited Echo - 93308 and

Limited Doppler

- 93321.

Study Quality: Technically limited. Patient was disoriented, confused

and unable

to withstand exam.

Measurements and Calculations

Aov VTI 0.238 m LVOT VTI 0.172 m LVOT diameter

Aov VMax 1.26 m/s LVOT Vmax 0.99 m/s Dimensionless

Index 0.79

Aov Pk Pressure 6.4 mmHg Aov Mn Pressure 4.0 mmHg

Gradient Gradient

MV Pk Gradient mmHg MV Mn Gradient 1.0

MV VTI 0.266 MV DT 250 msec

MV E Vmax 0.58 m/s MV A Vmax 0.85 m/s E/A 0.69

MV Area press 1/2 Time 3.03

IVRT E/E ' 9.70

Septal E ' 0.060 m/s Prop Velocity

Lateral E ' 0.06 m/s LA Pressure 13.93 mmHg

Average E' 0.060 m/s

MV Average E/E' 9.70

TV E Max TV Mn Grad PHT 72.50 msec TV VTI

Left Ventricle - Structure and Systolic Function: Global left

ventricular systolic function could not be accurately assessed. The

endocardium was not well seen. If clinically indicated, recommend

repeat imaging with contrast injection.

Left Ventricle - Diastole:Left ventricular diastolic function was

incompletely assessed. The Doppler derived transmitral left

ventricular inflow velocity pattern is A wave dominant. The Doppler

derived early diastolic deceleration time is prolonged at 250 msec.

Left Atrium: The left atrium is not well seen.

Right Atrium: The right atrium is not well seen.

Atrial Septum: Atrial septum is not well visualized.

Right Ventricle: The right ventricle is not well seen.

Aortic Valve: The aortic valve was not well seen.

Mitral Valve: The mitral valve is not well seen.

Tricuspid Valve: The tricuspid valve is not well seen.

Pulmonic Valve: The pulmonic valve is not well visualized.

Aorta: The aortic root is not adequately visualized.

Pericardium: No pericardial effusion seen.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Technically very limited study.

2. Global left ventricular systolic function could not be accurately

assessed.

3. The endocardium was not well seen. Consider repeat imaging with

contrast injection if clinically indicated.

4. No pericardial effusion.

5. Recommend follow up echocardiogram as clinically indicated.

012640 Jordan P Katz MD, FACC

Electronically signed by 012640 Jordan P Katz MD, FACC on 10/15/2015

at 4:26:31 PM

\*\*\* Final \*\*\*

Attending Cardiologist: KATZ, JORDAN

Ordered By: DING, YONGZENG

Order Date/Time: October 14, 2015 2:00 PM

Scan Initiation Date/Time:

Completion Date/Time: October 15, 2015 2:40 PM

Encounter Number: 010079900790

Accession Number: 6436517

Images were reviewed and interpreted by Attending Cardiologist: Dr. KATZ, JORDAN

Electronically Signed On: October 15, 2015 4:26 PM by Dr. KATZ, JORDAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10079900790

Report Date/Time: 10/15/2015 6:05:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR SEIZURE

History and Indication

SEIZURE

Technique

Contiguous axial slices were obtained from the skull base to the

vertex. Coronal and sagittal reformatted images were also performed.

Comparison

CT of the head without contrast from 12/19/2014.

Findings

This study is significantly limited by motion artifact. There is

prominence of the sulci within the bilateral cerebral and cerebellar

hemispheres greater than expected for the patient's age of 59 years

which given the patient's history is seizures is suspicious for

cerebral and cerebellar atrophy. Correlation with the patient's

medical and social history is recommended. Mild chronic microvascular

ischemic changes are noted. There is no significant mass effect or

midline shift. There is no evidence of hydrocephalus. There is no

large focus of intracranial hemorrhage, however, small foci of

intracranial hemorrhage may be obscured due to motion artifact. There

is no evidence of a depressed fracture. There is a large mucous

retention cyst in the right maxillary sinus. Given the limitations of

this study there has been no significant interval change.

Impression

Limited study as described. Evidence of cerebral and cerebellar

atrophy likely related to patient's history is seizures. No definite

interval change.

Attending Radiologist: WEST, STEVEN

Ordered By: DING, YONGZENG

Order Date/Time: October 15, 2015 5:00 PM

Scan Initiation Date/Time: October 15, 2015 6:00 PM

Completion Date/Time: October 15, 2015 6:05 PM

Encounter Number: 010079900790

Accession Number: 6438277

Images were reviewed and interpreted by Attending Radiologist: Dr. WEST, STEVEN

Electronically Signed On: October 15, 2015 10:54 PM by Dr. WEST, STEVEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/15/2015 11:40:00 PM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Clinical History

Chest pain

Technique

PA and lateral views of the chest are submitted.

Comparison

None

Findings

The cardiomediastinal contour is within normal limits, as is the

pulmonary vascularity. The lungs are clear without evidence of

effusion. There is no evidence of significant hilar or mediastinal

adenopathy.

Calcified aorta.

Impression

No acute cardiopulmonary process.

Attending Radiologist: EISENBERG, JASON

Ordered By: D'AMATO, ABRAM

Order Date: April 15, 2015 9:50 PM

Completion Date: April 15, 2015 11:40 PM

Encounter Number: 010086691978

Accession Number: 6202740

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: April 16, 2015 12:29 AM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/16/2015 12:29:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

ESRD

Indication

CHECK LINE PLACEMENT

Technique

CHEST AP PORTABLE/STAT/OR

Comparison

04/15/2015

Findings

There is a new right IJ catheter with the distal tip in the expected

region of the SVC. No pneumothorax. Bibasilar opacities which are

predominantly linear, likely atelectasis. Cardiac size is upper

limits of normal. There is mild pulmonary vascular congestion. Left

axillary stent in place.

Impression

New right IJ catheter with the tip in the expected region of the SVC.

No pneumothorax. Mild pulmonary vascular congestion.

Attending Radiologist: REITER, MICHAEL

Ordered By: ABBAS, SYED

Order Date: April 16, 2015 9:55 AM

Completion Date: April 16, 2015 12:29 PM

Encounter Number: 010086691978

Accession Number: 6203191

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: April 16, 2015 12:50 PM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/16/2015 12:35:00 PM

Report Name: ULTRASOUND KIDNEY TRANSPLANT PORTABLE

Given history is a 69-year-old female status post renal transplant.

Technique

Ultrasonography of a renal transplant using grayscale, color flow

and spectral doppler technique. Images were obtained in the sagittal

and transverse planes.

Comparison

No prior studies available for comparison

Findings;

Study is somewhat limited due to portable technique, surgical wound

A renal transplant is noted within the right iliac fossa. It measures

11.8 x 5.3 x 6.2 cm. It is normal in contour and echotexture. There

is no evidence of hydronephrosis. Trace fluid is noted at the level

of the lower pole. There is no evidence of perinephric fluid

collection or hematoma. Resistive indices were obtained at the level

of the arcuate, segmental /interlobar arteries, and the main renal

artery. The resistive indices at the level of the arcuate arteries

range between 0.69-0.75 at the level of the mid to lower pole. At

the upper pole the resistive index of the arcuate arteries

demonstrates a value of 0.50. at the level of the segmental

interlobar arteries at the level of the mid to lower pole the

resistive indices range between 0.75-0.7 9 . at the level of the

upper pole, the resistive index of the segmental / interlobar

arteries demonstrate a value of 0.5 8 . .These are within normal

limits however at the upper range of normal at the level of the mid

to lower pole. Normal Doppler spectral waveform is noted at these

levels. Peak systolic velocities at the right iliac artery is 305

centimeters/second. Velocities were obtained at the level of the

renal artery distally with a value of 103 centimeters/second, the mid

portion with a value of 217 centimeters/second and proximal with a

value of 235 centimeters/second and at the anastomotic site with a

value of 331 centimeters/second. Ratio at the renal artery to iliac

artery anastomotic site is 1.1. The renal vein is patent with normal

color flow. The urinary bladder is insert

Impression:

Study is somewhat limited due to portable technique, recent surgical

wound.

Status post right renal transplant.

No evidence of hydronephrosis.

Trace fluid at the level of the lower pole. No discrete collection

or hematoma appreciated.

Resistive indices are at the upper level of normal within the mid

and lower pole. Nonspecific

Elevated peak systolic velocities of the iliac artery and main renal

arteries. This may be due to systemic hypertension, more proximal

stenosis. Recommend follow up.

Attending Radiologist: MASON, MARYANNA

Ordered By: ABBAS, SYED

Order Date: April 16, 2015 10:00 AM

Completion Date: April 16, 2015 12:35 PM

Encounter Number: 010086691978

Accession Number: 6203193

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: April 16, 2015 1:08 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/17/2015 5:37:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

ESRD S/P DDRTX

Technique

A single AP view the chest.

Comparison

04/16/2015

Findings

Right IJ catheter unchanged. Low lung volumes limit evaluation. Mild

prominence of the hilar region suggesting pulmonary vascular

congestion again seen. No definite effusion, consolidation or

pneumothorax.

Impression

Mild prominence of the hilar region suggesting pulmonary vascular

congestion. No consolidation. No significant interval change.

Attending Radiologist: AREMAN, DAVID

Ordered By: SZAFRAN, APRIL ADAMS

Order Date: April 17, 2015 5:25 AM

Completion Date: April 17, 2015 5:37 AM

Encounter Number: 010086691978

Accession Number: 6204518

Images were reviewed and interpreted by Attending Radiologist: Dr. AREMAN, DAVID

Electronically Signed On: April 17, 2015 8:38 AM by Dr. AREMAN, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/17/2015 9:07:00 AM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

Status post renal transplant. On ventilator

Technique

Single supine view of the abdomen with portable machine

Comparison

Chest x-ray from 04/17/2014

Findings

There is a nonspecific bowel gas pattern without evidence of

obstruction or free intraperitoneal air.No organomegaly or abnormal

calcifications are seen within the abdomen or pelvis. Enteric tube is

noted in situ with its tip in the mid stomach. A catheter is noted

in the right lower quadrant of uncertain origin.

The osseous structures are grossly unremarkable.

Impression

No convincing evidence of free intraperitoneal gas seen. Nonspecific

catheter in the right lower quadrant. NG tube in situ.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: CHRISTIE, FLORENCE

Order Date: April 17, 2015 9:00 AM

Completion Date: April 17, 2015 9:07 AM

Encounter Number: 010086691978

Accession Number: 6204679

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: April 17, 2015 10:20 AM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/17/2015 9:07:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

PT CODE

Technique

A single AP view the chest.

Comparison

04/17/2015

Findings

The ETT tip is pointing into the right mainstem bronchus and should

be retracted. Stable right IJ central venous catheter. The trachea is

midline. The left hemithorax is obscured by cardiac pacing hardware.

There are bilaterally increased perihilar interstitial markings. No

pleural effusion, focal consolidation or pneumothorax.

Impression

Interval placement of ET tube with tip at the entrance of the right

mainstem bronchus. Tube should be retracted.

Pulmonary vascular congestion again seen.

The above findings were discussed with nurses in the operating room

where the patient was located at the time of dictation, 10:00 a.m.,

4/17/2015 with read back.

Attending Radiologist: AREMAN, DAVID

Ordered By: CHRISTIE, FLORENCE

Order Date: April 17, 2015 8:45 AM

Completion Date: April 17, 2015 9:07 AM

Encounter Number: 010086691978

Accession Number: 6204655

Images were reviewed and interpreted by Attending Radiologist: Dr. AREMAN, DAVID

Electronically Signed On: April 17, 2015 10:03 AM by Dr. AREMAN, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/17/2015 10:50:00 AM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Given history is a 69-year-old female status post renal transplant.

Evaluate for foreign bodies as per policy.

Surgical counts are correct

Supine portable intraoperative view of the abdomen was submitted.

Study is compared to prior exam dated 04/17/2015 earlier in the day

The upper abdomen is not entirely included on the exam. The study

demonstrates air-filled loops of small and large bowel may represent

an ileus no definite obstruction. There is no evidence of

pneumatosis. The psoas margins are obscured by bowel gas. No

abnormal foci of calcifications are identified. A ureteral pigtail

stent is noted within the right lower quadrant likely related to

renal transplant. . A surgical drain is noted within the right lower

quadrant. Surgical skin staples are seen overlying both proximal

thighs and right lower quadrant. Vascular calcifications are noted.

No unintentional radiopaque foreign body is noted. The osseous

structures are unremarkable.

Impression:

No unintentional radiopaque foreign body. This finding was discussed

with nurse Doolin on 04/17/2015 at 11:10 a.m.

Air distended loops of bowel possible ileus. No bowel obstruction.

Please read above

Attending Radiologist: MASON, MARYANNA

Ordered By: GABER, ABDEL AZIZ

Order Date: April 17, 2015 10:45 AM

Completion Date: April 17, 2015 10:50 AM

Encounter Number: 010086691978

Accession Number: 6204940

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: April 17, 2015 12:08 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/17/2015 11:35:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

S/P RENAL TRANSPLANT EXPLORATION; CODE BLUE S/P INTUBATION

History and Indication

ENDOTRACHIAL PLACEMENT

Technique

A single AP view the chest.

Comparison

Study from the previous day.

Findings

The endotracheal tube has been repositioned now, approximately 2 cm

above the carina. A right IJ is unchanged as is the enteric tube.

There is now a moderate to severe pulmonary vascular congestion worse

compared to the prior study. This is likely accentuated to some

extent by the lower level of inspiration.

The cardiac portion of the cardiomediastinal contour is enlarged.

External defibrillator devices are noted overlying the patient.

Impression

Interval repositioning of the endotracheal tube now 2 cm above the

carina.

Worsening now moderate to severe pulmonary vascular congestion.

Cardiomegaly.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: BARON, PAMELA SUE

Order Date: April 17, 2015 11:15 AM

Completion Date: April 17, 2015 11:35 AM

Encounter Number: 010086691978

Accession Number: 6205024

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: April 17, 2015 1:02 PM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/17/2015 4:49:00 PM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

DDRT CODE BLUE S/P EXPLORATION NOW HYPOTENSIVE

History and Indication

EVALUATE FOR PNEUMOTHORAX

Technique

A single AP view the chest.

Comparison

Study from earlier the same day.

Findings

Tubes and lines appear unchanged from prior study.

Again there is mild pulmonary vascular congestion unchanged from the

prior study. The cardiomediastinal silhouette is within normal

limits.

Impression

Persistent moderate pulmonary vascular congestion.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: CHEUNG, FELIX

Order Date: April 17, 2015 4:35 PM

Completion Date: April 17, 2015 4:49 PM

Encounter Number: 010086691978

Accession Number: 6205776

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: April 17, 2015 5:25 PM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/17/2015 8:37:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

Altered mental status

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

No images available for comparison.

Findings

There is no CT evidence of acute transcortical infarction.

Patchy foci of hypoattenuation within the periventricular and

subcortical white matter without mass effect are most compatible with

microvascular ischemic changes given presence of atherosclerotic

calcifications at the skullbase. There is a chronic appearing infarct

within the paramedian right frontal coronal radiata (axial image 13).

The ventricles, cisterns and sulci are age-appropriate in size.

There is no mass effect, midline shift or focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact. Mild right parietal subcutaneous soft

tissue swelling. A nasogastric tube is in place. There is fluid

layering within the nasopharynx. There is mild to moderate mucosal

thickening throughout the paranasal sinuses, with fluid layering

within the sphenoid sinuses bilaterally.

The mastoid air cells are clear. The partially visualized orbits are

unremarkable.

Impression

No CT evidence of acute transcortical infarction. Diffusion-weighted

MRI is significantly more sensitive for subtle acute ischemia.

Microvascular ischemic disease and chronic appearing right frontal

infarct.

Layering fluid within the sphenoid sinuses, correlate for acute

sinusitis.

Attending Radiologist: FILATOV, ALEXANDER

Ordered By: ABBAS, SYED

Order Date: April 17, 2015 7:05 PM

Completion Date: April 17, 2015 8:37 PM

Encounter Number: 010086691978

Accession Number: 6205898

Images were reviewed and interpreted by Attending Radiologist: Dr. FILATOV, ALEXANDER

Electronically Signed On: April 17, 2015 9:41 PM by Dr. FILATOV, ALEXANDER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/17/2015 10:21:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

CONFIRM PROPER TUBE POSITION

Technique

AP portable.

Comparison

4/17/15 .

Findings

Cardio mediastinal silhouette is unchanged from prior radiographs.

Endotracheal tube, right jugular venous catheter, and trach tube are

all unchanged in position. Again noted are prominent interstitial

markings predominantly centrally with some air space opacities, no

interval change. No pleural effusion. No pneumothorax.

.

Impression

Lines and tubes are unchanged since prior radiograph. Interstitial

and alveolar pulmonary edema,

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: BERG, WILLIAM

Order Date: April 17, 2015 9:10 PM

Completion Date: April 17, 2015 10:21 PM

Encounter Number: 010086691978

Accession Number: 6205980

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: April 18, 2015 2:27 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/18/2015 6:20:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/URGENT

Clinical History

RESPIRATORY INSUFF

Indication

EVALUATE FOR PNEUMONIA

Technique

Single portable frontal view of the chest.

Comparison

04/17/2015

Findings

Endotracheal tube, right-sided jugular venous catheter, and NG tube

again are seen unchanged in position. Cardiomediastinal silhouette is

within normal limits and unchanged. There is mild-to-moderate

pulmonary vascular congestion without significant interval change.

There is an area of opacifications within left lower lobe compatible

atelectasis versus effusion. Left-sided axillary stent is in place.

Impression

Tubes and lines as above.

Mild to moderate pulmonary vascular congestion, grossly unchanged.

Left lower lobe opacification compatible with atelectasis versus

effusion.

Attending Radiologist: FISHER, PAUL

Ordered By: ABBAS, SYED

Order Date: April 18, 2015 4:00 AM

Completion Date: April 18, 2015 6:20 AM

Encounter Number: 010086691978

Accession Number: 6205866

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: April 18, 2015 5:10 PM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/17/2015 5:30:00 PM

Report Name: PARTIAL ECHO

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: VIOLETA LAIGO Exam Date: 4/17/2015 at 5:13:29 PM Heart

Rate:

MR #: 30521785 Report Date: 4/18/2015 Rhythm:

ACC #: 6205921 Height: 0.00 cm BP: 128/75

DOB: 11/22/1945 Weight: 0.00 kg Location:

PACU

Age/Sex: 69 years / F BSA: 0.00 m²

Ref. Physician: Frank Darras, cc:

Sonographer: DSM

Indications: HYPOTENSION

Procedure: Limited Doppler - 93321, Limited Echo - 93308, Color Flow

Imaging -

93325, Portable, Fellow Study and On call.

Study Quality: This was a technically difficult study.

Left Ventricle - Structure and Systolic Function: Global left

ventricular systolic function could not be accurately assessed.

Left Atrium: The left atrium is not well seen.

Right Atrium: The right atrium is not well seen.

Atrial Septum: Atrial septum is not well visualized.

Right Ventricle: The right ventricle is not well seen.

Aortic Valve: The aortic valve was not well seen.

Mitral Valve: The mitral valve is not well seen.

Tricuspid Valve: The tricuspid valve is not well seen. Trace

tricuspid regurgitation is present. The degree of tricuspid

regurgitation was not sufficient for accurate calculation of

pulmonary artery systolic pressure.

Pulmonic Valve: The pulmonic valve is not well visualized.

Pericardium: There is a trivial circumferential pericardial effusion.

Based on the echocardiographic findings, there is no evidence of

tamponade physiology.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Global left ventricular systolic function could not be accurately

assessed.

2. Not all segments of the left ventricle were well imaged.

3. Trace tricuspid regurgitation.

4. Trivial circumferential pericardial effusion.

5. No tamponade physiology.

6. The aortic valve was not well seen.

012480 Howard Novotny MD, FACC

Electronically signed by 012480 Howard Novotny MD, FACC on 4/18/2015

at 9:49:28 AM

\*\*\* Final \*\*\*

Attending Cardiologist: NOVOTNY, HOWARD

Ordered By: ABBAS, SYED

Order Date: April 17, 2015 7:30 PM

Completion Date: April 17, 2015 5:30 PM

Encounter Number: 010086691978

Accession Number: 6205921

Images were reviewed and interpreted by Attending Cardiologist: Dr. NOVOTNY, HOWARD

Electronically Signed On: April 18, 2015 9:49 AM by Dr. NOVOTNY, HOWARD

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/18/2015 5:42:00 PM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/STAT

Clinical History

S/P KIDNEY TRANSPLANT, PEA ARREST

Indication

EVALUATE FOR PNEUMONIA

Technique

Single portable frontal view of the chest.

Comparison

Chest radiograph 04/18/2015 at 4:41 a.m.

Findings

Redemonstrated an endotracheal tube, right-sided jugular redness

catheter, and NG tube, unchanged in position. Cardiomediastinal

silhouette is within normal limits. There is again seen mild to

moderate pulmonary vascular congestion, similar to the prior study.

There is unchanged left lower lobe opacification, compatible with

effusion and adjacent atelectasis. Left-sided axillary stent again is

seen.

Impression

Tubes and lines as above.

Mild-to-moderate pulmonary vascular congestion, unchanged

Stable left lower lobe opacification compatible with small effusion

and adjacent atelectasis.

No significant interval change.

Attending Radiologist: FISHER, PAUL

Ordered By: LLENES, REY PHILLIP

Order Date: April 18, 2015 5:15 PM

Completion Date: April 18, 2015 5:42 PM

Encounter Number: 010086691978

Accession Number: 6206623

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: April 18, 2015 6:03 PM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/19/2015 3:31:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/ROUT

Clinical History

S/P KIDNEY TRANSPLANT, PEA ARREST

Additional History

EVALUATE FOR PNEUMONIA

Technique

Frontal view of the chest.

Comparison

4/18/2015

Findings

The right IJ approach central venous catheter, endotracheal tube,

enteric tube are seen and unchanged position.

Very slight interval decrease in the mild to moderate pulmonary

vascular congestion. There is a retrocardiac opacity likely

representing atelectasis and or effusion. The cardiomediastinal

silhouette is within normal limits.

Left axillary stent is again noted.

Impression

Lines and tubes in unchanged position.

Mild to moderate pulmonary vascular congestion with slight interval

decrease.

Left-sided pleural effusion and / or atelectasis.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: LLENES, REY PHILLIP

Order Date: April 19, 2015 4:00 AM

Completion Date: April 19, 2015 3:31 AM

Encounter Number: 010086691978

Accession Number: 6206626

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: April 19, 2015 11:20 AM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/20/2015 2:47:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

S/P SX

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 04/19/2015.

Findings

There is central vascular congestion with bilateral pulmonary edema.

Some blunting at the left costophrenic angle suggests possible small

pleural effusion. Heart is within normal limits of size. Endotracheal

tube, nasogastric tube and right IJ catheter with tip in the superior

vena cava noted and are in good position.

Impression

Central vascular congestion with pulmonary edema. Likely small

pleural effusion on the left. Heart size normal. Tubes and lines in

good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: CHANTACHOTE, CHANAK

Order Date: April 20, 2015 5:00 AM

Completion Date: April 20, 2015 2:47 AM

Encounter Number: 010086691978

Accession Number: 6207003

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: April 20, 2015 8:21 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/20/2015 9:47:00 AM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Female Adult Echocardiography Report

Name: VIOLETA LAIGO Exam Date/Time: 4/20/2015 9:16:36 AM Heart

Rate:

MR #: 30521785 Report Date: 4/20/2015 Heart

Rhythm:

ACC #: 6206323 Ht: 152.40 cm BP:

125/55 mmHg

DOB: 11/22/1945 Wt: 87.54 kg Location:

18S SICU

Age/Sex: 69 yearsF BSA: 1.84 m²

Ref. Physician: Darras, Frank, cc:

Sonographer: TS

Indications: Abnormal EKG

History: Code Blue, HTN, HLD, DM, Obesity, Renal transplant,

Peritonitis

Procedure: Complete Echocardiogram - 93306, Portable, Patient Supine

and Patient

intubated.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 2.40 cm 2.0 - 3.8 LA Diam 2.86 cm 3.0-4.0

IVS 1.00 cm 0.6 - 0.9 LA Area 15.10cm² <=20

LVID 4.19 cm 3.9 - 5.3 3.13 cm LA Vol 36.05 ml 18-58

LVPW 1.00 cm 0.6 - 1.0 LA Vol/BSA 19.61ml/m² 22+ / -6

RA Diam 3.24cm 2.9-4.5

Ao at the sinuses 2.70

Ao Ascending 3.23 cm

Ao Arch 2.10 cm

Ao Descending 2.42cm

LVEF 60 % (biplane method of discs)

LV FS 25.4

LV SV 58.5 ml

LV SI 31.8 ml/m²

Aov Cusp Sep 1.96 cm

(Systole)

Aov VTI 0.370 m LVOT VTI 0.166 m LVOT diameter

1.95 cm

Aov VMax 1.81 m/s LVOT Vmax 0.79 m/s Dimensionless

Index 0.44

Aov Pk Pressure 13.1 mmHg Aov Mn 6.2 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 1.34 cm² Aov Area Index 0.73 cm²/m²

(VTI)

AI DT 2559 msec

MV Pk Gradient mmHg MV Mn Gradient 1.5

MV VTI 0.221 MV DT 188 msec

MV E Vmax 0.83 m/s MV A Vmax 1.05 m/s E/A 0.79

MV Area press 1/2 Time 4.03

IVRT 123 E/E ' 13.78

Septal E ' 0.050 m/s Prop Velocity

Lateral E ' 0.06 m/s LA Pressure 20.54 mmHg

Average E' 0.055 m/s

MV Average E/E' 15.03

TR Vmax 2.11 m/s TR Pk Grad 17.8 mmHg RA Pressure 8 mmHg RVSP

25.8 mmHg

TV E Max TV Mn Grad mmHg PHT 54.56 msec TV VTI

PV Vmax 0.96 m/s PV Pk Grad 3.7 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. The relative wall thickness is

moderately increased (0.48). Global left ventricular systolic

function is normal. The ejection fraction is 60% by biplane method of

discs.

Left Ventricle - Diastole:The overall diastolic function is mildly

impaired (grade I, impaired relaxation pattern) with normal left

ventricular filling pressures.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is normal in size.

Atrial Septum: Atrial septum is not well visualized.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal. The tricuspid annular plane

systolic excursion is 2.01 cm consistent with normal right

ventricular systolic function. The right ventricular systolic

pressure, as estimated using the tricuspid regurgitation velocity, is

25.8 mmHg.

Aortic Valve: The aortic valve is trileaflet and is calcified with

normal excursion. Mild aortic valve insufficiency is present.

Mitral Valve: Mild mitral regurgitation is present.

Tricuspid Valve: Trace tricuspid regurgitation is present.

Pulmonic Valve: Trace pulmonary regurgitation is seen.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 2.70 cm. The ascending aorta is normal at 3.23 cm. The

aortic arch is normal at 2.10 cm. The descending aorta is normal in

size at 2.42 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.11 m/s, and

with an assumed right atrial pressure of 8 mmHg, the estimated

pulmonary artery systolic pressure is normal at 25.8 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 4/17/15. Compared to the prior study, a full study was now

performed and more information provided.

Summary:

1. Normal left ventricular cavity size.

2. Normal global left ventricular systolic function.

3. Mild diastolic dysfunction with normal left ventricular filling

pressures.

4. Normal right ventricular systolic function.

5. Trileaflet aortic valve and aortic sclerosis.

6. Mild aortic insufficiency.

7. Mild mitral regurgitation.

8. Trace tricuspid regurgitation.

9. Moderately increased relative wall thickness.

10. No pericardial effusion.

11. Normal aortic root diameter for body size.

012480 Howard Novotny MD, FACC

Electronically signed by 012480 Howard Novotny MD, FACC on 4/20/2015

at 11:50:22 AM

\*\*\* Final \*\*\*

Attending Cardiologist: NOVOTNY, HOWARD

Ordered By: CHEUNG, FELIX

Order Date: April 18, 2015 9:55 AM

Completion Date: April 20, 2015 9:47 AM

Encounter Number: 010086691978

Accession Number: 6206323

Images were reviewed and interpreted by Attending Cardiologist: Dr. NOVOTNY, HOWARD

Electronically Signed On: April 20, 2015 11:50 AM by Dr. NOVOTNY, HOWARD

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/21/2015 3:07:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

S/P KIDNEY TRANSPLANT, PEA ARREST

Additional History

EVALUATE FOR PNEUMONIA

Technique

Single portable AP supine view of the chest.

Comparison

Radiograph dated 04/20/2015

Findings

Endotracheal tube tip well positioned, 3.5 cm above the carina.

Enteric tube tip excluded from field of view but coursing well below

the diaphragm. Right internal jugular approach central venous

catheter tip projects over the SVC.

Enlarged Stable small left pleural effusion blunting the costophrenic

angle. Resolving bilateral perihilar pulmonary edema. There is no

pneumothorax. The cardiomediastinal silhouette is enlarged, stable

from prior examination. There is prominence of the pulmonary arterial

silhouette. Aortic arch is calcified.

Visualized osseous structures are within normal limits.

Impression

1. Resolving bilateral perihilar pulmonary edema.

2. Stable small left layering pleural effusion.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: LLENES, REY PHILLIP

Order Date: April 21, 2015 4:00 AM

Completion Date: April 21, 2015 3:07 AM

Encounter Number: 010086691978

Accession Number: 6207717

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: April 21, 2015 9:48 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/22/2015 2:48:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SICU

Technique

AP portable

Comparison

04/21/2000 15 .

Findings

Endotracheal tube is unchanged in position. Again noted is a right

jugular venous catheter with tip in SVC and endotracheal, unchanged.

Cardiomediastinal silhouette appears unremarkable. Small left

pleural effusion with left basilar atelectasis. Interval improvement

in pulmonary vascular congestion. Left axillary stent. No

pneumothorax identified.

Impression

Interval improvement in mild interstitial edema. Small left pleural

effusion with left basilar atelectasis.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: SVESTKA, MICHAEL

Order Date: April 22, 2015 4:00 AM

Completion Date: April 22, 2015 2:48 AM

Encounter Number: 010086691978

Accession Number: 6209357

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: April 22, 2015 10:18 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/23/2015 3:57:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

EVALUATE POST-OP

Technique

AP portable.

Comparison

04/22/2015

Findings

Endotracheal tube, NG tube, right jugular venous catheter, all remain

unchanged in position. Left axillary stent is again noted.

Cardiomediastinal silhouette is unchanged from prior radiographs of

the aortic arch calcification. Again noted are bilateral mid to

lower zone atelectasis. With small left pleural effusion. No

significant interval change. No pneumothorax.

Impression

Small left pleural effusion with bilateral mid to lower zone linear

atelectasis. No significant interval change.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: CHANTACHOTE, CHANAK

Order Date: April 23, 2015 4:00 AM

Completion Date: April 23, 2015 3:57 AM

Encounter Number: 010086691978

Accession Number: 6211312

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: April 23, 2015 7:29 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/24/2015 3:01:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

S/P KIDNEY TRANSPLANT, PEA ARREST

Additional History

EVALUATE FOR PNEUMONIA

Technique

Single portable AP supine view of the chest

Comparison

Radiograph dated 04/23/2015

Findings

Intubated with endotracheal tube tip well positioned at the level of

the clavicles. Enteric tube tip excluded from field of view coursing

well below the diaphragm. Status post interval removal of right

internal jugular approach central venous catheter.

Subsegmental bibasilar atelectasis is slightly improved from prior

exam. Stable small left pleural effusion. There is no pneumonic

airspace consolidation, pneumothorax, or pulmonary vascular

congestion. The cardiomediastinal silhouette is within normal limits.

Aortic arch is calcified.

Visualized osseous structures are stable from prior examination.

Impression

1. Slight interval improvement in bibasilar subsegmental

atelectasis.

2. Stable small left pleural effusion.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: LLENES, REY PHILLIP

Order Date: April 24, 2015 4:00 AM

Completion Date: April 24, 2015 3:01 AM

Encounter Number: 010086691978

Accession Number: 6212448

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: April 24, 2015 10:11 AM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/25/2015 3:24:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SICU

Additional History

SICU

Technique

Portable supine view of the chest.

Comparison

04/24/2015

Findings

Endotracheal tube with distal tip approximately 3.5 cm above the

carina. Enteric tube coursing inferiorly with distal tip not well

visualized. The lungs demonstrate a persistent small left pleural

effusion with bibasilar atelectasis. No focal consolidation or

pneumothorax. The cardiomediastinal silhouette is normal in size.

Atherosclerotic vascular calcification of the aorta.

Impression

1. Small left pleural effusion.

2. Bibasilar atelectasis.

3. Tubes stable position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: SVESTKA, MICHAEL

Order Date: April 25, 2015 4:00 AM

Completion Date: April 25, 2015 3:24 AM

Encounter Number: 010086691978

Accession Number: 6213925

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: April 25, 2015 10:19 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/26/2015 3:52:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SICU

Indication

SICU

Technique

CHEST AP PORTABLE/ROUT

Comparison

04/25/2015

Findings

All lines unchanged. The cardiomediastinal silhouette is unchanged.

No significant change noted in the left-sided pleural effusion.

Bibasilar subsegmental atelectasis are noted. Aortic calcifications

are visualized. There is no pneumothorax.

Impression

Unchanged left-sided small pleural effusion and bibasilar

atelectasis.

Attending Radiologist: ABBASI, ALMAS

Ordered By: SVESTKA, MICHAEL

Order Date: April 26, 2015 4:00 AM

Completion Date: April 26, 2015 3:52 AM

Encounter Number: 010086691978

Accession Number: 6215251

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: April 26, 2015 10:31 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/27/2015 3:08:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

S/P KIDNEY TRANSPLANT

Technique

Portable AP view of the Chest

Comparison

04/26/2015

Findings

The endotracheal tube and nasogastric tube are unchanged in position.

Re- identified is a left axillary vein stent.

There is linear atelectasis in the right midlung. There is a small

left-sided pleural effusion with left-sided atelectasis. Trachea is

midline and calcified. There is parahilar edema but no evidence of

pulmonary vascular congestion.

Impression

Small left-sided pleural effusion with atelectasis of the left lung

base. Linear atelectasis right mid lung. Perihilar edema. Heart size

normal. Tubes and lines in good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: LLENES, REY PHILLIP

Order Date: April 27, 2015 4:00 AM

Completion Date: April 27, 2015 3:08 AM

Encounter Number: 010086691978

Accession Number: 6215912

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: April 27, 2015 9:09 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/27/2015 4:29:00 PM

Report Name: CT:HEAD ROUTINE W/O CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR CHANGE IN CONSCIOUSNESS

History and Indication

UNRESP OFF SEDATION S/P KID XPLANT

Technique

Contiguous axial slices were obtained from the skull base to the

vertex. Coronal and sagittal reformatted images were also performed.

Comparison

Previous head CT performed 04/17/2015

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction. There is a chronic infarct in the right paramedian

frontal corona radiata. There is bilateral cerebral white-matter

hypodensity which most likely represents chronic ischemic small

vessel disease. There is unchanged prominence of the ventricles,

cisterns and sulci representing involutional change. There is no mass

effect, midline shift or other focal parenchymal abnormality. There

is no intracranial hemorrhage or extra-axial collection. The

calvarium is intact. There is interval clearing of the paranasal

sinuses and nasal cavity post removal of nasogastric tube.

Impression

1. No acute intracranial pathology or interval change from the

prior study.

2. Chronic right frontal lobe infarct and chronic microvascular

ischemic disease.

Attending Radiologist: WEST, STEVEN

Ordered By: SVESTKA, MICHAEL

Order Date: April 27, 2015 1:30 PM

Completion Date: April 27, 2015 4:29 PM

Encounter Number: 010086691978

Accession Number: 6217252

Images were reviewed and interpreted by Attending Radiologist: Dr. WEST, STEVEN

Electronically Signed On: April 27, 2015 4:54 PM by Dr. WEST, STEVEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/28/2015 3:18:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

S/P KIDNEY TRANSPLANT

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 04/27/2015.

Findings

Airspace opacification in the right lower lobe is again noted.

Airspace opacification is also noted in the left periaortic area with

likely atelectasis left lung base. Heart size is normal. Endotracheal

tube, nasogastric tube are in good position is unchanged. Vascular

stent is noted in the left axilla.

Impression

Airspace opacification right lower lobe left periaortic area likely

atelectasis. Atelectasis left lung base. Heart size is normal. Tubes

and lines in good position unchanged.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: LLENES, REY PHILLIP

Order Date: April 28, 2015 4:00 AM

Completion Date: April 28, 2015 3:18 AM

Encounter Number: 010086691978

Accession Number: 6216480

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: April 28, 2015 8:43 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/29/2015 3:38:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

S/P SX

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 04/28/2015.

Findings

Airspace opacification is noted in the right lung base little change

from prior examination. Airspace opacification is noted in the left

parahilar and periaortic area as well as left lung base. Heart size

is normal. Endotracheal tube and nasogastric tube are in good

position and unchanged from prior exam.

Impression

Airspace opacification right lower lung likely atelectasis. Airspace

opacification of the left parahilar region, left periaortic regions

and left lung base likely atelectasis consider possible superimposed

pneumonia. Tubes and lines in good position. Heart size normal.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: CHANTACHOTE, CHANAK

Order Date: April 29, 2015 4:00 AM

Completion Date: April 29, 2015 3:38 AM

Encounter Number: 010086691978

Accession Number: 6218556

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: April 29, 2015 9:19 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 4/30/2015 4:39:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

S/P KIDNEY TRANSPLANT

Indication

EVALUATE FOR PNEUMONIA

Technique

CHEST AP PORTABLE/ROUT

Comparison

Study on the previous day.

Findings

Endotracheal tube and enteric tube are unchanged in position. Left

retrocardiac opacity likely represents atelectasis. There is also a

linear opacity within the right mid lung consistent with atelectasis.

No pneumothorax. Cardiomediastinal silhouette is stable.

Impression

No significant interval change.

Attending Radiologist: REITER, MICHAEL

Ordered By: LLENES, REY PHILLIP

Order Date: April 30, 2015 4:00 AM

Completion Date: April 30, 2015 4:39 AM

Encounter Number: 010086691978

Accession Number: 6220024

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: April 30, 2015 8:48 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/1/2015 4:30:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

SICU

History and Indication

SICU

Technique

A single AP view the chest.

Comparison

Study from the previous day.

Findings

Tubes and lines appear unchanged from prior study.

The lung fields are clear there are no congestive changes, pleural

effusions or airspace consolidation. There is bibasilar atelectasis.

The cardiomediastinal silhouette is within normal limits.

Impression

Bibasilar atelectasis.

Clear lungs.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: SVESTKA, MICHAEL

Order Date: May 1, 2015 4:00 AM

Completion Date: May 1, 2015 4:30 AM

Encounter Number: 010086691978

Accession Number: 6221530

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: May 1, 2015 10:11 AM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/2/2015 5:20:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

SX

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 05/01/2015.

Findings

There has been clearing of the left lung base. There is residual

atelectasis right mid lung and right lower lung. Heart size is

normal. Endotracheal tube and nasogastric tube remain in good

position unchanged.

Impression

Clearing atelectasis left lung base. Residual atelectasis right lung

base. Tubes and lines in good position. Heart size normal.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: CHANTACHOTE, CHANAK

Order Date: May 2, 2015 4:00 AM

Completion Date: May 2, 2015 5:20 AM

Encounter Number: 010086691978

Accession Number: 6222697

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: May 2, 2015 10:24 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/3/2015 4:01:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

S/P KIDNEY TRANSPLANT

Technique

Single portable AP chest radiograph.

Comparison

Chest radiograph performed on 05/02/2015.

Findings

An endotracheal tube is seen with its tip at the level of the

clavicular heads. An NG tube is seen coursing below the diaphragm

was excluded from view.

There is linear subsegmental atelectasis at the right midlung. There

is no sizable pleural effusion. Increased markings at left lung base.

Question atelectasis versus a hiatal hernia. There is no pulmonary

vascular congestion or pneumothorax.

The cardiomediastinal silhouette is within normal limits.

Impression

Right midlung linear subsegmental atelectasis. Increasing markings at

left lung base may represent possible hiatal hernia versus

atelectasis Tubes and lines in good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: LLENES, REY PHILLIP

Order Date: May 3, 2015 4:00 AM

Completion Date: May 3, 2015 4:01 AM

Encounter Number: 010086691978

Accession Number: 6224252

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: May 3, 2015 9:18 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/4/2015 2:22:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

SICU

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 05/03/2015.

Findings

Persistent linear atelectasis right mid lung field. New linear

atelectasis left lung base. Heart size is within normal limits. Bony

thorax and extra thoracic osseous structures and soft tissues are

unremarkable. Endotracheal tube, nasogastric tube and the good

position.

Impression

Mild atelectasis right mid and left lower lung. Tubes and lines in

good position. Heart size normal

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: SVESTKA, MICHAEL

Order Date: May 4, 2015 4:00 AM

Completion Date: May 4, 2015 2:22 AM

Encounter Number: 010086691978

Accession Number: 6225053

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: May 4, 2015 7:40 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/5/2015 2:00:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SICU

Indication

SICU

Technique

CHEST AP PORTABLE/ROUT

Comparison

Study on the previous day.

Findings

Endotracheal tube and enteric tube are unchanged in position.

Bibasilar atelectasis. No focal consolidation or pneumothorax.

Cardiomediastinal silhouette is stable.

Impression

No significant interval change.

Attending Radiologist: REITER, MICHAEL

Ordered By: ABRAHAMS, ELDHOSE

Order Date: May 5, 2015 4:00 AM

Completion Date: May 5, 2015 2:00 AM

Encounter Number: 010086691978

Accession Number: 6226279

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: May 5, 2015 6:20 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/6/2015 12:05:00 PM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

EVAL FOR EFFUSION

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 05/05/2015.

Findings

Blunting of the left costophrenic angle suggests possible small

effusion. Airspace opacification in both lung bases is consistent

with atelectasis but is improved from prior exam. Heart size is

normal. No tracheal tube and nasogastric tube are in good position

unchanged prior exam.

Impression

Blunting left costophrenic angle may represent small left pleural

effusion. Airspace opacification bilaterally at the bases consistent

with atelectasis. Heart size normal. Tubes and lines in good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: RUBANO, JERRY

Order Date: May 6, 2015 11:20 AM

Completion Date: May 6, 2015 12:05 PM

Encounter Number: 010086691978

Accession Number: 6229418

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: May 6, 2015 12:33 PM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/7/2015 3:12:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SICU

Indication

EVALUATE FOR PLEURAL EFFUSIONS

Technique

Single portable AP view of the chest

Comparison

Chest radiograph dated 05/06/2015

Findings

The endotracheal tube is again identified above the level of the

carina and unchanged in position. The orogastric tube is again

identified extending below the left hemidiaphragm in unchanged

position. The cardiac size is within normal limits and unchanged. The

aortic knob is calcified. There is minimal pulmonary vascular

congestion.There is mild left basilar atelectasis.There is linear

atelectasis at the right lower lung field. No focal pneumonic

consolidation. No pneumothorax.

Impression

Minimal pulmonary vascular congestion. No effusions.

Mild left basilar atelectasis and linear atelectasis within the right

lower lobe.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: ARNOLD, ALISSA

Order Date: May 7, 2015 4:00 AM

Completion Date: May 7, 2015 3:12 AM

Encounter Number: 010086691978

Accession Number: 6230074

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: May 7, 2015 12:33 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/8/2015 3:22:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

SICU

History and Indication

SICU

Technique

A single AP view the chest.

Comparison

Study from the previous day.

Findings

The endotracheal tube and enteric tube have both been removed. There

is a new tracheostomy tube.

There is increasing subsegmental atelectasis left lower lobe,

laterally. Mild pulmonary vascular congestion is noted slightly worse

compared to the prior study.

The cardiomediastinal silhouette is mildly enlarged unchanged.

Impression

New subsegmental left lower lobe atelectasis.

Worsening, mild pulmonary vascular congestion.

Attending Radiologist: MOORE, WILLIAM H

Ordered By: ABRAHAMS, ELDHOSE

Order Date: May 8, 2015 6:00 AM

Completion Date: May 8, 2015 3:22 AM

Encounter Number: 010086691978

Accession Number: 6231110

Images were reviewed and interpreted by Attending Radiologist: Dr. MOORE, WILLIAM H

Electronically Signed On: May 8, 2015 8:43 AM by Dr. MOORE, WILLIAM H

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/9/2015 4:34:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SICU

Additional History

SICU

Technique

Portable supine view of the chest

Comparison

Radiograph dated 05/08/2015

Findings

Tracheostomy tube stable in position.The lungs demonstrate persistent

bibasilar atelectasis, perhaps slightly improved. No focal

consolidation, large pleural effusions, pneumothorax, or pulmonary

vascular congestion. The cardiomediastinal silhouette is within

normal limits.

Atherosclerotic vascular calcification of the aorta.

Impression

Persistent but mild bibasilar atelectasis.

Attending Radiologist: FISHER, PAUL

Ordered By: ABRAHAMS, ELDHOSE

Order Date: May 9, 2015 6:00 AM

Completion Date: May 9, 2015 4:34 AM

Encounter Number: 010086691978

Accession Number: 6232571

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: May 9, 2015 11:21 AM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/10/2015 5:13:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SICU

History and Indication

EVALUATE FOR PLEURAL EFFUSION

Technique

AP portable view of the chest

Comparison

Radiograph dated 05/09/2015

Findings

Tracheostomy tube is unchanged in position overlying the midline air

column. Cardiomediastinal silhouette is within normal limits.

Calcification in the aortic knob is noted.

There is persistent bibasilar atelectasis. There is no evidence of a

pneumothorax, effusion, or pulmonary vascular congestion.

Impression

Persistent bibasilar atelectasis.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: ARNOLD, ALISSA

Order Date: May 10, 2015 4:00 AM

Completion Date: May 10, 2015 5:13 AM

Encounter Number: 010086691978

Accession Number: 6233815

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: May 10, 2015 5:54 PM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/11/2015 3:01:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SICU

Indication

SICU

Technique

CHEST AP PORTABLE/ROUT

Comparison

Study on the previous day.

Findings

Tracheostomy tube is unchanged in position. There is a small

left-sided pleural effusion with associated left basilar atelectasis.

Linear opacity at the right base also likely represents atelectasis.

No pneumothorax. Cardiomediastinal silhouette is stable. Unchanged

left axillary stent.

Impression

Persistent small left-sided pleural effusion and associated left

basilar atelectasis.

Attending Radiologist: REITER, MICHAEL

Ordered By: ABRAHAMS, ELDHOSE

Order Date: May 11, 2015 6:00 AM

Completion Date: May 11, 2015 3:01 AM

Encounter Number: 010086691978

Accession Number: 6234248

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: May 11, 2015 7:50 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/12/2015 3:05:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

SICU

Technique

A single AP view the chest.

Comparison

Compared to prior study of 05/11/2015.

Findings

Persistent linear atelectasis is noted in the right mid lung fields.

There is atelectasis and effusion at the left lung base which is

likely layering. Heart size is within normal limits. The

tracheostomy tube is in place bony thorax of extra thoracic osseous

structures are unremarkable except for a vascular stent the left

axillary region.

Impression

Linear atelectasis right lung base and mid right lung. Layering

pleural effusion with atelectasis left lung. Heart size normal.

Tracheostomy tube in good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: ARNOLD, ALISSA

Order Date: May 12, 2015 4:00 AM

Completion Date: May 12, 2015 3:05 AM

Encounter Number: 010086691978

Accession Number: 6235218

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: May 12, 2015 8:06 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/13/2015 3:03:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

LINE OR TUBE PLACEMENT

Technique

AP portable

Comparison

05/12/2015

Findings

Tracheostomy tube is unchanged in position. Cardiomediastinal

silhouette is unremarkable. Small left pleural effusion with left

basilar atelectasis. Right mid zone atelectasis. No focal

consolidation identified. Left axillary vascular stent is

identified. No pneumothorax. Biapical pleural thickening. No

displaced rib fractures.

Impression

small left pleural effusion with left basilar atelectasis. No

significant interval change.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: COOPER, RACHEL

Order Date: May 13, 2015 4:00 AM

Completion Date: May 13, 2015 3:03 AM

Encounter Number: 010086691978

Accession Number: 6237250

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: May 13, 2015 8:22 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/14/2015 12:23:00 PM

Report Name: ULTRASOUND KIDNEY TRANSPLANT PORTABLE

Examination

ULTRASOUND KIDNEY TRANSPLANT PORTABLE/ROUT

Renal transplant US:

Clinical History

S/P KIDNEY TRANSPLANY

Technique

Grayscale ultrasound, color Doppler and spectral Doppler

interrogation were utilized to evaluate the transplant kidney.

Comparison

There are no images available for comparison

Findings

This study is somewhat limited due to patient condition.

Renal transplant is found in right lower quadrant.

Transplant is 10.9 x 6.5 x 6.4 cm. There is no evidence for

hydronephrosis.

Echogenicity is homogeneous and normal. Small amount of free fluid is

noted around the transplant.

Analysis of peak systolic velocity from main renal vessels and

various

vessels with transplant appear normal. The right main renal vein

appear unremarkable.

Resistance indices (RIs) obtained are upper normal limits, in the

range of 0.80- 0.84.

Urinary bladder is collapsed.

Impression

1. No evidence of hydronephrosis.

2. Small amount of perinephric fluid.

3. Resistive indices are upper normal limits.

2. Otherwise unremarkable evaluation the right renal transplant

Attending Radiologist: ABBASI, ALMAS

Ordered By: CHRISTIE, FLORENCE

Order Date: May 14, 2015 9:40 AM

Completion Date: May 14, 2015 12:23 PM

Encounter Number: 010086691978

Accession Number: 6239912

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: May 14, 2015 1:53 PM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/17/2015 9:36:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Desaturations, cough.

Technique

Single portable frontal view of the chest.

Comparison

Tracheostomy tube is unchanged in position. There has been some

interval increase in left-sided pleural effusion. There is bibasilar

atelectasis. There is no pulmonary vascular congestion or

pneumothorax. Cardio mediastinal silhouette is unchanged.

Findings

Tracheostomy tube is unchanged in position. There has been some

interval increase in left-sided pleural effusion. There is a

questionable trace right-sided pleural effusion. There is bibasilar

atelectasis. There is no pulmonary vascular congestion or

pneumothorax. Cardio mediastinal silhouette is unchanged.

Impression

Interval increase in left-sided pleural effusion. Questionable trace

right-sided pleural effusion. Bibasilar atelectasis.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: POVCHER, OLGA

Order Date: May 17, 2015 8:55 AM

Completion Date: May 17, 2015 9:36 AM

Encounter Number: 010086691978

Accession Number: 6243708

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: May 17, 2015 9:58 AM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/20/2015 9:52:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

S/P KIDNEY TRANSPLANT

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 05/17/2015.

Findings

Is bilateral parahilar edema. Atelectasis at the left lung base has

cleared substantially with mild residual. Mild atelectasis right lung

base. Heart size is normal. Tracheostomy tube in place.

Impression

Improving but persistent atelectasis left lung base. Mild atelectasis

right lung base. Parahilar edema. Heart size normal. Tracheostomy

tube in good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: CHRISTIE, FLORENCE

Order Date: May 20, 2015 9:10 AM

Completion Date: May 20, 2015 9:52 AM

Encounter Number: 010086691978

Accession Number: 6248124

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: May 20, 2015 10:46 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 5/23/2015 6:49:00 AM

Report Name: MRI BRAIN WO IV CONTRAST

Clinical History

EVALUATION OF STROKE

History and Indication

S/P CARDIAC ARREST WITH PERSISTENTLY ALTERED MENTAL STATUS. R/O

INFARCT

Technique

Multiple sequences were performed through the brain in multiple

planes.

Comparison

Non contrast head CT dated 04/17/2015.

Findings

The ventricles, sulci, and fissures are prominent consistent with

age-related volume loss. There is no abnormally restricted diffusion,

acute intracranial hemorrhage, mass, or extra-axial collection.

There is symmetric bilaterally intrinsic T1 hyperintense signal with

susceptibility in the basal ganglia involving the globus pallidus,

putamen, and head of caudate nucleus, although nonspecific may

represent mineralization, sequelae of hepatic insufficiency, versus

hyperalimentation. There is extensive confluent periventricular and

multiple foci of deep and subcortical white matter T2/FLAIR

hyperintensity consistent with to chronic microvascular disease.

There is no midline shift or evidence for recurrence internal

herniation. The major intracranial vascular structures demonstrate T2

flow voids. The midline structures are normal position. The pituitary

gland is unremarkable.

The visualized orbits and soft tissues are unremarkable. The

visualized paranasal sinuses and right mastoid air cells are clear.

There is partial opacification of the left mastoid air cells.

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Impression

Severe chronic microvascular disease with age related volume loss.

Symmetric signal abnormality in the bilateral basal ganglia as

described above; differential considerations include mineralization,

sequelae of hepatic insufficiency, versus hyperalimentation.

Attending Radiologist: BANGIYEV, LEV

Ordered By: POVCHER, OLGA

Order Date: May 22, 2015 9:50 PM

Completion Date: May 23, 2015 6:49 AM

Encounter Number: 010086691978

Accession Number: 6252305

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: May 23, 2015 10:32 AM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 6/4/2015 12:03:00 PM

Report Name: FLUORO GUID CVC RE/PLACE ADD

Clinical History

69-year-old female with history of kidney transplant, anoxic brain

injury, needs PICC for long-term intravenous access.

Technique

PROCEDURE PERFORMED: Peripherally inserted central venous catheter

placement

CONSENT: The risks, benefits, treatment options, potential

complications and personnel involved were discussed with the patient.

All questions were answered and consent was obtained. The staff

physician personally verified consent.

TIME OUT: A time out was performed immediately prior to procedure

start with the nursing, anesthesia and interventional team, correctly

identifying the patient name, date of birth, procedure, anatomy

(including marking of site and side), patient position, procedure

consent form, relevant diagnostic and radiology test results,

antibiotic administration, safety precautions, and procedure-specific

equipment needs. The patient's medications and allergies were

reviewed in the electronic medical record and reconciled to the

proposed procedure/treatment. The appropriate elements of the

pre-procedure discussion was performed.

Patient position: Supine

Anesthesia: No sedation was used

Local anesthesia: Lidocaine 1 %

Image guidance: Ultrasound and fluoroscopy

Total Fluoroscopy time: 0.8 minutes

Contrast: None.

Access site: Right brachial vein

Indwelling device: 5 French Double-lumen 38 centimeter long PICC

Tip location: Cavoatrial junction

Estimated blood loss: Minimal

PROCEDURE: Ultrasound was used to image the right upper arm. The

right brachial was found to be patent was chosen for PICC placement.A

hard copy image was stored in the patient's records.Thetarget area

was prepped and draped using a maximal sterile barrier technique,

including cap, mask, sterile gown, sterile gloves, a large sterile

sheet, hand hygiene and 2% chlorhexidine for cutaneous antisepsis (or

acceptable alternative antiseptics, per current guideline).

After local anesthesia, the needle was placed into the chosen vein

using real-time ultrasound guidance. The needle was exchanged over

guide wire for a peel-away sheath. The catheter was trimmed to the

appropriate length. The catheter was placed through the peel-away

sheath under fluoroscopic guidance. The catheter drew and flushed

easily. The catheter was flushed with normal saline, capped, and

secured to the skin with a Stat Lock adhesive device. Sterile

dressings were applied.

The patient tolerated the procedure well and left the department

without evidence of any significant complication.

Dr. Amit Gupta, Interventional Radiologist was present during the

entire procedure.

Impression

Successful placement of a peripherally inserted central venous

catheter (PICC). The catheter is ready for use.

Attending Radiologist: GUPTA, AMIT

Ordered By: CHRISTIE, FLORENCE

Order Date: June 4, 2015 10:50 AM

Completion Date: June 4, 2015 12:03 PM

Encounter Number: 010086691978

Accession Number: 6265665

Images were reviewed and interpreted by Attending Radiologist: Dr. GUPTA, AMIT

Electronically Signed On: June 4, 2015 1:12 PM by Dr. GUPTA, AMIT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 6/10/2015 5:11:00 PM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/URGENT

Clinical History

S/P KIDNEY TRANSPLANT

Additional History

EVALUATE FOR PNEUMONIA

Technique

Frontal chest radiograph

Comparison

5/20/2015

Findings

There has been interval placement of a right approach PICC line with

distal tip likely in the brachiocephalic vein. The insertion site is

not included on this radiograph. Tracheostomy tube is again noted

just beneath the level of clavicles. There is mild pulmonary vascular

congestion as well as development of a left-sided pleural effusion

with subjacent atelectasis. The cardiomediastinal silhouette is

unchanged.

Impression

Mild pulmonary venous congestion with small left pleural effusion and

left basilar atelectasis.

Interval placement of a right approach PICC line with distal tip

likely in the left brachiocephalic vein

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: CHRISTIE, FLORENCE

Order Date: June 10, 2015 3:45 PM

Completion Date: June 10, 2015 5:11 PM

Encounter Number: 010086691978

Accession Number: 6275450

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: June 10, 2015 7:43 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 6/18/2015 5:06:00 PM

Report Name: FLUORO GUID CVC RE/PLACE ADD

Clinical History

Request for PICC replacement. Indwelling line is malpositioned and

is bleeding at the skin entry site.

Technique

Risks, benefits, and alternatives to PICC replacement were discussed

with the patient's daughter-in-law and informed written consent was

obtained. Patient was brought to the fluoroscopy and placed supine.

Right upper extremity and expose PICC were prepped with 2 percent

chlorhexidine solution and draped. Original PICC was retracted, cut,

then exchanged over a wire for a peel-away sheath. A new dual lumen

PICC was trimmed to the appropriate length and placed through the

peel-away sheath. . Final images of the chest and right upper

extremity were stored. Exposed catheter was secured to the skin with

a Stat Lock device and a sterile bio occlusive dressing was placed.

Both ports flushed and aspirated easily. The patient was brought back

to the holding area having tolerated this procedure well.

Maximal Sterile Barrier Technique was used during CVC Insertion

Cap/mask/sterile gown/gloves/large sterile sheet. Hand hygiene/2 %

chlorhexidine for cutaneous antisepsis

Comparison

None.

Findings

PICC ends at the right atrium/SVC. Length is 38 cm. Fluoroscopy used

to confirm placement. Final image shows no unintended radiopaque

foreign bodies left behind.

Impression

Technically successful wire exchange of right arm PICC. No immediate

postprocedure complications. New device is ready for use. Fluoroscopy

time 0.7 min.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: TAM, JUSTINA

Order Date: June 18, 2015 4:17 PM

Completion Date: June 18, 2015 5:06 PM

Encounter Number: 010086691978

Accession Number: 6278241

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: June 19, 2015 3:31 PM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 6/29/2015 8:26:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

INCREASED CONGESTION AFTER TRANSFUSION

History and Indication

EVALUATE FOR CHF

Technique

AP portable view of the chest

Comparison

Radiograph 06/10/2015

Findings

No change in position of the right-sided PICC line or the

tracheostomy tube.

There is mild pulmonary vascular congestion and a small left pleural

effusion with adjacent atelectasis. The cardiomediastinal silhouette

is unchanged.

Impression

Mild pulmonary vascular congestion with a small left pleural effusion

which is unchanged.

Attending Radiologist: REITER, MICHAEL

Ordered By: POVCHER, OLGA

Order Date/Time: June 29, 2015 8:10 PM

Scan Initiation Date/Time: June 29, 2015 8:14 PM

Completion Date/Time: June 29, 2015 8:26 PM

Encounter Number: 010086691978

Accession Number: 6300150

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: June 29, 2015 10:47 PM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 7/6/2015 10:29:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Fever

Technique

AP portable view of the chest.

Comparison

Radiograph of the chest dated 06/29/2015.

Findings

There is mild pulmonary vascular congestion. There is a small left

pleural effusion. There is bibasilar atelectasis. The

cardiomediastinal silhouette is enlarged, stable from prior study.

Arthrosclerotic calcification of the aortic notch is noted. The aorta

is tortuous.

Again noted is a tracheostomy tube over the tracheal air column.

There is a right sided approach PICC line with tip in the superior

vena cava.

Impression

1. Mild vascular congestion with stable cardiomegaly.

2. Small left-sided pleural effusion with bibasilar atelectasis.

3. Tracheostomy tube and PICC line are in good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: D'AMATO, ABRAM

Order Date/Time: July 6, 2015 7:55 PM

Scan Initiation Date/Time: July 6, 2015 10:26 PM

Completion Date/Time: July 6, 2015 10:29 PM

Encounter Number: 010086691978

Accession Number: 6308215

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: July 7, 2015 10:22 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 7/13/2015 2:05:00 PM

Report Name: ULTRASOUND KIDNEY TRANSPLANT EVAL

Clinical History

Increasing creatinine after stent removal.

Technique

From right lower quadrant transplant ultrasound is performed with

color and spectral Doppler.

Comparison

Prior study most recently 05/14/2015.

Findings

The study is limited due to patient's inability to cooperate and

unresponsiveness as well as contraction.

The right lower quadrant transplant measures 12.4 cm in length.

There is demonstrated mild transplant hydronephrosis status post

stent removal. Cortical echogenicity appears within normal limits.

No hypoechoic perinephric collection or fluid is seen.

Intrarenal resistive indices are borderline to moderately elevated at

0.76 to 0.85 which is not significantly changed from prior studies

previously 0.80-0.84.

There is limited visibility of the iliac artery and anastomosis

however the following measurements were obtained: Feeding iliac

artery demonstrates velocity of 134 cm/sec. Anastomotic velocity is

209 cm/sec. Proximal renal artery velocity is 191 cm/sec. Mid renal

artery velocity is 157 cm/sec and distal renal artery velocity close

to the hilum is 144 cm/sec.

There is patency of the main renal vein and iliac vein draining

transplant.

Urinary bladder is not fully distended but is grossly within normal

limits.

Impression

Limited study.

Interval development of mild right lower quadrant transplant

hydronephrosis status post stent removal.

Redemonstration of borderline- to moderately elevated intrarenal

resistive indices.

No evidence for renal artery stenosis.

Attending Radiologist: CUNNINGHAM, ROBIN

Ordered By: ZHAO, KAI

Order Date/Time: July 13, 2015 10:45 AM

Scan Initiation Date/Time: July 13, 2015 1:24 PM

Completion Date/Time: July 13, 2015 2:05 PM

Encounter Number: 010086691978

Accession Number: 6316012

Images were reviewed and interpreted by Attending Radiologist: Dr. CUNNINGHAM, ROBIN

Electronically Signed On: July 13, 2015 3:58 PM by Dr. CUNNINGHAM, ROBIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 7/20/2015 9:05:00 AM

Report Name: ULTRASOUND KIDNEY TRANSPLANT EVAL

Given history is a 69-year-old female status post stent placement for

hydronephrosis. Examination requested for re-evaluation.

Technique:

Ultrasonography of a renal transplant using grayscale, color flow

and spectral Doppler technique. Images were obtained in the sagittal

and transverse planes.

Comparison:

07/13/2015

Findings:

A renal transplant is noted within the right iliac fossa. It measures

11.8 x 6.7 x 6.5 cm. It is normal in contour and echotexture. There

is no evidence of hydronephrosis. The prior hydronephrosis appears

resolved. The stent however is not visualized. There is no evidence

of perinephric fluid collection or hematoma. Resistive indices were

obtained at the level of the arcuate, segmental /interlobar arteries,

and the main renal artery. The resistive indices at the level of the

arcuate arteries range between 0.72-0.78 at the level of the

segmental interlobar arteries range between to 0.84-0.88. These are

elevated particularly at the level of the segmental interlobar

arteries. These have not significantly changed from prior exam.

Normal Doppler spectral waveform is noted at these levels. Peak

systolic velocities at the right iliac artery is 178

centimeters/second. Velocities were obtained at the level of the

renal artery distally with a value of 108 centimeters/second, the mid

portion with a value of 125 centimeters/second and proximal with a

value of 161 centimeters/second and at the anastomotic site with a

value of 149 centimeters/second. Ratio at the renal artery to iliac

artery anastomotic site is not elevated. The renal vein and draining

the iliac vein or patent with normal color flow velocities measuring

58.4 centimeters/second and 46.8 centimeters/second respectively. The

urinary bladder is decompressed around a Foley catheter and cannot be

evaluated.

Impression:

Status post right renal transplant.

No evidence of hydronephrosis. Resolution of prior right

hydronephrosis. Ureteral stent is not appreciated.

No evidence of perinephric fluid collection.

Resistive indices are elevated, without significant change. This is

nonspecific. Followup can be obtained.

Attending Radiologist: MASON, MARYANNA

Ordered By: ZHAO, KAI

Order Date/Time: July 20, 2015 6:00 AM

Scan Initiation Date/Time: July 20, 2015 8:28 AM

Completion Date/Time: July 20, 2015 9:05 AM

Encounter Number: 010086691978

Accession Number: 6324199

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: July 20, 2015 9:36 AM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 8/3/2015 10:15:00 AM

Report Name: ULTRASOUND KIDNEY TRANSPLANT EVAL

Given history is a 69-year-old female with rising creatinine status

post transplant and ureteral stent placement.

Technique:

Ultrasonography of a renal transplant using grayscale, color flow

and spectral Doppler technique. Images were obtained in the sagittal

and transverse planes.

Comparison:

07/20/2015

Findings:

The study is limited due to patient body habitus

A renal transplant is noted within the right iliac fossa. It measures

11.7 x 5.5 x 7.1 cm. It is normal in contour and echotexture. There

is no evidence of hydronephrosis.A ureteral stent is partially

visualized within the right renal pelvis and within the urinary

bladder. There is no evidence of perinephric fluid collection or

hematoma. Resistive indices were obtained at the level of the

arcuate, segmental /interlobar arteries, and the main renal artery.

The resistive indices at the level of the arcuate arteries range

between 0.76-0.81 at the level of the segmental interlobar arteries

range between need 0.80- 0.87 these are elevated particularly at the

level of the segmental /interlobar arteries. These have not

significantly changed from prior exam. Normal Doppler spectral

waveform is noted at these levels. Peak systolic velocities at the

right iliac artery is 152 centimeters/second. Velocities were

obtained at the level of the renal artery distally with a value of 72

centimeters/second, the mid portion with a value of 69

centimeters/second and proximal with a value of 184

centimeters/second and at the anastomotic site with a value of

158-173 centimeters/second. Ratio at the renal artery to iliac artery

anastomotic site isnot elevated .The renal vein is patent with normal

color flow and a velocity of 44 centimeters/second. The draining

iliac vein is patent with a velocity of 35 centimeters/second.

Minimal Ascites is now seen new from prior exam. The urinary bladder

is decompressed around a Foley catheter and cannot be evaluated.

Impression:

Status post right renal transplant.

No evidence of hydronephrosis.

No evidence of perinephric fluid collection.

Resistive indices are elevated without significant change. This is

nonspecific may be seen with ATN, rejection. correlate with

laboratory values. Followup can be obtained.

Interval development of minimal ascites.

Attending Radiologist: MASON, MARYANNA

Ordered By: DEBARTOLO, MERRIT

Order Date/Time: August 3, 2015 6:00 AM

Scan Initiation Date/Time: August 3, 2015 9:24 AM

Completion Date/Time: August 3, 2015 10:15 AM

Encounter Number: 010086691978

Accession Number: 6341722

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: August 3, 2015 4:13 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 8/4/2015 9:17:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

RENAL TRANSPLANT WITH INCREASED SECRETIONS

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 07/06/2015.

Findings

There is mild central vascular congestion with bilateral small

pleural effusions somewhat greater on the left than the right. There

is mild cardiomegaly. Endotracheal tube and right PICC line are noted

in good position with tip of the catheter in the superior vena cava.

Impression

Mild central vascular congestion with bilateral small pleural

effusions greater on the left than the right. Mild cardiomegaly.

Tubes and lines in good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: August 4, 2015 7:50 AM

Scan Initiation Date/Time: August 4, 2015 9:07 AM

Completion Date/Time: August 4, 2015 9:17 AM

Encounter Number: 010086691978

Accession Number: 6344723

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: August 4, 2015 1:26 PM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 8/9/2015 10:35:00 PM

Report Name: ULTRASOUND KIDNEY TRANSPLANT EVAL

Examination

Ultrasound of renal transplant

Clinical History

Rising serum creatinine.

Technique

Grayscale ultrasound, color Doppler aspect of Doppler interrogation

were utilized to evaluate the transplant kidney.

Comparison

08/03/2015

Findings

The right lower quadrant transplant kidney is 10.8 cm in length.

There is no hydronephrosis. The renal parenchyma unremarkable.

Intrarenal RI's range from 0.77-1.0. The main renal artery and

feeding iliac artery and arterial anastomosis have normal waveforms.

The main renal vein and draining iliac vein have questionably

abnormal waveforms.

There appears to be a new, large somewhat heterogeneous but

predominantly echogenic collection in the right lower quadrant which

appears to be inferior to the transplant and measures up to 15 cm in

maximum dimension. It is avascular.

The urinary bladder is not identified.

Impression

1. Normal-sized kidney without hydronephrosis.

2. Suggestive evidence of new, large hematoma at the right lower

quadrant without apparent compression of the renal transplant. More

definitive evaluation with CT is recommended. Findings and

recommendation communicated by Dr. Mankes to nurse practitioner

Christie on 08/10/2015 at 9:30 a.m..

3. Abnormally wide range of intrarenal resistive indices from

normal to lack of any diastolic flow. It is uncertain if these

measurements are accurate.

4. Questionably abnormal renal vein and iliac vein waveforms,

possibly artifactual.

5. No evidence of renal artery stenosis.

Attending Radiologist: MANKES, SETH

Ordered By: D'AMATO, ABRAM

Order Date/Time: August 9, 2015 3:00 PM

Scan Initiation Date/Time: August 9, 2015 9:08 PM

Completion Date/Time: August 9, 2015 10:35 PM

Encounter Number: 010086691978

Accession Number: 6351774

Images were reviewed and interpreted by Attending Radiologist: Dr. MANKES, SETH

Electronically Signed On: August 10, 2015 9:30 AM by Dr. MANKES, SETH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 8/10/2015 11:35:00 AM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

Status post kidney transplant and biopsy. Hematoma seen on

ultrasound.

Technique

Routine study. Post Processed reconstructions included.

Contrast

No intravenous contrast administered.

Comparison

Renal ultrasound performed on 8/9/2015.

Findings

LUNG BASES: Small bilateral pleural effusions and bibasilar (left

greater than right) atelectasis. Cardiomegaly with coronary artery

calcifications.

Abdomen:

STOMACH: Percutaneous gastrostomy tube present. 7 mm density within

the stomach, likely medication.

LIVER: Normal size. No mass.

BILIARY TRACT: Mild cholecystolithiasis. No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: There is a right lower quadrant kidney transplant with a

nephroureteral stent in place, with tube ends coiled within the

transplanted renal pelvis and bladder. A fat plane is present around

the transplanted kidney, and known adjacent hemorrhage/ hematoma is

intraperitoneally. The native kidneys are atrophic, left greater than

right.

BOWEL: Normal caliber. No wall thickening. Colonic diverticulosis.

Evaluation for superimposed diverticulitis not adequately performed

due to intraperitoneal fluid.

PERITONEUM: There is moderate hemoperitoneum/hematoma in the right

lower quadrant enveloping several loops of small bowel, with

additional and more simple fluid seen more superiorly.

RETROPERITONEUM: No lymphadenopathy by measurement criteria.

VESSELS: Normal caliber aorta. Scattered vascular calcifications.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion. Calcifications

present in the uterus, likely leiomyomas.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Collapsed around a Foley catheter. Coiled distal end of the

ureteral stent in place.

BONES: No acute fracture or dislocation. Osteopenia.

Other: There is at least moderate diffuse anasarca. No significant

subcutaneous air is present; correlate for route of unknown biopsy.

There is an anterior abdominal wall hernia containing part of a

transverse colon bowel loop.

Impression

1. Moderate hemoperitoneum/hematoma in the right lower quadrant

enveloping several loops of bowel, with additional and more simple

fluid seen superiorly. No air seen in the subcutaneous fat to assess

for biopsy trajectory; correlate with biopsy technique. No

significant pneumoperitoneum.

2. Transplanted kidney in the right lower quadrant with thin

surrounding fat plane and no significant hydronephrosis.

Nephroureteral stent present with tubing coiled within the

transplanted renal pelvis and superolateral aspect of the bladder.

3. Anasarca.

4. Small bilateral pleural effusions with bibasilar atelectasis.

Cardiomegaly.

Above case discussed with NP Christie by Dr. K Baker of Radiology at

about 12:00 PM on 08/10/2015 via telephone.

Attending Radiologist: BAKER, KEVIN S

Ordered By: CHRISTIE, FLORENCE

Order Date/Time: August 10, 2015 9:35 AM

Scan Initiation Date/Time: August 10, 2015 11:21 AM

Completion Date/Time: August 10, 2015 11:35 AM

Encounter Number: 010086691978

Accession Number: 6352468

Images were reviewed and interpreted by Attending Radiologist: Dr. BAKER, KEVIN S

Electronically Signed On: August 10, 2015 12:07 PM by Dr. BAKER, KEVIN S

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 8/12/2015 3:20:00 PM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT ABDOMEN AND PELVIS WITHOUT CONTRAST

Clinical History

Patient with history of deceased donor of renal transplant presents

with acute kidney injury and biopsy findings of Prograf toxicity.

Technique

Contiguous helical CT images of the abdomen and pelvis were obtained,

without intravenous contrast enhancement. Multiplanar reconstructions

in soft tissue windows were provided for interpretation following

image acquisition.

Comparison

Prior CT dated 08/10/2015.

Findings

LUNG BASES: Trace bilateral pleural effusions with overlying passive

atelectasis. Calcified right basilar granuloma. Cardiomegaly with

atherosclerotic coronary disease. No pathologic amount of pericardial

fluid.

Abdomen:

Evaluation abdominal viscera is limited due to streak artifact

associated with the patient arm positioning.

LIVER: Normal size. Homogeneous attenuation. Nonspecific

calcification of hepatic segment 6 (series 2 image 29) likely sequela

of prior granulomatous disease.

BILIARY TRACT: No intrahepatic or extrahepatic biliary ductal

dilatation. Cholecystolithiasis with relatively contracted

gallbladder.

PANCREAS: Unremarkable.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: The bilateral native kidneys are markedly atrophic, right

greater than left. 3 mm calculus is noted within a left lower pole

minor calyx. The right lower quadrant transplant kidney is again

noted without evidence of hydronephrosis. A nephroureteral stent is

noted, its proximal end coiled in the upper pole collecting system,

distal end coiled within a relatively collapsed bladder.

BOWEL: Percutaneous gastrostomy tube is again noted with the balloon

in the gastric body. No wall thickening.

PERITONEUM: There is a high attenuation (60-65 HU) fluid collection

layering along the inferior peritoneal reflection and interdigitating

between small bowel loops within the right lower quadrant, not

significantly changed in size and attenuation when compared with

prior study and again consistent with intraperitoneal

hemorrhage/hematoma. Simple fluid is seen within the left pericolic

gutter extending inferiorly along the peritoneal reflection,

marginally decreased in volume from prior study. No pneumoperitoneum.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta.

ABDOMINAL WALL: Small ventral hernia containing partial loop of

transverse colon.

OTHER: Diffuse anasarca and fatty atrophy of the abdominopelvic

musculature.

Pelvis:

REPRODUCTIVE ORGANS: Dystrophic calcification within the uterus

likely degenerating leiomyomata.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Within normal limits for age. No aggressive appearing focal

osseous lesion. Diffuse demineralization.

Other: Diffuse anasarca, unchanged.

Impression

1. Redemonstration of intraperitoneal hemorrhage/hematoma,

predominantly in the right lower quadrant, without significant

change.

2. Minimal decrease in volume of simple fluid ascites of the

left paracolic gutter.

3. Right lower quadrant transplant kidney without evidence of

hydronephrosis. Thin fat plane surrounding the transplanted kidney

implies that the adjacent hematoma is likely not overly compressive.

4. Unchanged trace bilateral pleural effusions.

5. Unchanged diffuse anasarca.

Attending Radiologist: BAKER, KEVIN S

Ordered By: CHRISTIE, FLORENCE

Order Date/Time: August 12, 2015 1:50 PM

Scan Initiation Date/Time: August 12, 2015 3:06 PM

Completion Date/Time: August 12, 2015 3:20 PM

Encounter Number: 010086691978

Accession Number: 6356186

Images were reviewed and interpreted by Attending Radiologist: Dr. BAKER, KEVIN S

Electronically Signed On: August 12, 2015 3:58 PM by Dr. BAKER, KEVIN S

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 8/14/2015 12:17:00 PM

Report Name: CHEST AP PORTABLE

Given history is a 69-year-old female with fever. Evaluate for

pneumonia

Technique:

AP portable view of the chest were submitted .

Comparison:

08/04/2015

Findings:

A right PICC catheter and tracheostomy tube are again noted. The left

subclavian vascular stent is noted. The trachea is midline. The aorta

is calcified otherwise the mediastinal silhouette is normal in

appearance. The cardiac size appears enlarged. . The lungs

demonstrate a left pleural effusion with adjacent compressive

atelectasis. No right pleural effusion. Prior pulmonary congestion

appears improved No definitive pulmonary congestion. There is no

evidence of pneumothorax. Degenerative change of the spine is

partially visualized.

Impression:

Left pleural effusion with adjacent compressive atelectasis without

significant change.

Improved pulmonary congestion

Cardiomegaly.

Attending Radiologist: MASON, MARYANNA

Ordered By: D'AMATO, ABRAM

Order Date/Time: August 14, 2015 11:55 AM

Scan Initiation Date/Time: August 14, 2015 12:08 PM

Completion Date/Time: August 14, 2015 12:17 PM

Encounter Number: 010086691978

Accession Number: 6358849

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: August 14, 2015 1:00 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 8/26/2015 4:13:00 PM

Report Name: FLUORO GUID CVC RE/PLACE ADD

Clinical History

Multi-drug resistant UTI, renal transplant.

Technique

PROCEDURE:

Risks, benefits, and alternatives were discussed with the patient who

appeared to understand and granted informed consent. The patient was

brought to the angio suite and placed in the supine position on the

fluoroscopic table. Limited ultrasound of the right arm was performed

and an image was stored. The patient's right upper arm was prepped

and draped in the usual sterile fashion. Maximal sterile barrier

technique was used,including cap, mask, sterile gown, gloves, large

sterile sheet, hand hygiene, and 2% chlorhexidine for cutaneous

antisepsis. 1% lidocaine was used for local anesthesia. Under direct

ultrasound guidance, a right brachial vein was accessed with a

micropuncture needle. The micropuncture needle was changed over an

0.018" guidewire for a 6.5 French dilator with peel-away sheath and

the wire was used to estimate appropriate catheter length. Through

the peel-away sheath, a 6 French x 42 cm triple lumen Power PICC was

advanced and positioned fluoroscopically with its tip at the

cavoatrial junction. The sheath was then removed. Final fluoroscopic

images of the chest and right arm access site were obtained. The line

was then secured and flushed. The patient tolerated the procedure

with no immediate complication.

Fluoro Time: 0.3 minutes

FINDINGS:

Limited ultrasound demonstrates patent and compressible basilic and

brachial veins in the right upper arm. There was successful placement

of a 6 French x 42 cm triple-lumen Power PICC via a right brachial

vein, with tip positioned at the cavoatrial junction.

Impression

Successful placement of a 6 French x 42 cm triple lumen Power PICC

via a right brachial vein.

Attending Radiologist: MALESON, ANDREW

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: August 26, 2015 2:51 PM

Scan Initiation Date/Time: August 26, 2015 2:48 PM

Completion Date/Time: August 26, 2015 4:13 PM

Encounter Number: 010086691978

Accession Number: 6369360

Images were reviewed and interpreted by Attending Radiologist: Dr. MALESON, ANDREW

Electronically Signed On: August 28, 2015 9:25 AM by Dr. MALESON, ANDREW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/6/2015 7:48:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Respiratory failure, status post tracheostomy

Technique

AP view of the chest.

Comparison

AP view of the chest dated August 14, 2015

Findings

Again seen is the tracheostomy, right upper extremity approach PICC

line, and left subclavian/axillary vascular status, all of which are

unchanged in position. There is persistent left pleural effusions

with subjacent atelectasis versus pneumonia, not significantly

changed. There is redemonstrated pulmonary vascular congestion,

unchanged. Heart size is again noted to be enlarged. Calcification

is present in the aorta. Trachea is midline. Osseous structures are

grossly intact.

Impression

1. Redemonstrated left pleural effusions with subjacent

atelectasis versus consolidation, unchanged.

2. Persistent pulmonary congestion.

3. Redemonstrated cardiomegaly.

Attending Radiologist: BAKER, KEVIN S

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: September 6, 2015 7:30 AM

Scan Initiation Date/Time: September 6, 2015 7:39 AM

Completion Date/Time: September 6, 2015 7:48 AM

Encounter Number: 010086691978

Accession Number: 6387175

Images were reviewed and interpreted by Attending Radiologist: Dr. BAKER, KEVIN S

Electronically Signed On: September 6, 2015 8:27 AM by Dr. BAKER, KEVIN S

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/7/2015 11:28:00 AM

Report Name: ULTRASOUND KIDNEY TRANSPLANT EVAL

Examination

ULTRASOUND KIDNEY TRANSPLANT EVAL/STAT

Clinical History

DDRTX

History and Indication

EVALUATE GRAFT DUE TO RISING CREATININE

Technologist Comments

No comments

Technique

Grayscale ultrasound, color Doppler aspect of Doppler interrogation

were utilized to evaluate the transplant kidney.

Comparison

CT performed the same day and prior ultrasound dated 08/09/2015

Findings

The right lower quadrant transplant kidney measures 12.9 x 7.9 x 7.4

cm in size.

There is no evidence for hydronephrosis.

There is a 12.4 x 4.7 x 4.6 cm the fluid collection anterior and

medial to the transplant kidney.

The renal parenchyma appears of normal echogenicity.

Resistive indices are slightly elevated ranging from 0.71-0.84.

The iliac artery demonstrates normal triphasic waveform with

approximate velocity of 187 cm/sec.

The main renal artery and feeding iliac artery and arterial

anastomosis have normal waveforms.

The main renal artery velocity is approximately 186 cm/second at the

anastomosis, estimated at 109 cm/sec proximally near the anastomosis,

47.1 Cm/sec in the midportion and 43.4 cm/sec distally near the

transplant hilum.

The main renal vein is patent.

The urinary bladder is decompressed with a Foley.

Impression

Right lower quadrant transplant kidney with a 12.4 x 4.7 cm fluid

collection anteromedial to the transplant kidney.

Elevated resistive indices ranging from 0.71-0.84. This is a

nonspecific finding occurring most frequently in the setting of

rejection, although the differential includes ATN, drug toxicity, to

name a few possibilities. Clinical correlation is recommended.

Attending Radiologist: BARISH, MATTHEW

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: September 7, 2015 10:05 AM

Scan Initiation Date/Time: September 7, 2015 10:53 AM

Completion Date/Time: September 7, 2015 11:28 AM

Encounter Number: 010086691978

Accession Number: 6387992

Images were reviewed and interpreted by Attending Radiologist: Dr. BARISH, MATTHEW

Electronically Signed On: September 7, 2015 11:53 AM by Dr. BARISH, MATTHEW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/7/2015 11:32:00 AM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of the Abdomen and Pelvis

Clinical History

DDRTX

Additional History

RISING CREATININE AFTER RENAL TRANSPLANT

Technique

Routine study. Post Processed reconstructions included. Contrast

administered as described below:

Contrast

No IV contrast

Comparison

CT dated 12/2015

Findings

LUNG BASES: There is stable consolidation in the medial aspect of the

lingula as well as posteriorly. Atelectasis is seen at the left base.

Moderate cardiomegaly is stable.

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: Several stones are again seen in the neck of the

gallbladder. There is no biliary dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Atrophic native kidneys. Stable calculi in the left kidney.

Transplant kidney and pelvic sidewalls: The right lower quadrant

transplant kidney currently measures 9.0 x 6.9 x 12.2 cm which is

slightly increased when compared to the prior study where it measured

8.0 x 6.4 x 12.1 cm. Transplant kidney ureteral stent is in place.

Small amount of gas is seen within the collecting system likely

refluxed through the stent. There is an 8.7 x 8.8 x 5.2 cm hyperdense

fluid collection representing hematoma medial to the transplant

kidney. This is similar in appearance to the prior study.

BOWEL: Peg in place in the left upper quadrant. Ventral abdominal

wall hernia containing colon.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta.

ABDOMINAL WALL: Ventral abdominal wall hernia containing the

transverse colon.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

GROIN: No lymphadenopathy.

BLADDER: Foley catheter in a decompressed bladder.

BONES: Within normal limits for age. No focal lesion.

OTHER: None

Impression

1. Right lower quadrant hematoma medial to the right lower

quadrant transplant kidney.

2. Slight increase in size of the transplant kidney compared to

the prior study could represent transplant kidney edema.

3. Ventral abdominal wall hernia containing transverse colon.

4. Stable consolidation in the lingula and left base.

5. Stable cardiomegaly.

Attending Radiologist: BARISH, MATTHEW

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: September 7, 2015 10:10 AM

Scan Initiation Date/Time: September 7, 2015 11:30 AM

Completion Date/Time: September 7, 2015 11:32 AM

Encounter Number: 010086691978

Accession Number: 6387993

Images were reviewed and interpreted by Attending Radiologist: Dr. BARISH, MATTHEW

Electronically Signed On: September 7, 2015 12:13 PM by Dr. BARISH, MATTHEW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/17/2015 4:34:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

FEVER

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 09/06/2015.

Findings

Lungs are free of active consolidation, there is blunting of the left

costal phrenic angle which may represent atelectasis is versus edema.

Minimal atelectasis is noted in the retrocardiac region. Right lung

is clear. Heart is the upper limit of normal in size. Tracheostomy

tube and right PICC line are in good position unchanged from prior

examination. Tip is in the superior vena cava.

Impression

Atelectasis effusion left cardiophrenic angle. Heart is upper limit

of normal in size. The right lung is clear. Tubes and lines in good

position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: BERG, WILLIAM

Order Date/Time: September 16, 2015 11:45 PM

Scan Initiation Date/Time: September 17, 2015 3:55 AM

Completion Date/Time: September 17, 2015 4:34 AM

Encounter Number: 010086691978

Accession Number: 6400462

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: September 17, 2015 9:30 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/21/2015 4:44:00 PM

Report Name: ULTRASOUND KIDNEY TRANSPLANT EVAL

Examination

ULTRASOUND KIDNEY TRANSPLANT EVAL/URGENT

Clinical History

ESRD

History and Indication

EVALUATE TRANSPLANTED KIDNEY

Technique

Grayscale ultrasound, color Doppler aspect of Doppler interrogation

were utilized to evaluate the transplant kidney.

Comparison

CT and ultrasound from 09/07/2015.

Findings

The right lower quadrant transplant kidney measures 11.7 cm in size.

There is no evidence for hydronephrosis. The renal parenchyma appears

of normal echogenicity.

Again demonstrated is a fluid collection anterior and medial to the

transplant kidney which has slightly decreased in size now measuring

11 x 4 x 4 cm.

Resistive indices are within normal range with intrarenal RI's

ranging from 0.61 to 0.77.

The iliac artery demonstrates normal triphasic waveform with

approximate velocity of 156 cm/sec.

The main renal artery and feeding iliac artery and arterial

anastomosis have normal waveforms.

The main renal vein is patent.

The urinary bladder is collapsed around a Foley catheter.

Impression

1. Fluid collection anterior and medial to right kidney has

slightly decreased in size since prior study.

2. Normal intrarenal resistive indices.

Attending Radiologist: MANKES, SETH

Ordered By: CHRISTIE, FLORENCE

Order Date/Time: September 21, 2015 1:10 PM

Scan Initiation Date/Time: September 21, 2015 4:13 PM

Completion Date/Time: September 21, 2015 4:44 PM

Encounter Number: 010086691978

Accession Number: 6405670

Images were reviewed and interpreted by Attending Radiologist: Dr. MANKES, SETH

Electronically Signed On: September 21, 2015 4:53 PM by Dr. MANKES, SETH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/22/2015 7:16:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

RENAL TRANSPLANT COMPLICATED BY RESPIRATORY FAILURE

Indication

EVALUATE FOR PNEUMONIA

Technique

CHEST AP PORTABLE/STAT

Comparison

09/17/2015

Findings

Tracheostomy tube and right-sided PICC are unchanged in position.

There is a small left-sided pleural effusion and left retrocardiac

opacity, likely atelectasis. No pneumothorax. Cardiomediastinal

silhouette is stable.

Impression

No significant interval change.

Attending Radiologist: REITER, MICHAEL

Ordered By: RITTENBERG, DANIEL

Order Date/Time: September 22, 2015 6:45 AM

Scan Initiation Date/Time: September 22, 2015 6:58 AM

Completion Date/Time: September 22, 2015 7:16 AM

Encounter Number: 010086691978

Accession Number: 6406594

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: September 22, 2015 8:27 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/28/2015 5:04:00 PM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

Fever and emesis. Additional history of end-stage renal disease

status post renal transplant and multifactorial encephalopathy.

Technique

Routine study. Post processed reconstructions included.

Contrast

No oral or IV contrast.

Comparison

CT of the abdomen from 09/07/2015. No prior CT of the chest.

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: Minimal scarring / atelectasis noted. Small calcified

granuloma is seen in right lung base. .

LARGE AIRWAYS: Patent. Tracheostomy tube is in place.

PLEURA: No effusion or pneumothorax.

HEART: Heart is mildly enlarged. . No pathologic pericardial

effusion.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

Abdomen and pelvis:

LIVER: Normal size. No mass.

BILIARY TRACT: No biliary ductal dilatation. Uncomplicated

cholelithiasis is noted

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Native kidneys are atrophic. Some punctate nonobstructing

calculi are noted in the lower pole of left kidney. An apparent

miniscule cyst is seen in the upper pole of left kidney.

Right lower quadrant transplant kidney is present with the ureteral

stent in place. There is poor visualization of the renal sinus fat

but no frank hydronephrosis, unchanged.

BOWEL: Gastrostomy tube is in place. Normal caliber. No wall

thickening.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

Abdominal wall: Wide neck bowel containing supraumbilical ventral

hernia is noted. There is a smaller left parasagittal fat containing

hernia more inferiorly.

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: Again demonstrated is a moderately large

hematoma medial to the transplant kidney, slightly smaller in overall

size with decreasing attenuation. No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Within normal limits for age. Healed sternal fracture is

noted. .

Impression

1. No acute pathology identified which would explain fever and

emesis.

2. Poor visualization of renal sinus fat in transplant kidney,

unchanged, raising a possibility of transplant failure. Correlate

with renal function.

3. Slight decrease in size and attenuation of peritransplant

hematoma.

4. Uncomplicated ventral hernias.

Attending Radiologist: MANKES, SETH

Ordered By: TAM, JUSTINA

Order Date/Time: September 28, 2015 3:35 PM

Scan Initiation Date/Time: September 28, 2015 4:59 PM

Completion Date/Time: September 28, 2015 5:04 PM

Encounter Number: 010086691978

Accession Number: 6415250

Images were reviewed and interpreted by Attending Radiologist: Dr. MANKES, SETH

Electronically Signed On: September 29, 2015 8:26 AM by Dr. MANKES, SETH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/28/2015 5:04:00 PM

Report Name: CT CHEST WO IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

Fever and emesis. Additional history of end-stage renal disease

status post renal transplant and multifactorial encephalopathy.

Technique

Routine study. Post processed reconstructions included.

Contrast

No oral or IV contrast.

Comparison

CT of the abdomen from 09/07/2015. No prior CT of the chest.

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: Minimal scarring / atelectasis noted. Small calcified

granuloma is seen in right lung base. .

LARGE AIRWAYS: Patent. Tracheostomy tube is in place.

PLEURA: No effusion or pneumothorax.

HEART: Heart is mildly enlarged. . No pathologic pericardial

effusion.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

Abdomen and pelvis:

LIVER: Normal size. No mass.

BILIARY TRACT: No biliary ductal dilatation. Uncomplicated

cholelithiasis is noted

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Native kidneys are atrophic. Some punctate nonobstructing

calculi are noted in the lower pole of left kidney. An apparent

miniscule cyst is seen in the upper pole of left kidney.

Right lower quadrant transplant kidney is present with the ureteral

stent in place. There is poor visualization of the renal sinus fat

but no frank hydronephrosis, unchanged.

BOWEL: Gastrostomy tube is in place. Normal caliber. No wall

thickening.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

Abdominal wall: Wide neck bowel containing supraumbilical ventral

hernia is noted. There is a smaller left parasagittal fat containing

hernia more inferiorly.

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: Again demonstrated is a moderately large

hematoma medial to the transplant kidney, slightly smaller in overall

size with decreasing attenuation. No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Within normal limits for age. Healed sternal fracture is

noted. .

Impression

1. No acute pathology identified which would explain fever and

emesis.

2. Poor visualization of renal sinus fat in transplant kidney,

unchanged, raising a possibility of transplant failure. Correlate

with renal function.

3. Slight decrease in size and attenuation of peritransplant

hematoma.

4. Uncomplicated ventral hernias.

Attending Radiologist: MANKES, SETH

Ordered By: TAM, JUSTINA

Order Date/Time: September 28, 2015 4:10 PM

Scan Initiation Date/Time:

Completion Date/Time: September 28, 2015 5:04 PM

Encounter Number: 010086691978

Accession Number: 6415326

Images were reviewed and interpreted by Attending Radiologist: Dr. MANKES, SETH

Electronically Signed On: September 29, 2015 8:26 AM by Dr. MANKES, SETH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/28/2015 7:07:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

End stage renal disease

Technique

Frontal view of the chest.

Comparison

9/22/15 .

Findings

Cardiac silhouette is enlarged. but likely stable. Tracheostomy is

midline. Right-sided PICC line tip projects over cavoatrial junction.

There is a left pleural effusion and left basal atelectasis likely

unchanged. Mild pulmonary vascular congestion is also noted.

Impression

No significant interval change. Left effusion and left base

atelectasis. Mild pulmonary vascular congestion.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: CHRISTIE, FLORENCE

Order Date/Time: September 28, 2015 1:55 PM

Scan Initiation Date/Time: September 28, 2015 6:52 PM

Completion Date/Time: September 28, 2015 7:07 PM

Encounter Number: 010086691978

Accession Number: 6415027

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: September 28, 2015 8:18 PM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 9/30/2015 11:08:00 AM

Report Name: FLUORO GUID CVC RE/PLACE ADD

Clinical History

For PICC exchange.

Technique

PROCEDURE:

The patient was brought to the angio suite and placed in the supine

position on the fluoroscopic table. Limited ultrasound of the right

arm was performed and an image was stored. The patient's right upper

arm and indwelling catheter were prepped and draped in the usual

sterile fashion. Maximal sterile barrier technique was used,including

cap, mask, sterile gown, gloves, large sterile sheet, hand hygiene,

and 2% chlorhexidine for cutaneous antisepsis. 1% lidocaine was used

for local anesthesia. The indwelling PICC was cut and removed over a

guidewire. A 6.5 French dilator with peel-away sheath was advanced,

and the wire was used to estimate appropriate catheter length.

Through the peel-away sheath, a 6 French x 34 cm triple lumen Power

PICC was advanced and positioned fluoroscopically with its tip at the

cavoatrial junction. The sheath was then removed. Final fluoroscopic

images of the chest and right arm access site were obtained. The line

was then secured and flushed. The patient tolerated the procedure

with no immediate complication.

Fluoro Time: 1.1 minutes

FINDINGS:

There was successful exchange for a new 6 French x 43cm triple-lumen

Power PICC, with tip positioned at the cavoatrial junction. No

unintentional radiopaque foreign body was present at the access site.

Impression

Successful exchange for a new 6 French x 43 cm triple lumen Power PICC.

Attending Radiologist: MALESON, ANDREW

Ordered By: TAM, JUSTINA

Order Date/Time: September 30, 2015 10:12 AM

Scan Initiation Date/Time: September 30, 2015 10:28 AM

Completion Date/Time: September 30, 2015 11:08 AM

Encounter Number: 010086691978

Accession Number: 6415307

Images were reviewed and interpreted by Attending Radiologist: Dr. MALESON, ANDREW

Electronically Signed On: October 2, 2015 9:21 AM by Dr. MALESON, ANDREW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 10/15/2015 3:57:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

EVALUATE FOR PNEUMONIA

Technique

AP portable.

Comparison

09/28/ 2015.

Findings

Cardio mediastinal silhouette is enlarged and unchanged from prior

radiographs. Small left pleural effusion with left basilar

atelectasis. Mild pulmonary venous congestion. No evidence of

pneumothorax. Tracheostomy tube is identified. Stent is identified in

the left subclavian vessels. Right PICC with tip in the SVC.

Impression

small left pleural effusion with left basilar atelectasis and mild

pulmonary venous congestion.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: October 15, 2015 2:25 AM

Scan Initiation Date/Time: October 15, 2015 2:34 AM

Completion Date/Time: October 15, 2015 3:57 AM

Encounter Number: 010086691978

Accession Number: 6437158

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: October 15, 2015 12:22 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 10/15/2015 3:09:00 PM

Report Name: ULTRASOUND KIDNEY TRANSPLANT EVAL

Given history is a 69-year-old female status post renal transplant.

Technique:

Ultrasonography of a renal transplant using grayscale, color flow

and spectral Doppler technique. Images were obtained in the sagittal

and transverse planes.

Comparison:

09/21/2015

Findings:

A renal transplant is noted within the right iliac fossa. It measures

10.7 x 7.1 x 6.3 cm. It is normal in contour and echotexture. There

is no evidence of hydronephrosis. At the level of the right lower

pole is a 8.0 x 4.3 x 3.6 cm fluid collection. There is suggestion

of thin internal linear septation and possible internal echoes

representing debris. This may represent an evolving hematoma,

seroma. Is slightly diminished in size from prior exam previously

measuring 10.9 x 8 x 5.6 x 4.1 cm. Resistive indices were obtained at

the level of the arcuate, segmental /interlobar arteries, and the

main renal artery. The resistive indices at the level of the arcuate

arteries range between 0.61-0.72 at the level of the segmental

interlobar arteries range between 0.60-0.75. These are within normal

limits. Normal Doppler spectral waveform is noted at these levels.

Peak systolic velocities at the right iliac artery is 104

centimeters/second. Velocities were obtained at the level of the

renal artery distally with a value of 65.4centimeters/second, the mid

portion with a value of 70.9 centimeters/second and proximal with a

value of 64.2 centimeters/second and at the anastomotic site with a

value of 102 centimeters/second. Ratio at the renal artery to iliac

artery anastomotic site is within normal limits. The renal vein is

patent with normal color flow and a velocity of 40.5

centimeters/second. The urinary bladder is partially visualized and

unremarkable.

Impression:

Status post right renal transplant.

No evidence of hydronephrosis.

Right perinephric collection, diminished in size from prior exam may

represent mildly complex seroma, resolving hematoma.

Resistive indices within normal range.

Attending Radiologist: MASON, MARYANNA

Ordered By: CHRISTIE, FLORENCE

Order Date/Time: October 15, 2015 10:45 AM

Scan Initiation Date/Time: October 15, 2015 2:23 PM

Completion Date/Time: October 15, 2015 3:09 PM

Encounter Number: 010086691978

Accession Number: 6437651

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: October 15, 2015 3:36 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 10/17/2015 6:19:00 PM

Report Name: WRIST LEFT 2 VIEWS

Clinical History

Left arm pain

Technique

Two-views of the left clavicle, 2 views of the left humerus: 2 views

of the left elbow, 2 views of the left forearm in 2 views of the left

wrist.

Comparison

None relevant.

Findings

Left elbow: no acute fracture or dislocation. No significant soft

tissue abnormality.

Left humerus: no acute fracture or dislocation. Stent is noted in

the left subclavian / axillary region. No significant soft tissue

abnormality.

Left clavicle: No acute fracture or dislocation.

Left forearm and left wrist: Diffuse osteopenia. Degenerative

changes left wrist. No acute fracture or dislocation identified.

Severe vascular calcification. Soft tissue swelling surrounding the

left wrist

Impression

No acute fracture or dislocation. Diffuse osteopenia left wrist.

Severe vascular calcification. Soft tissue swelling of the left

wrist.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: October 17, 2015 9:40 AM

Scan Initiation Date/Time: October 17, 2015 6:05 PM

Completion Date/Time: October 17, 2015 6:19 PM

Encounter Number: 010086691978

Accession Number: 6440534

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: October 18, 2015 12:30 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 10/17/2015 6:19:00 PM

Report Name: CLAVICLE LEFT

Clinical History

Left arm pain

Technique

Two-views of the left clavicle, 2 views of the left humerus: 2 views

of the left elbow, 2 views of the left forearm in 2 views of the left

wrist.

Comparison

None relevant.

Findings

Left elbow: no acute fracture or dislocation. No significant soft

tissue abnormality.

Left humerus: no acute fracture or dislocation. Stent is noted in

the left subclavian / axillary region. No significant soft tissue

abnormality.

Left clavicle: No acute fracture or dislocation.

Left forearm and left wrist: Diffuse osteopenia. Degenerative

changes left wrist. No acute fracture or dislocation identified.

Severe vascular calcification. Soft tissue swelling surrounding the

left wrist

Impression

No acute fracture or dislocation. Diffuse osteopenia left wrist.

Severe vascular calcification. Soft tissue swelling of the left

wrist.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: October 17, 2015 9:40 AM

Scan Initiation Date/Time: October 17, 2015 6:00 PM

Completion Date/Time: October 17, 2015 6:19 PM

Encounter Number: 010086691978

Accession Number: 6440535

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: October 18, 2015 12:30 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 10/17/2015 6:19:00 PM

Report Name: ELBOW LEFT 2 VIEWS

Clinical History

Left arm pain

Technique

Two-views of the left clavicle, 2 views of the left humerus: 2 views

of the left elbow, 2 views of the left forearm in 2 views of the left

wrist.

Comparison

None relevant.

Findings

Left elbow: no acute fracture or dislocation. No significant soft

tissue abnormality.

Left humerus: no acute fracture or dislocation. Stent is noted in

the left subclavian / axillary region. No significant soft tissue

abnormality.

Left clavicle: No acute fracture or dislocation.

Left forearm and left wrist: Diffuse osteopenia. Degenerative

changes left wrist. No acute fracture or dislocation identified.

Severe vascular calcification. Soft tissue swelling surrounding the

left wrist

Impression

No acute fracture or dislocation. Diffuse osteopenia left wrist.

Severe vascular calcification. Soft tissue swelling of the left

wrist.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: October 17, 2015 9:40 AM

Scan Initiation Date/Time: October 17, 2015 6:03 PM

Completion Date/Time: October 17, 2015 6:19 PM

Encounter Number: 010086691978

Accession Number: 6440536

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: October 18, 2015 12:30 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 10/17/2015 6:19:00 PM

Report Name: FOREARM LEFT (RADIUS AND ULNA)

Clinical History

Left arm pain

Technique

Two-views of the left clavicle, 2 views of the left humerus: 2 views

of the left elbow, 2 views of the left forearm in 2 views of the left

wrist.

Comparison

None relevant.

Findings

Left elbow: no acute fracture or dislocation. No significant soft

tissue abnormality.

Left humerus: no acute fracture or dislocation. Stent is noted in

the left subclavian / axillary region. No significant soft tissue

abnormality.

Left clavicle: No acute fracture or dislocation.

Left forearm and left wrist: Diffuse osteopenia. Degenerative

changes left wrist. No acute fracture or dislocation identified.

Severe vascular calcification. Soft tissue swelling surrounding the

left wrist

Impression

No acute fracture or dislocation. Diffuse osteopenia left wrist.

Severe vascular calcification. Soft tissue swelling of the left

wrist.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: October 17, 2015 9:40 AM

Scan Initiation Date/Time: October 17, 2015 6:04 PM

Completion Date/Time: October 17, 2015 6:19 PM

Encounter Number: 010086691978

Accession Number: 6440537

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: October 18, 2015 12:30 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 10/17/2015 6:19:00 PM

Report Name: HUMERUS LEFT

Clinical History

Left arm pain

Technique

Two-views of the left clavicle, 2 views of the left humerus: 2 views

of the left elbow, 2 views of the left forearm in 2 views of the left

wrist.

Comparison

None relevant.

Findings

Left elbow: no acute fracture or dislocation. No significant soft

tissue abnormality.

Left humerus: no acute fracture or dislocation. Stent is noted in

the left subclavian / axillary region. No significant soft tissue

abnormality.

Left clavicle: No acute fracture or dislocation.

Left forearm and left wrist: Diffuse osteopenia. Degenerative

changes left wrist. No acute fracture or dislocation identified.

Severe vascular calcification. Soft tissue swelling surrounding the

left wrist

Impression

No acute fracture or dislocation. Diffuse osteopenia left wrist.

Severe vascular calcification. Soft tissue swelling of the left

wrist.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: SZAFRAN, APRIL ADAMS

Order Date/Time: October 17, 2015 9:40 AM

Scan Initiation Date/Time: October 17, 2015 6:01 PM

Completion Date/Time: October 17, 2015 6:19 PM

Encounter Number: 010086691978

Accession Number: 6440538

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: October 18, 2015 12:30 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 10/28/2015 2:02:00 PM

Report Name: MRI BRAIN WO IV CONTRAST

Clinical History

F/U

History and Indication

ESRD

Technique

Multiple sequences were performed through the brain in multiple

planes.

Comparison

CT from 04/27/15 and MRI from 05/23/2015.

Findings

There is no evidence of restricted diffusion to suggest acute

infarction.

Ventricles, cisterns and sulci are age appropriate in size.

Again there is diffuse hypointense signal in the basal ganglia

bilaterally on SWI images which is hyperintense on T1 images probably

representing increased mineral deposition,

sequelae of hepatic insufficiency, or hyperalimentation. Again there

is moderate confluent hyperdensity in the cerebral white matter

bilaterally, likely chronic small vessel disease.

There is no mass, mass effect, midline shift.

There is no intracranial hemorrhage or extra-axial collection.

There is normal flow voids in the major arteries of the circle of

Willis.

The pituitary gland is normal in size.

There is no significant disease in the paranasal sinuses.

No gross abnormality is noted within the orbits.

Impression

No acute hemorrhage or acute infarct. No interval change from prior

study.

Attending Radiologist: YAN, ZENGMIN

Ordered By: CHRISTIE, FLORENCE

Order Date/Time: October 26, 2015 1:40 PM

Scan Initiation Date/Time: October 28, 2015 10:28 AM

Completion Date/Time: October 28, 2015 2:02 PM

Encounter Number: 010086691978

Accession Number: 6452138

Images were reviewed and interpreted by Attending Radiologist: Dr. YAN, ZENGMIN

Electronically Signed On: October 28, 2015 4:34 PM by Dr. YAN, ZENGMIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 10/30/2015 11:55:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

ESRD

Technique

A single AP view the chest.

Comparison

10/15/2015

Findings

The trachea is midline. Mild central pulmonary vascular markings.

Stable left axillary is vascular stent. No focal consolidation,

pleural effusion or pneumothorax.

Impression

Mild central congestive changes. No consolidation or effusion.

Attending Radiologist: AREMAN, DAVID

Ordered By: CHRISTIE, FLORENCE

Order Date/Time: October 30, 2015 10:15 AM

Scan Initiation Date/Time: October 30, 2015 11:22 AM

Completion Date/Time: October 30, 2015 11:55 AM

Encounter Number: 010086691978

Accession Number: 6457986

Images were reviewed and interpreted by Attending Radiologist: Dr. AREMAN, DAVID

Electronically Signed On: October 30, 2015 12:20 PM by Dr. AREMAN, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/7/2015 11:13:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Respiratory failure

Technique

Frontal view of the chest.

Comparison

10/30/15

Findings

Cardiomediastinal silhouette is stable. Atherosclerotic

calcifications are present. There is a right PICC line with tip

projecting over the cavoatrial junction. No significant pulmonary

vascular congestion. There is mild linear atelectasis in the left

mid lung.

Impression

Minimal subsegmental left midlung atelectasis. No pulmonary vascular

congestion or airspace disease.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: BERG, WILLIAM

Order Date/Time: November 7, 2015 10:15 AM

Scan Initiation Date/Time: November 7, 2015 10:59 AM

Completion Date/Time: November 7, 2015 11:13 AM

Encounter Number: 010086691978

Accession Number: 6468405

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: November 7, 2015 1:01 PM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/7/2015 6:25:00 PM

Report Name: ABDOMEN SERIES PORTABLE (FLAT/ERECT)

Clinical History

Sudden onset nausea and vomiting

Technique

Supine and erect views of the abdomen

Comparison

04/17/2015

Findings

There is nonspecific and nonobstructive bowel gas pattern. There is

no extraluminal air. Large amount of stool is seen in the ascending

colon.

Impression

Nonobstructive bowel gas pattern. No free air. Large amount of stool

is seen in the ascending colon.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: BERG, WILLIAM

Order Date/Time: November 7, 2015 1:55 PM

Scan Initiation Date/Time: November 7, 2015 6:18 PM

Completion Date/Time: November 7, 2015 6:25 PM

Encounter Number: 010086691978

Accession Number: 6468560

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: November 8, 2015 8:25 AM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/8/2015 1:43:00 PM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

Emesis - evaluate for bowel obstruction. H/O RENAL TRANSPLANT; G-TUBE

IN PLACE

Technique

Routine study. Post Processed reconstructions included.

Contrast

Oral contrast administration only as per the clinician's request.

Comparison

CT from 09/28/2015.

Findings

LUNG BASES: Several calcified granulomas noted. Minimal scarring /

atelectasis is seen. . No pleural effusion.

Abdomen and pelvis:

LIVER: Normal size. No mass.

BILIARY TRACT: Uncomplicated cholelithiasis. There is no biliary

ductal dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Native kidneys are atrophic. Punctate nonobstructing

calculus is seen in the lower pole of native kidney.

Moderate hydronephrosis is demonstrated in the transplant kidney. A

dilated transplant ureter is not visualized. There has been modest

interval decrease in size and attenuation of peritransplant hematoma.

BOWEL and peritoneum: Gastrostomy tube appears partially dislodged;

however, no oral contrast is seen within the peritoneal cavity and

presumably the oral contrast was administered via the gastrostomy

tube. Normal caliber bowel without wall thickening. No increased

intraluminal fluid. Some oral contrast is seen in proximal right

colon. Uncomplicated diverticulosis is present. There is no free

fluid, abscess or pneumoperitoneum.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta.

Abdominal wall: Wide neck fat containing abdominal wall hernia is

demonstrated.

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Within normal limits for age. No focal lesion.

Impression

1. No evidence of bowel obstruction.

2. Questionable partial dislodgement of gastrostomy tube which

is likely artifactual as there is no spillage of oral contrast into

the peritoneal cavity and presumably the oral contrast was

administered through the gastrostomy tube.

3. Moderate hydronephrosis of transplant kidney without evidence

of hydroureter. The possibility of ureteropelvic junction obstruction

is raised.

4. Modest further interval resolution of hematoma adjacent to

the transplant kidney.

5. Uncomplicated cholelithiasis.

6. Uncomplicated wide neck ventral hernia.

Attending Radiologist: MANKES, SETH

Ordered By: REDGER, KIRK

Order Date/Time: November 8, 2015 9:35 AM

Scan Initiation Date/Time: November 8, 2015 1:35 PM

Completion Date/Time: November 8, 2015 1:43 PM

Encounter Number: 010086691978

Accession Number: 6469049

Images were reviewed and interpreted by Attending Radiologist: Dr. MANKES, SETH

Electronically Signed On: November 8, 2015 2:31 PM by Dr. MANKES, SETH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/10/2015 8:27:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Status post aspiration, evaluate for infiltrate

Technique

AP chest

Comparison

AP chest 11/07/2015

Findings

The lung volumes are low. The cardiomediastinal silhouette is stable

in size. There is a right upper extremity PICC line in unchanged

position. There is opacification of the retrocardiac area. There is

no sizable pleural effusions are definable pneumothorax.

Impression

Retrocardiac opacification, likely atelectasis although aspiration

must be considered in the proper clinical setting.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: VERMA, RICHA

Order Date/Time: November 10, 2015 7:35 AM

Scan Initiation Date/Time: November 10, 2015 8:16 AM

Completion Date/Time: November 10, 2015 8:27 AM

Encounter Number: 010086691978

Accession Number: 6471117

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: November 10, 2015 9:58 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/11/2015 10:47:00 PM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

UNRESPONSIVE

Technique

A single AP view the chest.

Comparison

Chest x-ray dated 11/10/2015.

Findings

The cardiac silhouette cannot be accurately assessed as due to

portable technique. The aorta is tortuous and partially calcified.

The pulmonary vascularity is normal. There is linear density in the

left lower lung may represent scarring versus subsegmental

atelectasis. There is otherwise no airspace consolidation or pleural

effusion. There is no appreciable pneumothorax.

There is unchanged vascular stent in the left axilla. The visualized

osseous structures demonstrate degenerative change.

Impression

No acute airspace disease or pleural effusion.

Attending Radiologist: BANGIYEV, LEV

Ordered By: SANKARI, LAYLA

Order Date/Time: November 11, 2015 10:25 PM

Scan Initiation Date/Time: November 11, 2015 10:33 PM

Completion Date/Time: November 11, 2015 10:47 PM

Encounter Number: 010086691978

Accession Number: 6473977

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: November 11, 2015 11:14 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/11/2015 11:15:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

CVA SYMPTOMS

History and Indication

69F UNRESPONSIVE

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

Brain MRI dated 10/28/2015.

Findings

The ventricles, sulci, and fissures are prominent consistent with

cerebral volume loss. There is extensive confluent periventricular,

subcortical, and deep white matter hypodensity consistent with severe

chronic microvascular disease. There are hypodensities in bilateral

putamen, may represent chronic infarcts. There are ill-defined

hypodensities involving bilateral occipital lobes weight loss of gray

white matter differentiation may represent posterior reversible

encephalopathy syndrome versus acute infarcts. There are extensive

atherosclerotic calcifications in the visualized intracranial carotid

arteries. There is no intracranial hemorrhage or extra-axial

collection.

The visualized orbits and soft tissues are unremarkable. The

visualized paranasal sinuses and mastoid air cells are clear.

Impression

Bilateral occipital lobe hypodensity is seen with loss of gray white

matter differentiation may represent acute infarcts versus posterior

reversible encephalopathy syndrome (PRESS).

Severe chronic microvascular disease with cerebral volume loss.

Attending Radiologist: BANGIYEV, LEV

Ordered By: RAMKISHUN, CHARLES

Order Date/Time: November 11, 2015 10:30 PM

Scan Initiation Date/Time: November 11, 2015 11:04 PM

Completion Date/Time: November 11, 2015 11:15 PM

Encounter Number: 010086691978

Accession Number: 6473978

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: November 11, 2015 11:42 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/12/2015 2:22:00 AM

Report Name: MRI BRAIN WO IV CONTRAST

Clinical History

EVALUATION OF STROKE

History and Indication

ALTERED MENTAL STATUS

Technique

Multiple sequences were performed through the brain in multiple

planes.

Comparison

Brain MRI dated 10/28/2015.

Findings

The ventricles, sulci, and fissures are prominent consistent with

cerebral volume loss. There is extensive confluent periventricular,

subcortical, and deep white matter T2/FLAIR hyperintensity consistent

with severe chronic microvascular disease. There is no abnormal

diffusion restriction, intracranial hemorrhage, mass, or extra-axial

collection. The midline structures are normally positioned. The

pituitary gland is normal in size. The major intracranial vascular

structures demonstrate T2 flow voids.

The orbits and visualized soft tissues are normal. The visualized

paranasal sinuses and mastoid air cells are clear.

Impression

No acute intracranial findings or interval change.

Severe chronic microvascular disease with cerebral volume loss.

Attending Radiologist: BANGIYEV, LEV

Ordered By: POVCHER, OLGA

Order Date/Time: November 11, 2015 11:45 PM

Scan Initiation Date/Time: November 12, 2015 1:43 AM

Completion Date/Time: November 12, 2015 2:22 AM

Encounter Number: 010086691978

Accession Number: 6473992

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: November 12, 2015 2:51 AM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/12/2015 3:29:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

S/P EMESIS, R/O ASPIRATION

Technique

A single AP view the chest.

Comparison

Chest x-ray dated 11/11/2015.

Findings

There is unchanged in position in the right-sided approach peak. The

cardiac silhouette cannot be adequately assessed due to portable

technique. The aorta is partially calcified and slightly tortuous.

The pulmonary vascularity is normal. There is no airspace opacity or

pleural effusion. There is unchanged in position vascular stent in

the left axilla.

The visualized osseous structures demonstrated degenerative change.

Impression

No acute airspace disease or pleural effusion.

Attending Radiologist: BANGIYEV, LEV

Ordered By: POVCHER, OLGA

Order Date/Time: November 12, 2015 2:35 AM

Scan Initiation Date/Time: November 12, 2015 2:47 AM

Completion Date/Time: November 12, 2015 3:29 AM

Encounter Number: 010086691978

Accession Number: 6474022

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: November 12, 2015 4:28 AM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/12/2015 1:14:00 PM

Report Name: CHEST AP PORTABLE

Examination

Portable chest radiograph

Clinical History

S/P CENTRAL LINE PLACEMENT

Technique

Single AP view of chest is presented.

Comparison

11/12/2015 at 2:47 a.m.

Findings

Lines, tubes, and devices: Her right upper extremity PICC unchanged

in position. Interval placement of a left jugular central venous

catheter with tip overlying the upper SVC, however, the position of

the tip in the azygos vein cannot be excluded.

Lungs and Pleura: An airspace opacities noted in the right upper lung

with few adjacent nodular nodular opacities which are new since the

prior exam. No pulmonary edema.No large pleural effusion or

pneumothorax.

Cardiomediastinal structures: Cardiomediastinal silhouette can not

be well assessed upon due to technique (antero-posterior projection)

, however has not significantly changed since the prior exam.

Bones/Soft tissues: No acute osseous abnormality.

Impression

Interval placement of a left jugular central venous catheter with tip

overlying the upper SVC, however, the tip position in the azygos vein

cannot be excluded. Consider repositioning by either advancing the

catheter further or retracting by 2-3 centimeters. Findings

communicated to Dr. Richa Verma on 11/12/2015 at 1340 hours

New airspace opacities in the right upper lung, concerning for an

infectious /inflammatory process.

Attending Radiologist: GUPTA, AMIT

Ordered By: MILLS, BARBARA

Order Date/Time: November 12, 2015 12:00 PM

Scan Initiation Date/Time: November 12, 2015 10:19 AM

Completion Date/Time: November 12, 2015 1:14 PM

Encounter Number: 010086691978

Accession Number: 6474608

Images were reviewed and interpreted by Attending Radiologist: Dr. GUPTA, AMIT

Electronically Signed On: November 12, 2015 1:39 PM by Dr. GUPTA, AMIT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/13/2015 9:39:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Line or tube placement

Technique

Portable frontal view of the chest.

Comparison

11/12/2015.

Findings

The left-sided IJ line is noted with tip in the SVC. There has been

interval removal of the right PICC line. Left axilla vascular stent

is unchanged. There is increasing small left pleural effusion.

There is mild pulmonary vascular congestion. The mediastinal and

cardiac silhouettes are not significantly changed. Aortic

calcification is again seen.

Impression

Interval removal of the right PICC line. Left IJ line in place with

its tip projected in the region of SVC.

Small left pleural effusion. Mild pulmonary vascular congestion.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: KIM, KYUNG HO

Order Date/Time: November 13, 2015 7:20 PM

Scan Initiation Date/Time: November 13, 2015 9:34 PM

Completion Date/Time: November 13, 2015 9:39 PM

Encounter Number: 010086691978

Accession Number: 6476876

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: November 14, 2015 10:02 AM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/16/2015 2:53:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

R/O INFILTRATE

Technique

A single AP view the chest.

Comparison

Prior study from 11/13/2015.

Findings

Left jugular central line is again noted probably at the junction of

the brachiocephalic vein and SVC, unchanged. There is improved left

basilar airspace opacity. There is mild right basilar atelectasis.

There is no pneumothorax. The cardiomediastinal silhouette is within

normal limits.

Bony structures appear grossly normal.

Impression

Improved left basilar airspace opacity.

Attending Radiologist: YAN, ZENGMIN

Ordered By: CAIATI, ROBERT

Order Date/Time: November 16, 2015 6:00 AM

Scan Initiation Date/Time: November 16, 2015 1:14 AM

Completion Date/Time: November 16, 2015 2:53 AM

Encounter Number: 010086691978

Accession Number: 6477801

Images were reviewed and interpreted by Attending Radiologist: Dr. YAN, ZENGMIN

Electronically Signed On: November 16, 2015 3:10 AM by Dr. YAN, ZENGMIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/27/2015 12:14:00 PM

Report Name: FLUORO GUID CVC RE/PLACE ADD

Clinical History

Anoxic brain injury, end-stage renal disease. Patient requires

durable venous access.

Technique

Right arm PICC line.

PROCEDURE:

The procedure and possible complications were explained to the son

and informed consent was obtained. The patient was brought to the

Radiology suite and placed in the supine position on the fluoroscopic

table. The patient's right upper arm was prepped and draped in the

usual sterile fashion. 1% lidocaine was used for local anesthesia.

Ultrasound evaluation of potential access site was performed. After

successfully identifying a patent vessel, with the use of ultrasound

guidance, the brachia vein was accessed with a micropuncture needle.

The micropuncture needle was eventually changed over a wire for a 5.5

French dilator with peel-away sheath. Through the peel-away sheath,

under fluoroscopic observation, a 5 French x 39 cm double lumen PICC

line was advanced until the distal tip was present at the right

atrial/superior vena cava junction. The sheath was then removed. The

line was then secured and flushed. Imaging of the access site

demonstrated no foreign body within the soft tissue. Patient

tolerated the procedure well with no post procedure complications.

Maximal Sterile Barrier Technique was used during CVC Insertion

Cap/mask/sterile gown/gloves/large sterile sheet. Hand hygiene/2 %

chlorhexidine for cutaneous antisepsis. The patient was transferred

back to the floor in stable condition.

Fluoro Time: 2.4 minutes

Impression

SUCCESSFUL PLACEMENT OF A 5 FRENCH X 39 CM DOUBLE LUMEN RIGHT ARM

PICC LINE AS DESCRIBED ABOVE.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: PESTIEAU, SARAH

Order Date/Time: November 27, 2015 10:18 AM

Scan Initiation Date/Time: November 27, 2015 11:00 AM

Completion Date/Time: November 27, 2015 12:14 PM

Encounter Number: 010086691978

Accession Number: 6491930

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: November 27, 2015 2:23 PM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/28/2015 12:15:00 PM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

Multiple medical problems and prolonged hospital stay. PEG tube with

increased residual. Abdominal pain. Evaluate for bowel obstruction.

Technique

Supine portable radiograph of the abdomen.

Comparison

Radiograph of the abdomen from 11/07/2015 and CT of the abdomen and

pelvis from 11/08/2015

Findings

PEG tube is noted in the left upper quadrant of the abdomen. There

are multiple air-filled loops of small and large bowel are arranged

in a nonobstructive fashion, although a few small-bowel loops are at

the upper limits and normal in caliber. Multiple surgical clips are

noted in the right aspect of the pelvis. There are mild degenerative

changes in the bilateral hip joints. Vascular calcifications are

present. Osseous structures are osteopenic. There is no gross

/obvious pneumoperitoneum, with evaluation severely limited on supine

radiography.

Impression

Few small bowel loops at the upper limit of normal in caliber, but no

significant dilatation to definitively implicate obstruction.

Attending Radiologist: BAKER, KEVIN S

Ordered By: HOELZER, MAUREEN

Order Date/Time: November 28, 2015 11:50 AM

Scan Initiation Date/Time: November 28, 2015 12:11 PM

Completion Date/Time: November 28, 2015 12:15 PM

Encounter Number: 010086691978

Accession Number: 6493421

Images were reviewed and interpreted by Attending Radiologist: Dr. BAKER, KEVIN S

Electronically Signed On: November 28, 2015 12:46 PM by Dr. BAKER, KEVIN S

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 11/28/2015 6:24:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Tachypnea and diaphoresis. Patient has history of immunosuppression.

Technique

AP portable radiograph of the chest.

Comparison

Radiographic chest 11/16/15 .

Findings

There has been placement of a right upper extremity PICC line with

its tip overlying the region of the right atrium. There has been

interval removal of the left internal jugular central venous

catheter. A left axillary vascular stent is noted.

There is a left basilar airspace opacity which is likely unchanged

when compared to the prior study. There is a probable left pleural

effusion. There is equivocal minimal pulmonary vascular congestion.

The aortic knob is calcified. There is no pneumothorax.

Impression

1. Unchanged left basilar airspace opacity, likely pleural

effusion with atelectasis (as there does appear to be some volume

loss) but correlate to exclude the possibility of an infectious

process.

2. Equivocal minimal pulmonary vascular congestion.

Attending Radiologist: BAKER, KEVIN S

Ordered By: HOELZER, MAUREEN

Order Date/Time: November 28, 2015 4:00 PM

Scan Initiation Date/Time: November 28, 2015 6:17 PM

Completion Date/Time: November 28, 2015 6:24 PM

Encounter Number: 010086691978

Accession Number: 6493578

Images were reviewed and interpreted by Attending Radiologist: Dr. BAKER, KEVIN S

Electronically Signed On: November 29, 2015 7:54 AM by Dr. BAKER, KEVIN S

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 12/1/2015 2:26:00 PM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Female Adult Echocardiography Report

Name: VIOLETA LAIGO Exam Date/Time: 12/1/2015 1:35:51 PM Heart

Rate:

MR #: 30521785 Report Date: 12/1/2015 Heart

Rhythm:

ACC #: 6494629 Ht: 152.40 cm BP:

144/75 mmHg

DOB: 11/22/1945 Wt: 63.96 kg Location:

15S

Age/Sex: 70 yearsF BSA: 1.61 m²

Ref. Physician: Kyung Kim, cc:

Sonographer: DQ

Indications: elevated troponins

History: HTN, HLD, DM, obesity, renal transplant

Procedure: Complete Echocardiogram - 93306 and Patient Supine.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 1.86 cm 2.0 - 3.8 LA Diam 2.31 cm 3.0-4.0

IVS 1.30 cm 0.6 - 0.9 LA Area 16.2cm² <=20

LVID 3.58 cm 3.9 - 5.3 2.51 cm LA Vol 44.23 ml 18-58

LVPW 1.40 cm 0.6 - 1.0 LA Vol/BSA 27.49ml/m² 22+ / -6

RA Diam 3.10cm 2.9-4.5

Ao at the sinuses 3.04

Ao Ascending 3.27 cm

LVEF 55 % (visual estimation)

LV FS 29.8

LV Mass 174.8 g LV Mass Index/BSA 108.7 g/m²

LV SV 28.8 ml

LV SI 17.9 ml/m²

Aov Cusp Sep 1.81 cm

(Systole)

Aov VTI 0.339 m LVOT VTI 0.243 m LVOT diameter

Aov VMax 1.88 m/s LVOT Vmax 1.25 m/s Dimensionless

Index 0.67

Aov Pk Pressure 14.1 mmHg Aov Mn Pressure 6.6 mmHg

Gradient Gradient

AI DT 1508 msec

MV VTI MV DT 171 msec

MV E Vmax 0.76 m/s MV A Vmax 1.00 m/s E/A 0.76

MV Area press 1/2 Time 4.43

IVRT E/E ' 15.20

Septal E ' 0.040 m/s Prop Velocity

Lateral E ' 0.05 m/s LA Pressure 22.84 mmHg

Average E' 0.045 m/s

MV Average E/E' 16.88

TR Vmax 2.64 m/s TR Pk Grad 27.9 mmHg RA Pressure 8 mmHg RVSP

35.9 mmHg

TV E Max TV Mn Grad mmHg PHT 49.69 msec TV VTI

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is decreased. Ventricular wall thickness is

moderately increased. Left ventricular mass by the area-length

technique, is normal, at 174.8 g.(108.7 g/m²). The relative wall

thickness is severely increased (0.75). Global left ventricular

systolic function is normal. The ejection fraction is 55% by visual

estimation.

Left Ventricle - Diastole:The overall diastolic function is mildly

impaired (grade I, impaired relaxation pattern) with elevated left

ventricular filling pressures.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is normal in size.

Atrial Septum: Atrial septum is not well visualized.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal. The right ventricular

systolic pressure, as estimated using the tricuspid regurgitation

velocity, is 35.9 mmHg.

Aortic Valve: The aortic valve is trileaflet with normal excursion.

Mild aortic valve insufficiency is present.

Mitral Valve: The mitral valve leaflets are sclerotic. Trace mitral

regurgitation is present.

Tricuspid Valve: Trace tricuspid regurgitation is present.

Pulmonic Valve: Trace pulmonary regurgitation is seen.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.04 cm. The ascending aorta is normal at 3.27 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.64 m/s, and

with an assumed right atrial pressure of 8 mmHg, the estimated

pulmonary artery systolic pressure is mildly elevated at 35.9 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 4/20/15. There is borderline worsening in the parameters of left

ventricular diastolic filling as compared to the prior study.

Summary:

1. Small left ventricular cavity size.

2. Moderately increased left ventricular wall thickness.

3. Normal global left ventricular systolic function.

4. Mild diastolic dysfunction with elevated filling pressures.

5. Normal right ventricular systolic function.

6. Trileaflet aortic valve with normal excursion.

7. Mild aortic insufficiency.

8. Sclerotic mitral valve leaflets.

9. Trace mitral regurgitation.

10. Trace tricuspid regurgitation.

11. Mildly elevated pulmonary artery systolic pressure.

12. No pericardial effusion.

13. Normal aortic root diameter for body size.

14. Borderline worsening in left ventricular diastolic filling since

the prior study.

012480 Howard Novotny MD, FACC

Electronically signed by 012480 Howard Novotny MD, FACC on 12/1/2015

at 3:09:29 PM

\*\*\* Final \*\*\*

Attending Cardiologist: NOVOTNY, HOWARD

Ordered By: PESTIEAU, SARAH

Order Date/Time: November 30, 2015 7:15 AM

Scan Initiation Date/Time:

Completion Date/Time: December 1, 2015 2:26 PM

Encounter Number: 010086691978

Accession Number: 6494629

Images were reviewed and interpreted by Attending Cardiologist: Dr. NOVOTNY, HOWARD

Electronically Signed On: December 1, 2015 3:09 PM by Dr. NOVOTNY, HOWARD

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 12/19/2015 4:19:00 AM

Report Name: ABDOMEN SERIES PORTABLE (FLAT/ERECT)

Clinical History

High to feed residuals

Technique

Portable upright and supine frontal views of the abdomen

Comparison

November 28, 2015

Findings

Gas is noted scattered throughout multiple loops of small bowel

without evidence for obstruction. There is an ovoid radiopaque

density overlying the left upper quadrant, likely representing a PEG

port. Multiple surgical clips overlie the pelvis. No other abnormal

intra-abdominal calcifications are seen. There is no evidence of

free air.

Impression

Nonobstructive bowel gas pattern. No evidence of free air.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: YEUNG, POMIN

Order Date/Time: December 19, 2015 3:00 AM

Scan Initiation Date/Time: December 19, 2015 3:59 AM

Completion Date/Time: December 19, 2015 4:19 AM

Encounter Number: 010086691978

Accession Number: 6520774

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: December 19, 2015 11:16 AM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 12/24/2015 10:21:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/URGENT

Clinical History

A/W ENCEPHALOPATHY

Indication

POSSIBLE INFILTRATE

Technique

Single portable frontal view of the chest

Comparison

Chest radiograph dated 11/28/2015

Findings

There is a right jugular central line with its tip at the proximal

SVC, retracted and appropriate in position. Cardiomediastinal

silhouette is within normal limits. No significant pulmonary vascular

congestion. Persistent opacification within the left lung base

compatible with atelectasis and / or effusion, unchanged. No new

focal airspace consolidation. No right-sided pleural effusion. No

pneumothorax.

Impression

Right-sided PICC line as described, appropriate in position.

Unchanged opacification within the left lower lobe compatible with

atelectasis and/or effusion.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: TOMY, RITTY

Order Date/Time: December 24, 2015 9:25 AM

Scan Initiation Date/Time: December 24, 2015 10:18 AM

Completion Date/Time: December 24, 2015 10:21 AM

Encounter Number: 010086691978

Accession Number: 6526282

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: December 24, 2015 10:40 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 12/25/2015 8:49:00 PM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

Bowel progression

Technique

Supine view of the abdomen

Comparison

None

Findings

Gastrostomy tube is noted. There is a nonspecific bowel gas pattern

without evidence of obstruction. There is copious stool within the

colon.Is not prominently. There are surgical clips in the right

hemipelvis.

The osseous structures are grossly unremarkable.

Impression

Nonobstructive bowel gas pattern. Stool throughout the colon.

Attending Radiologist: FISHER, PAUL

Ordered By: LIN, JUAN

Order Date/Time: December 25, 2015 7:20 PM

Scan Initiation Date/Time: December 25, 2015 8:38 PM

Completion Date/Time: December 25, 2015 8:49 PM

Encounter Number: 010086691978

Accession Number: 6527275

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: December 26, 2015 9:42 AM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 12/30/2015 11:04:00 PM

Report Name: MRI PELVIS MSK WO IV CONTRAST

Clinical History

Sacral decubitus stage III ulcer, concern for underlying

osteomyelitis.

Technique

Multiplanar multisequence noncontrast MRI of the pelvis. No IV

contrast. Study is limited secondary to patient motion and could not

tolerate any additional imaging.

Comparison

No prior studies available for comparison.

Findings

The study is limited and incomplete. There is motion degradation.

There is no sagittal imaging and there is no fat-suppressed imaging

in the axial plane.

There is evidence of a decubitus ulcer in the midline at the level of

the coccyx. There is evidence of abnormal fluid extending from the

skin deeply into the subcutaneous tissues. This extends to the margin

of the inferior sacrum/ superior margin of the coccyx. Given

incomplete imaging and significant motion artifact, cannot adequately

evaluate for osteomyelitis. However, there is no marked abnormal

signal in the visualized sacrum.

There is no evidence for avascular necrosis involving the femoral

heads.

There is diffuse muscular atrophy of the visualized muscles. There

are regions of mild muscle edema. There is also mild subcutaneous

edema. .

There is a transplanted kidney in the right superior pelvis. There is

hydronephrosis within in the visualized transplanted kidney. This was

noted on CT scan of 11/08/2015. There may be a few punctate/tiny

cysts. There is a mass just medial to the transplanted kidney which

appears smaller than prior CT which could represent resolving

hematoma. There are several nabothian cysts identified.

Impression

Limited, incomplete study.

Decubitus ulcer at the midline at the level of the sacrococcygeal

junction with focal edema/fluid / granulation tissue likely

corresponding to the ulcer extending from the skin to the

subcutaneous tissues. While there is no overt abnormal marrow signal,

and the area subjacent to the ulcer is not adequately imaged.

Therefore, if the patient cannot tolerate MR, recommend nuclear

medicine consultation and imaging to better evaluate for

osteomyelitis.

Transplanted right kidney demonstrating hydronephrosis. Probable

hematoma just medial to the right kidney which has decreased in size

compared to prior CT.

Attending Radiologist: GOULD, ELAINE

Ordered By: PAVELING, JACKIE

Order Date/Time: December 28, 2015 5:50 PM

Scan Initiation Date/Time: December 30, 2015 10:49 PM

Completion Date/Time: December 30, 2015 11:04 PM

Encounter Number: 010086691978

Accession Number: 6529850

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: December 31, 2015 10:59 AM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 12/31/2015 1:29:00 PM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Female Adult Echocardiography Report

Name: VIOLETA LAIGO Exam Date/Time: 12/31/2015 12:41:58 PM Heart

Rate:

MR #: 30521785 Report Date: 12/31/2015 Heart

Rhythm:

ACC #: 6533159 Ht: 152.40 cm BP:

103/53 mmHg

DOB: 11/22/1945 Wt: 58.06 kg

Location: 15S

Age/Sex: 70 yearsF BSA: 1.54 m²

Ref. Physician: PESTIEAU, cc:

Sonographer: SAJ

Indications: R/O ENDOCARDITIS

History: HTN, HLD, DM, OBESITY, RENAL TRANSPLANT

Procedure: Complete Echocardiogram - 93306.

Measurements and Calculations

Diast Nl Syst Nl

RV 2.80 cm 2.0 - 3.8 LA Diam 2.90 cm 3.0-4.0

IVS 0.75 cm 0.6 - 0.9 LA Area 16.5cm² <=20

LVID 3.94 cm 3.9 - 5.3 2.51 cm LA Vol 34.00 ml 18-58

LVPW 0.97 cm 0.6 - 1.0 LA Vol/BSA 22.02ml/m² 22+ / -6

RA Diam 3.01cm 2.9-4.5

Ao at the sinuses 2.90

Ao Ascending 3.13 cm

Ao Arch 3.63 cm

LVEF 55 % (visual estimation)

LV FS 36.3

LV SV 27.4 ml

LV SI 17.7 ml/m²

Aov Cusp Sep 1.20 cm

(Systole)

Aov VTI 0.241 m LVOT VTI 0.157 m LVOT diameter

1.90 cm

Aov VMax 1.79 m/s LVOT Vmax 0.88 m/s Dimensionless

Index 0.49

Aov Pk Pressure 12.8 mmHg Aov Mn 6.0 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 1.84 cm² Aov Area Index 1.19 cm²/m²

(VTI)

MV Pk Gradient mmHg MV Mn Gradient 1.5

MV VTI MV DT 153 msec

MV E Vmax 0.57 m/s MV A Vmax 0.76 m/s E/A 0.75

MV Area press 1/2 Time 4.96

IVRT E/E ' 14.19

Septal E ' 0.050 m/s Prop Velocity

Lateral E ' 0.04 m/s LA Pressure 17.54 mmHg

Average E' 0.045 m/s

MV Average E/E' 12.61

TR Vmax 2.67 m/s TR Pk Grad 28.6 mmHg RA Pressure 8 mmHg RVSP

36.6 mmHg

TV E Max TV Mn Grad mmHg PHT 44.37 msec TV VTI

PV Vmax 1.40 m/s PV Pk Grad 7.8 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

normal. The relative wall thickness is mildly increased (0.44).

Global left ventricular systolic function is normal. The ejection

fraction is 55% by visual estimation. Left ventricular basal

fractional shortening is normal. No regional wall motion

abnormalities are seen.

Left Ventricle - Diastole:The Doppler derived transmitral left

ventricular inflow velocity pattern is A wave dominant. The Doppler

derived early diastolic deceleration time is short at 153 msec. The

velocity of the early diastolic septal mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.050 m/s. The

velocity of the early diastolic lateral mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.04 m/s. The

overall diastolic function is mildly impaired (grade I, impaired

relaxation pattern) with elevated left ventricular filling pressures.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is normal in size.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal.

Aortic Valve: The aortic valve is trileaflet. There are mild

fibrocalcific changes on the aortic valve leaflets with normal

leaflet excursion. Mild aortic valve insufficiency is present.

Mitral Valve: Mild to moderate fibrocalcific changes are present on

the mitral subvalvular chordal apparatus. There are mild

fibrocalcific changes on the mitral valve leaflets. Mitral leaflet

mobility is normal. Systolic anterior motion of the mitral valve is

not seen. Prolapse of the mitral valve is not seen. No evidence of

mitral stenosis is seen. Trace mitral regurgitation is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Mild

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is normal. Trace pulmonary

regurgitation is seen. No evidence of pulmonic stenosis on Doppler

examination.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 2.90 cm. The ascending aorta is normal at 3.13 cm. There

is mild aortic root calcification.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.67 m/s, and

with an assumed right atrial pressure of 8 mmHg, the estimated

pulmonary artery systolic pressure is mildly elevated at 36.6 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: Prior examinations are available and were reviewed for

comparison purposes. The most recent available prior study is from

12/1/2015. There is no significant change in the findings since the

last echocardiogram.

Summary:

1. Normal left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Mildly increased relative wall thickness.

4. Normal global left ventricular systolic function.

5. No regional left ventricular wall motion abnormalities.

6. Mild diastolic dysfunction with elevated filling pressures.

7. Normal right ventricular systolic function.

8. Aortic valve sclerosis.

9. Mild aortic insufficiency.

10. Mitral valve leaflet sclerosis.

11. Fibrocalcific changes are present on the mitral subvalvular

chordal apparatus.

12. Trace mitral regurgitation.

13. Mild tricuspid regurgitation.

14. Trace pulmonic regurgitation.

15. Mild aortic root calcification.

16. Mildly elevated pulmonary artery systolic pressure.

17. No valvular vegetations are seen. A TEE study can be considered

for further evaluation if clinically indicated.

012640 Jordan P Katz MD, FACC

Electronically signed by 012640 Jordan P Katz MD, FACC on 12/31/2015

at 2:05:14 PM

\*\*\* Final \*\*\*

Attending Cardiologist: KATZ, JORDAN

Ordered By: JAIN, EERA

Order Date/Time: December 31, 2015 11:45 AM

Scan Initiation Date/Time:

Completion Date/Time: December 31, 2015 1:29 PM

Encounter Number: 010086691978

Accession Number: 6533159

Images were reviewed and interpreted by Attending Cardiologist: Dr. KATZ, JORDAN

Electronically Signed On: December 31, 2015 2:05 PM by Dr. KATZ, JORDAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 1/6/2016 2:54:00 PM

Report Name: ULTRASOUND KIDNEY TRANSPLANT EVAL

Given history is 70-year-old female with renal transplant. Evaluate

for hydronephrosis

Technique:

Ultrasonography of a renal transplant using grayscale, color flow

and spectral Doppler technique. Images were obtained in the sagittal

and transverse planes.

Comparison:

10/15/2015

Findings:

A renal transplant is noted within the right iliac fossa. It measures

11.6 x 7.3 x 7.1 cm. It is normal in contour however with suggestion

of mild increased echotexture may be seen with medical renal disease.

There has been interval development of mild to moderate

hydronephrosis. There are now internal echoes within the collecting

system with appearance of layering fluid levels. This may be

secondary to debris, proteinaceous material, infection/ pyonephrosis.

Correlate with urine culture and urine analysis. The prior peri

nephric collection at the level of the lower pole has diminished in

size currently measuring approximately 4.4 x 2.3 cm. This may

represent a seroma, lymphocele. Resistive indices were obtained at

the level of the arcuate, segmental /interlobar arteries, and the

main renal artery. The resistive indices at the level of the arcuate

arteries range between 0.6-0.76 at the level of the segmental

interlobar arteries range between 0.62-0.71. These are within normal

limits. Normal Doppler spectral waveform is noted at these levels.

Peak systolic velocities at the right iliac artery is 72.7

centimeters/second. Velocities were obtained at the level of the

renal artery distally with a value of 133 centimeters/second, the mid

portion with a value of 246 centimeters/second and proximal with a

value of 385 centimeters/second and at the anastomotic site with a

value of 544 centimeters/second. Ratio at the renal artery to iliac

artery anastomotic site is elevated with a value of 7.5. The above

findings are consistent with anastomotic stenosis. .The renal vein is

patent with normal color flow the value of 45.8 cm/s. The draining

iliac vein is patent with a value of 31.2 cm/s. The urinary bladder

is is decompressed and cannot be evaluated.

Impression:

Status post right renal transplant. Possibly mildly echogenic may be

secondary to medical renal disease

Findings consistent with anastomotic stenosis

Mild-to-moderate hydronephrosis with internal echoes may represent

debris or proteinaceous material exclude infection.

Correlate with urinalysis and urine culture

Improving perinephric collection with residual 4.3 x 2.3 cm

collection may represent seroma, lymphocele.

Intrarenal Resistive indices within normal limits

Attending Radiologist: MASON, MARYANNA

Ordered By: SULTANA, REBEKA

Order Date/Time: January 6, 2016 11:40 AM

Scan Initiation Date/Time: January 6, 2016 1:57 PM

Completion Date/Time: January 6, 2016 2:54 PM

Encounter Number: 010086691978

Accession Number: 6539448

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 6, 2016 3:33 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 1/18/2016 2:44:00 PM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

Persistent gastric residual. Post PEG tube.

Technique

2 frontal supine abdominal radiographs.

Comparison

12/25/2015 abdominal radiograph.

Findings

Peg tube is again appreciated in the left abdomen. A nonspecific gas

pattern is present with air located in both small and large bowel.

Evaluation for free intraperitoneal air is limited on the supine

radiographs. Surgical clips are appreciated in the right pelvis

compatible with right renal transplant.

Degenerative changes are present within the spine.

Impression

Peg tube unchanged significantly in appearance. Nonspecific gas

pattern.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: DING, YONGZENG

Order Date/Time: January 18, 2016 1:05 PM

Scan Initiation Date/Time: January 18, 2016 1:45 PM

Completion Date/Time: January 18, 2016 2:44 PM

Encounter Number: 010086691978

Accession Number: 6554218

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 18, 2016 2:54 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 1/21/2016 5:47:00 PM

Report Name: FLUORO GUID CVC RE/PLACE ADD

Clinical History

Request for PICC. Difficult venous access. Patient requires durable

venous access, failed renal transplant.

Technique

Risks, benefits, and alternatives to PICC placement were discussed

with the patient's son and informed written consent was obtained. She

was brought to fluoroscopy and placed supine. Right upper extremity

was prepped with 2 percent chlorhexidine solution and draped. A

suitable vein could not be located using surface anatomy.

Accordingly, ultrasound was used to identify the right brachial vein.

1 percent lidocaine was given subcutaneously. Under constant

ultrasound guidance, a 21 gauge needle was advanced into the vein in

a single pass. Micro wire was advanced centrally. Needle was

exchanged for a peel-away sheath. A dual lumen PICC was trimmed to

the appropriate length, then placed through the sheath. The peel-away

was removed. Final images of the chest and right upper extremity were

stored. Exposed catheter was secured to the skin with a Stat Lock

device and a sterile bio occlusive dressing was placed. Both ports

flushed and aspirated easily. The patient was brought back to the

holding area having tolerated this procedure well.

Maximal Sterile Barrier Technique was used during CVC Insertion

Cap/mask/sterile gown/gloves/large sterile sheet. Hand hygiene/2 %

chlorhexidine for cutaneous antisepsis

Comparison

None.

Findings

PICC ends at the right atrium/SVC. Length is 34 cm. Fluoroscopy used

to confirm placement. Final image shows no unintended radiopaque

foreign bodies left behind.

Impression

Technically successful placement of right arm PICC. No immediate

postprocedure complications. The device is ready for use. Fluoroscopy

time 0.7 min.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: ROCCO, VERONICA

Order Date/Time: January 21, 2016 10:40 AM

Scan Initiation Date/Time: January 21, 2016 5:21 PM

Completion Date/Time: January 21, 2016 5:47 PM

Encounter Number: 010086691978

Accession Number: 6558649

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: January 22, 2016 12:57 PM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 1/22/2016 9:40:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

ESRD CVA FEVER

Technique

A single AP view the chest.

Comparison

12/24/2015

Findings

Stable right-sided PICC line. Thin linear densities at left lung base

again seen likely representing platelike atelectasis versus scarring.

No effusion, consolidation or pneumothorax.

Impression

Stable right PICC line. Left basilar atelectasis versus scarring. No

consolidation or effusion.

Attending Radiologist: AREMAN, DAVID

Ordered By: DING, YONGZENG

Order Date/Time: January 22, 2016 8:05 AM

Scan Initiation Date/Time: January 22, 2016 9:38 AM

Completion Date/Time: January 22, 2016 9:40 AM

Encounter Number: 010086691978

Accession Number: 6559894

Images were reviewed and interpreted by Attending Radiologist: Dr. AREMAN, DAVID

Electronically Signed On: January 22, 2016 9:48 AM by Dr. AREMAN, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 2/1/2016 2:23:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Cardiac arrest. Hypoxic encephalopathy. Fever. Evaluate for

pneumonia.

Technique

AP portable chest radiograph

Comparison

Chest radiograph of 01/22/2016.

Findings

Right upper extremity PICC line is noted with its tip at the

cavoatrial junction. Left axillary vascular stent is re-identified.

Small left-sided pleural effusion with subjacent atelectasis.

Retrocardiac infectious process cannot be ruled out. Linear

atelectasis at the left base. Right hemithorax is clear. No

pneumothorax.

Cardiomediastinal silhouette is stable. Aorta is calcified and

tortuous. Mild pulmonary vascular congestion.

Osseous structures are stable.

Impression

1. Small left-sided pleural effusion with subjacent atelectasis.

Retrocardiac infectious process cannot be ruled out.

2. Mild pulmonary vascular congestion.

Attending Radiologist: ABBASI, ALMAS

Ordered By: SHEMI, TIVERE

Order Date/Time: February 1, 2016 6:00 AM

Scan Initiation Date/Time: February 1, 2016 1:07 AM

Completion Date/Time: February 1, 2016 2:23 AM

Encounter Number: 010086691978

Accession Number: 6570763

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: February 1, 2016 11:23 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10086691978

Report Date/Time: 2/1/2016 5:26:00 PM

Report Name: HAND RIGHT PORTABLE

Clinical History

70-year-old woman with new onset of right hand swelling. History of

possible needle stick.

Technique

Three-views of the right hand performed portable.

Comparison

No prior radiographs of right hand are available.

Findings

Evaluation is somewhat limited by AP flexion of the digits and less

than optimal positioning of the hand on the lateral view.

Overall bones appear somewhat osteopenic. There are mild erosive/

degenerative changes at the basal joint and mild loss of joint space

at the DIP joints. There is no obvious evidence for subperiosteal

bone resorption or acro-osteolysis. There is no displaced fracture or

dislocation given the limitations puree there is a small corticated

ossicle versus old ununited ulnar styloid tip.

There is marked soft tissue swelling particularly along the dorsum of

the hand with a more focal nodular area of soft tissue prominence

versus mass extending over at least 5 cm. Recommend directed

ultrasound to assess whether this is related to edema, hematoma,

neoplasm or fluid collection.

There is peripheral vascular calcification.

Impression

Diffuse soft tissue swelling along the dorsum of the hand extending

into the fingers with a more focal area of abnormal soft tissue at

the level of the metacarpals dorsally. Recommend directed

ultrasound.

Osteopenia.

No definitive acute fracture or dislocation given the limitations as

noted above.

Mild degenerative changes.

Vascular calcifications.

Attending Radiologist: GOULD, ELAINE

Ordered By: SHEMI, TIVERE

Order Date/Time: February 1, 2016 4:30 PM

Scan Initiation Date/Time: February 1, 2016 5:21 PM

Completion Date/Time: February 1, 2016 5:26 PM

Encounter Number: 010086691978

Accession Number: 6572236

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: February 2, 2016 11:09 AM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10090715110

Report Date/Time: 8/17/2015 2:38:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Shortness of breath, cough

Technique

Single AP view of the chest.

Comparison

Comparison is made to 12/10/2013

Findings

There are causes overlying the mediastinum. Trachea is midline.

Cardiomediastinal silhouette is within normal limits.

The lungs are clear, with no evidence of any focal consolidation,

large pleural effusion, pulmonary vascular congestion, or

pneumothorax. There are areas of bilateral lower lobe linear

atelectasis.

Visualized osseous structures are grossly normal.

Impression

Linear atelectasis in the bilateral bases. No focal consolidation.

Attending Radiologist: WEST, STEVEN

Ordered By: MOHAMMADY, NAJIM

Order Date/Time: August 17, 2015 2:00 PM

Scan Initiation Date/Time: August 17, 2015 2:15 PM

Completion Date/Time: August 17, 2015 2:38 PM

Encounter Number: 010090715110

Accession Number: 6361964

Images were reviewed and interpreted by Attending Radiologist: Dr. WEST, STEVEN

Electronically Signed On: August 17, 2015 2:46 PM by Dr. WEST, STEVEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10090715110

Report Date/Time: 9/25/2015 10:11:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

64-year-old male with shortness of breath.

Technique

The a single AP view of the chest was performed.

Comparison

Comparison is made 07/08/2017 2015.

Findings

No infiltrates or effusions. The heart is normal size. Multiple left

rib fractures are healed.

Impression

Healed left rib fractures. Otherwise unremarkable.

Attending Radiologist: SARADOFF, CHRISTOPHER V

Ordered By: BHASHYAM, SANDEEP

Order Date/Time: September 25, 2015 9:30 PM

Scan Initiation Date/Time: September 25, 2015 10:09 PM

Completion Date/Time: September 25, 2015 10:11 PM

Encounter Number: 010090715110

Accession Number: 6412649

Images were reviewed and interpreted by Attending Radiologist: Dr. SARADOFF, CHRISTOPHER V

Electronically Signed On: September 25, 2015 11:46 PM by Dr. SARADOFF, CHRISTOPHER V

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10090715110

Report Date/Time: 10/4/2015 1:51:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

64 MALE WITH PRODUCTIVE COUGH

Additional History

EVALUATE FOR PNEUMONIA

Technique

Portable AP view of the chest.

Comparison

Portable AP chest X-Ray from 09/25/2015.

Findings

The trachea is midline. The cardiomediastinal silhouette appears

within normal limits for size.There is no evidence of focal

consolidation, large pleural effusion, pneumothorax, or pulmonary

vascular congestion. Visualized osseous structures multiple healed

left rib fractures.

Impression

No acute cardiopulmonary disease.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: ASIF, AINUL

Order Date/Time: October 4, 2015 8:30 AM

Scan Initiation Date/Time: October 4, 2015 1:49 PM

Completion Date/Time: October 4, 2015 1:51 PM

Encounter Number: 010090715110

Accession Number: 6422854

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: October 4, 2015 2:31 PM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10090715110

Report Date/Time: 11/19/2015 9:53:00 AM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: GERARD FISHER Exam Date: 11/19/2015 at 9:05:02 AM Heart

Rate:

MR #: 00075354 Report Date: 11/19/2015 Rhythm:

ACC #: 6483304 Height: 175.26 cm BP:

140/84

DOB: 3/19/1951 Weight: 106.60 kg

Location: 15N

Age/Sex: 64 years / M BSA: 2.21 m²

Ref. Physician: Dr. Ainul ASIF, cc:

Sonographer: BJ

Indications: dyspnea

History: dysnpea and near syncope, Hep C, dementia, obese, suicidal

ideation,

EtOH

Procedure: Comp. Echo w/contrast - C8929 and Definity Contrast -

Q9957. The use

of contrast was indicated for enhancement of endocardial

border

definition. There were no contraindications for the use of

contrast

in this patient. Verbal consent was given by the patient

who is aware

of the possible adverse reactions associated with the use

of

contrast. No adverse reactions or hemodynamic compromise

identified.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.57 cm 2.0 - 3.8 LA Diam 4.00 cm 3.0-4.0

IVS 1.27 cm 0.6 - 1.0 LA Area 24.4cm² <=20

LVID 4.51 cm 4.2 - 5.9 3.27 cm LA Vol 81.50 ml 18-58

LVPW 1.48 cm 0.6 - 1.0 LA Vol/BSA 36.84ml/m² 22+ / -6

RA Diam 4.0cm 2.9-4.5

Ao at the sinuses 2.80 cm

LVEF 67 % (biplane method of discs)

LV FS 27.5

LV SV 62.3 ml

LV SI 28.2 ml/m²

Aov Cusp Sep (Systole) 2.20 cm

Aov VTI LVOT VTI LVOT diameter 2.10 cm

MV VTI MV DT 185 msec

MV E Vmax 1.05 m/s MV A Vmax 1.45 m/s E/A 0.72

MV Area press 1/2 Time 4.10

IVRT E/E ' 26.25

Septal E ' 0.046 m/s Prop Velocity

Lateral E ' 0.04 m/s LA Pressure 32.14 mmHg

Average E' 0.043 m/s

MV Average E/E' 24.39

TR Vmax 2.64 m/s TR Pk Grad 27.9 mmHg RA Pressure 8 mmHg RVSP

35.9 mmHg

TV E Max TV Mn Grad mmHg PHT 53.65 msec TV VTI

PV Vmax 0.84 m/s PV Pk Grad 2.8 mmHg PV Mn Grad 2.0 mmHg RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

moderately increased. The relative wall thickness is severely

increased (0.61). The peak pressure gradient across the left

ventricular outflow tract is 66 mmHg, consistent with severe degree

of left ventricular outflow tract obstruction. There is no

significant change in the pressure gradient across the left

ventricular outflow tract during Valsalva and/or amyl nitrite

inhalation, suggestive of no evidence of dynamic left ventricular

outflow tract obstruction. Global left ventricular systolic function

is normal. The ejection fraction is 67% by biplane method of discs.

Left ventricular basal fractional shortening is decreased. No

regional wall motion abnormalities are seen.

Left Ventricle - Diastole:The overall diastolic function is mildly

impaired (grade I, impaired relaxation pattern) with normal left

ventricular filling pressures.

Left Atrium: The left atrium is moderately dilated in size.

Right Atrium: The right atrium is normal in size.

Atrial Septum: Atrial septum is not well visualized. Atrial septum is

structurally normal and intact on 2D and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal. The right ventricular

fractional area change is 33.33% which is normal. The tricuspid

annular plane systolic excursion is 2.0 cm consistent with normal

right ventricular systolic function. The right ventricular systolic

pressure, as estimated using the tricuspid regurgitation velocity, is

35.9 mmHg.

Aortic Valve: The aortic valve is composed of three leaflets, which

appear normally formed. No evidence of aortic valve insufficiency is

present.

Mitral Valve: There is moderate mitral annular calcification. Severe

systolic anterior motion of the anterior leaflet of the mitral valve.

Prolapse of the mitral valve is not seen. Trace mitral regurgitation

is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Trace

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is not well visualized.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 2.80 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.64 m/s, and

with an assumed right atrial pressure of 8 mmHg, the estimated

pulmonary artery systolic pressure is mildly elevated at 35.9 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: Prior examinations are available and were reviewed for

comparison purposes. The most recent available prior study is from

1/17/2014. There is no significant change in the findings since the

last echocardiogram.

Summary:

1. Normal left ventricular cavity size.

2. Moderately increased left ventricular wall thickness.

3. Severely increased relative wall thickness.

4. Normal global left ventricular systolic function.

5. No regional left ventricular wall motion abnormalities.

6. Severe degree of left ventricular outflow tract obstruction.

7. No evidence of dynamic left ventricular outflow tract obstruction.

8. Moderately dilated left atrial size.

9. Mild diastolic dysfunction with normal left ventricular filling

pressures.

10. Normal right ventricular systolic function.

11. Normal trileaflet aortic valve.

12. Trace tricuspid regurgitation.

13. Severe systolic anterior motion of the mitral valve.

14. Trace mitral regurgitation.

15. Mildly elevated pulmonary artery systolic pressure.

16. No pericardial effusion.

17. Normal aortic root diameter for body size.

18. Normal atrial septum by 2D and color Doppler.

015260 Kathleen Stergiopoulos MD, PhD, FASE, FACC

Electronically signed by 015260 Kathleen Stergiopoulos MD, PhD, FASE,

FACC on 11/19/2015 at 3:00:27 PM

\*\*\* Final \*\*\*

Attending Cardiologist: STERGIOPOULOS, KATHLEEN

Ordered By: THARAKAN, MATHEW

Order Date/Time: November 18, 2015 7:00 PM

Scan Initiation Date/Time:

Completion Date/Time: November 19, 2015 9:53 AM

Encounter Number: 010090715110

Accession Number: 6483304

Images were reviewed and interpreted by Attending Cardiologist: Dr. STERGIOPOULOS, KATHLEEN

Electronically Signed On: November 19, 2015 3:00 PM by Dr. STERGIOPOULOS, KATHLEEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10090715110

Report Date/Time: 11/21/2015 8:39:00 AM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Clinical History

64M OBESITY, ALCOHOL ABUSE, DEPRESSION, DEMENTIA , CHRONIC HCV,

BARRETTS ESOPHAGUS, HLD, TOBACCO ABUSE, H/O IVDA, RECENT RLE DVT P/W

DOE

Presenting Diagnosis

POSSIBLE EFFUSION

Technique

PA and lateral views of the chest

Comparison

Comparison is made to 10/04/2015

Findings

Cardiomediastinal silhouette is within normal limits. There is

calcification of the aortic arch.

No focal consolidation. No large pleural effusion or pneumothorax. No

pulmonary vascular congestion.

Mild degenerative changes of the thoracic spine. Multiple healed

left-sided rib fractures.

Impression

No focal consolidation or pleural effusion.

Attending Radiologist: FISHER, PAUL

Ordered By: THARAKAN, MATHEW

Order Date/Time: November 20, 2015 7:15 PM

Scan Initiation Date/Time: November 21, 2015 8:35 AM

Completion Date/Time: November 21, 2015 8:39 AM

Encounter Number: 010090715110

Accession Number: 6486312

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: November 21, 2015 11:11 AM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10090715110

Report Date/Time: 12/15/2015 2:46:00 PM

Report Name: MYO PERF SPECT MULTI W/WALL EJ

Report :

MYOCARDIAL PERFUSION IMAGING:

Please refer to the combined Cardiology/Nuclear Medicine report for

complete patient results.

Study was interpreted by Dr. Mann and Dr. Franceschi.

IMPRESSION:

Please refer to the combined Cardiology/Nuclear Medicine report for

complete patient results.

Attending Radiologist: FRANCESCHI, DINKO

Ordered By: LIN, JUAN

Order Date/Time: December 8, 2015 8:30 AM

Scan Initiation Date/Time: December 8, 2015 9:56 AM

Completion Date/Time: December 15, 2015 2:46 PM

Encounter Number: 010090715110

Accession Number: 6505362

Images were reviewed and interpreted by Attending Radiologist: Dr. FRANCESCHI, DINKO

Electronically Signed On: December 15, 2015 5:47 PM by Dr. FRANCESCHI, DINKO

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10090715110

Report Date/Time: 12/15/2015 12:53:00 PM

Report Name: REGADENOSON STRESS TEST

Results

Test Type: Regadenoson/Sestamibi/SPECT Imaging

Stony Brook University Hospital

Ht:(in.): 69 Wt:(lbs.): 229 Previous study: None.

Clinical indication: Chest pain, dyspnea on exertion, palpitations.

History: ETOH abuse, depression, dementia, hepatitis-C, and DVT.

CAD risk factors: Obesity, tobacco abuse.

Medications: Eliquis, Aricept, vitamin-D, Advair, folic acid,

gabapentin, hydrochlorothiazide, Namenda, multivitamin, nicotine

patch, Protonix, potassium.

Site location: University Hospital

Stress lab staff: Angela Abbott CVT, J.Swartz NP

Nuclear Technologist: Janet Oseni CNMT

Date of stress imaging: 12/15/2015 Date of rest

imaging: 12/08/2015

Pre-stress ECG interpretation

Rate: 87 beats/minute PR: 0.20 sec. QRS: 0.10 sec. QT:

0.40 sec.

Sinus rhythm, left ventricular hypertrophy, nonspecific ST T wave

abnormality

Protocol: Intravenous Regadenoson

0.4 mg of regadenoson was administered as a rapid intravenous

injection followed by 5 ml of an intravenous saline flush. The

resting heart rate and blood pressure were 87 beats/minute and 126/78

mmHg. The heart rate and blood pressure at maximal vasodilation were

106 beats/minute and 109/64 mmHg.

Low level treadmill exercise during regadenoson administration: No.

ECG changes: No significant change above abnormal baseline.

Arrhythmias: None.

Symptoms: None.

Transient physical findings: None.

The patient underwent SPECT myocardial perfusion imaging following

the intravenous injection of 29.7 millicuries of technetium-99m

sestamibi at peak pharmacologic stress and 11.7 millicuries of

technetium-99m sestamibi at rest. Stress cardiac images were acquired

utilizing a gated tomographic technique.

Nuclear Imaging Results

The overall quality of the study was: good

Study artifacts: Inferior diaphragmatic attenuation

Left ventricular cavity size: Mildly dilated. The left ventricular

end-diastolic volume is 184 mL

Transient ischemic dilation (TID):Absent

TID ratio: 1.23

Myocardial perfusion images: Demonstrates a large fixed defect of

mild intensity of the inferior wall consistent with inferior

diaphragmatic attenuation artifact. There also was a moderate-size

reversible defect of mild intensity of the inferolateral wall

consistent with ischemia.

Left ventricular ejection fraction: 46%.

Post-stress gated SPECT wall motion analysis: Normal wall thickening

and mild global hypokinesis.

Impression

1. Abnormal regadenoson technetium-99m sestamibi perfusion

scintigraphy demonstrating no myocardial infarction but a moderate

sized area of mild inferolateral ischemia.

2. Normal hemodynamic response to regadenoson.

3. No significant electrocardiographic ST segment changes after

regadenoson administration.

4. The post-stress gated cardiac images revealed normal wall

thickening with mild global hypokinesis..

5. The calculated left ventricular ejection fraction was 46%.

6. Dr. Moin, Cardiology consult fellow, notified of test results.

The study was supervised by Dr. Noelle Mann.

The study was interpreted by Dr. Noelle Mann and Dr. Franceschi.

Dr. Franceschi personally provided the nuclear myocardial perfusion

imaging services for this exam.

Attending Cardiologist: MANN, NOELLE

Ordered By: STAMORAN, VLADIMIR

Order Date/Time: December 14, 2015 4:20 PM

Scan Initiation Date/Time: December 8, 2015 9:56 AM

Completion Date/Time: December 15, 2015 12:53 PM

Encounter Number: 010090715110

Accession Number: 6514033

Images were reviewed and interpreted by Attending Cardiologist: Dr. MANN, NOELLE

Electronically Signed On: December 15, 2015 4:38 PM by Dr. MANN, NOELLE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10090715110

Report Date/Time: 1/1/2016 6:51:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Rule out infiltrate

Technique

Portable view of the chest

Comparison

11/21/2015

Findings

The cardiac silhouette appears enlarged. The aorta is uncoiled and

atherosclerotic. Pulmonary vessels appear to be within normal limits.

There is no focal airspace consolidation, pleural effusion, or

pneumothorax.

There are degenerative changes of the visualized acromioclavicular

joints. There also degenerative changes of the thoracic spine.

Multiple healed left-sided rib fractures are noted.

Impression

No focal consolidation.

Attending Radiologist: GOULD, ELAINE

Ordered By: CAIATI, ROBERT

Order Date/Time: January 1, 2016 5:45 AM

Scan Initiation Date/Time: January 1, 2016 6:41 AM

Completion Date/Time: January 1, 2016 6:51 AM

Encounter Number: 010090715110

Accession Number: 6533751

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: January 1, 2016 8:03 AM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 9/30/2015 9:35:00 PM

Report Name: FOOT BILATERAL (ROUTINE)

Clinical History

History of diabetes. Evaluate for osteomyelitis.

Technique

6 radiographs of the right and left foot.

Comparison

None.

Findings

There is no acute fracture or dislocation. Severe vascular

calcifications are noted. The patient is status post amputation of

the right 2nd and 3rd digits from the proximal phalanges. The patient

is also status post amputation of the left 2nd digit from the

proximal phalanx.

There is marked degenerative derangement of the left midfoot.

There are no definite lytic osseous lesions to suggest osteomyelitis.

Impression

No definite plain radiographic evidence of osteomyelitis. Given the

severe degenerative/ disuse changes, multiple amputations, and lack

of prior studies for comparison, if there is clinical concern for

active osteomyelitis bone scan or MRI would be the imaging modality

of choice.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: NG, JENNIFER

Order Date/Time: September 30, 2015 9:00 PM

Scan Initiation Date/Time: September 30, 2015 9:02 PM

Completion Date/Time: September 30, 2015 9:35 PM

Encounter Number: 010092216877

Accession Number: 6418830

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: September 30, 2015 10:40 PM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 10/24/2015 5:18:00 PM

Report Name: FOOT LEFT (ROUTINE)

Clinical History

Left foot swelling and tender nodule. History of diabetes.

Technique

3 radiographs of the left foot.

Comparison

None.

Findings

Patient is status post amputation of the left 2nd phalanges. The of

the head of the 2nd metatarsal appears within normal limits with no

evidence of bony erosion. No definite soft tissue abnormality is

seen. There are degenerative changes of the visualized osseous

structures. Pes planus soft tissue along the underside of the plantar

surface of the foot is not included in the field of view. There is

soft tissue swelling diffusely, most prominent along the underside of

the foot.

Impression

Status post amputation of the left 2nd phalanges. No evidence of bony

erosion or soft tissue abnormality is seen. Soft tissue swelling most

significant along the plantar surface which is partially excluded

from the field of view.

Attending Radiologist: SARADOFF, CHRISTOPHER V

Ordered By: SHAH, RIAN

Order Date/Time: October 24, 2015 1:00 PM

Scan Initiation Date/Time: October 24, 2015 5:15 PM

Completion Date/Time: October 24, 2015 5:18 PM

Encounter Number: 010092216877

Accession Number: 6450142

Images were reviewed and interpreted by Attending Radiologist: Dr. SARADOFF, CHRISTOPHER V

Electronically Signed On: October 24, 2015 5:43 PM by Dr. SARADOFF, CHRISTOPHER V

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 10/26/2015 6:52:00 PM

Report Name: CT LOWER EXTREMITY WITH IV CONTRAST LEFT

Clinical History

73-year-old man with type 2 diabetes, previous amputation and plantar

soft tissue mass. Evaluate for abscess. .

Technique

CT of the left foot was performed after administration of 125 mL

Omnipaque 350. Axial, coronal, sagittal, 3D reconstructed images were

obtained

Comparison

No prior CT available for comparison. Correlation made to prior foot

radiographs done on 10/24/2015.

Findings

The patient is status post amputation of the 2nd toe.

There are 2 small focal areasof soft tissue irregularity along the

plantar and plantar medial medial aspect of the foot. Correlate

clinically for any skin wounds or ulceration.

Slightly more distal in the foot, there is a large rim enhancing

fluid collection measuring approximately 4.0 x 3.7 x 2.2 centimeters

in the plantar aspect of the foot. This is seen on series 400 image

81. This can be consistent with an abscess within the plantar soft

tissues of the foot. This hypo attenuating region is surrounded by

some soft tissue prominence or phlegmonous change. This is in the

region of the plantar fascia and extends superficially with bulging

of the overlying soft tissues and likely extends into the deeper

soft tissues of the foot. This abscess is just plantar to the cuboid

bone. There is a small focal erosion in the cuboid. It is uncertain

whether this is related to neuropathic change however underlying

osteomyelitis cannot be excluded.

There is significant deformity of the tarsal metatarsal joints,

tarsal-tarsal, subtalar, and ankle joints with severe arthrosis, and

cystic changes and subchondral sclerosis. There is collapse of the

arch with pronation of the foot and medial subluxation/ incongruency

at the navicular talus/cuneiform articulations, likely chronic.

Findings are compatible neuropathic arthropathy. Large bony spur

noted off the talar head. There multiple small ossific fragments are

identified in all the joints mentioned previously, which appears

smooth and well corticated, likely related to chronic injury. No

definitive acute fracture. There is no obvious dislocation at the

tarsometatarsal articulations.

There are multiple calcifications in the medial soft tissues along

the distal ankle, likely multiple calcified phleboliths. There is

significant soft tissue swelling along the medial ankle.

There is fatty atrophy of the visualized muscles, compatible diabetic

myopathy.

Impression

Hypo- attenuating peripherally enhancing mass along plantar aspect of

the foot at the level of the cuboid with surrounding edematous

changes most consistent with fluid/abscess formation.

2 areas of focal skin/superficial soft tissue irregularity.

Correlate clinically for any ulceration along the plantar foot.

Collapse of the plantar arch with neuropathic arthropathy involving

the mid foot. Status post amputation of 2nd toe.

Small well-defined erosion along plantar cuboid possibly part of

neuropathic process.

Limited evaluation for osteomyelitis on CT. Recommend nuclear

medicine consultation and at least 3 phase bone scan, as indicated ,

to assess for osteomyelitis.

Dr. Teng discussed findings with Dr. Twinkle Dhawan on 10/27/2015 at

9:40 AM.

Attending Radiologist: GOULD, ELAINE

Ordered By: LAVENBURG, PHILIP

Order Date/Time: October 25, 2015 12:30 PM

Scan Initiation Date/Time: October 26, 2015 6:33 PM

Completion Date/Time: October 26, 2015 6:52 PM

Encounter Number: 010092216877

Accession Number: 6450848

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: October 27, 2015 9:46 AM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 10/28/2015 7:51:00 PM

Report Name: MRI FOOT LEFT WO AND WITH IV CONTRAST

Clinical History

Left foot abscess along its plantar portion. History of diabetes.

History of diabetic neuropathy. History of Charcot foot. Swelling of

the left foot. Pain in the left foot.

Technique

Multiplanar multisequence magnetic resonance imaging of the left foot

was obtained both before and after the administration of 20 mL of

intravenous gadolinium contrast material.

Comparison

Compared to CT exam from 2 days ago.

Findings

Patient demonstrates end-stage midfoot arthropathy with severe

disorganization and osteoarthritic changes of the talonavicular,

calcaneocuboid, navicular cuneiform and the most lateral

tarsometatarsal joints. There is collapse of the normal longitudinal

arch of the midfoot. At the plantar aspect of the foot at the level

of the cuboid bone there is a 2.4 x 1.8 x 3.0 cm rim enhancing fluid

collection of overlying blistering of skin, as seen on series 12

image 15 and series 10 image 47. This results in breakthrough of the

degenerated medial and lateral bands of the plantar fascia, with a

tract extending deep, near the cuboid bone, as seen on series 10

image 46. There is a prominent adjacent phlegmon with slight erosion

of the plantar aspect of the cuboid with minimal bone marrow edema.

The patient is status post amputation of the 2nd metatarsal distal to

the head, with smooth margins. The Achilles tendon demonstrates mild

insertional degeneration. The peroneus longus tendon is degenerated

and not well seen about the plantar aspect of the midfoot. Peroneus

brevis demonstrates insertional degeneration The posterior tibial

tendon demonstrates distention degeneration. The flexor hallucis

longus tendon is degenerated, as is the flexor digitorum longus

tendon, with reactive tenosynovitis. The dorsal extensor tendons are

without rupture.

Impression

MRI of the left foot both before and after the administration of

intravenous gadolinium contrast, demonstrates end-stage Charcot

midfoot arthropathy with superimposed subcutaneous plantar abscess at

the level of the cuboid, which extends through the severely

degenerative plantar fascia and abuts the cuboid bone. The plantar

aspect of the cuboid demonstrates erosive changes, consistent with

early osteomyelitis. There is also a fistulous tract which extends

from this abscess more deep into the cuboid region, suspicious for

early septic arthritis/osteomyelitis seeding of the disorganized

midfoot joints.

Attending Radiologist: FELDMANN, ERIC

Ordered By: DHAWAN, TWINKLE

Order Date/Time: October 28, 2015 4:15 PM

Scan Initiation Date/Time: October 28, 2015 6:28 PM

Completion Date/Time: October 28, 2015 7:51 PM

Encounter Number: 010092216877

Accession Number: 6455661

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: October 29, 2015 8:47 AM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 11/5/2015 11:19:00 AM

Report Name: PERCUTANEOUS BIOPSY RAD

Clinical History

Request for biopsy cuboid bone left foot. Diabetic left foot with

ulcers and osteomyelitis.

Technique

Risks, benefits, and alternatives to bone biopsy were discussed with

the patient and informed written consent was obtained. He was brought

to the CT scanner and placed supine. Deep IV sedation was given and

vital signs were monitored continuously by anesthesia workers 1/2 hr.

A marker grid was placed on the lateral portion of the mid left foot

and images were obtained. Skin was marked, prepped with 2 percent

chlorhexidine solution and draped. 1 percent lidocaine was given

subcutaneously. A 17 gauge Percu-cut hand bone biopsy device was

advanced into the cuboid bone, confirmed by CT images. A core sample

was taken and placed in formalin for surgical pathology. Procedure

was repeated, and the 2nd core sample was placed in a sterile cup for

culture and sensitivity. Sterile dressing was applied. Final CT

images were obtained. The patient was awakened by anesthesia workers

who brought him back to the recovery area having tolerated this

procedure well.

Comparison

MRI left foot 10/28/2015.

Findings

Final images show no hemorrhage or fracture.

Impression

Technically successful biopsy cuboid bone left foot. No immediate

postprocedure complications. DLP 280 mGy-cm

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: LEKHRAJ, JUSTINA

Order Date/Time: November 5, 2015 8:53 AM

Scan Initiation Date/Time: November 5, 2015 10:31 AM

Completion Date/Time: November 5, 2015 11:19 AM

Encounter Number: 010092216877

Accession Number: 6464195

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: November 6, 2015 2:10 PM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 11/6/2015 1:02:00 PM

Report Name: CHEST AP(PORT) CENTRAL LINE PL

Clinical History

Evaluate PICC

Technique

Portable AP radiograph optimized for PICC evaluation

Comparison

No prior study for comparison

Findings

There is a right approach PICC with tip overlying the cavoatrial

junction. No unintended radiopaque foreign body is seen.

No focal consolidation or pleural effusion.

Impression

Right-sided PICC with tip overlying the cavoatrial junction

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: HOUSEHOLDER, TRAVIS

Order Date/Time: November 6, 2015 10:45 AM

Scan Initiation Date/Time: November 6, 2015 12:49 PM

Completion Date/Time: November 6, 2015 1:02 PM

Encounter Number: 010092216877

Accession Number: 6467081

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: November 6, 2015 5:50 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 11/23/2015 9:33:00 AM

Report Name: CHEST AP(PORT) CENTRAL LINE PL

Given history is a 73-year-old male status post right upper extremity

PICC placement

Technique:

AP portable views of the chest and right humerus were submitted .

Comparison:

11/06/2015

Findings:

A Right PICC catheter is seen with its tip at the atrial caval

junction. No unintentional radiopaque foreign body is noted at the

insertion site or along the course of the catheter tubing. The

trachea is midline. The cardiomediastinal silhouette is normal in

appearance. The lungs are without consolidation, congestion or

pleural effusion. Left basilar linear atelectasis or scarring is

noted. There is no evidence of pneumothorax. The diaphragms are

normal in position and smooth in contour. Degenerative change of the

right acromioclavicular joint is noted and of the spine, partially

visualized.

Impression:

Right PICC catheter tip at the atrial caval junction. No

unintentional radiopaque foreign body.

Left basilar linear atelectasis or scarring.

No evidence of pulmonary consolidation or effusion

Attending Radiologist: MASON, MARYANNA

Ordered By: SCOTT, JOSHUA

Order Date/Time: November 23, 2015 8:55 AM

Scan Initiation Date/Time: November 23, 2015 9:31 AM

Completion Date/Time: November 23, 2015 9:33 AM

Encounter Number: 010092216877

Accession Number: 6487834

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: November 23, 2015 10:15 AM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 12/8/2015 8:02:00 PM

Report Name: FOOT LEFT 2 VWS PORTABLE

Clinical History

Diabetic neuropathy.

Technique

2 views left foot

Comparison

10/24/2015

Findings

Severe pes planus with Charcot arthropathy change again seen.

Redemonstration of resection of the 2nd ray. Claw toe deformities of

digits 3 through 5 again appreciated. There is plantar soft tissue

swelling in the midfoot. No radiographic evidence of osseous

destructive changes

Impression

Neuropathic left foot without evidence of acute osteomyelitis.

Attending Radiologist: KOLANKO, NICHOLAS

Ordered By: VETTICHIRA, BICKY

Order Date/Time: December 8, 2015 7:05 PM

Scan Initiation Date/Time: December 8, 2015 7:56 PM

Completion Date/Time: December 8, 2015 8:02 PM

Encounter Number: 010092216877

Accession Number: 6506634

Images were reviewed and interpreted by Attending Radiologist: Dr. KOLANKO, NICHOLAS

Electronically Signed On: December 9, 2015 9:30 AM by Dr. KOLANKO, NICHOLAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 12/15/2015 11:42:00 AM

Report Name: FOOT LEFT 2 VWS PORTABLE

Clinical History

Postsurgery.

Technique

Left foot, 2 views, portable

Comparison

12/08/2015

Findings

There has been interval amputation of the 1st toe to the level of the

metatarsophalangeal joint. Antibiotic impregnated beads are noted.

There is collapse of the plantar arch with mild rocker bottom

deformity. There is also soft tissue swelling along the plantar

aspect of the foot at the level of the cuboid metatarsal region.

Proliferative changes are noted at the talonavicular articulation.

There is some vertebral positioning of the talus with medial

subluxation of navicular in reference to the. There was previous

amputation of 2nd toe. There appears to be resection arthroplasty at

the 3rd PIP joint. Correlate clinically. There is an overlying

bandage. There is soft tissue swelling.

Impression

Interval amputation of the 1st toe with placement of impregnated

beads.

Asymmetry at the 3rd PIP joint. Correlate for resection

arthroplasty.

Soft tissue prominence versus swelling along plantar aspect of

midfoot. Correlate clinically for significance.

Attending Radiologist: GOULD, ELAINE

Ordered By: MARTIN, BERNARD

Order Date/Time: December 15, 2015 11:00 AM

Scan Initiation Date/Time: December 15, 2015 11:37 AM

Completion Date/Time: December 15, 2015 11:42 AM

Encounter Number: 010092216877

Accession Number: 6515132

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: December 15, 2015 1:13 PM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 12/16/2015 12:44:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

73 YOM POD 1 TOE AMP NOW FEBRILE SOB

Indication

EVALUATE POST-OP

Technique

CHEST AP PORTABLE/URGENT

Comparison

11/23/2015

Findings

Right-sided PICC line is in place. The cardiomediastinal silhouette

is within normal limits. Mild pulmonary vascular congestion is noted.

There is no focal consolidation or pleural effusion.

Impression

Mild pulmonary vascular congestion.

Attending Radiologist: ABBASI, ALMAS

Ordered By: KYRIAKAKOS, CHRISTOPHER

Order Date/Time: December 16, 2015 10:45 AM

Scan Initiation Date/Time: December 16, 2015 12:44 PM

Completion Date/Time: December 16, 2015 12:44 PM

Encounter Number: 010092216877

Accession Number: 6516861

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: December 16, 2015 12:52 PM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 12/31/2015 4:38:00 PM

Report Name: MRI FOOT LEFT WO IV CONTRAST

Clinical History

Question of osteomyelitis.

Technique

Short axis T1, T2 fat suppression and sagittal T1 weighted images of

the left forefoot was performed.

Comparison

Comparison to prior MRI 10/28/2015.

Findings

Study is somewhat limited on this 3 sequence exam with mild motion

degradation.

Patient is status post amputation of the left 2nd and 3rd toes.

There is significant motion artifact, the patient was unable to

complete the exam.

There is abnormal soft tissue signal the plantar aspects of the

midfoot (series 4, image 38) with edema or mild fluid that extends

from the superficial tissues through the external fascia into the

deep soft tissues.

There is abnormal soft tissue signal noted at the distal aspects of

the 1st metatarsal stump with susceptibility artifact, which may be

postsurgical in nature. There is questionable marrow edema and

questionable T1 signal at the 1st metatarsal head, however not

definite given significant motion artifact.

There is significant intertarsal and tarsometatarsal arthropathy

progressed from prior study from 10/28/2015. There is no definitive

osteomyelitis involving the tarsal bones or metatarsal bones. Cannot

adequately assess the phalanges.

There is edema and atrophy of the intrinsic muscles of the foot,

likely related to diabetic myopathy. There are hammertoe deformities.

Impression

Markedly limited study secondary to motion artifact, and incomplete

exam. Patient unable to complete the exam secondary to motion.

Nonspecific soft tissue prominence along plantar aspect of the foot

at the level of the cuboid.

Abnormal soft tissue signal noted at the distal aspect of the 1st

metatarsal -amputation site which may be postsurgical.

Suboptimal assessment for osteomyelitis.

If patient cannot tolerate MRI, consider followup with bone scan or

PET-CT.

Attending Radiologist: GOULD, ELAINE

Ordered By: SHAH, RAHUL

Order Date/Time: December 29, 2015 3:10 PM

Scan Initiation Date/Time: December 31, 2015 4:13 PM

Completion Date/Time: December 31, 2015 4:38 PM

Encounter Number: 010092216877

Accession Number: 6530989

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: January 1, 2016 9:34 AM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 1/2/2016 1:09:00 PM

Report Name: MRI FOOT LEFT WO AND WITH IV CONTRAST

Clinical History

73-year-old IDDM male with history of reported previous cuboid

osteomyelitis. Patient presents for evaluation of recurrent

osteomyelitis status post amputation of the hallux, antibiotic bead

placement, flexor release of the 3rd and 4th toes, 3rd digit

arthroplasty, and sesamoidectomy 12/15/2015

Technique

Multiplanar multisequence MR imaging of the left forefoot was

obtained before and after the administration of 20.5 cc Magnevist

intravenous contrast agent

Comparison

Prior limited of the foot 12/31/2015 and MRI of 10/28/2015

Findings

Evaluation is mildly limited due to patient motion artifact which

somewhat degrades image quality.

The patient is again noted to be status post resection of the 2nd and

3rd toes as well hallux from the level of the MTP joint. There is

persistent marrow edema noted within the head, neck, and shaft of the

1st metatarsal which appears to demonstrate mild enhancement. This is

nonspecific and can be reactive or due to underlying osteomyelitis .

There is a serpiginous fluid collection with surrounding reactive

soft tissue edema extending both medial and plantar to the 1st distal

metatarsal which may or may not be communicating with medial and

distal skin defect (series 11 images 11-14). This fluid collection is

seen on series 11 image 18 and extends over approximately 2.6 cm in

transverse dimensions by approximately 0.7 cm in craniocaudal

dimensions.

There is re-demonstration of abnormal soft tissue signal within the

soft tissues of the plantar midfoot (series 6 images 34-43). Within

this abnormality there is diffuse granulation tissue and edema. No

focal drainable collection. Superficial ulceration is noted (series 7

image 40). No suspicious marrow edema or abnormal enhancement to

suspect underlying osteomyelitis.

There is marrow edema within the distal shaft, head and neck of the

3rd metatarsal as well as adjacent proximal phalanx. This edema

pattern is nonspecific. May be reactive given the lack of a

well-defined soft tissue defect overlying this area. There is a small

effusion particularly along the dorsum of the 3rd MTP articulations

with the small outpouching of fluid noted dorsally as seen on series

4 image 23 .

Superficial soft tissue deformity at the medial aspect of the 1st

metatarsal stump with focal susceptibility artifact, likely

postsurgical in nature. 4 there are mild erosive changes which appear

stable compared to prior study without definitive evidence for acute

osteomyelitis although evaluation is somewhat limited due to

inadequate fat suppression.

Advanced intertarsal and tarsometatarsal arthropathy is again noted.

There is collapse of the medial arch again noted which should be

correlated for developing rocker bottom configuration. Diffuse

intramuscular edema and fatty atrophy of the intrinsic foot muscles

is unchanged in extent.

Impression

Serpiginous fluid collection which appears to extend from the distal

and medial soft tissues adjacent to the 1st metatarsal head into the

overlying plantar soft tissues. Correlate clinically for

communicating draining ulcer.

Subchondral marrow edema pattern within the distal shaft and head /

neck region of 1st metatarsal. There is mild postcontrast

enhancement. This is indeterminate for osteomyelitis. It could be

reactive although osteomyelitis is not excluded.

Subchondral edema within the 3rd metatarsal phalangeal articulation

with a small to moderate effusion projecting into the dorsal soft

tissues. This is favored to be reactive.

The results of this examination were verbally communicated via

telephone conference with read back verification to Dr R. Shah On

01/04/2016 at 11:05 a.m. by Dr. Claire.

Attending Radiologist: GOULD, ELAINE

Ordered By: SHAH, RAHUL

Order Date/Time: January 2, 2016 6:15 AM

Scan Initiation Date/Time: January 2, 2016 12:27 PM

Completion Date/Time: January 2, 2016 1:09 PM

Encounter Number: 010092216877

Accession Number: 6534316

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: January 4, 2016 12:26 PM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092216877

Report Date/Time: 1/10/2016 12:05:00 PM

Report Name: ULTRASOUND KIDNEYS COMPLETE

Given history is a 73-year-old male with left toe cellulitis and

osteomyelitis with rising creatinine. Evaluate for hydronephrosis

chronic kidney changes.

Technique

Ultrasonography of the kidneys was performed using grayscale and

color flow Doppler technique. Images were obtained in the sagittal

and transverse planes.

Comparison

No prior renal ultrasound

Findings

Study is slightly limited due to bowel gas. Left lower pole is

somewhat limited in visualization.

The right kidney measures 12.5 x 4.9 x 5.9 cm. The left kidney

measures 10.5 x 5.2 x 6.0 cm. Both are normal in contour and

echotexture. Both are without hydronephrosis or perinephric fluid

collection. There is no ultrasonographic evidence of intrarenal

calculus. The urinary bladder is unremarkable without wall

thickening, debris or calculi.

Impression

No hydronephrosis.

Attending Radiologist: MASON, MARYANNA

Ordered By: PODANY, WENDY

Order Date/Time: January 9, 2016 2:50 PM

Scan Initiation Date/Time: January 10, 2016 11:49 AM

Completion Date/Time: January 10, 2016 12:05 PM

Encounter Number: 010092216877

Accession Number: 6543825

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 10, 2016 12:19 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/3/2015 11:17:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WO IV CONTRAST/STAT/CTER

Clinical History

MULTIPLE TRAUMA VICTIM

History and Indication

MULTIPLE TRAUMA

Technique

Contiguous axial slices were obtained from the skull base to the

vertex. Additionally, coronal and sagittal planar reformats were

provided for interpretation following image acquisition.

Comparison

None.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

The ventricles, cisterns and sulci are prominent size for age,

representing moderate involutional changes.

There is no mass effect or midline shift.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact. Left forehead scalp hematoma is noted.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No acute intracranial hemorrhage. No acute calvarial injury. Small

left forehead scalp hematoma.

Attending Radiologist: REITER, MICHAEL

Ordered By: KIM, JUNG

Order Date/Time: October 3, 2015 8:50 PM

Scan Initiation Date/Time: October 3, 2015 10:52 PM

Completion Date/Time: October 3, 2015 11:17 PM

Encounter Number: 010092304368

Accession Number: 6422629

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: October 3, 2015 11:22 PM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/3/2015 11:17:00 PM

Report Name: CT SPINE CERVICAL WO IV CONTRAST

Examination

CT SPINE CERVICAL WITHOUT CONTRAST

Clinical History

MULTIPLE TRAUMA

History and Indication

MULTIPLE TRAUMA VICTIM

Technique

1.25 mm. thick helical axial slices were obtained from skull base to

the upper thoracic spine and then sagittal and coronal reformatted

images were obtained.

Comparison

No images available for comparison.

Findings

No acute fracture, traumatic subluxation or aggressive bone

destruction is noted. Lateral masses are symmetric. Prevertebral

soft tissues are within normal limits. C1 arch is intact. Vertebral

body heights are maintained. There is no disc protrusion, spinal

stenosis, or neural foraminal narrowing within the cervical spine.

Visualized thyroid is grossly unremarkable. Visualized lung apices

are clear.

Soft tissue information is limited. No evidence of large disc

protrusion or critical spinal stenosis is noted.

Impression

No acute fracture or traumatic subluxation within the cervical spine.

Attending Radiologist: REITER, MICHAEL

Ordered By: KIM, JUNG

Order Date/Time: October 3, 2015 8:50 PM

Scan Initiation Date/Time: October 3, 2015 10:55 PM

Completion Date/Time: October 3, 2015 11:17 PM

Encounter Number: 010092304368

Accession Number: 6422630

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: October 3, 2015 11:24 PM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/3/2015 11:18:00 PM

Report Name: CT CHEST WITH IV CONTRAST

Examination

CT CHEST ABD AND PELVIS WITH IV CONTRAST/STAT/CTER

Clinical History

MULTIPLE TRAUMA VICTIM

History and Indication

MULTIPLE TRAUMA

Technique

Contiguous helical CT images of the chest abdomen and pelvis were

obtained, with intravenous contrast enhancement as below. Axial

reconstructions in soft tissue windows, in addition to coronal and

sagittal planar reformats, were provided for interpretation following

image acquisition.

Contrast

Contrast Agent OMNIPAQUE 300 110 milliliters 10/03/2015 INTRAVENOUS

Comparison

None.

Findings

Chest:

LUNGS: Patchy dependent ground-glass opacities lower lobes

bilaterally. Bibasilar atelectasis.

LARGE AIRWAYS: Patent.

PLEURA: No fluid or pneumothorax.

VESSELS: Normal caliber thoracic aorta without signs of injury.

HEART: Normal size. No pathologic pericardial effusion.

MEDIASTINUM and HILA: No pneumomediastinum. No hematoma. No

lymphadenopathy.

Abdomen:

LIVER: Normal size. No laceration or other focal pathology. Mild,

diffuse steatosis.

BILIARY: No dilatation.

PANCREAS: No contusion, fracture or other pathology.

SPLEEN: Mildly enlarged. No laceration.

ADRENALS: No hemorrhage, nodule, mass.

KIDNEYS: No contusion or other injury. No mass, calculus or

hydronephrosis. Sub cm left lower pole hypodensity, too small to

characterize.

BOWEL: Normal caliber. No wall thickening. Normal appendix (image 89

series 8).

PERITONEUM: No hemoperitoneum, other fluid, or free air.

RETROPERITONEUM: No hemorrhage or lymphadenopathy.

VESSELS: Normal caliber aorta

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No hemorrhage or lymphadenopathy.

BLADDER: Unremarkable.

BONES: Acute minimally displaced fractures lateral left 4th through

6th ribs. Questionable nondisplaced fractures lateral right 4th

through 9th rib fractures. No aggressive focal lesion.

Impression

Bilateral contiguous rib fractures as above, likely with associated

mild pulmonary contusion. No acute traumatic abdominopelvic visceral

injury. Diffuse hepatic steatosis.

Attending Radiologist: BARISH, MATTHEW

Ordered By: KIM, JUNG

Order Date/Time: October 3, 2015 8:50 PM

Scan Initiation Date/Time:

Completion Date/Time: October 3, 2015 11:18 PM

Encounter Number: 010092304368

Accession Number: 6422633

Images were reviewed and interpreted by Attending Radiologist: Dr. BARISH, MATTHEW

Electronically Signed On: October 3, 2015 11:50 PM by Dr. BARISH, MATTHEW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/3/2015 11:18:00 PM

Report Name: CT ABD AND PELVIS WITH IV CONTRAST

Examination

CT CHEST ABD AND PELVIS WITH IV CONTRAST/STAT/CTER

Clinical History

MULTIPLE TRAUMA VICTIM

History and Indication

MULTIPLE TRAUMA

Technique

Contiguous helical CT images of the chest abdomen and pelvis were

obtained, with intravenous contrast enhancement as below. Axial

reconstructions in soft tissue windows, in addition to coronal and

sagittal planar reformats, were provided for interpretation following

image acquisition.

Contrast

Contrast Agent OMNIPAQUE 300 110 milliliters 10/03/2015 INTRAVENOUS

Comparison

None.

Findings

Chest:

LUNGS: Patchy dependent ground-glass opacities lower lobes

bilaterally. Bibasilar atelectasis.

LARGE AIRWAYS: Patent.

PLEURA: No fluid or pneumothorax.

VESSELS: Normal caliber thoracic aorta without signs of injury.

HEART: Normal size. No pathologic pericardial effusion.

MEDIASTINUM and HILA: No pneumomediastinum. No hematoma. No

lymphadenopathy.

Abdomen:

LIVER: Normal size. No laceration or other focal pathology. Mild,

diffuse steatosis.

BILIARY: No dilatation.

PANCREAS: No contusion, fracture or other pathology.

SPLEEN: Mildly enlarged. No laceration.

ADRENALS: No hemorrhage, nodule, mass.

KIDNEYS: No contusion or other injury. No mass, calculus or

hydronephrosis. Sub cm left lower pole hypodensity, too small to

characterize.

BOWEL: Normal caliber. No wall thickening. Normal appendix (image 89

series 8).

PERITONEUM: No hemoperitoneum, other fluid, or free air.

RETROPERITONEUM: No hemorrhage or lymphadenopathy.

VESSELS: Normal caliber aorta

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No hemorrhage or lymphadenopathy.

BLADDER: Unremarkable.

BONES: Acute minimally displaced fractures lateral left 4th through

6th ribs. Questionable nondisplaced fractures lateral right 4th

through 9th rib fractures. No aggressive focal lesion.

Impression

Bilateral contiguous rib fractures as above, likely with associated

mild pulmonary contusion. No acute traumatic abdominopelvic visceral

injury. Diffuse hepatic steatosis.

Attending Radiologist: BARISH, MATTHEW

Ordered By: KIM, JUNG

Order Date/Time: October 3, 2015 8:50 PM

Scan Initiation Date/Time: October 3, 2015 10:59 PM

Completion Date/Time: October 3, 2015 11:18 PM

Encounter Number: 010092304368

Accession Number: 6422634

Images were reviewed and interpreted by Attending Radiologist: Dr. BARISH, MATTHEW

Electronically Signed On: October 3, 2015 11:50 PM by Dr. BARISH, MATTHEW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/3/2015 11:46:00 PM

Report Name: CT SPINE THORACIC WO IV CONTRAST

Examination

CT SPINE THORACIC WITHOUT CONTRAST

Clinical History

TRAUMA

Technique

CT of the thoracic spine was performed with thin contiguous axial

slices. Subsequently, computer reformations were obtained in the

coronal and sagittal planes.

Comparison

No available images for comparison.

Findings

There is no evidence of disc protrusion. The spinal canal centrally

and laterally is of good caliber. There is no evidence of vertebral

fracture or bone destruction. Please refer to concomitant dedicated

chest imaging for extra spinous findings. There is a 2.2 x 1.2

centimeter lesion in the right paraspinal subcutaneous fat in the mid

thoracic level which is nonspecific. Density is 41 Hounsfield units

centrally. This may represent a sebaceous cyst.

Impression

No acute fracture or traumatic subluxation within the thoracic spine.

Attending Radiologist: KOLANKO, NICHOLAS

Ordered By: KIM, JUNG

Order Date/Time: October 3, 2015 8:50 PM

Scan Initiation Date/Time: October 3, 2015 10:59 PM

Completion Date/Time: October 3, 2015 11:46 PM

Encounter Number: 010092304368

Accession Number: 6422631

Images were reviewed and interpreted by Attending Radiologist: Dr. KOLANKO, NICHOLAS

Electronically Signed On: October 4, 2015 12:01 AM by Dr. KOLANKO, NICHOLAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/3/2015 11:46:00 PM

Report Name: CT SPINE LUMBAR WO IV CONTRAST

Examination

CT SPINE LUMBAR WITHOUT CONTRAST

Clinical History

MULTIPLE TRAUMA

History and Indication

MULTIPLE TRAUMA VICTIM

Technique

Thin axial slices were obtained through the lumbar spine.

Subsequently, oblique axial, sagittal and coronal reformatted images

were obtained.

Comparison

No images available for comparison.

Findings

There are 5 non rib-bearing lumbar vertebral bodies, the lowermost

well-formed disk aside L5-S1. Vertebral body heights and alignment

are maintained. There is no disc protrusion, spinal stenosis, or

neural foramina narrowing within the lumbar spine.

No acute fracture, aggressive bone destruction or traumatic

subluxation is seen.

Impression

No acute fracture or traumatic subluxation within the lumbar spine.

Attending Radiologist: KOLANKO, NICHOLAS

Ordered By: KIM, JUNG

Order Date/Time: October 3, 2015 8:50 PM

Scan Initiation Date/Time: October 3, 2015 10:59 PM

Completion Date/Time: October 3, 2015 11:46 PM

Encounter Number: 010092304368

Accession Number: 6422632

Images were reviewed and interpreted by Attending Radiologist: Dr. KOLANKO, NICHOLAS

Electronically Signed On: October 4, 2015 12:02 AM by Dr. KOLANKO, NICHOLAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/4/2015 7:22:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

S/P FALL

Additional History

POSSIBLE PNEUMOTHORAX

Technique

Portable AP view of the chest.

Comparison

CT chest 10/03/2015

Findings

The trachea is midline. The cardiomediastinal silhouette appears

within normal limits for size. There is persistent mild bibasilar

atelectasis left greater than right.There is no focal consolidation,

large pleural effusion, pneumothorax, or pulmonary vascular

congestion. Previously described rib fractures are not well

appreciated on this portable AP radiograph.

Impression

Mild bibasilar atelectasis left greater than right.

Previously described rib fractures are not well appreciated on this

portable AP radiograph; see CT from 10/03/2015.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: PYKE, OWEN

Order Date/Time: October 4, 2015 6:35 AM

Scan Initiation Date/Time: October 4, 2015 7:13 AM

Completion Date/Time: October 4, 2015 7:22 AM

Encounter Number: 010092304368

Accession Number: 6422804

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: October 4, 2015 9:00 AM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/5/2015 4:30:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Rib fractures

Technique

Portable AP film of the chest

Comparison

Comparison is made to 10/04/2015

Findings

The trachea is midline. The cardiomediastinal silhouette is within

normal limits.

Shallow inspiration with crowding of vascular markings. Bibasal

atelectasis. Small left pleural effusion. No evidence of

pneumothorax. Multiple left-sided rib fractures are identified.

Impression

Small left pleural effusion and bibasilar atelectasis.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: ZHAO, KAI

Order Date/Time: October 5, 2015 6:00 AM

Scan Initiation Date/Time: October 5, 2015 3:37 AM

Completion Date/Time: October 5, 2015 4:30 AM

Encounter Number: 010092304368

Accession Number: 6422929

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: October 5, 2015 9:11 AM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/10/2015 11:35:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Lost tooth.

Technique

AP portable view of the chest.

Comparison

Radiograph of the chest dated 10/05/2015.

Findings

There is mild left basilar atelectasis with slight blunting of left

costophrenic angle noted. Mild pleural fluid. Heart and mediastinal

structures appear without change. There is no focal consolidation.

Previously reported left-sided rib fractures are poorly visualized.

Paragraph

There are degenerative changes of left shoulder is suggested.

Impression

Mild retrocardiac/basilar atelectasis with slight blunting of left

costophrenic angle without change.

Attending Radiologist: GOULD, ELAINE

Ordered By: PYKE, OWEN

Order Date/Time: October 10, 2015 9:20 AM

Scan Initiation Date/Time: October 10, 2015 10:51 AM

Completion Date/Time: October 10, 2015 11:35 AM

Encounter Number: 010092304368

Accession Number: 6431510

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: October 10, 2015 11:43 AM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/10/2015 11:38:00 AM

Report Name: ABDOMEN SUPINE (KUB)

Clinical History

Evaluate for foreign body. Swallowed tooth.

Technique

Supine view of the abdomen with exclusion of the diaphragms.

Comparison

No prior abdominal plain films.

Findings

There is a nonspecific bowel gas pattern. Air is identified within

the rectosigmoid region. There is scattered stool within the colon.

There is a vague radiodensity in the left hemipelvis. It is

uncertain whether this could represent superimposition of structures

and stool although given concern for foreign body would recommend a

followup radiograph in approximately 5-6 hours.

Impression

Nonspecific bowel gas pattern.

No definitive metallic density identified.

Vague focal density in the left hemipelvis of indeterminate etiology.

It is possibly related to stool although foreign body is not excluded

in this patient with concern for swallowed tooth. Recommend a

followup radiograph of the abdomen/pelvis.

Attending Radiologist: GOULD, ELAINE

Ordered By: PYKE, OWEN

Order Date/Time: October 10, 2015 9:20 AM

Scan Initiation Date/Time: October 10, 2015 10:48 AM

Completion Date/Time: October 10, 2015 11:38 AM

Encounter Number: 010092304368

Accession Number: 6431511

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: October 10, 2015 11:54 AM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 10/11/2015 9:25:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

CHIPPED TOOTH, SWALLOWED?

Indication

LOCATION OF CHIPPED TOOTH

Technique

CHEST AP PORTABLE/ROUT

Comparison

Study on the previous day.

Findings

Go unchanged left basilar opacity, likely atelectasis. Low lung

volumes. No focal consolidation or pneumothorax. There is no

radiopaque foreign body. Cardiomediastinal silhouette is stable.

Impression

No significant interval change.

Attending Radiologist: REITER, MICHAEL

Ordered By: FORSYTH, EDWARD

Order Date/Time: October 11, 2015 8:05 PM

Scan Initiation Date/Time: October 11, 2015 9:24 PM

Completion Date/Time: October 11, 2015 9:25 PM

Encounter Number: 010092304368

Accession Number: 6432644

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: October 12, 2015 5:51 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 11/2/2015 11:32:00 AM

Report Name: LOWER LEG RIGHT (TIB-FIB) PORTABLE

Clinical History

S/p trauma.

Technique

AP, lateral views of the left and right tibia and fibula.

Comparison

None.

Findings

There is no acute fracture or dislocation. The alignment is

unremarkable.

Impression

No acute fracture.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: SHAH, ANISH

Order Date/Time: November 2, 2015 11:10 AM

Scan Initiation Date/Time: November 2, 2015 11:16 AM

Completion Date/Time: November 2, 2015 11:32 AM

Encounter Number: 010092304368

Accession Number: 6460733

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: November 2, 2015 11:36 AM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 11/2/2015 11:32:00 AM

Report Name: LOWER LEG LEFT (TIB-FIB) PORTABLE

Clinical History

S/p trauma.

Technique

AP, lateral views of the left and right tibia and fibula.

Comparison

None.

Findings

There is no acute fracture or dislocation. The alignment is

unremarkable.

Impression

No acute fracture.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: SHAH, ANISH

Order Date/Time: November 2, 2015 11:25 AM

Scan Initiation Date/Time: November 2, 2015 11:19 AM

Completion Date/Time: November 2, 2015 11:32 AM

Encounter Number: 010092304368

Accession Number: 6460792

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: November 2, 2015 11:36 AM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092304368

Report Date/Time: 11/19/2015 11:02:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/STAT

Clinical History

PN

Indication

EVALUATE FOR PNEUMONIA

Technique

Single portable frontal view of the chest

Comparison

Chest radiograph dated 10/11/2015

Findings

Trachea is midline. Cardiomediastinal silhouette is within normal

limits. No significant pulmonary vascular congestion. Interval

resolution of the previously seen an left lung base atelectasis. No

focal airspace consolidation, pleural effusion or pneumothorax.

Degenerative changes in the left shoulder again are noted, unchanged.

Impression

No focal airspace consolidation, pleural effusion or pneumothorax.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: MARTIR, JACLYN

Order Date/Time: November 19, 2015 10:05 AM

Scan Initiation Date/Time: November 19, 2015 11:01 AM

Completion Date/Time: November 19, 2015 11:02 AM

Encounter Number: 010092304368

Accession Number: 6483812

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: November 19, 2015 11:47 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092679892

Report Date/Time: 10/15/2015 1:05:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

MULTIPLE TRAUMA

Technique

A single AP view the chest.

Comparison

None.

Findings

The lung fields are clear there are no congestive changes, pleural

effusions or airspace consolidation. The cardiomediastinal silhouette

is within normal limits. No pneumothorax.

Bony structures appear grossly normal.

Impression

No acute intrathoracic disease.

Attending Radiologist: AREMAN, DAVID

Ordered By: MCINTOSH, BRADEN

Order Date/Time: October 15, 2015 12:40 AM

Scan Initiation Date/Time: October 15, 2015 12:42 AM

Completion Date/Time: October 15, 2015 1:05 AM

Encounter Number: 010092679892

Accession Number: 6437137

Images were reviewed and interpreted by Attending Radiologist: Dr. AREMAN, DAVID

Electronically Signed On: October 15, 2015 3:31 AM by Dr. AREMAN, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092679892

Report Date/Time: 10/15/2015 6:55:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

S/P BURN

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 10/15/2015. At 12:10 a.m.

Findings

The lung fields are clear there are no congestive changes, pleural

effusions or airspace consolidation. Minimal atelectasis right lung

base. The cardiomediastinal silhouette is within normal limits.

Bony structures appear grossly normal.

Impression

Minimal atelectasis right lung base. Heart size normal.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: EL-ATTRACHE, BENFAUZI

Order Date/Time: October 15, 2015 4:45 AM

Scan Initiation Date/Time: October 15, 2015 6:35 AM

Completion Date/Time: October 15, 2015 6:55 AM

Encounter Number: 010092679892

Accession Number: 6437185

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: October 15, 2015 8:49 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092679892

Report Date/Time: 10/15/2015 2:32:00 PM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: ADAM PRAHASKY Exam Date: 10/15/2015 at 1:25:37 Heart Rate:

103

PM

MR #: 30780346 Report Date: 10/15/2015 Rhythm:

Sinus

Tachycardia

ACC #: 6437527 Height: 172.72 cm BP: 173/84

DOB: 1/22/1973 Weight: 69.85 kg Location:

18S SICU

Age/Sex: 42 years / M BSA: 1.83 m²

Ref. Physician: RUTIGLIANO, cc:

Sonographer: RT

Indications: SHOCK

History: S/P serious suicide attempt via self immolation, Severe

depression

Procedure: Comp. Echo w/contrast - C8929, Definity Contrast - Q9957,

Portable

and Patient Supine. The use of contrast was indicated for

enhancement

of endocardial border definition. There were no

contraindications for

the use of contrast in this patient. Verbal consent was

given by the

patient who is aware of the possible adverse reactions

associated

with the use of contrast. No adverse reactions or

hemodynamic

compromise identified.

Study Quality: This was a technically difficult study.

Measurements and Calculations

Diast Nl Syst Nl

RV 2.34 cm 2.0 - 3.8 LA Diam 2.81 cm 3.0-4.0

IVS 1.09 cm 0.6 - 1.0 LA Area 10.85cm² <=20

LVID 4.05 cm 4.2 - 5.9 2.69 cm LA Vol 25.20 ml 18-58

LVPW 1.00 cm 0.6 - 1.0 LA Vol/BSA 13.78ml/m² 22+ / -6

RA Diam 2.75cm 2.9-4.5

Ao at the sinuses 3.47 cm

LVEF 60 % (visual estimation)

LV FS 33.4

Aov VTI 0.132 m LVOT VTI 0.110 m LVOT diameter

2.14 cm

Aov VMax 1.16 m/s LVOT Vmax 0.72 m/s Dimensionless

Index 0.62

Aov Pk Pressure 5.4 mmHg Aov Mn Pressure 3.1 mmHg

Gradient Gradient

Aov Area (VTI) 2.97 cm² Aov Area Index 1.62 cm²/m²

(VTI)

MV VTI MV DT 239 msec

MV E Vmax 0.53 m/s MV A Vmax 0.54 m/s E/A 0.98

MV Area press 1/2 Time 3.18

IVRT E/E ' 10.55

Septal E ' 0.060 m/s Prop Velocity

Lateral E ' 0.05 m/s LA Pressure 13.79 mmHg

Average E' 0.055 m/s

MV Average E/E' 9.59

TR Vmax 1.40 m/s TR Pk Grad 7.9 mmHg RA Pressure 3 mmHg RVSP

10.9 mmHg

TV E Max TV Mn Grad mmHg PHT 69.27 msec TV VTI

PV Vmax 0.77 m/s PV Pk Grad 2.4 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is decreased. Ventricular wall thickness is

normal. Global left ventricular systolic function is normal. The

ejection fraction is 60% by visual estimation. Left ventricular basal

fractional shortening is normal. No regional wall motion

abnormalities are seen.

Left Ventricle - Diastole:The Doppler derived transmitral left

ventricular inflow velocity pattern is A wave dominant. The Doppler

derived early diastolic deceleration time is normal at 239 msec. The

velocity of the early diastolic septal mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.060 m/s. The

velocity of the early diastolic lateral mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.05 m/s. The

overall diastolic function is mildly impaired (grade I, impaired

relaxation pattern) with normal left ventricular filling pressures.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is normal in size. Suggestion of

tissue density in the right atrium adjacent to the tricuspid annulus,

most consistent with annular fat deposition.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. The right

ventricular diastolic area is 15.60 cm which is normal. The right

ventricular systolic area is 10.03 cm which is normal. Global right

ventricular systolic function is normal. The right ventricular

fractional area change is 35.71% which is normal. The tricuspid

annular plane systolic excursion is 1.72 cm consistent with normal

right ventricular systolic function. The right ventricular systolic

pressure, as estimated using the tricuspid regurgitation velocity, is

10.9 mmHg.

Aortic Valve: The aortic valve was not well seen. Normal Doppler

interrogation flow patterns without stenosis or insufficiency.

Mitral Valve: The mitral valve is structurally normal. Trace mitral

regurgitation is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Trace

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is not well visualized.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.47 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 1.40 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is normal at 10.9 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Decreased left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Normal global left ventricular systolic function.

4. No regional left ventricular wall motion abnormalities.

5. Mild diastolic dysfunction with normal left ventricular filling

pressures.

6. Normal right ventricular systolic function.

7. Suggestion of tissue density in the right atrium adjacent to the

tricuspid annulus, most consistent with annular fat deposition.

8. Normal atrial septum by 2D and color Doppler.

9. The aortic valve was not well seen.

10. No aortic stenosis or insufficiency.

11. Trace mitral regurgitation.

12. Trace tricuspid regurgitation.

13. Normal aortic root diameter for body size.

14. No pericardial effusion.

014970 Smadar Kort MD, FACC, FASE

Electronically signed by 014970 Smadar Kort MD, FACC, FASE on

10/15/2015 at 3:18:30 PM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: POLITO, CHRISTOPHER

Order Date/Time: October 15, 2015 10:10 AM

Scan Initiation Date/Time:

Completion Date/Time: October 15, 2015 2:32 PM

Encounter Number: 010092679892

Accession Number: 6437527

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: October 15, 2015 3:18 PM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092679892

Report Date/Time: 10/16/2015 3:58:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Trauma

Technique

Portable AP view of the chest

Comparison

Comparison is made to 10/15/2015

Findings

Cardiomediastinal silhouette is within normal limits.

Low lung volumes. Bibasilar linear atelectasis. No focal

consolidation, congestion or effusions. . No pneumothorax. Surgical

clip is noted within the right axilla.

Visualized osseous structures are unremarkable.

Impression

No pulmonary consolidation or effusion.

Bibasilar linear atelectasis.

Attending Radiologist: MASON, MARYANNA

Ordered By: POLITO, CHRISTOPHER

Order Date/Time: October 16, 2015 6:00 AM

Scan Initiation Date/Time: October 16, 2015 3:51 AM

Completion Date/Time: October 16, 2015 3:58 AM

Encounter Number: 010092679892

Accession Number: 6437348

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: October 16, 2015 4:56 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092679892

Report Date/Time: 10/17/2015 3:27:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Burn

Technique

Frontal view of the chest.

Comparison

1 day prior.

Findings

Cardiomediastinal silhouette is within normal limits. There is no

pneumothorax. Findings suggest interval development of bilateral

pleural effusions, right greater than left. There is also mild

pulmonary vascular congestion but no frank pulmonary edema. Left

midline catheter.

Impression

Findings suggest interval development of bilateral pleural effusions

which appear to be moderate on the right and small on the left. Given

the rapidity of onset, conceivably the imaging findings could

represent atelectasis and not effusions.

Mild pulmonary vascular congestion but I do not appreciate a definite

frank pulmonary edema.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: PATEL, SRUTI

Order Date/Time: October 17, 2015 6:00 AM

Scan Initiation Date/Time: October 17, 2015 1:21 AM

Completion Date/Time: October 17, 2015 3:27 AM

Encounter Number: 010092679892

Accession Number: 6439112

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: October 17, 2015 11:07 AM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092679892

Report Date/Time: 10/18/2015 3:20:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Burn

Technique

Frontal view of the chest

Comparison

Previous day.

Findings

There is a left midline catheter. Cardiomediastinal silhouette is

within normal limits. Bilateral layering pleural effusions with

subjacent atelectasis are unchanged. There is no pneumothorax. No

definite pulmonary vascular congestion.

Impression

Bilateral layering pleural effusions and subjacent atelectasis

without interval change. No definite pulmonary congestion.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: POLITO, CHRISTOPHER

Order Date/Time: October 18, 2015 6:00 AM

Scan Initiation Date/Time: October 18, 2015 2:09 AM

Completion Date/Time: October 18, 2015 3:20 AM

Encounter Number: 010092679892

Accession Number: 6440515

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: October 18, 2015 11:51 AM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092679892

Report Date/Time: 10/19/2015 6:54:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

S/P GASOLINE BURN

Indication

POSSIBLE EFFUSION

Technique

CHEST AP PORTABLE/URGENT

Comparison

Study on the previous day.

Findings

Interval decrease in bilateral pleural effusions/ atelectasis. No

pneumothorax. Cardiomediastinal silhouette is within normal limits.

The left midline catheter in place.

Impression

Decreased bilateral pleural effusions/atelectasis.

Attending Radiologist: REITER, MICHAEL

Ordered By: TROSTLER, MICHAEL

Order Date/Time: October 19, 2015 6:00 AM

Scan Initiation Date/Time: October 19, 2015 6:39 AM

Completion Date/Time: October 19, 2015 6:54 AM

Encounter Number: 010092679892

Accession Number: 6441100

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: October 19, 2015 7:45 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 10/19/2015 6:22:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Concern for infiltrate versus fluid overload

Technique

Portable AP view of the chest

Comparison

Comparison is made to 08/24/2015.

Findings

Mediastinal silhouette is within normal limits. Heart size is

enlarged, questionably enlarged from prior versus differences in

technique.

There is elevation of the right hemidiaphragm and dense opacification

in the right lung base. No pneumothorax. Mild pulmonary vascular

congestion.

Impression

1. Heart size is enlarged, questionably slightly enlarged from

prior versus differences in technique. If there is clinical concern

for pericardial effusion, echocardiogram would be suggested.

Otherwise followup radiography.

2. Mild pulmonary vascular congestion.

3. Elevation of right hemidiaphragm and dense opacification at

right lung base likely represents a pleural effusion and associated

atelectasis. Possibility of right lower lobe airspace

disease/pneumonia is also in the differential.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: YU, CONNIE

Order Date/Time: October 19, 2015 6:10 PM

Scan Initiation Date/Time: October 19, 2015 6:12 PM

Completion Date/Time: October 19, 2015 6:22 PM

Encounter Number: 010092829612

Accession Number: 6443071

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: October 19, 2015 6:36 PM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 10/20/2015 10:45:00 AM

Report Name: ULTRASOUND KIDNEYS COMPLETE

Examination

Renal ultrasound

Clinical History

R/O PYELONEPHRITIS/HYDRONEPHROSIS

AKI ON CKD, CHF, PNA, UTI

Technique

Grayscale ultrasound and color Doppler interrogation were utilized to

evaluate the kidneys.

Comparison

None available.

Findings

The right kidney is 10.3 x 4.7 x 5.3 cm in size.

The left kidney is 10.9 x 5.5 x 5.9 cm in size.

There is no hydronephrosis. No renal calculi are visualized. The

renal parenchyma is normal in echogenicity.

The urinary bladder is collapsed around a Foley catheter.

The small amount of perihepatic ascites.

There are bilateral pleural effusions.

Impression

1. No hydronephrosis or obvious evidence of renal calculi.

2. Small amount of perihepatic ascites.

3. Bilateral pleural effusions.

Attending Radiologist: ABBASI, ALMAS

Ordered By: BYKHOVSKY, MICHAEL

Order Date/Time: October 20, 2015 3:25 AM

Scan Initiation Date/Time: October 20, 2015 10:23 AM

Completion Date/Time: October 20, 2015 10:45 AM

Encounter Number: 010092829612

Accession Number: 6443334

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: October 20, 2015 11:46 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 10/21/2015 1:45:00 PM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: QUINTON EVANS Exam Date: 10/21/2015 at 12:51:24 PM Heart

Rate:

MR #: 30698378 Report Date: 10/21/2015 Rhythm:

ACC #: 6443316 Height: 172.72 cm BP:

149/74

DOB: 12/27/1940 Weight: 86.64 kg

Location: 12S

Age/Sex: 74 years / M BSA: 2.00 m²

Ref. Physician: Getu Teressa, cc:

Sonographer: DQ

Indications: SOB

History: SOB, CHF, HTN, DM, HLD, PVD, CKD

Procedure: Complete Echocardiogram - 93306 and Patient Supine.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.14 cm 2.0 - 3.8 LA Diam 4.50 cm 3.0-4.0

IVS 1.13 cm 0.6 - 1.0 LA Area 19.63cm² <=20

LVID 4.52 cm 4.2 - 5.9 3.47 cm LA Vol 59.02 ml 18-58

LVPW 1.37 cm 0.6 - 1.0 LA Vol/BSA 29.45ml/m² 22+ / -6

RA Diam 4.79cm 2.9-4.5

Ao at the sinuses 3.24 cm

Ao Ascending 2.95 cm

LVEF 62 % (biplane method of discs)

LV FS 23.2

LV SV 48.7 ml

LV SI 24.3 ml/m²

Aov Cusp Sep 2.17 cm

(Systole)

Aov VTI 0.276 m LVOT VTI 0.234 m LVOT diameter

Aov VMax 1.14 m/s LVOT Vmax 0.91 m/s Dimensionless

Index 0.80

Aov Pk Pressure 5.2 mmHg Aov Mn Pressure 2.7 mmHg

Gradient Gradient

MV VTI MV DT 190 msec

MV E Vmax 1.06 m/s MV A Vmax 0.76 m/s E/A 1.39

MV Area press 1/2 Time 3.98

IVRT E/E ' 23.50

Septal E ' 0.030 m/s Prop Velocity

Lateral E ' 0.04 m/s LA Pressure 36.87 mmHg

Average E' 0.038 m/s

MV Average E/E' 28.20

TR Vmax 3.06 m/s TR Pk Grad 37.5 mmHg RA Pressure 3 mmHg RVSP

40.5 mmHg

TV E Max TV Mn Grad mmHg PHT 55.22 msec TV VTI

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

mildly increased. A false tendon is present which is a normal

variant. The relative wall thickness is severely increased (0.55).

Global left ventricular systolic function is normal. The ejection

fraction is 62% by biplane method of discs. Left ventricular basal

fractional shortening is decreased. No regional wall motion

abnormalities are seen.

Left Ventricle - Diastole:The Doppler derived transmitral left

ventricular inflow velocity pattern is E wave dominant. The Doppler

derived early diastolic deceleration time is normal at 190 msec. The

velocity of the early diastolic septal mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.030 m/s. The

velocity of the early diastolic lateral mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.04 m/s. The

overall diastolic function is moderately impaired (grade II,

pseudonormal pattern) with elevated left ventricular filling

pressures.

Left Atrium: The left atrium is mildly dilated in size.

Right Atrium: The right atrium is mildly dilated in size.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. The right

ventricular diastolic area is 26.55 cm which is normal. The right

ventricular systolic area is 15.50 cm which is normal. Global right

ventricular systolic function is normal. The right ventricular

fractional area change is 41.62% which is normal. The tricuspid

annular plane systolic excursion is 1.64 cm consistent with normal

right ventricular systolic function. The right ventricular systolic

pressure, as estimated using the tricuspid regurgitation velocity, is

40.5 mmHg.

Aortic Valve: The aortic valve was not well seen. Normal Doppler

interrogation flow patterns without stenosis or insufficiency.

Mitral Valve: The mitral valve is structurally normal. Trace mitral

regurgitation is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Mild

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is normal. Trace pulmonary

regurgitation is seen.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.24 cm. The ascending aorta is normal at 2.95 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 3.06 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is mildly elevated at 40.5 mmHg.

Pericardium: There is a moderate circumferential pericardial effusion.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 8/17.

Summary:

1. Normal left ventricular cavity size.

2. Mildly increased left ventricular wall thickness.

3. Severely increased relative wall thickness.

4. Normal global left ventricular systolic function.

5. No regional left ventricular wall motion abnormalities.

6. Moderate diastolic dysfunction with elevated left ventricular

filling pressures.

7. Normal right ventricular systolic function.

8. Mildly dilated left atrial size.

9. Mildly dilated right atrial size.

10. Normal atrial septum by 2D and color Doppler.

11. The aortic valve was not well seen.

12. No aortic stenosis or insufficiency.

13. Trace mitral regurgitation.

14. Mild tricuspid regurgitation.

15. Mildly elevated pulmonary artery systolic pressure.

16. Normal aortic root diameter for body size.

17. Moderate circumferential pericardial effusion.

014970 Smadar Kort MD, FACC, FASE

Electronically signed by 014970 Smadar Kort MD, FACC, FASE on

10/21/2015 at 2:09:16 PM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: BYKHOVSKY, MICHAEL

Order Date/Time: October 20, 2015 1:40 AM

Scan Initiation Date/Time:

Completion Date/Time: October 21, 2015 1:45 PM

Encounter Number: 010092829612

Accession Number: 6443316

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: October 21, 2015 2:09 PM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 10/21/2015 5:34:00 PM

Report Name: CT CHEST WO IV CONTRAST

Examination

CT of CHEST.

Clinical History

Recent pneumonia treatment. Congestive heart failure. Urinary tract

infection.

Technique

Routine study. Post processed reconstructions included.

Contrast

No contrast appeared

Comparison

2 months ago.

Findings

BASE OF NECK: Heterogeneous thyroid.

LUNGS: Moderate-sized layering right pleural effusion. Small

layering left pleural effusion and adjacent multisegmental left lower

lobe atelectasis most of which is mostly due to bronchomalacia and

mucous. There is near complete atelectasis of the right lower lobe

secondary to mucous plugging and adjacent compression from the

moderate-sized right pleural effusion. There are small areas of

mineralization / high attenuation within the bilateral lower lobe

periphery, which could be secondary to tumoral calcinosis in a

setting of hyperparathyroidism or aspiration of prior contrast

material, unchanged from prior. There is mild biapical centrilobular

emphysema. There is a old 9 x 8 mm nodule within the right middle

lobe as seen on series 4 image 140. There are numerous left lower

lobe nodules have grown less. There is moderate bronchi within the

right middle lobe with mucus. There is multisegmental left lower lobe

atelectasis.

LARGE AIRWAYS: There is a prominent tracheal size. Bronchomalacia

and bilateral lower lobe main bronchi.

VESSELS: Normal caliber thoracic aorta.

HEART: Enlarged heart with a small circumferential pericardial

effusion. Dense coronary artery calcifications. No gross thoracic

aortic aneurysm.

MEDIASTINUM and HILA: Scattered lymph nodes.

AXILLAE: No lymphadenopathy.

BONES: No gross acute fracture or aggressive destructive process.

Degenerative thoracic spondylosis. Anasarca with a coalescent fluid

collection within the right lateral spurious anterior.

UPPER ABDOMEN: Tiny layering gallstones in the gallbladder.

Impression

1. Moderate-sized layering right pleural effusion with near

complete atelectasis of the right lower lobe.

2. Small layering left pleural effusion with ground-glass

throughout the left lower lobe which could represent edema or

pneumonia, new from prior.

3. Bilateral lower lung bronchomalacia and bronchitis,

diffusely.

4. Cardiomegaly with small pericardial effusion.

5. Anasarca, most coalescent in the right serratus anterior

region.

6. Small biapical centrilobular emphysema.

7. Right middle lobe 9 mm nodule warrants follow up in 3 to 6

months with low-dose noncontrast chest CT.

Attending Radiologist: FELDMANN, ERIC

Ordered By: BYKHOVSKY, MICHAEL

Order Date/Time: October 20, 2015 2:15 AM

Scan Initiation Date/Time: October 21, 2015 5:29 PM

Completion Date/Time: October 21, 2015 5:34 PM

Encounter Number: 010092829612

Accession Number: 6443326

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: October 22, 2015 1:22 AM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 10/22/2015 1:47:00 PM

Report Name: CHEST AP PORTABLE

Examination

Portable chest radiograph

Clinical History

FLUID OVERLOAD

Technique

Single AP view of chest is presented.

Comparison

10/19/2015

Findings

Lines, tubes, and devices: There appears to be a stent in the left

neck, unchanged since the prior exam.

Lungs and Pleura: Interval decrease in size of right pleural

effusion. On the current exam the pleural effusion appears smaller

in size. No large left pleural effusion. No pneumothorax. Mildly

prominent interstitial markings are noted bilaterally, likely

representing mild interstitial pulmonary edema. No hazy opacity in

the right lung base likely represents atelectasis.

Cardiomediastinal structures: Cardiomediastinal silhouette can not

be well assessed upon due to technique (antero-posterior projection)

however has not significantly changed since the prior exam.

Bones/Soft tissues: No acute osseous abnormality.

Impression

1. Interval decrease in size of right pleural effusion, on the

current exam is a right pleural effusion is small in size.

2. Mildly prominent interstitial markings in both lungs, likely

representing interstitial pulmonary edema.

3. Hazy opacity in the right lung base likely represents atelectasis,

underlying pneumonia cannot be excluded.

Attending Radiologist: GUPTA, AMIT

Ordered By: SHAH, RIAN

Order Date/Time: October 22, 2015 1:10 PM

Scan Initiation Date/Time: October 22, 2015 1:35 PM

Completion Date/Time: October 22, 2015 1:47 PM

Encounter Number: 010092829612

Accession Number: 6447748

Images were reviewed and interpreted by Attending Radiologist: Dr. GUPTA, AMIT

Electronically Signed On: October 22, 2015 3:50 PM by Dr. GUPTA, AMIT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 10/23/2015 3:12:00 PM

Report Name: QUINTON CATHETER (NON-TUNNELED)

Clinical History

74-year-old male with history ofworsening renal failure.. The patient

is in need ofhemodialysis. Plan is to place a non tunneled large bore

dialysis type catheter for these purposes.

Please note the attending radiologist Dr. Ferretti was present for

the entire procedure.

Technique

Ultrasound was used to image the rightneck. Theright internal jugular

vein was found to be patent. Hard copy image was stored in the

patient's records.

Following sterile preparation and draping and using standard aseptic

technique and following local lidocaine infusion real-time ultrasound

guidance was used to place a micropuncture needle into

therightinternal jugular vein. Following multiple guidewire and

catheter exchanges a 12 French sheath was placed. Then a 12 French

by 20 cm large-bore dialysis catheter was advanced through the sheath

so that its tip is in the SVC/ right atrial junction.

No complications. The patient tolerated the procedure well. The

patient was transported to the floor in stable conditions. Moderate

sedation was not used.

Maximal sterile barrier technique was used during the Perma-Cath

insertion. Cap, mask, sterile gown, gloves, large sterile sheet was

used. Hand hygiene protocol was followed. 2 percent chlorhexidine was

used for cutaneous antisepsis.

A total of 0.4 minutes of fluoroscopy time was used.

Comparison

None

Findings

Patent right internal jugular vein.

Impression

12 French by 15 cm of high-flow,non tunneled dialysis type catheter

placed via a right internal jugular vein approach with tip in the

SVC/right atrial junction.

Attending Radiologist: FERRETTI, JOHN

Ordered By: GOOLSARRAN, NIRVANI

Order Date/Time: October 23, 2015 1:20 PM

Scan Initiation Date/Time: October 23, 2015 2:26 PM

Completion Date/Time: October 23, 2015 3:12 PM

Encounter Number: 010092829612

Accession Number: 6449196

Images were reviewed and interpreted by Attending Radiologist: Dr. FERRETTI, JOHN

Electronically Signed On: October 26, 2015 8:56 AM by Dr. FERRETTI, JOHN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 10/29/2015 9:46:00 AM

Report Name: PERMACATH PLACEMENT (TUNNELED)

Clinical History

74-year-old male with history of acute interstitial nephritis

requiring hemodialysis. Patient is in need of more durable

hemodialysis access. Plan is to place a large bore, tunneled,

dual-lumen,dialysis type catheter for these purposes, exchanging for

indwelling Quentin catheter.

Please note the attending radiologist Dr. Ferretti was present for

the entire procedure.

Technique

An indwelling right internal jugular approach Quentin catheter was

examined. Under fluoroscopic guidance and over an Amplatz wire. The

Quentin catheter was removed in its entirety and exchanged for a 16

French peel-away sheath.

Lidocaine mixed with epinephrine was then infused in a tract from the

right infraclavicular area to the venotomy site and a tunnel was

created. Catheter was advanced through the tunnel to the vascular

access site in the neck and then the catheter was advanced through

the sheath. Distal tip was left in the right superior cavoatrial

junction. Under fluoroscopic guidance. Sheath was removed. The

catheter was then dressed in a sterile manner. Both lumens were

flushed and locked with dilute heparin, 100 mg/ mL.

The patient tolerated the procedure well and no immediate post

Perma-Cath complications observed.

Moderate sedation was used. The patient was transported to his

hospital floor in stable conditions.

Maximal sterile barrier technique was used during the Perma-Cath

insertion. Cap, mask, sterile gown, gloves, large sterile sheet was

used. Hand hygiene protocol was followed. 2 percent chlorhexidine was

used for cutaneous antisepsis.

A total of 0.9 minutes of fluoroscopy was used.

Comparison

Chest radiograph dated 10/22/2015.

Findings

Patent right internal jugular vein.

Impression

15.6 French x 19 cm length, dual-lumen, large-bore, tunneled,

hemodialysis catheter placed via a right internal jugular vein

approach with distal tip in the superior cavoatrial junction.

Indwelling Quentin catheter removed in its entirety.

No complications. Catheter ready for use.

Attending Radiologist: FERRETTI, JOHN

Ordered By: SHAH, RIAN

Order Date/Time: October 29, 2015 7:55 AM

Scan Initiation Date/Time: October 29, 2015 7:52 AM

Completion Date/Time: October 29, 2015 9:46 AM

Encounter Number: 010092829612

Accession Number: 6455193

Images were reviewed and interpreted by Attending Radiologist: Dr. FERRETTI, JOHN

Electronically Signed On: October 29, 2015 3:39 PM by Dr. FERRETTI, JOHN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 11/1/2015 8:56:00 AM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Clinical History

CHF, preop evaluation for BKA.

Technique

PA and lateral views of the chest are submitted.

Comparison

Radiograph of the chest dated 10/22/15 .

Findings

There is a right-sided approach dialysis catheter with tip in the

distal superior vena cava.

There is mild pulmonary vascular congestion. There is no evidence of

pneumothorax or pleural effusion. The cardiomediastinal silhouette is

enlarged, stable from prior study.

Impression

Right-sided approach dialysis catheter with tip in the distal

superior vena cava.

Mild pulmonary vascular congestion with stable cardiomegaly.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: DHAWAN, TWINKLE

Order Date/Time: November 1, 2015 6:00 AM

Scan Initiation Date/Time: November 1, 2015 8:43 AM

Completion Date/Time: November 1, 2015 8:56 AM

Encounter Number: 010092829612

Accession Number: 6459475

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: November 1, 2015 12:44 PM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 11/3/2015 4:48:00 AM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

FEVER, POSSIBLE PNEUMONIA

Technique

A single AP view the chest.

Comparison

Compared to a prior study of 11/01/2015.

Findings

There is central vascular congestion with interstitial edema

bilaterally. There is mild cardiomegaly. Dialysis catheter from the

right IJ approach with the tips in the superior vena cava is again

noted.

Impression

Central vascular congestion and interstitial edema bilaterally.

Cardiomegaly. Right IJ dialysis catheter in good position.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: STRONG, EMILY

Order Date/Time: November 3, 2015 3:00 AM

Scan Initiation Date/Time: November 3, 2015 4:19 AM

Completion Date/Time: November 3, 2015 4:48 AM

Encounter Number: 010092829612

Accession Number: 6461882

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: November 3, 2015 7:47 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10092829612

Report Date/Time: 11/16/2015 5:18:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

CHF

Indication

EVALUATE PRE-OPERATIVE

Technique

CHEST AP PORTABLE/URGENT

Comparison

11/03/2015

Findings

Dual lumen right IJ catheter is unchanged in position. Mild pulmonary

vascular congestion. No focal consolidation or pneumothorax.

Cardiomediastinal silhouette is stable.

Impression

Mild pulmonary vascular congestion. No focal consolidation.

Attending Radiologist: REITER, MICHAEL

Ordered By: FLEISCHNER, ZACHARY

Order Date/Time: November 16, 2015 4:05 PM

Scan Initiation Date/Time: November 16, 2015 4:55 PM

Completion Date/Time: November 16, 2015 5:18 PM

Encounter Number: 010092829612

Accession Number: 6479548

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: November 17, 2015 6:00 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 11/4/2015 5:45:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Sepsis, fever. Evaluate for pneumonia.

Technique

Single frontal view of the chest

Comparison

None.

Findings

The cardiac silhouette is normal in size. The aorta is within normal

limits. Pulmonary vessels are unremarkable.

There are minimal reticular opacities in the upper lobes suggesting

an element of chronic changes. . There is left basilar linear

atelectasis/scarring. There is no focal airspace consolidation.

There is no pleural effusion or pneumothorax.

Impression

No acute consolidation.

Attending Radiologist: GOULD, ELAINE

Ordered By: LEE, CHRISTOPHER

Order Date/Time: November 4, 2015 4:40 PM

Scan Initiation Date/Time: November 4, 2015 5:26 PM

Completion Date/Time: November 4, 2015 5:45 PM

Encounter Number: 010093362225

Accession Number: 6464825

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: November 4, 2015 5:58 PM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 11/11/2015 5:07:00 PM

Report Name: ABDOMEN SERIES PORTABLE (FLAT/ERECT)

Clinical History

Rule out obstruction

Technique

Portable upright and supine AP views of the abdomen

Comparison

Comparison is made to chest x-ray dated 11/04/2015

Findings

No evidence of pneumoperitoneum on the upright radiograph.

There is a single loop of large bowel, seen in the upper abdomen

measuring approximately 9.7 centimeters in maximal diameter. No

definite sigmoid colon is seen within the lower abdomen, and the

dilated loop of colon could represent sigmoid volvulus. Significant

stool is seen within the mid and distal colon. No abnormal

calcifications are seen.

Impression

Dilated loop of large bowel in the upper abdomen, with no definite

sigmoid colon seen in the lower abdomen, which raises the possibility

of sigmoid volvulus. Remaining bowel is normal in caliber. Consider

correlation with CT of the abdomen and pelvis if clinically

warranted.

Attending Radiologist: REITER, MICHAEL

Ordered By: LINGAM, VEENA

Order Date/Time: November 11, 2015 3:35 PM

Scan Initiation Date/Time: November 11, 2015 5:01 PM

Completion Date/Time: November 11, 2015 5:07 PM

Encounter Number: 010093362225

Accession Number: 6473648

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: November 11, 2015 5:41 PM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 11/11/2015 10:37:00 PM

Report Name: CT ABD AND PELVIS WITH IV CONTRAST

Examination

CT of the Abdomen and Pelvis

Clinical History

ABD PAIN, CONSTIPATION W/ INTERMITTENT LOOSE STOOLS

Additional History

R/O VOLVULUS

Technique

Routine study. Post Processed reconstructions included. Contrast

administered as described below:

Contrast

Contrast Agent OMNIPAQUE 300 110 mg/dl 11/11/2015 INTRAVENOUS

Comparison

None

Findings

LUNG BASES: Clear. No pleural effusion.

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: Common bile duct is mildly dilated measuring 11 mm in

maximal diameter. No evidence of intrahepatic biliary dilatation. The

gallbladder is unremarkable.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: Normal caliber. No wall thickening. Large amount of stool seen

throughout the colon consistent with constipation. There is no

evidence of volvulus.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta.

ABDOMINAL WALL: No hernia or mass

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Lumbar scoliosis with marked degenerative changes.

OTHER: None

Impression

Large amount of stool seen throughout the colon consistent with

constipation. No evidence of volvulus.

Attending Radiologist: BARISH, MATTHEW

Ordered By: LINGAM, VEENA

Order Date/Time: November 11, 2015 5:55 PM

Scan Initiation Date/Time: November 11, 2015 10:27 PM

Completion Date/Time: November 11, 2015 10:37 PM

Encounter Number: 010093362225

Accession Number: 6473843

Images were reviewed and interpreted by Attending Radiologist: Dr. BARISH, MATTHEW

Electronically Signed On: November 11, 2015 11:06 PM by Dr. BARISH, MATTHEW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 12/8/2015 10:02:00 PM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Examination

CHEST ROUTINE PA/AP AND LATERAL/URGENT

Clinical History

COUGH

Presenting Diagnosis

POSSIBLE INFILTRATE

Technique

Two views of the chest are presented.

Comparison

Compared to a prior study of 11/04/2015.

Findings

Patient's taken reduced inspiration with low lung volumes. Increased

airspace opacification is noted of the left lung base. Right lung is

clear. Heart size is within normal limits. Bony thorax and extra

thoracic osseous structures and soft tissues are unremarkable.

Impression

Airspace opacification right lung base. Pneumonia versus atelectasis.

Bursitis normal. Right lung clear.

Attending Radiologist: HARRINGTON, DONALD P.

Ordered By: HOELZER, MAUREEN

Order Date/Time: December 8, 2015 4:55 PM

Scan Initiation Date/Time: December 8, 2015 9:51 PM

Completion Date/Time: December 8, 2015 10:02 PM

Encounter Number: 010093362225

Accession Number: 6506519

Images were reviewed and interpreted by Attending Radiologist: Dr. HARRINGTON, DONALD P.

Electronically Signed On: December 9, 2015 8:38 AM by Dr. HARRINGTON, DONALD P.

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 12/9/2015 6:37:00 PM

Report Name: CT CHEST WO IV CONTRAST

Clinical History

Shortness-of-breath. Cough.

Technique

Contiguous axial CT images of the chest were obtained without

contrast. Coronal and sagittal reconstructions obtained.

Comparison

No prior chest CT available for direct comparison.

Correlation is made with 12/09/2015 and 12/08/2015 chest x-ray.

Findings

Exam is limited by motion.

Large airways of the central tracheobronchial tree are patent. There

are secretions layering along the left posterolateral wall of the

trachea. There is bronchial wall thickening throughout with some

impaction of the distal airway and both lower lobes, left more than

right. There is mild nonspecific focal narrowing along the proximal

left lower lobe bronchus, which is likely secondary to motion and

respiration.

There is mild upper lobe predominant centrilobular emphysematous

changes. There is focal area of mild ground-glass airspace opacity

with interlobular septal thickening in the apicoposterior segment of

the left upper lobe. There are also patchy nodular ground-glass

opacities scattered within the left lower lobe, most notably in the

superior segment. There is mild subsegmental atelectatic change in

the dependent left lower lobe. There is a 2 millimeter nodule in the

right lung apex (image 45 of series 4). Dependent changes are present

in both lung bases.

There is no pleural effusion or pneumothorax.

The heart is not enlarged. There is no pericardial effusion.

Thoracic aorta is of normal caliber. There are no pathologically

enlarged mediastinal lymph nodes there is no evidence for hilar

adenopathy within the limitations of a noncontrast CT. There are a

few nonspecific subcentimeter mediastinal lymph nodes in the

prevascular space and pretracheal space.

There is a small hiatus hernia. Evaluation of the upper abdomen

demonstrates no adrenal gland nodular mass.

There is no evidence of axillary adenopathy.

There is focal asymmetric soft tissue within the retroareolar left

breast.

There are chronic fractures along the lateral left 10th and 11th

ribs, unchanged from 11/11/2015 CT abdomen/pelvis. There is a dextro

convex curvature of the thoracic spine, with mild right lateral

subluxation of the L1 on L2. Subcentimeter sclerotic lesion in the

lateral right 8th rib is unchanged, most likely an enostosis.

There is globular calcification along the right supraspinatus tendon,

compatible with calcific tendinopathy.

Impression

1. Patchy areas of ground-glass opacity in the left upper lobe and

left lower lobe, as described above, are most likely infectious.

2. Mild centrilobular emphysematous changes. A 2 mm, nonspecific

nodular opacity in the right lung apex.

3. Focal asymmetric soft tissue within the retroareolar left breast,

may be asymmetric glandular tissue. Please correlate with mammogram

to exclude other processes.

4. Right supraspinatus calcific tendinopathy.

Attending Radiologist: WOROCH, LUBOSLAV

Ordered By: HOELZER, MAUREEN

Order Date/Time: December 9, 2015 10:15 AM

Scan Initiation Date/Time: December 9, 2015 6:28 PM

Completion Date/Time: December 9, 2015 6:37 PM

Encounter Number: 010093362225

Accession Number: 6507126

Images were reviewed and interpreted by Attending Radiologist: Dr. WOROCH, LUBOSLAV

Electronically Signed On: December 10, 2015 10:01 AM by Dr. WOROCH, LUBOSLAV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 12/22/2015 6:33:00 PM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

Abdominal distention, constipation

Technique

2 views of the abdomen

Comparison

Supine and erect views of the abdomen dated 11/11/2015

Findings

Fecal loading is identified in the ascending transverse and

descending colon. There appears to be air in the rectum.

Nonspecific bowel gas pattern. There are no abnormal intra-abdominal

calcifications. There is mild levoscoliosis of the lumbar spine.

There are moderate to severe degenerative changes in the lower lumbar

spine.

Impression

Fecal loading throughout the colon.Nonspecific and nonobstructive

bowel gas pattern.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: RIQUELME, LUIS A

Order Date/Time: December 22, 2015 5:20 PM

Scan Initiation Date/Time: December 22, 2015 6:30 PM

Completion Date/Time: December 22, 2015 6:33 PM

Encounter Number: 010093362225

Accession Number: 6524473

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: December 22, 2015 9:51 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 12/30/2015 11:52:00 AM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

Possible obstruction. Abdominal pain.

Technique

AP supine frontal abdominal radiograph.

Comparison

Abdominal radiograph from 12/22/2015 and CT of the abdomen and pelvis

from 11/11/2015.

Findings

Nonspecific bowel gas pattern. Fecal material is noted within the

entire large bowel. No pneumatosis or portal venous gas is

identified.

No abnormal abdominal calcifications are identified. There is no

evidence for organomegaly.

There is S-shaped scoliosis of the thoracolumbar spine with the

rightward lower thoracic and leftward lumbar curvatures.

Impression

1. Nonspecific bowel gas pattern.

2. Fecal material noted throughout the entire large bowel.

Please correlate for constipation.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: HOELZER, MAUREEN

Order Date/Time: December 30, 2015 10:40 AM

Scan Initiation Date/Time: December 30, 2015 11:41 AM

Completion Date/Time: December 30, 2015 11:52 AM

Encounter Number: 010093362225

Accession Number: 6531860

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: December 30, 2015 2:21 PM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 1/2/2016 12:49:00 AM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

61 YEAR OLD FEMALE WITH HISTORY OF CVA 3/2014, MI, R LEG DVT AND PE

12/2014 ON LOVENOX, SEIZURE DISORDER, SPINAL STENOSIS, NEUROGENIC

BLADDER WITH INDWELLING FOLEY CATHETER PW ABD PAIN.

Technique

Routine study. Post Processed reconstructions included.

Contrast

None administered.

Comparison

CT from 11/11/2015.

Findings

LUNG BASES: Clear. No pleural effusion.

Abdomen and pelvis:

LIVER: Normal size. No mass.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: Small hiatal hernia. Normal caliber. No wall thickening. There

is considerable distal throughout the colon, increased since the

prior study.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM and pelvic sidewalls: There is new enlargement of

right psoas muscle with heterogeneous attenuation. No

lymphadenopathy.

VESSELS: Normal caliber aorta.

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

BLADDER: Foley catheter is in place. There is some layering high

attenuation in the bladder. .

BONES: Mild scoliosis is present. Advanced degenerative spinal

changes are noted. Partial fusion of L4 and L5 vertebral bodies is

identified, unchanged, possibly secondary to prior osteomyelitis.

Impression

1. New (since 11/11/2015) heterogeneous diffuse enlargement of

right psoas muscle most consistent with hemorrhage.

2. No acute GI tract pathology. Likely constipation.

3. Layering high attenuation in the bladder raising the

possibility of bladder calculi vs some residual contrast enhanced

urine if the patient has undergone arterial or IV contrast

administration in the prior week.

Attending Radiologist: MANKES, SETH

Ordered By: JAIN, EERA

Order Date/Time: January 1, 2016 2:45 PM

Scan Initiation Date/Time: January 2, 2016 12:41 AM

Completion Date/Time: January 2, 2016 12:49 AM

Encounter Number: 010093362225

Accession Number: 6534011

Images were reviewed and interpreted by Attending Radiologist: Dr. MANKES, SETH

Electronically Signed On: January 2, 2016 11:15 AM by Dr. MANKES, SETH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 1/14/2016 10:43:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

INC. MYOCLONUS,JERKING IN THE SETTING OF PRIOR STROKE

History and Indication

H/O CVA IN PAST, SZ S/O , INC . MYOCLONUS

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

No images available for comparison.

Findings

There is no CT evidence of acute transcortical infarction. There is

no intracranial hemorrhage or extra-axial collection. No focal mass,

mass effect or midline shift.

There are chronic appearing infarcts within the interior right

frontal lobe as well as the paramedian right parietal lobes as well

as the left frontal lobe, with evidence of encephalomalacia/gliosis

and volume loss.

Moderate to advanced age related volume loss without hydrocephalus.

There are patchy foci of hypoattenuation within the periventricular

and subcortical white matter most compatible with microvascular

ischemic changes given the appearance of atherosclerotic vascular

calcifications.

The calvarium is intact.

Small mucous retention cyst or polyp within the right frontal sinus.

Otherwise there is no significant disease in the visualized paranasal

sinuses and mastoids.

Impression

1. No CT evidence of acute transcortical infarct.

2. Microvascular ischemic disease with chronic appearing

infarcts within the bilateral frontal and right paramedian parietal

lobes.

Attending Radiologist: FILATOV, ALEXANDER

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 14, 2016 12:20 PM

Scan Initiation Date/Time: January 14, 2016 10:31 PM

Completion Date/Time: January 14, 2016 10:43 PM

Encounter Number: 010093362225

Accession Number: 6549929

Images were reviewed and interpreted by Attending Radiologist: Dr. FILATOV, ALEXANDER

Electronically Signed On: January 15, 2016 11:21 AM by Dr. FILATOV, ALEXANDER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10093362225

Report Date/Time: 1/15/2016 9:24:00 PM

Report Name: CT ABD AND PELVIS WITH IV CONTRAST

Examination

CT ABD AND PELVIS WITH IV CONTRAST/URGENT

CT of Abdomen and Pelvis.

Clinical History

CAD, STROKE, DVA, COPD, NEUROGENIC BLADDER WITH CHRONIC UTI/FOLEY, HX

OF PSOAS HEMATOMA SEEN ON CT SCAN 1/2/16- PLEASE FOLLOW UP

Technique

Routine study. Post Processed reconstructions included.

Contrast

Contrast Agent OMNIPAQUE 300 95 milliliters 01/15/2016 INTRAVENOUS

Comparison

Prior CT from 01/02/2016

Findings

LUNG BASES: Redemonstration of tree-in-bud nodules in the left lung

lingula and lower lobe. These could be infectious in etiology.

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Subcentimeter nonenhancing cyst is seen in the left kidney.

No hydronephrosis is seen.

BOWEL: Significant residual stool noted in the large bowel. The

enteric contrast has progressed to the cecum excluding any

significant small bowel obstruction.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: There is a redemonstration of heterogenous

collection in the right psoas muscle measuring approximately 6.6 x

3.5 cm including the psoas muscle, previously 6.6 x 4.6 cm.

VESSELS: Compression of the right common iliac vein is noted

secondary to the compression by the enlarged right psoas muscle. No

sign of thrombus is identified in the IVC. Normal caliber aorta with

calcified atherosclerotic changes noted.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Partially decompressed bladder with a Foley catheter in

situ.

BONES: Extensive degenerative changes and scoliosis noted in the

lower lumbar spine.

Impression

Interval slight decrease in the fluid collection in the right psoas

muscle. Associated extensive degenerative changes in the lower

lumbar spine are noted. MRI of the lumbar spine with and without

contrast may be beneficial to exclude any infectious etiology for the

right psoas muscle collection.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: ROCCO, VERONICA

Order Date/Time: January 15, 2016 2:40 PM

Scan Initiation Date/Time: January 15, 2016 9:16 PM

Completion Date/Time: January 15, 2016 9:24 PM

Encounter Number: 010093362225

Accession Number: 6551878

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: January 16, 2016 9:46 AM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/3/2016 6:55:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Altered mental status. Evaluate for possible infiltrate.

Technique

AP chest radiograph.

Comparison

Chest radiograph 7/12/14.

Findings

The lung volumes are low. The trachea is midline. The

cardiomediastinal silhouette is stable in size. There are no focal

airspace consolidations. There are no pleural effusions or

pneumothorax.

Impression

No acute pulmonary process is identified.

Attending Radiologist: SARADOFF, CHRISTOPHER V

Ordered By: KIM, JUNG

Order Date/Time: January 3, 2016 5:50 PM

Scan Initiation Date/Time: January 3, 2016 6:51 PM

Completion Date/Time: January 3, 2016 6:55 PM

Encounter Number: 010095069224

Accession Number: 6535440

Images were reviewed and interpreted by Attending Radiologist: Dr. SARADOFF, CHRISTOPHER V

Electronically Signed On: January 3, 2016 8:45 PM by Dr. SARADOFF, CHRISTOPHER V

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/3/2016 8:21:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

Chronic alcoholism with altered mental status.

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

No images available for comparison.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

The ventricles, cisterns and sulci are age-appropriate in size.

Chronic ischemic microvascular changes are noted. There is no mass

effect, midline shift or focal parenchymal abnormality.

There is no intracranial hemorrhage or extra-axial collection.

Involutional changes are noted without evidence of hydrocephalus.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No evidence of intracranial hemorrhage.

No evidence of an acute ischemic territory infarct.

Attending Radiologist: SARADOFF, CHRISTOPHER V

Ordered By: WEISS, SARAH

Order Date/Time: January 3, 2016 6:05 PM

Scan Initiation Date/Time: January 3, 2016 8:00 PM

Completion Date/Time: January 3, 2016 8:21 PM

Encounter Number: 010095069224

Accession Number: 6535450

Images were reviewed and interpreted by Attending Radiologist: Dr. SARADOFF, CHRISTOPHER V

Electronically Signed On: January 3, 2016 10:11 PM by Dr. SARADOFF, CHRISTOPHER V

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/3/2016 8:21:00 PM

Report Name: CT SPINE CERVICAL WO IV CONTRAST

Examination

CT SPINE CERVICAL WITHOUT CONTRAST

Clinical History

Altered mental status.

Technique

1.25 mm. thick helical axial slices were obtained from skull base to

the upper thoracic spine and then sagittal and coronal reformatted

images were obtained.

Comparison

No images available for comparison.

Findings

No fracture, subluxation or bone destruction is noted.

Soft tissue information is limited. No evidence of large disc

protrusion or critical spinal stenosis is noted. Degenerative changes

with osteophyte formation are noted.

MRI should be obtained, if the patient is MRI compatible, if further

information regarding disc protrusion, hematoma or spinal cord

pathology is required.

Impression

NO ACUTE FRACTURE OR SUBLUXATION. Moderate degenerative changes in

the lower cervical spine.

Attending Radiologist: SARADOFF, CHRISTOPHER V

Ordered By: WEISS, SARAH

Order Date/Time: January 3, 2016 6:10 PM

Scan Initiation Date/Time: January 3, 2016 8:00 PM

Completion Date/Time: January 3, 2016 8:21 PM

Encounter Number: 010095069224

Accession Number: 6535453

Images were reviewed and interpreted by Attending Radiologist: Dr. SARADOFF, CHRISTOPHER V

Electronically Signed On: January 3, 2016 10:11 PM by Dr. SARADOFF, CHRISTOPHER V

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/3/2016 8:22:00 PM

Report Name: CT CHEST WITH IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

57-year-old female with chronic alcoholism, now jaundiced altered

mental status.

Technique

Routine study. Post processed reconstructions included.

Contrast

Contrast Agent OMNIPAQUE 350 70 milliliters 01/03/2016 INTRAVENOUS

Comparison

None available.

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: Evaluation of lungs is somewhat limited due to motion

artifact. Peripheral patchy areas of ground-glass opacity are seen

bilaterally. Areas of airspace consolidation with air bronchograms,

mostly in perihilar regions, are seen bilaterally. Bronchial wall

thickening and bronchiectasis are noted bilaterally.

LARGE AIRWAYS: Patent.

PLEURA: No effusion or pneumothorax.

HEART: Normal size. No pathologic pericardial effusion.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

VESSELS: Pulmonary trunk measures up to 3.3 cm, this may be secondary

to pulmonary hypertension. Atherosclerotic vascular calcifications of

a normal caliber aorta are noted.

Abdomen:

LIVER: Hepatic cirrhosis. Liver is enlarged. No mass.

BILIARY TRACT: No dilatation. Gallbladder is unremarkable.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: There is no evidence of bowel obstruction. Diverticulosis

without evidence of diverticulitis. There is pericolonic fat

stranding adjacent to the ascending colon with bowel wall thickening

concerning for portal coagulopathy.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy. There is a moderate

amount of free fluid/ ascites within the pelvis.

BLADDER: The bladder is collapsed with Foley catheter.

BONES: Within normal limits for age. No focal lesion.

Impression

Bilateral areas of pulmonary consolidation with air bronchograms

which may be secondary to aspiration pneumonitis or of an infectious

etiology.

Pericolonic fat stranding and bowel wall thickening involving the

ascending colon concerning for portal coagulopathy and/or portal

hypertension.

Hepatic cirrhosis.

Diverticulosis.

Ascites within the pelvis.

Attending Radiologist: SARADOFF, CHRISTOPHER V

Ordered By: WEISS, SARAH

Order Date/Time: January 3, 2016 6:10 PM

Scan Initiation Date/Time:

Completion Date/Time: January 3, 2016 8:22 PM

Encounter Number: 010095069224

Accession Number: 6535454

Images were reviewed and interpreted by Attending Radiologist: Dr. SARADOFF, CHRISTOPHER V

Electronically Signed On: January 4, 2016 7:06 AM by Dr. SARADOFF, CHRISTOPHER V

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/3/2016 8:22:00 PM

Report Name: CT ABD AND PELVIS WITH IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

57-year-old female with chronic alcoholism, now jaundiced altered

mental status.

Technique

Routine study. Post processed reconstructions included.

Contrast

Contrast Agent OMNIPAQUE 350 70 milliliters 01/03/2016 INTRAVENOUS

Comparison

None available.

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: Evaluation of lungs is somewhat limited due to motion

artifact. Peripheral patchy areas of ground-glass opacity are seen

bilaterally. Areas of airspace consolidation with air bronchograms,

mostly in perihilar regions, are seen bilaterally. Bronchial wall

thickening and bronchiectasis are noted bilaterally.

LARGE AIRWAYS: Patent.

PLEURA: No effusion or pneumothorax.

HEART: Normal size. No pathologic pericardial effusion.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

VESSELS: Pulmonary trunk measures up to 3.3 cm, this may be secondary

to pulmonary hypertension. Atherosclerotic vascular calcifications of

a normal caliber aorta are noted.

Abdomen:

LIVER: Hepatic cirrhosis. Liver is enlarged. No mass.

BILIARY TRACT: No dilatation. Gallbladder is unremarkable.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: There is no evidence of bowel obstruction. Diverticulosis

without evidence of diverticulitis. There is pericolonic fat

stranding adjacent to the ascending colon with bowel wall thickening

concerning for portal coagulopathy.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy. There is a moderate

amount of free fluid/ ascites within the pelvis.

BLADDER: The bladder is collapsed with Foley catheter.

BONES: Within normal limits for age. No focal lesion.

Impression

Bilateral areas of pulmonary consolidation with air bronchograms

which may be secondary to aspiration pneumonitis or of an infectious

etiology.

Pericolonic fat stranding and bowel wall thickening involving the

ascending colon concerning for portal coagulopathy and/or portal

hypertension.

Hepatic cirrhosis.

Diverticulosis.

Ascites within the pelvis.

Attending Radiologist: SARADOFF, CHRISTOPHER V

Ordered By: WEISS, SARAH

Order Date/Time: January 3, 2016 6:10 PM

Scan Initiation Date/Time: January 3, 2016 8:07 PM

Completion Date/Time: January 3, 2016 8:22 PM

Encounter Number: 010095069224

Accession Number: 6535455

Images were reviewed and interpreted by Attending Radiologist: Dr. SARADOFF, CHRISTOPHER V

Electronically Signed On: January 3, 2016 10:08 PM by Dr. SARADOFF, CHRISTOPHER V

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/3/2016 11:36:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Evaluate right IJ approach central venous catheter placement.

Technique

Portable Ap view of the chest.

Comparison

Study on the same Day at 18:51.

Findings

Right IJ approach central venous catheter tip lies within the right

atrium, withdrawal by approximately 4 cm is recommended. Endotracheal

tube is 2.8 cm above the carina. Nasogastric tube overlies the GE

junction within the distal esophagus, advancement is recommended.

Cardiomediastinal silhouette is within normal limits. There are

patchy areas of airspace opacity in bilateral lungs concerning for

fluid overload/pulmonary edema, however, an infectious process cannot

be ruled out. There are no pleural effusions or pneumothorax.

Impression

Right IJ approach central venous catheter tip overlies the right

atrium, withdrawal by approximately 4 cm is recommended.

Nasogastric tube advancement is recommended.

Endotracheal tube is 2.8 cm above the carina.

Patchy areas of airspace opacity in bilateral lungs concerning for

fluid overload/pulmonary edema, however, an infectious process cannot

be ruled out.

Findings discussed with Dr. Weiss.

Attending Radiologist: SARADOFF, CHRISTOPHER V

Ordered By: ERASO, DANIEL

Order Date/Time: January 3, 2016 10:45 PM

Scan Initiation Date/Time: January 3, 2016 11:32 PM

Completion Date/Time: January 3, 2016 11:36 PM

Encounter Number: 010095069224

Accession Number: 6535553

Images were reviewed and interpreted by Attending Radiologist: Dr. SARADOFF, CHRISTOPHER V

Electronically Signed On: January 4, 2016 12:01 AM by Dr. SARADOFF, CHRISTOPHER V

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/4/2016 1:17:00 AM

Report Name: CHEST AP PORTABLE

Given history is a 57-year-old female status post line and tube

repositioning.

Technique:

AP portable view of the chest were submitted .

Comparison:

01/03/2016

Findings:

Study limited due to poor inspiration. Endotracheal tube is noted

with its tip 2.5 cm above the carina. Right internal jugular central

venous catheter has been retracted with its tip in the distal SVC.

NG tube overlies the stomach. The distal tip is not visualized. The

trachea is midline. The mediastinal silhouette is normal in

appearance. The cardiac size appears within normal limits. The lungs

ar again demonstrate bilateral airspace opacities most marked in the

left perihilar region without change may represent pneumonia or

edema. There is no evidence of Pleural effusion. There is no evidence

of pneumothorax. The diaphragms are smooth in contour. The

visualized osseous structures are unremarkable.

Impression:

no significant change bilateral airspace opacities.

Lines and tubes, repositioned as above in appropriate position.

Attending Radiologist: MASON, MARYANNA

Ordered By: WEISS, SARAH

Order Date/Time: January 4, 2016 12:50 AM

Scan Initiation Date/Time: January 4, 2016 1:02 AM

Completion Date/Time: January 4, 2016 1:17 AM

Encounter Number: 010095069224

Accession Number: 6535595

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 4, 2016 9:57 AM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/4/2016 5:57:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SEVERE HYPOKALEMIA, OGT REPLACED D/T CLOGGED LINE

Indication

LINE OR TUBE PLACEMENT

Technique

CHEST AP PORTABLE/ER

Comparison

01/04/2016

Findings

All lines are unchanged. no new line is visualized. The

cardiomediastinal silhouette is unchanged. No significant change

noted in the bilateral airspace opacities. There is no pleural

effusion. No pneumothorax is seen.

Impression

Persistent bilateral airspace opacities.

Attending Radiologist: ABBASI, ALMAS

Ordered By: CONLON, JOSEPH

Order Date/Time: January 4, 2016 5:40 AM

Scan Initiation Date/Time: January 4, 2016 5:51 AM

Completion Date/Time: January 4, 2016 5:57 AM

Encounter Number: 010095069224

Accession Number: 6535642

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: January 4, 2016 9:02 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/4/2016 12:18:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

ETT MOVED BACK

Indication

LINE OR TUBE PLACEMENT

Technique

CHEST AP PORTABLE/STAT/ER

Comparison

Prior from the same day.

Findings

ET tube tip is approximately 2.6 cm above carina. All other lines

are unchanged. The cardiomediastinal silhouette is unchanged. No

significant change noted in the bilateral airspace opacities. There

is no pneumothorax.

Impression

ET tube tip is approximately 2.6 cm above carina.

Attending Radiologist: ABBASI, ALMAS

Ordered By: HAMO, CARINE

Order Date/Time: January 4, 2016 11:35 AM

Scan Initiation Date/Time: January 4, 2016 12:01 PM

Completion Date/Time: January 4, 2016 12:18 PM

Encounter Number: 010095069224

Accession Number: 6536276

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: January 4, 2016 12:31 PM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/5/2016 1:46:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/ER

Clinical History

57YO F INTUBATED

Additional History

EVALUATE FOR PNEUMONIA

Technique

Frontal view of the chest.

Comparison

01/04/2016

Findings

Again noted is a right IJ approach central venous catheter with

distal tip at the cavoatrial junction unchanged position. The

endotracheal tube is seen approximately 2.6 cm above the carina in

good position. An enteric tube is seen with tip overlying the

stomach in good position.

There is improved aeration of the left midlung zone. There is no

change in the right peripheral airspace opacity. There is residual

airspace opacity within the right left midlung zone. There are no

large pleural effusions. No pneumothorax.The cardiomediastinal

silhouette is within unchanged.

Impression

Lines and tubes in unchanged position.

Bilateral airspace opacities with improved aeration of the left mid

lung zone.

Attending Radiologist: WEST, STEVEN

Ordered By: SMESTAD, ANDIE LEIGH

Order Date/Time: January 5, 2016 4:00 AM

Scan Initiation Date/Time: January 5, 2016 12:53 AM

Completion Date/Time: January 5, 2016 1:46 AM

Encounter Number: 010095069224

Accession Number: 6537043

Images were reviewed and interpreted by Attending Radiologist: Dr. WEST, STEVEN

Electronically Signed On: January 5, 2016 9:07 AM by Dr. WEST, STEVEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/6/2016 2:17:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Intubated patient

Technique

Single portable frontal view of the chest

Comparison

January 5, 2016

Findings

Tubes and lines are unchanged. There has been interval worsening of

left lung airspace disease, consistent with pneumonia and or

aspiration pneumonitis. Right upper lobe airspace opacity is

persistent, but mildly improved. There are no large pleural

effusions. There is no pneumothorax. Cardiomediastinal silhouette

is unchanged.

Impression

Interval worsening of left lung airspace disease, consistent with

pneumonia and or aspiration pneumonitis. Right upper lobe airspace

opacity is persistent, but mildly improved.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: SMESTAD, ANDIE LEIGH

Order Date/Time: January 6, 2016 4:00 AM

Scan Initiation Date/Time: January 6, 2016 1:53 AM

Completion Date/Time: January 6, 2016 2:17 AM

Encounter Number: 010095069224

Accession Number: 6538691

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: January 6, 2016 10:39 AM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/7/2016 3:27:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

57YO F INTUBATED

Indication

EVALUATE FOR PNEUMONIA

Technique

CHEST AP PORTABLE/ROUT

Comparison

Study on the previous day.

Findings

Endotracheal tube, enteric tube and right IJ catheter are unchanged

in position. Low lung volumes with patchy opacities present within

the left lower lung as well as the peripheral right mid lung. No

pneumothorax. Cardiomediastinal silhouette is stable.

Impression

No significant interval change.

Attending Radiologist: REITER, MICHAEL

Ordered By: SMESTAD, ANDIE LEIGH

Order Date/Time: January 7, 2016 4:00 AM

Scan Initiation Date/Time: January 7, 2016 2:30 AM

Completion Date/Time: January 7, 2016 3:27 AM

Encounter Number: 010095069224

Accession Number: 6540135

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 7, 2016 6:57 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/7/2016 2:08:00 PM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Female Adult Echocardiography Report

Name: LAURA CAPUANO Exam Date/Time: 1/7/2016 1:23:28 PM Heart

Rate: 110

MR #: 30159123 Report Date: 1/7/2016 Heart

Rhythm: Sinus

Tachycardia

ACC #: 6541254 Ht: 165.10 cm BP: 88/61

mmHg

DOB: 11/26/1958 Wt: 56.25 kg Location:

17S MICU

Age/Sex: 57 yearsF BSA: 1.61 m²

Ref. Physician: STRACHAN, cc:

Sonographer: SAJ

Fellow: ML

Indications: R/O ISCHEMIA

History: ABNORMAL EKG

Procedure: Comp. Echo w/contrast - C8929, Definity Contrast - Q9957,

Portable,

Patient Supine and Patient intubated. The use of contrast

was

indicated for enhancement of endocardial border

definition. There

were no contraindications for the use of contrast in this

patient. No

adverse reactions or hemodynamic compromise identified.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 2.52 cm 2.0 - 3.8 LA Diam 2.80 cm 3.0-4.0

IVS 0.82 cm 0.6 - 0.9 LA Area 7.72cm² <=20

LVID 3.65 cm 3.9 - 5.3 3.11 cm LA Vol 24.00 ml 18-58

LVPW 0.75 cm 0.6 - 1.0 LA Vol/BSA 14.87ml/m² 22+ / -6

RA Diam 2.20cm 2.9-4.5

Ao at the sinuses 3.00

Ao Ascending 3.05 cm

Ao Arch 2.59 cm

LVEF 37 % (biplane method of discs)

LV FS 14.8

LV SV 34.1 ml

LV SI 21.1 ml/m²

Aov Cusp Sep 2.10 cm

(Systole)

Aov VTI 0.166 m LVOT VTI 0.135 m LVOT diameter

1.80

cm

Aov VMax 1.10 m/s LVOT Vmax 0.89 m/s Dimensionless

Index 0.81

Aov Pk Pressure 4.8 mmHg Aov Mn 3.0 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 2.07 cm² Aov Area Index 1.28 cm²/m²

(VTI)

MV VTI MV DT 143 msec

MV E Vmax 0.35 m/s MV A Vmax 0.55 m/s E/A 0.63

MV Area press 1/2 Time 5.32

IVRT E/E ' 5.84

Septal E ' 0.050 m/s Prop Velocity

Lateral E ' 0.06 m/s LA Pressure 9.80 mmHg

Average E' 0.055 m/s

MV Average E/E' 6.37

TR Vmax 2.28 m/s TR Pk Grad 20.8 mmHg RA Pressure 3 mmHg RVSP

23.8 mmHg

TV E Max TV Mn Grad mmHg PHT 41.32 msec TV VTI

PV Vmax 1.07 m/s PV Pk Grad 4.6 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is decreased. Ventricular wall thickness is

normal. Moderately reduced global left ventricular systolic function

with diffuse hypokinesis. The ejection fraction is 37% by biplane

method of discs. Left ventricular basal fractional shortening is

decreased. The mid inferior wall is moderately hypokinetic. The mid

inferior septum is moderately hypokinetic. The inferior apex is

moderately hypokinetic. The septal apex is moderately hypokinetic.

Left Ventricle - Diastole:The Doppler derived transmitral left

ventricular inflow velocity pattern is A wave dominant. The Doppler

derived early diastolic deceleration time is short at 143 msec. The

velocity of the early diastolic septal mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.050 m/s. The

velocity of the early diastolic lateral mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.06 m/s. The

overall diastolic function is mildly impaired (grade I, impaired

relaxation pattern) with normal left ventricular filling pressures.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is small in size. Inferior vena cava

diameter is normal (1.5-2.1cm) with normal respiratory variability

consistent with a right atrial pressure of 3 mmHg.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. The right

ventricular diastolic area is 18.60 cm which is normal. The right

ventricular systolic area is 11.00 cm which is normal. The right

ventricular systolic pressure, as estimated using the tricuspid

regurgitation velocity, is 23.8 mmHg.

Aortic Valve: The aortic valve is composed of three leaflets, which

appear normally formed. No evidence of aortic valve insufficiency is

present.

Mitral Valve: The mitral valve is structurally normal. Trace mitral

regurgitation is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Mild

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is not well visualized. Trace

pulmonary regurgitation is seen.

Aorta: The ascending aorta is normal at 3.05 cm. The aortic arch is

normal at 2.59 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.28 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is normal at 23.8 mmHg.

Pericardium: There is a trivial lateral pericardial effusion. Based

on the echocardiographic findings, there is no evidence of tamponade

physiology. The pericardium appears to contain fluid.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Small left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Moderately reduced global left ventricular systolic function with

diffuse hypokinesis.

4. Segmental wall motion abnormalities (see above).

5. Small right atrial size.

6. Mild diastolic dysfunction with normal left ventricular filling

pressures.

7. Normal trileaflet aortic valve.

8. Trace mitral regurgitation.

9. Mild tricuspid regurgitation.

10. Normal aortic root diameter for body size.

11. Normal atrial septum by 2D and color Doppler.

12. Trivial lateral pericardial effusion.

13. No tamponade physiology.

015260 Kathleen Stergiopoulos MD, PhD, FASE, FACC

Electronically signed by 015260 Kathleen Stergiopoulos MD, PhD, FASE,

FACC on 1/7/2016 at 3:18:28 PM

\*\*\* Final \*\*\*

Attending Cardiologist: STERGIOPOULOS, KATHLEEN

Ordered By: SMESTAD, ANDIE LEIGH

Order Date/Time: January 7, 2016 12:55 PM

Scan Initiation Date/Time:

Completion Date/Time: January 7, 2016 2:08 PM

Encounter Number: 010095069224

Accession Number: 6541254

Images were reviewed and interpreted by Attending Cardiologist: Dr. STERGIOPOULOS, KATHLEEN

Electronically Signed On: January 7, 2016 3:18 PM by Dr. STERGIOPOULOS, KATHLEEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/8/2016 9:59:00 AM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

57-year-old with firm abdomen. Evaluate for bowel obstruction.

Technique

Supine abdominal radiograph.

Comparison

CT of the abdomen and pelvis from 01/03/2016.

Findings

Multiple overlying wires limit evaluation of the upper abdomen.

Enteric tube is noted with its tip in the proximal gastric body.

There is a nonspecific bowel gas pattern.

No abnormal intra-abdominal calcifications are identified.

Osseous structures are unremarkable. The lower pelvis is excluded

from the exam.

Impression

Nonspecific bowel gas pattern.

Attending Radiologist: CUNNINGHAM, ROBIN

Ordered By: SMESTAD, ANDIE LEIGH

Order Date/Time: January 8, 2016 9:25 AM

Scan Initiation Date/Time: January 8, 2016 9:49 AM

Completion Date/Time: January 8, 2016 9:59 AM

Encounter Number: 010095069224

Accession Number: 6542282

Images were reviewed and interpreted by Attending Radiologist: Dr. CUNNINGHAM, ROBIN

Electronically Signed On: January 8, 2016 10:16 AM by Dr. CUNNINGHAM, ROBIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/9/2016 2:38:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/ROUT

Clinical History

57YO F INTUBATED

Indication

EVALUATE FOR PNEUMONIA

Technique

Portable chest

Comparison

2 days previously

Findings

An endotracheal tube remains in good position, its tip at the level

of the clavicles. An NG tube remains in good position in stomach.

Right IJ central line remains in good position with its tip at the

caval atrial junction. Patchy airspace consolidations, are again seen

in the bilateral peripheral lung zones, unchanged.

Impression

No significant change

Attending Radiologist: FISHER, PAUL

Ordered By: SMESTAD, ANDIE LEIGH

Order Date/Time: January 9, 2016 4:00 AM

Scan Initiation Date/Time: January 9, 2016 1:52 AM

Completion Date/Time: January 9, 2016 2:38 AM

Encounter Number: 010095069224

Accession Number: 6543358

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: January 9, 2016 10:35 AM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/10/2016 4:23:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATION FOR STROKE

History and Indication

PATIENT INTUBATED

Technique

Contiguous axial slices were obtained from the skull base to the

vertex. Sagittal and coronal reformats were obtained.

Comparison

CT of the head dated 01/03/2016

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There is mild dilatation of the lateral and 3rd ventricles due to

central atrophy. There is no hydrocephalus. There is moderate

cerebral cortical and cerebellar atrophy which are significantly

advanced for the patient's stated age. Correlate with medical in

social history.

There is no mass effect, midline shift or focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No evidence of acute infarct.

Atrophy significantly advanced for the patient's stated age.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: STEFANOWSKI, KAMIL

Order Date/Time: January 10, 2016 12:00 PM

Scan Initiation Date/Time: January 10, 2016 4:08 PM

Completion Date/Time: January 10, 2016 4:23 PM

Encounter Number: 010095069224

Accession Number: 6544342

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: January 10, 2016 4:59 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/10/2016 4:23:00 PM

Report Name: CT ABD AND PELVIS WITH IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

57-year-old female with increasing white blood cell count

Technique

Routine study. Post processed reconstructions included.

Contrast

95 mL 300 Omnipaque intravenous contrast

Comparison

01/03/2016

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: Subtle ground-glass opacities are seen scattered throughout

both lungs in the same distribution as on the prior exam however

improved, less consolidated may represent improving infectious

process, improving edema.

LARGE AIRWAYS: Endotracheal tube is now noted in adequate position

Patent.

PLEURA: Trace left pleural effusion with adjacent compressive

atelectasis. No right effusion or pneumothorax.

HEART and vessels: Normal size. No pathologic pericardial effusion.

Main pulmonary artery measures 3.3 cm may be seen with pulmonary

artery hypertension. Correlate clinically. The thoracic aorta is

normal in caliber.

MEDIASTINUM and HILA: A new right internal jugular central venous

catheter is seen with its tip in the distal SVC. No lymphadenopathy.

AXILLAE: No lymphadenopathy.

Abdomen:

LIVER: Liver is enlarged measuring 20.6 cm in craniocaudad dimension.

Extensive hepatic steatosis and heterogeneity cannot exclude

underlying cirrhosis. . No mass.

BILIARY TRACT: Slight increased attenuation within the gallbladder

may possibly represent small stone and or sludge otherwise

unremarkable No biliary dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: An NG tube is now seen with its tip in the stomach. Mild

dilatation of small bowel loops may represent an ileus without

evidence of obstruction. Diffuse wall thickening of the colon may be

secondary to infectious or inflammatory colitis. Few scattered

sigmoid diverticular are noted

PERITONEUM: Moderate to severe Ascites is now seen throughout the

abdomen and pelvis worsened as compared to the prior exam No free

air, or abscess collection.

RETROPERITONEUM: No lymphadenopathy.

Pelvis:

REPRODUCTIVE ORGANS: Endometrial canal appears mildly prominent and

of low attenuation. Correlate with menstrual status exclude

underlying endometrial pathology. pelvic ultrasound can be obtained

as indicated. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Foley catheter is noted within the urinary bladder.

Unremarkable.

BONES and soft tissues: Within normal limits for age. No focal

lesion. Subcutaneous edema is now seen, worsened

Impression

Colonic wall thickening may be secondary to infectious or

inflammatory colitis. No evidence of bowel obstruction.

Moderate to severe ascites, increased from prior exam. Worsened

subcutaneous edema.

Hepatomegaly and hepatic steatosis. Cirrhosis cannot be excluded.

Correlate with laboratory values No focal hepatic lesion.

Mildly prominent endometrial canal correlate with menstrual status

exclude underlying endometrial pathology. Pelvic ultrasound can be

obtained as indicated.

Improved bilateral airspace opacities with trace residual may be

secondary to improving infection and pulmonary edema

Trace left pleural effusion with adjacent compressive atelectasis.

Dilated pulmonary artery correlate for pulmonary artery hypertension

Attending Radiologist: MASON, MARYANNA

Ordered By: STEFANOWSKI, KAMIL

Order Date/Time: January 10, 2016 12:00 PM

Scan Initiation Date/Time: January 10, 2016 4:12 PM

Completion Date/Time: January 10, 2016 4:23 PM

Encounter Number: 010095069224

Accession Number: 6544343

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 10, 2016 5:06 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/10/2016 4:23:00 PM

Report Name: CT CHEST WITH IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

57-year-old female with increasing white blood cell count

Technique

Routine study. Post processed reconstructions included.

Contrast

95 mL 300 Omnipaque intravenous contrast

Comparison

01/03/2016

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: Subtle ground-glass opacities are seen scattered throughout

both lungs in the same distribution as on the prior exam however

improved, less consolidated may represent improving infectious

process, improving edema.

LARGE AIRWAYS: Endotracheal tube is now noted in adequate position

Patent.

PLEURA: Trace left pleural effusion with adjacent compressive

atelectasis. No right effusion or pneumothorax.

HEART and vessels: Normal size. No pathologic pericardial effusion.

Main pulmonary artery measures 3.3 cm may be seen with pulmonary

artery hypertension. Correlate clinically. The thoracic aorta is

normal in caliber.

MEDIASTINUM and HILA: A new right internal jugular central venous

catheter is seen with its tip in the distal SVC. No lymphadenopathy.

AXILLAE: No lymphadenopathy.

Abdomen:

LIVER: Liver is enlarged measuring 20.6 cm in craniocaudad dimension.

Extensive hepatic steatosis and heterogeneity cannot exclude

underlying cirrhosis. . No mass.

BILIARY TRACT: Slight increased attenuation within the gallbladder

may possibly represent small stone and or sludge otherwise

unremarkable No biliary dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: An NG tube is now seen with its tip in the stomach. Mild

dilatation of small bowel loops may represent an ileus without

evidence of obstruction. Diffuse wall thickening of the colon may be

secondary to infectious or inflammatory colitis. Few scattered

sigmoid diverticular are noted

PERITONEUM: Moderate to severe Ascites is now seen throughout the

abdomen and pelvis worsened as compared to the prior exam No free

air, or abscess collection.

RETROPERITONEUM: No lymphadenopathy.

Pelvis:

REPRODUCTIVE ORGANS: Endometrial canal appears mildly prominent and

of low attenuation. Correlate with menstrual status exclude

underlying endometrial pathology. pelvic ultrasound can be obtained

as indicated. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Foley catheter is noted within the urinary bladder.

Unremarkable.

BONES and soft tissues: Within normal limits for age. No focal

lesion. Subcutaneous edema is now seen, worsened

Impression

Colonic wall thickening may be secondary to infectious or

inflammatory colitis. No evidence of bowel obstruction.

Moderate to severe ascites, increased from prior exam. Worsened

subcutaneous edema.

Hepatomegaly and hepatic steatosis. Cirrhosis cannot be excluded.

Correlate with laboratory values No focal hepatic lesion.

Mildly prominent endometrial canal correlate with menstrual status

exclude underlying endometrial pathology. Pelvic ultrasound can be

obtained as indicated.

Improved bilateral airspace opacities with trace residual may be

secondary to improving infection and pulmonary edema

Trace left pleural effusion with adjacent compressive atelectasis.

Dilated pulmonary artery correlate for pulmonary artery hypertension

Attending Radiologist: MASON, MARYANNA

Ordered By: STEFANOWSKI, KAMIL

Order Date/Time: January 10, 2016 12:00 PM

Scan Initiation Date/Time:

Completion Date/Time: January 10, 2016 4:23 PM

Encounter Number: 010095069224

Accession Number: 6544344

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 10, 2016 5:06 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/11/2016 2:02:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Patient intubated to evaluate for pneumonia.

Technique

AP portable view of the chest.

Comparison

Prior studies most recently 01/09/2016

Findings

PORTABLE CHEST:

A single projection of the chest reveals unchanged position of ET

tube above the carina, right jugular venous catheter tip at

cavoatrial junction, and NG tube tip and side port in the stomach.

Films demonstrate low lung volumes which limit the evaluation

resulting in crowding of vessels and exaggeration of the heart size.

No acute focal consolidation is evident. Continued improvement with

trace residual bilateral opacities. No large pleural effusions.

Impression

No new acute focal consolidation allowing for limitations due to low

lung volumes. Trace residual bilateral opacities significantly

demonstrating continued significant improvement.

Attending Radiologist: CUNNINGHAM, ROBIN

Ordered By: STEFANOWSKI, KAMIL

Order Date/Time: January 11, 2016 4:00 AM

Scan Initiation Date/Time: January 11, 2016 12:58 AM

Completion Date/Time: January 11, 2016 2:02 AM

Encounter Number: 010095069224

Accession Number: 6544518

Images were reviewed and interpreted by Attending Radiologist: Dr. CUNNINGHAM, ROBIN

Electronically Signed On: January 11, 2016 8:59 AM by Dr. CUNNINGHAM, ROBIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/17/2016 11:41:00 AM

Report Name: ULTRASOUND SUBPHREN SP/ASCITE

Examination

ULTRASOUND SUBPHREN SP/ASCITE/ROUT

Clinical History

S/P 2.8 L PARACENTESIS ON 1-12, CHECKING FOR REACCUMULATION

Indication

EVALUATE ASCITES

Technique

Limited ultrasonographic imaging of 4 quadrants of the abdomen

Technologist Comments

Comparison

None.

Findings

Moderate to severe ascites is seen without evidence of septations.

Impression

Moderate to severe ascites with the largest pocket of fluid in the

right lower quadrant.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 16, 2016 6:55 PM

Scan Initiation Date/Time: January 17, 2016 11:18 AM

Completion Date/Time: January 17, 2016 11:41 AM

Encounter Number: 010095069224

Accession Number: 6552824

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: January 17, 2016 12:09 PM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/18/2016 5:38:00 PM

Report Name: PARACENTESIS W/IMAGE INC ALL

Clinical History

Ascites

Technique

PROCEDURE:

Risks, benefits, and alternatives were discussed with the patient's

proxy, who appeared to understand and granted informed consent.

Patient placed in the supine position while in the stretcher. Nurse

monitoring was performed throughout the entire procedure. Limited

initial ultrasound of the abdomen was performed and images were

stored.

A suitable entry site was marked, prepped and draped in the usual

sterile fashion. Following administration of 1% lidocaine anesthetic,

and using real-time ultrasound guidance,a 5 French Yueh catheter

needle was advanced into the peritoneal cavity and another image was

stored.

The catheter was advanced, connected to suction, and fluid was

removed in the usual manner. The catheter was removed and a sterile

dressing was applied. The patient tolerated the procedure well

without immediate complication. The attending interventional

radiologist Dr. Maleson was present and supervised the entire

procedure.

FINDINGS:

Limited initial ultrasound reveals a small pocket of ascites on the

right. There was successful ultrasound-guided paracentesis as

described. 3.9 liters of clear yellow fluid readily drained.

Impression

Successful ultrasound-guided paracentesis. 3.9 liters removed.

Attending Radiologist: MALESON, ANDREW

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 18, 2016 4:23 PM

Scan Initiation Date/Time: January 18, 2016 4:32 PM

Completion Date/Time: January 18, 2016 5:38 PM

Encounter Number: 010095069224

Accession Number: 6553165

Images were reviewed and interpreted by Attending Radiologist: Dr. MALESON, ANDREW

Electronically Signed On: January 20, 2016 3:30 PM by Dr. MALESON, ANDREW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/20/2016 2:27:00 PM

Report Name: MYO PERF SPECT MULTI W/WALL EJ

Report :

MYOCARDIAL PERFUSION IMAGING:

Please refer to the combined Cardiology/Nuclear Medicine report for

complete patient results.

Study was interpreted by Dr. Katz and Dr. Franceschi.

IMPRESSION:

Please refer to the combined Cardiology/Nuclear Medicine report for

complete patient results.

Attending Radiologist: FRANCESCHI, DINKO

Ordered By: ABBENE, DEA

Order Date/Time: January 20, 2016 9:05 AM

Scan Initiation Date/Time: January 20, 2016 11:53 AM

Completion Date/Time: January 20, 2016 2:27 PM

Encounter Number: 010095069224

Accession Number: 6556711

Images were reviewed and interpreted by Attending Radiologist: Dr. FRANCESCHI, DINKO

Electronically Signed On: January 20, 2016 5:51 PM by Dr. FRANCESCHI, DINKO

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/20/2016 1:09:00 PM

Report Name: REGADENOSON STRESS TEST

Results

Test Type: Regadenoson/Sestamibi/SPECT Imaging

Stony Brook University Hospital

Ht:(in.): 66 Wt:(lbs.): 138 Previous study: No

Clinical indication: Ejection fraction on echocardiogram 37 percent.

Patient admitted with altered mental status admitted to MICU with

aspiration pneumonia and liver dysfunction. Status post

paracentesis.

History: Anemia, ETOH

CAD risk factors: age, active tobacco smoker unknown amount for

approximately 40 years.

Medications: Carvedilol, folic acid, Lasix, lactulose, multivitamin,

Protonix, Aldactone, thiamine, Pentoxifylline, rifaximin

Site location: University Hospital

Stress lab staff: Susan Clarke RN, J. Swartz NP

Nuclear Technologist: Samantha Claros CNMT, Anthony Boccia CNMT

Date of stress imaging: 01/20/2016 Date of rest

imaging: 01/20/2016

Pre-stress ECG interpretation

Rate: 81 beats/minute PR: 0.16 sec. QRS: 0.08 sec. QT:

0.44 sec.

Sinus rhythm, Early precordial R wave transition in lead V2, T wave

inversions in leads I, II, V5 and V6, T wave flattening in leads AVF

and V4

Protocol: Intravenous Regadenoson

0.4 mg of regadenoson was administered as a rapid intravenous

injection followed by 5 ml of an intravenous saline flush. The

resting heart rate and blood pressure were 81 beats/minute and 99/69

mmHg. The heart rate and blood pressure at maximal vasodilation were

100 beats/minute and 83/68 mmHg.

Low level treadmill exercise during regadenoson administration: No.

ECG changes: There were no significant new electrocardiographic ST

segment changes.

Arrhythmias: None.

Symptoms: None.

Transient physical findings: None.

The patient underwent SPECT myocardial perfusion imaging following

the intravenous injection of 39.5 millicuries of technetium-99m

sestamibi at peak pharmacologic stress and 11.7 millicuries of

technetium-99m sestamibi at rest. Stress cardiac images were acquired

utilizing a gated tomographic technique.

Nuclear Imaging Results

The overall quality of the study was: Good.

Study artifacts: None identified.

Left ventricular cavity size: Relatively small left ventricular

chamber size.

Transient ischemic dilation (TID): No.

TID ratio: 1.03

Myocardial perfusion images: Normal left ventricular myocardial

perfusion pattern. A photopenic region was noted just superior to the

liver on review of both the stress and resting sets of rotational

cardiac images and may represent abdominal ascites. Clinical

correlation is advised.

Left ventricular ejection fraction: 67%.

Post-stress gated SPECT wall motion analysis: Normal left ventricular

myocardial wall thickening and excursion.

Impression

1. Normal regadenoson technetium-99m sestamibi perfusion scintigraphy

demonstrating no evidence of myocardial infarction or ischemia. A

photopenic region was noted just superior to the liver on review of

both the stress and resting sets of rotational cardiac images and may

represent abdominal ascites. Clinical correlation is advised..

2. Normal hemodynamic response to regadenoson.

3. No significant new electrocardiographic ST segment changes after

regadenoson administration.

4. The post-stress gated cardiac images revealed normal left

ventricular myocardial wall thickening and excursion.

5. The calculated left ventricular ejection fraction was 67%.

The study was supervised by Dr. Jordan Katz.

The study was interpreted by Dr. Jordan Katz and Dr. Dinko

Franceschi.

Dr. Dinko Franceschi personally provided the nuclear myocardial

perfusion imaging services for this exam.

Attending Cardiologist: KATZ, JORDAN

Ordered By: ABBENE, DEA

Order Date/Time: January 19, 2016 5:35 PM

Scan Initiation Date/Time: January 20, 2016 11:53 AM

Completion Date/Time: January 20, 2016 1:09 PM

Encounter Number: 010095069224

Accession Number: 6556318

Images were reviewed and interpreted by Attending Cardiologist: Dr. KATZ, JORDAN

Electronically Signed On: January 20, 2016 4:02 PM by Dr. KATZ, JORDAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095069224

Report Date/Time: 1/21/2016 12:25:00 AM

Report Name: ULTRASOUND SUBPHREN SP/ASCITE

Examination

Subphrenic ultrasound.

Clinical History

Evaluate for ascites. Patient with recurrent ascites.

Technique

Limited gray scale ultrasound images obtained of the right upper and

right lower quadrants of the abdomen.

Comparison

Ultrasound subphrenic ultrasound from 01/17/2016 .

Findings

Moderate to severe ascites without internal septations identified.

This study is severely limited in the evaluation of abdominal

viscera. Within these limits, no gross abnormality is identified.

Impression

Moderate to severe ascites without internal septations identified.

Attending Radiologist: MANKES, SETH

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 20, 2016 7:20 PM

Scan Initiation Date/Time: January 21, 2016 12:02 AM

Completion Date/Time: January 21, 2016 12:25 AM

Encounter Number: 010095069224

Accession Number: 6557992

Images were reviewed and interpreted by Attending Radiologist: Dr. MANKES, SETH

Electronically Signed On: January 21, 2016 9:12 AM by Dr. MANKES, SETH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/4/2016 5:37:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Chest pain.

Technique

AP portable radiograph of the chest.

Comparison

Radiograph of the chest from 06/22/2014

Findings

There is no focal consolidation, large pleural effusion,

pneumothorax. The cardiac silhouette is within normal size limits.

There are degenerative changes of the visualized osseous structures.

Mild pulmonary vascular congestion.

Impression

Mild pulmonary vascular congestion.

Attending Radiologist: EISENBERG, JASON

Ordered By: LIU, YUCHEN

Order Date/Time: January 4, 2016 5:00 PM

Scan Initiation Date/Time: January 4, 2016 5:34 PM

Completion Date/Time: January 4, 2016 5:37 PM

Encounter Number: 010095110994

Accession Number: 6537072

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: January 4, 2016 6:05 PM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/4/2016 5:48:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

AMS

History and Indication

ACUTE AMS

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

Comparison is made to CT of the head from 06/22/2014.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

Midline posterior fossa arachnoid cyst is again noted and unchanged

since the prior exam.

There is mild age-related volume loss and periventricular white

matter hypodensity most compatible with chronic small vessel disease

without significant interval change since the prior exam.

There is no mass effect or midline shift.

There is no intracranial hemorrhage or extra-axial collection. There

are dense atherosclerotic calcifications of the bilateral carotid

siphons.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No acute intracranial hemorrhage or territorial infarction.

Microvascular ischemic disease and involutional change without

significant interval change since the prior exam. Stable midline

posterior fossa arachnoid cyst.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: LIU, YUCHEN

Order Date/Time: January 4, 2016 5:00 PM

Scan Initiation Date/Time: January 4, 2016 5:42 PM

Completion Date/Time: January 4, 2016 5:48 PM

Encounter Number: 010095110994

Accession Number: 6537076

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: January 4, 2016 6:11 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/4/2016 8:25:00 PM

Report Name: ULTRASOUND KIDNEYS BILATERAL PORTABLE

Examination

Renal ultrasound.

Clinical History

Evaluate for acute kidney injury.

Technique

Grayscale ultrasound and color Doppler interrogation were utilized to

evaluate the kidneys.

Comparison

Ultrasound of the kidneys from 06/22/2014 .

Findings

The right kidney is 11 x 5.9 x 6.0 cm in size.

The left kidney is 11.5 x 1.6 x 5.2 cm in size.

Bilateral kidneys are mildly echogenic without significant interval

change since the prior exam.

There is no hydronephrosis. No renal calculi are visualized, but CT

scan is more sensitive for detection of small renal calculi and

sequelae The renal parenchyma is mildly echogenic without significant

interval change since the prior exam.

The urinary bladder is unremarkable.

Impression

Bilateral echogenic kidneys without significant interval change which

likely represents medical renal disease. No hydronephrosis.

Attending Radiologist: FELDMANN, ERIC

Ordered By: KIM, JUNG

Order Date/Time: January 4, 2016 7:30 PM

Scan Initiation Date/Time: January 4, 2016 8:03 PM

Completion Date/Time: January 4, 2016 8:25 PM

Encounter Number: 010095110994

Accession Number: 6537214

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 4, 2016 9:34 PM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/4/2016 11:25:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Chest pain

Line placement

Technique

Single frontal view of the chest

Comparison

01/04/2016

Findings

PORTABLE CHEST:

There is been interval placement of a right internal jugular approach

central venous catheter. The tip is in the superior vena cava.

There is persistent mild pulmonary vascular congestion. There is no

pneumothorax or pleural effusion. Cardiomediastinal contours are

grossly unchanged.

Impression

Right IJ catheter tip in SVC. No pneumothorax.

Stable mild pulmonary vascular congestion.

Attending Radiologist: EISENBERG, JASON

Ordered By: KIM, JUNG

Order Date/Time: January 4, 2016 10:50 PM

Scan Initiation Date/Time: January 4, 2016 11:15 PM

Completion Date/Time: January 4, 2016 11:25 PM

Encounter Number: 010095110994

Accession Number: 6537327

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: January 4, 2016 11:32 PM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/4/2015 8:11:00 PM

Report Name: PARTIAL ECHO

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: JOHN BIEGEL Exam Date: 1/4/2016 at 8:01:58 PM Heart Rate:

88

MR #: 00146821 Report Date: 1/5/2016 Rhythm:

Sinus Rhythm

ACC #: 6537578 Height: 180.34 cm BP: /

DOB: 3/6/1939 Weight: 86.18 kg Location:

4L ER

Age/Sex: 76 years / M BSA: 2.06 m²

Ref. Physician: Dr. Peter Viccellio, cc:

Sonographer: ML

Indications: CHF

Procedure: Limited Doppler - 93321, Limited Echo - 93308, Color Flow

Imaging -

93325, Portable, Stat, On call and Fellow Study.

Study Quality: This was a technically difficult study.

Left Ventricle - Structure and Systolic Function: Global left

ventricular systolic function is normal. No regional wall motion

abnormalities are seen.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal.

Aortic Valve: The aortic valve is trileaflet with normal excursion.

Mitral Valve: The mitral valve is structurally normal.

Tricuspid Valve: The tricuspid valve is structurally normal.

Pulmonic Valve: The pulmonic valve is normal.

Pericardium: No pericardial effusion seen.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 1/18/11. Compared to the prior study, a partial study was now

performed and less information provided.

Summary:

1. Normal global left ventricular systolic function.

2. No regional left ventricular wall motion abnormalities.

3. Not all segments of the left ventricle were well imaged.

4. Normal right ventricular systolic function.

5. Trileaflet aortic valve with normal excursion.

6. No pericardial effusion.

014970 Smadar Kort MD, FACC, FASE

Electronically signed by 014970 Smadar Kort MD, FACC, FASE on

1/5/2016 at 9:12:40 AM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: VICCELLIO, PETER

Order Date/Time: January 5, 2016 7:10 AM

Scan Initiation Date/Time:

Completion Date/Time: January 4, 2015 8:11 PM

Encounter Number: 010095110994

Accession Number: 6537578

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: January 5, 2016 9:12 AM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/6/2016 8:58:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/URGENT

Clinical History

76YO M AMS RHONCHUS BREATH SOUNDS

Additional History

EVALUATE FOR PNEUMONIA

Technique

Frontal view of the chest.

Comparison

01/04/2016

Findings

There is a right IJ approach intravenous catheter with distal tip at

the cavoatrial junction. There is interval worsening of the

pulmonary vascular congestion now moderate. There are small

bilateral pleural effusions. There is no focal consolidation, or

pneumothorax. The cardiomediastinal silhouette is unchanged.

Impression

Worsening pulmonary vascular congestion with small bilateral pleural

effusions.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: SMESTAD, ANDIE LEIGH

Order Date/Time: January 6, 2016 8:15 AM

Scan Initiation Date/Time: January 6, 2016 8:38 AM

Completion Date/Time: January 6, 2016 8:58 AM

Encounter Number: 010095110994

Accession Number: 6539085

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: January 6, 2016 10:09 AM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/6/2016 1:40:00 PM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: JOHN F BIEGEL Exam Date: 1/6/2016 at 12:37:20 PM Heart

Rate: 64

MR #: 00146821 Report Date: 1/6/2016 Rhythm:

Sinus Rhythm

ACC #: 6538836 Height: 172.72 cm BP: 148/60

DOB: 3/6/1939 Weight: 81.19 kg Location:

17S MICU

Age/Sex: 76 years / M BSA: 1.95 m²

Ref. Physician: STRACHAN, cc:

Sonographer: SAJ

Indications: R/O ISCHEMIA

History: BUNDLE BRANCH BLOCK, CP, SLEEP APNEA, IDDM, NEUROPATHY,

SPINAL

STENOSIS, DMII, HTN,

Procedure: Comp. Echo w/contrast - C8929, Definity Contrast - Q9957,

Patient

Supine and Portable. The use of contrast was indicated for

enhancement of endocardial border definition. There were no

contraindications for the use of contrast in this patient.

No adverse

reactions or hemodynamic compromise identified.

Study Quality: This was a technically difficult study.

Measurements and Calculations

Diast Nl Syst Nl

RV 2.73 cm 2.0 - 3.8 LA Diam 3.52 cm 3.0-4.0

IVS 0.98 cm 0.6 - 1.0 LA Area 24.40cm² <=20

LVID 5.06 cm 4.2 - 5.9 3.95 cm LA Vol 88.00 ml 18-58

LVPW 0.95 cm 0.6 - 1.0 LA Vol/BSA 45.13ml/m² 22+ / -6

RA Diam 5.01cm 2.9-4.5

Ao at the sinuses 3.54 cm

Ao Ascending 3.23 cm

Ao Arch 3.20 cm

LVEF 55 % (visual estimation)

LV FS 21.8

Aov Cusp Sep 2.19 cm

(Systole)

Aov VTI 0.190 m LVOT VTI 0.118 m LVOT diameter

1.97

cm

Aov VMax 1.13 m/s LVOT Vmax 0.72 m/s Dimensionless

Index 0.64

Aov Pk Pressure 5.1 mmHg Aov Mn 2.1 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 1.89 cm² Aov Area Index 0.97 cm²/m²

(VTI)

MV VTI MV DT 235 msec

MV E Vmax 0.62 m/s MV A Vmax 0.65 m/s E/A 0.96

MV Area press 1/2 Time 3.22

IVRT E/E ' 6.92

Septal E ' 0.070 m/s Prop Velocity

Lateral E ' 0.09 m/s LA Pressure 11.55 mmHg

Average E' 0.080 m/s

MV Average E/E' 7.78

TV E Max TV Mn Grad PHT 68.23 msec TV VTI

PV Vmax 0.84 m/s PV Pk Grad 2.8 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

normal. The interventricular septum has a sigmoid configuration. This

is often a normal variant with aging. The relative wall thickness is

normal (0.38). Global left ventricular systolic function is normal.

The ejection fraction is 55% by visual estimation. Left ventricular

basal fractional shortening is decreased. No regional wall motion

abnormalities are seen.

Left Ventricle - Diastole:The Doppler derived transmitral left

ventricular inflow velocity pattern is A wave dominant. The Doppler

derived early diastolic deceleration time is normal at 235 msec. The

velocity of the early diastolic septal mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.070 m/s. The

velocity of the early diastolic lateral mitral annular movement, as

determined by tissue Doppler imaging is reduced at 0.09 m/s. The

overall diastolic function is mildly impaired (grade I, impaired

relaxation pattern) with normal left ventricular filling pressures.

Left Atrium: The left atrium is severely dilated in size.

Right Atrium: The right atrium is moderately dilated in size.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. The right

ventricular diastolic area is 20.01 cm which is normal. The right

ventricular systolic area is 13.23 cm which is normal. Global right

ventricular systolic function is normal. The right ventricular

fractional area change is 33.88% which is normal. The tricuspid

annular plane systolic excursion is 1.86 cm consistent with normal

right ventricular systolic function.

Aortic Valve: The aortic valve is trileaflet with normal excursion.

Normal Doppler interrogation flow patterns without stenosis or

insufficiency.

Mitral Valve: The mitral valve is structurally normal. Trace mitral

regurgitation is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Trace

tricuspid regurgitation is present. The degree of tricuspid

regurgitation was not sufficient for accurate calculation of

pulmonary artery systolic pressure.

Pulmonic Valve: The pulmonic valve is normal.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.54 cm. The ascending aorta is normal at 3.23 cm. The

aortic arch is normal at 3.20 cm.

Pericardium: No pericardial effusion seen.

Miscellaneous: Right pleural effusion noted.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 1/4. There is no significant change in the findings since the

last echocardiogram.

Summary:

1. Normal left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Normal global left ventricular systolic function.

4. No regional left ventricular wall motion abnormalities.

5. Mild diastolic dysfunction with normal left ventricular filling

pressures.

6. Normal right ventricular systolic function.

7. Severely dilated left atrial size.

8. Moderately dilated right atrial size.

9. Normal atrial septum by 2D and color Doppler.

10. Trileaflet aortic valve with normal excursion.

11. No aortic stenosis or insufficiency.

12. Trace mitral regurgitation.

13. Trace tricuspid regurgitation.

14. Normal aortic root diameter for body size.

15. No pericardial effusion.

16. Right pleural effusion.

014970 Smadar Kort MD, FACC, FASE

Electronically signed by 014970 Smadar Kort MD, FACC, FASE on

1/6/2016 at 2:19:56 PM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: SANKARI, LAYLA

Order Date/Time: January 5, 2016 7:50 PM

Scan Initiation Date/Time:

Completion Date/Time: January 6, 2016 1:40 PM

Encounter Number: 010095110994

Accession Number: 6538836

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: January 6, 2016 2:19 PM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/9/2016 6:16:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

NG tube placement.

Technique

AP portable view of the chest.

Comparison

01/06/2016.

Findings

There is a central venous catheter with tip overlying the superior

vena cava. Enteric tube with tip in the stomach.

The left costophrenic angle and left margin of the chest are excluded

on this study.

Again seen are bilateral pulmonary vascular congestion, stable from

prior study. Cardiomediastinal silhouette is stable from prior study.

There is no evidence of pneumothorax.

Impression

Lines and tubes as described above. The tip of the nasogastric tube

overlies the stomach.

Bilateral pulmonary vascular congestion, grossly unchanged from prior

study.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: STAMORAN, VLADIMIR

Order Date/Time: January 9, 2016 5:25 PM

Scan Initiation Date/Time: January 9, 2016 5:51 PM

Completion Date/Time: January 9, 2016 6:16 PM

Encounter Number: 010095110994

Accession Number: 6543925

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 9, 2016 6:24 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/10/2016 1:52:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/STAT

Clinical History

EVALUATE FOR NGT

Indication

EVALUATE FOR NGT

Technique

Lower chest and upper abdomen. Dedicated examination for NG tube

position, not intended for full evaluation of the chest.

Technologist Comments

Comparison

01/09/2016.

Findings

The nasogastric tube has been advanced and its tip is now in the

distal body of the stomach.

In the visualized portions of the lungs there is increased airspace

opacity with relative peripheral sparing likely representing

worsening pulmonary edema.

Tip of a Quentin catheter is noted in the superior vena cava.

Impression

NG tube has been advanced to the distal body of the stomach.

Visualized portions of the lungs show increased pulmonary edema.

Attending Radiologist: BALSAM, DVORAH

Ordered By: BHASHYAM, SANDEEP

Order Date/Time: January 10, 2016 12:20 AM

Scan Initiation Date/Time: January 10, 2016 1:28 AM

Completion Date/Time: January 10, 2016 1:52 AM

Encounter Number: 010095110994

Accession Number: 6544117

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: January 10, 2016 9:15 AM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/14/2016 2:07:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/STAT

Clinical History

EVALUATE FOR SOB

Additional History

EVALUATE FOR SOB

Technique

Frontal view of the chest.

Comparison

01/10/2016

Findings

Again noted is a right IJ approach intravenous catheter with distal

tip within the SVC. There is an enteric tube which courses below the

left hemidiaphragm. There is no significant interval change in the

diffuse increased airspace opacities and moderate pulmonary vascular

congestion. There is a small right-sided pleural effusion. There is

no pneumothorax. There is suggestion of right apical pleural

thickening. The cardiac silhouette is unchanged. The aortic knob is

calcified.

Impression

Lines and tubes in unchanged position.

Unchanged diffuse increased alveolar opacities likely representing

pulmonary edema.

Attending Radiologist: WEST, STEVEN

Ordered By: BHASHYAM, SANDEEP

Order Date/Time: January 14, 2016 1:00 AM

Scan Initiation Date/Time: January 14, 2016 1:30 AM

Completion Date/Time: January 14, 2016 2:07 AM

Encounter Number: 010095110994

Accession Number: 6549269

Images were reviewed and interpreted by Attending Radiologist: Dr. WEST, STEVEN

Electronically Signed On: January 14, 2016 10:46 AM by Dr. WEST, STEVEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/14/2016 9:36:00 AM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR CHANGE IN CONSCIOUSNESS

History and Indication

76 HISTORY OF CHRONIC DEMYELINATING POLYNEUROPATHY, DM, OSA, HTN,

PRESENTED WITH ACUTE ONSET OF CONFUSION.

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

No images available for comparison.

Findings

Stable midline posterior fossa arachnoid cyst is noted. there is no

intracranial hemorrhage or extra-axial collection. There is no mass

effect or midline shift.

There is no loss of gray-white matter distinction or other signs of

acute transcortical infarction.

The ventricles, cisterns and sulci are age appropriate in size.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

1. No acute intracranial hemorrhage or transcortical infarction.

2. Stable arachnoid cyst.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: BHASHYAM, SANDEEP

Order Date/Time: January 14, 2016 2:00 AM

Scan Initiation Date/Time: January 14, 2016 9:27 AM

Completion Date/Time: January 14, 2016 9:36 AM

Encounter Number: 010095110994

Accession Number: 6549282

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: January 14, 2016 10:34 AM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/14/2016 9:25:00 AM

Report Name: RAD PROCEDURE WO GUIDANCE

Clinical History

Request for removal of a non tunneled dialysis catheter. Patient no

longer requires the device.

Technique

Risks, benefits, and alternatives to removal of a non tunneled

dialysis catheter were discussed with the patient and informed

written consent was obtained. He was brought to the examination room

in a stretcher. Exposed Quentin catheter and adjacent skin were

prepped with 2 percent chlorhexidine solution and draped. Catheter

was removed with manual traction. Hemostasis was obtained with manual

pressure. Sterile dressing was applied; the patient was sent back to

his hospital room having tolerated the procedure well.

Comparison

None.

Findings

Quentin catheter removed in entirety.

Impression

Technically successful removal of a non tunneled dialysis catheter.

No immediate postprocedure complications.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: STAMORAN, VLADIMIR

Order Date/Time: January 13, 2016 2:15 PM

Scan Initiation Date/Time:

Completion Date/Time: January 14, 2016 9:25 AM

Encounter Number: 010095110994

Accession Number: 6548673

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: January 18, 2016 1:12 PM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/18/2016 7:58:00 PM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Examination

PA and lateral views of the chest

Clinical History

Non ST elevation MI

Technique

PA and lateral chest radiograph

Comparison

Radiograph 01/14/2016

Findings

Interval decrease in conspicuity of pulmonary vascular congestion

with mild residual. Small bilateral pleural effusions are noted with

subjacent atelectasis. No focal consolidation or pneumothorax. The

cardiomediastinal silhouette is unchanged. Interval removal of

enteral tube.

Impression

Improving pulmonary vascular congestion, now mild in severity.

Small bilateral pleural effusions .

interval removal of the enteric tube. No pneumothorax.

Attending Radiologist: AREMAN, DAVID

Ordered By: KRIEGSFELD, TERESA

Order Date/Time: January 18, 2016 11:50 AM

Scan Initiation Date/Time: January 18, 2016 7:56 PM

Completion Date/Time: January 18, 2016 7:58 PM

Encounter Number: 010095110994

Accession Number: 6554063

Images were reviewed and interpreted by Attending Radiologist: Dr. AREMAN, DAVID

Electronically Signed On: January 19, 2016 9:02 AM by Dr. AREMAN, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/19/2016 11:31:00 AM

Report Name: REGADENOSON STRESS TEST

Results

Test Type: Regadenoson/Sestamibi/SPECT Imaging

Stony Brook University Hospital

Ht:(in.): 68 Wt:(lbs.): 170 Previous study: No.

Clinical indication: CAD, positive troponin leak and a BNP of 18498,

admitted January 4, 2016 with altered mental status.

History: Type 2 diabetes, hypertension, OSA, AKI on hemodialysis.

CAD risk factors: Age.

Medications: Insulin, Zofran, Flomax, thiamine, Effexor, Tylenol,

Dilaudid, heparin.

Site location: University Hospital

Stress lab staff: M.Chapman CVT, J.Swartz NP

Nuclear Technologist: Samantha Claros CNMT, Anthony Boccia CNMT

Date of stress imaging: 01/19/2016 Date of rest

imaging: 01/19/2016

Pre-stress ECG interpretation

Rate: 75 beats/minute PR: 0.18 sec. QRS: 0.08 sec. QT:

0.40 sec.

Sinus rhythm inferior and lateral ST T wave abnormality

Protocol: Intravenous Regadenoson

0.4 mg of regadenoson was administered as a rapid intravenous

injection followed by 5 ml of an intravenous saline flush. The

resting heart rate and blood pressure were 75 beats/minute and 142/82

mmHg. The heart rate and blood pressure at maximal vasodilation were

84 beats/minute and 111/61 mmHg.

Low level treadmill exercise during regadenoson administration: No.

ECG changes: No significant ST change above abnormal baseline

Arrhythmias: Rare isolated PVCs.

Symptoms: Shortness of breath and nausea.

Transient physical findings: Aminophylline 125 milligrams IV push

given.

The patient underwent SPECT myocardial perfusion imaging following

the intravenous injection of 39 millicuries of technetium-99m

sestamibi at peak pharmacologic stress and 12.9 millicuries of

technetium-99m sestamibi at rest. Stress cardiac images were acquired

utilizing a gated tomographic technique.

Nuclear Imaging Results

The overall quality of the study was: Good

Study artifacts: None

Left ventricular cavity size: Normal. The left ventricular

end-diastolic volume is 140 mL

Transient ischemic dilation (TID):Absent

TID ratio: 1.09

Myocardial perfusion images: Demonstrates a moderate-sized partially

reversible defect of mild to moderate intensity of the anteroapical

and apical walls consistent with a partial thickness infarction with

mild ischemia.

Left ventricular ejection fraction: 35%.

Post-stress gated SPECT wall motion analysis: Decreased apical wall

thickening with severe apical hypokinesis.

Impression

1. Abnormal regadenoson technetium-99m sestamibi perfusion

scintigraphy demonstrating a partial-thickness anterior apical and

apical infarction with mild ischemia..

2. Normal hemodynamic response to regadenoson.

3. No significant electrocardiographic ST segment changes after

regadenoson administration.

4. The post-stress gated cardiac images revealed Decreased apical

wall thickening with severe apical hypokinesis.

5. The calculated left ventricular ejection fraction was 35%.

6. Cardiology consult team notified of test results.

The study was supervised by Dr. Noelle Mann.

The study was interpreted by Dr. Noelle Mann and Dr. Franceschi.

Dr. Mann personally provided the nuclear myocardial perfusion imaging

services for this exam.

Attending Cardiologist: MANN, NOELLE

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 18, 2016 3:45 PM

Scan Initiation Date/Time: January 19, 2016 9:54 AM

Completion Date/Time: January 19, 2016 11:31 AM

Encounter Number: 010095110994

Accession Number: 6554499

Images were reviewed and interpreted by Attending Cardiologist: Dr. MANN, NOELLE

Electronically Signed On: January 19, 2016 5:22 PM by Dr. MANN, NOELLE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095110994

Report Date/Time: 1/19/2016 12:31:00 PM

Report Name: MYO PERF SPECT MULTI W/WALL EJ

Report :

MYOCARDIAL PERFUSION IMAGING:

Please refer to the combined Cardiology/Nuclear Medicine report for

complete patient results.

Study was interpreted by Dr. Mann and Dr. Franceschi.

IMPRESSION:

Please refer to the combined Cardiology/Nuclear Medicine report for

complete patient results.

Attending Radiologist: FRANCESCHI, DINKO

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 19, 2016 9:05 AM

Scan Initiation Date/Time: January 19, 2016 9:54 AM

Completion Date/Time: January 19, 2016 12:31 PM

Encounter Number: 010095110994

Accession Number: 6555044

Images were reviewed and interpreted by Attending Radiologist: Dr. FRANCESCHI, DINKO

Electronically Signed On: January 19, 2016 5:58 PM by Dr. FRANCESCHI, DINKO

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095127337

Report Date/Time: 1/5/2016 5:13:00 PM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/URGENT

Clinical History

HIV, HCV, OSTEO ON IV ABX, WITH ANEMIA. CONFIRM PICC PLACEMENT

Additional History

LINE OR TUBE PLACEMENT

Technique

Dedicated chest radiograph for PICC placement.

Comparison

11/10/2015

Findings

There is a right approach PICC line with distal tip at the cavoatrial

junction. There is no evidence of an unintended radiopaque foreign

body.There are mild increased bronchovascular markings which may

represent mild pulmonary vascular congestion. There is no focal

consolidation, large pleural effusions, pneumothorax. The

cardiomediastinal silhouette is within normal limits.Degenerative

changes of the right glenohumeral joint are present. Evaluation of

the left hemi thorax is somewhat limited as the study was performed

for right PICC evaluation.

Impression

Right approach PICC line with the distal tip at the cavoatrial

junction.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: SACKHEIM, JULIA

Order Date/Time: January 5, 2016 4:10 PM

Scan Initiation Date/Time: January 5, 2016 5:01 PM

Completion Date/Time: January 5, 2016 5:13 PM

Encounter Number: 010095127337

Accession Number: 6538607

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: January 6, 2016 8:34 AM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095127337

Report Date/Time: 1/7/2016 9:01:00 PM

Report Name: MRI THORACIC SPINE WITH IV CONTRAST

Examination

Follow up.

Clinical History

Osteomyelitis, follow up.

Technique

Multiple sequences were obtained through the thoracic and lumbar

spine before and following intravenous gadolinium injection. cc of

Magnevist was injected.

Contrast

Contrast Agent GADAVIST 6 milliliters 01/07/2016 INTRAVENOUS

Comparison

Prior study dated 11/03/2015.

Findings

There is interval resolution of previously seen enhancing T2

hyperintense epidural collection along the right dorsal aspect of the

spinal canal extending from mid T7 through T12 levels. There is

persistent linearly enhancing T2 hyperintense soft tissue adjacent to

the vertebral bodies T9, T10, T11, and superior endplate of T12

without appreciable rim enhancing collections. There is interval

increase in T11 compression fracture deformity and retropulsion of

the posterior aspect of T11 with moderate to severe compression of

the cord.

There is bone edema characterized by increased T2/STIR signal

involving the inferior endplate of T10 and superior endplate of T11

with mild associated postcontrast enhancement in the prevertebral

soft tissues which may represent residual osteomyelitis and

phlegmonous change. The intervertebral discs at T10-11 and T11-12 are

relatively uninvolved with interval increase in degeneration. There

is interval decrease in T2/ STIR hyperintense signal with decreased

enhancement along superior end plate of T6.

There is no abnormal intradural or intramedullary enhancement. There

is no appreciable abnormal enhancement along the cauda equina roots.

There is no evidence of cord signal abnormality. There is extensive

paraspinal subcutaneous edema in the

mid lumbar region.

The remainder of the vertebral bodies demonstrate normal height and

morphology. There is no evidence of subluxation.

There is no disc herniation in the thoracic spine. There is small

left pleural effusion.

Evaluation of the intervertebral disc spaces in the lumbar spine as

follows:

L2-3: There is disc osteophyte complex asymmetric to the left

indenting thecal sac resulting in mild spinal canal stenosis. There

is moderate left and mild right neural foraminal stenosis. findings

are unchanged.

L3-4: There is disc osteophyte complex indenting thecal sac in

combination with bilateral facet arthropathy and mild thickening of

ligamentum flavum resulting in moderate spinal canal stenosis. There

is severe left and mild to moderate right neural foraminal stenosis.

The findings are unchanged.

L4-5: There is disc osteophyte complex indenting thecal sac in

combination with bilateral facet joint and ligamentum flavum

thickening results in moderate spinal canal stenosis. There is mild

to moderate bilateral neural foraminal stenosis, right greater than

left.

L5-S1: There is shallow disc bulge indenting thecal sac resulting in

mild spinal canal stenosis. There is moderate bilateral neural

foraminal stenosis.

Impression:

Interval resolution of previously seen enhancing T2 hyperintense

epidural collection along the right dorsal aspect of the spinal canal

extending from mid T7 through T12 levels. Persistent linearly

enhancing and T2 hyperintense soft tissue adjacent to the vertebral

bodies T9, T10, T11, and superior endplate of T12 without appreciable

rim enhancing collections compatible with phlegmon. Persistent

enhancing prevertebral soft tissue phlegmonous change at T9-T12.

Interval increase in T11 compression fracture deformity and

retropulsion of the posterior aspect of T11 with moderate to severe

compression of the cord. No abnormal cord signal or abnormal

intramedullary enhancement. Recommend neurosurgical consultation.

Other findings as described.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: CABALLERO, JOSEPH

Order Date/Time: January 7, 2016 3:10 PM

Scan Initiation Date/Time: January 7, 2016 7:16 PM

Completion Date/Time: January 7, 2016 9:01 PM

Encounter Number: 010095127337

Accession Number: 6541537

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: January 7, 2016 11:28 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095127337

Report Date/Time: 1/7/2016 9:00:00 PM

Report Name: MRI LUMBAR SPINE WITH IV CONTRAST

Examination

Follow up.

Clinical History

Osteomyelitis, follow up.

Technique

Multiple sequences were obtained through the thoracic and lumbar

spine before and following intravenous gadolinium injection. cc of

Magnevist was injected.

Contrast

Contrast Agent GADAVIST 6 milliliters 01/07/2016 INTRAVENOUS

Comparison

Prior study dated 11/03/2015.

Findings

There is interval resolution of previously seen enhancing T2

hyperintense epidural collection along the right dorsal aspect of the

spinal canal extending from mid T7 through T12 levels. There is

persistent linearly enhancing T2 hyperintense soft tissue adjacent to

the vertebral bodies T9, T10, T11, and superior endplate of T12

without appreciable rim enhancing collections. There is interval

increase in T11 compression fracture deformity and retropulsion of

the posterior aspect of T11 with moderate to severe compression of

the cord.

There is bone edema characterized by increased T2/STIR signal

involving the inferior endplate of T10 and superior endplate of T11

with mild associated postcontrast enhancement in the prevertebral

soft tissues which may represent residual osteomyelitis and

phlegmonous change. The intervertebral discs at T10-11 and T11-12 are

relatively uninvolved with interval increase in degeneration. There

is interval decrease in T2/ STIR hyperintense signal with decreased

enhancement along superior end plate of T6.

There is no abnormal intradural or intramedullary enhancement. There

is no appreciable abnormal enhancement along the cauda equina roots.

There is no evidence of cord signal abnormality. There is extensive

paraspinal subcutaneous edema in the

mid lumbar region.

The remainder of the vertebral bodies demonstrate normal height and

morphology. There is no evidence of subluxation.

There is no disc herniation in the thoracic spine. There is small

left pleural effusion.

Evaluation of the intervertebral disc spaces in the lumbar spine as

follows:

L2-3: There is disc osteophyte complex asymmetric to the left

indenting thecal sac resulting in mild spinal canal stenosis. There

is moderate left and mild right neural foraminal stenosis. findings

are unchanged.

L3-4: There is disc osteophyte complex indenting thecal sac in

combination with bilateral facet arthropathy and mild thickening of

ligamentum flavum resulting in moderate spinal canal stenosis. There

is severe left and mild to moderate right neural foraminal stenosis.

The findings are unchanged.

L4-5: There is disc osteophyte complex indenting thecal sac in

combination with bilateral facet joint and ligamentum flavum

thickening results in moderate spinal canal stenosis. There is mild

to moderate bilateral neural foraminal stenosis, right greater than

left.

L5-S1: There is shallow disc bulge indenting thecal sac resulting in

mild spinal canal stenosis. There is moderate bilateral neural

foraminal stenosis.

Impression:

Interval resolution of previously seen enhancing T2 hyperintense

epidural collection along the right dorsal aspect of the spinal canal

extending from mid T7 through T12 levels. Persistent linearly

enhancing and T2 hyperintense soft tissue adjacent to the vertebral

bodies T9, T10, T11, and superior endplate of T12 without appreciable

rim enhancing collections compatible with phlegmon. Persistent

enhancing prevertebral soft tissue phlegmonous change at T9-T12.

Interval increase in T11 compression fracture deformity and

retropulsion of the posterior aspect of T11 with moderate to severe

compression of the cord. No abnormal cord signal or abnormal

intramedullary enhancement. Recommend neurosurgical consultation.

Other findings as described.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: CABALLERO, JOSEPH

Order Date/Time: January 7, 2016 3:10 PM

Scan Initiation Date/Time:

Completion Date/Time: January 7, 2016 9:00 PM

Encounter Number: 010095127337

Accession Number: 6541536

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: January 8, 2016 7:10 AM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095127337

Report Date/Time: 1/8/2016 5:49:00 PM

Report Name: SPINE THORACIC AP AND LATERAL

Clinical History

T11 burst fracture.

Technique

2 views of thoracic spine.

Comparison

MRI of thoracic spine on 01/07/2016.

Findings

Again seen is T11 burst fracture. The remainder of the thoracic

vertebral bodies demonstrate normal height. There is no evidence of

acute subluxation.

Impression

T11 burst fracture.

Attending Radiologist: FISHER, PAUL

Ordered By: SAID, JOSEPH

Order Date/Time: January 8, 2016 3:00 PM

Scan Initiation Date/Time: January 8, 2016 5:38 PM

Completion Date/Time: January 8, 2016 5:49 PM

Encounter Number: 010095127337

Accession Number: 6543026

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: January 9, 2016 12:43 PM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095127337

Report Date/Time: 1/8/2016 7:04:00 PM

Report Name: CT SPINE THORACIC WO IV CONTRAST

Examination

CT SPINE THORACIC WITHOUT CONTRAST

Clinical History

COMPRESSION FRACUTRE OF SPINE

History and Indication

COMPRESSION FRACTURE

Technique

CT of the thoracic spine was performed with thin contiguous axial

slices. Subsequently, computer reformations were obtained in the

coronal and sagittal planes.

Comparison

No available images for comparison.

Findings

Evaluation of the soft tissue contents of the thoracic spine is

limited on CT. Please refer to the MRI report for details regarding

this disease another soft tissue information.

Again noted is marked destruction and compression of the T11

vertebral body with retropulsion of noncalcified tissue which indents

the thecal sac and abuts the ventral surface of the spinal cord.

there is partial destruction of the inferior endplate of T10 with

foci of hypodensity in the inferior aspect of this vertebra with

adjacent sclerosis.

There is no other vertebral fracture or bone destruction noted.

Impression

Marked compression and destruction of the T11 vertebral body with

retropulsion causing spinal stenosis at this level. Please see MRI

for further details. Partial destruction of the inferior aspect of

the T10 vertebral body is noted.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: CABALLERO, JOSEPH

Order Date/Time: January 8, 2016 10:30 AM

Scan Initiation Date/Time: January 8, 2016 5:54 PM

Completion Date/Time: January 8, 2016 7:04 PM

Encounter Number: 010095127337

Accession Number: 6542446

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: January 9, 2016 9:14 AM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095127337

Report Date/Time: 1/8/2016 7:04:00 PM

Report Name: CT SPINE LUMBAR WO IV CONTRAST

Examination

CT SPINE LUMBAR WITHOUT CONTRAST

Clinical History

COMPRESSION FRACTURE OF SPINE

History and Indication

COMPRESSION FRACTURE OF SPINE

Technique

Thin axial slices were obtained through the lumbar spine.

Subsequently, sagittal and coronal reformatted images were obtained.

Comparison

MRI 01/07/2016

Findings

The study was performed to evaluate for fracture. No oblique axial

images were performed through the disc spaces and disc and other soft

tissue information is limited. Please refer to the MRI report for

details regarding this disease.

No fracture, bone destruction or subluxation is seen in the lumbar

spine. Several Schmorl's nodes are noted. Degenerative sclerotic

changes are noted at L1-2 and L5-S1.

There is multilevel degenerative disc disease.

Impression

Multiple Schmorl's nodes are noted. There is no compression fracture

of the lumbar vertebrae .

Attending Radiologist: PEYSTER, ROBERT

Ordered By: CABALLERO, JOSEPH

Order Date/Time: January 8, 2016 10:30 AM

Scan Initiation Date/Time: January 8, 2016 5:58 PM

Completion Date/Time: January 8, 2016 7:04 PM

Encounter Number: 010095127337

Accession Number: 6542447

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: January 9, 2016 9:08 AM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095127337

Report Date/Time: 1/12/2016 4:49:00 PM

Report Name: BONE DEEP PERCUTANEOUS

Clinical History

Request for bone/disc biopsy. Ongoing osteomyelitis/ discitis at T11,

progression of compression fracture.

Technique

Risks, benefits, and alternatives to vertebral body bone and

intervertebral disc biopsy were discussed with the patient and

informed written consent was obtained. Consent was also obtained for

moderate IV sedation. The patient was brought to the CT scanner and

placed prone. A marker grid was placed on the patient's back. Initial

images were obtained. Patient positioning was adjusted on two more

occasions, and CT images revealed the marker grid. Skin was marked,

prepped with 2 percent chlorhexidine solution and draped. 1 percent

lidocaine was given subcutaneously. Moderate IV sedation was given

and vital signs were monitored continuously for 1/2 hr. A 17 gauge

trocar was advanced alongside the T11 vertebral body on the left,

seen on CT images. Trocar was adjusted on 2 more occasions, then

advanced into the T11 vertebral body, and by CT images. Two 18 gauge

core samples were taken, one sent for culture and sensitivity, the

other for surgical pathology. Trocar was removed and a sterile

dressing was applied. Final CT images were obtained. The patient was

sent back to his hospital room having tolerated this procedure well.

Comparison

CT spine 01/08/2016 .

Findings

Final images show no hemorrhage.

Impression

Technically successful core biopsies T11 vertebral body. No immediate

postprocedure complications.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: CABALLERO, JOSEPH

Order Date/Time: January 12, 2016 3:05 PM

Scan Initiation Date/Time: January 12, 2016 3:16 PM

Completion Date/Time: January 12, 2016 4:49 PM

Encounter Number: 010095127337

Accession Number: 6545196

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: January 14, 2016 12:56 PM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095172762

Report Date/Time: 1/5/2016 7:20:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

CHF exacerbation.

Technique

AP portable radiograph of the chest.

Comparison

Radiograph of the chest from 08/12/2014

Findings

Left subclavian approach AICD is noted.

There is moderate pulmonary vascular congestion/ mild interstitial

edema. The cardiac silhouette is enlarged, stable from the prior

study. There is mild elevation of the right hemidiaphragm with

blunting of the left costophrenic angle which may be secondary to

pleural thickening and a small effusion. Concomitant atelectasis

cannot be excluded. There is also blunting of left costophrenic

angle unchanged from the preceding examination.

No acute fractures. .

Impression

1. Radiographic evidence of mild interstitial pulmonary edema.

2. Stable cardiomegaly.

3. Blunting of the right costophrenic angle and elevation of the

right diaphragm which may be secondary to atelectasis and possible

right pleural effusion.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: MOHAMMADY, NAJIM

Order Date/Time: January 5, 2016 6:30 PM

Scan Initiation Date/Time: January 5, 2016 6:50 PM

Completion Date/Time: January 5, 2016 7:20 PM

Encounter Number: 010095172762

Accession Number: 6538789

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 5, 2016 7:39 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095172762

Report Date/Time: 1/6/2016 9:58:00 AM

Report Name: LOWER LEG LEFT (TIB-FIB) PORTABLE

Clinical History

Exclude gas

Technique

Two-views of the left tibia and fibula.

Comparison

08/14/2014

Findings

There is no acute fracture or dislocation. The alignment is

unremarkable. There is soft tissue swelling about the lower leg with

reticulation of the subcutaneous tissues. However no air is noted in

the soft tissues.

Impression

No acute fracture. The soft tissues swelling of the left lower leg,

correlate clinically for cellulitis. No soft tissue air.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: SAM, STANLEY

Order Date/Time: January 6, 2016 8:05 AM

Scan Initiation Date/Time: January 6, 2016 9:48 AM

Completion Date/Time: January 6, 2016 9:58 AM

Encounter Number: 010095172762

Accession Number: 6539082

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 6, 2016 11:26 AM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095172762

Report Date/Time: 1/6/2016 9:58:00 AM

Report Name: ABDOMEN SERIES PORTABLE (FLAT/ERECT)

Clinical History

Rule out small bowel obstruction. Evaluate for free air.

Technique

Erect and supine abdominal radiographs.

Comparison

Chest radiograph on 01/05/2016.

Findings

Upright view is limited secondary to poor contrast resolution. Within

these limitations, no gross free intraperitoneal air identified.

There is a nonspecific bowel gas pattern. No evidence for pneumatosis

or portal venous gas.

AICD is in place.

Right iliac artery stent is noted.

Impression

Nonobstructive bowel gas pattern.

No evidence for free intraperitoneal air.

Attending Radiologist: ABBASI, ALMAS

Ordered By: SAM, STANLEY

Order Date/Time: January 6, 2016 8:05 AM

Scan Initiation Date/Time: January 6, 2016 9:48 AM

Completion Date/Time: January 6, 2016 9:58 AM

Encounter Number: 010095172762

Accession Number: 6539081

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: January 6, 2016 12:10 PM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095172762

Report Date/Time: 1/17/2016 4:35:00 PM

Report Name: ULTRASOUND KIDNEYS COMPLETE

Examination

ULTRASOUND KIDNEYS COMPLETE/PEND

Clinical History

HX OF NEPHROCALCINOSIS. CHF

Indication

AKI ON CKD

Technique

Transabdominal ultrasonographic evaluation of the kidneys.

Technologist Comments

Comparison

Prior examination from 08/13/2014

Findings

The right kidney measures 10.4 x 4.5 x 4.4 centimeters and the left

kidney measures 10.2 x 4.4 centimeters. Echogenic renal medulla is

noted. No hydronephrosis seen.

Impression

No hydronephrosis.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: DING, YONGZENG

Order Date/Time: January 17, 2016 2:05 PM

Scan Initiation Date/Time: January 17, 2016 4:03 PM

Completion Date/Time: January 17, 2016 4:35 PM

Encounter Number: 010095172762

Accession Number: 6553224

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: January 17, 2016 4:40 PM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095172762

Report Date/Time: 1/18/2016 10:23:00 AM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

History of acute kidney injury on chronic kidney disease, PVD, CAD,

CHF. Now the patient is "Jerky."

History and Indication

AKI ON CKD PVD CAD CHF

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

No images available for comparison.

Findings

There is no loss of gray-white matter distinction or other sign of

acute transcortical infarction. There is no mass effect, midline

shift or focal parenchymal abnormality. There is no intracranial

hemorrhage or extra-axial collection.

There is cortical and cerebellar atrophy and prominence of the

cingulate sulci and sylvian fissures. There is prominence of the

cisterna magna. Correlate for medical-social history.

The ventricles are age-appropriate in size. The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

1. No CT evidence of acute transcortical infarct or

axial/extra-axial collection.

2. Cortical and cerebellar atrophy with prominence of the

sylvian fissures and cingulate sulci, out of proportion for patient

age. Correlate for medical-social history.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: DING, YONGZENG

Order Date/Time: January 18, 2016 8:10 AM

Scan Initiation Date/Time: January 18, 2016 10:11 AM

Completion Date/Time: January 18, 2016 10:23 AM

Encounter Number: 010095172762

Accession Number: 6553606

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: January 18, 2016 4:01 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095172762

Report Date/Time: 1/18/2016 2:39:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

EVALUATE FOR CHF

Technique

AP portable

Comparison

01/05/2016

Findings

Left chest wall ICD with lead tip overlying the right ventricle.

Cardiac mediastinal silhouette is enlarged but unchanged from prior

radiographs. Small bilateral pleural effusions left greater than

right with bibasilar atelectasis. Increased opacity in the

retrocardiac region, may represent left lower lobe consolidation.

Moderate pulmonary venous congestion with probable airspace opacities

in the right mid to lower zone. No evidence of pneumothorax.

Impression

cardiomegaly with moderate pulmonary venous congestion and small

bilateral pleural effusions with bibasilar atelectasis. Airspace

opacities in the right lung and left lower lobe consolidation may

represent superimposed pulmonary edema.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: DING, YONGZENG

Order Date/Time: January 18, 2016 12:55 PM

Scan Initiation Date/Time: January 18, 2016 1:34 PM

Completion Date/Time: January 18, 2016 2:39 PM

Encounter Number: 010095172762

Accession Number: 6554192

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: January 18, 2016 6:03 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095172762

Report Date/Time: 1/19/2016 10:37:00 AM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

AMS JERKY R/O CVA

History and Indication

AKI, CAD CHF

Technique

Contiguous axial slices were obtained from the skull base to the

vertex. Coronal and sagittal reformatted images were also performed.

Comparison

CT head without contrast from January 18, 2016.

Findings

There is no loss of gray-white matter distinction or other sign of

acute transcortical infarction. There is no mass effect, midline

shift or focal parenchymal abnormality. There is no intracranial

hemorrhage or extra-axial collection.

There is cortical and cerebellar atrophy and prominence of the

cingulate sulci and sylvian fissures. There is prominence of the

cisterna magna. Correlate for medical-social history.

The ventricles are age-appropriate in size. The calvarium and the

skullbase appear intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

1. No CT evidence of acute transcortical infarct or

axial/extra-axial collection.

2. Cortical and cerebellar atrophy with prominence of the

sylvian fissures and cingulate sulci, out of proportion for patient

age. Correlate for medical-social history.

3. No interval change.

Attending Radiologist: WEST, STEVEN

Ordered By: DING, YONGZENG

Order Date/Time: January 19, 2016 6:00 AM

Scan Initiation Date/Time: January 19, 2016 10:23 AM

Completion Date/Time: January 19, 2016 10:37 AM

Encounter Number: 010095172762

Accession Number: 6554816

Images were reviewed and interpreted by Attending Radiologist: Dr. WEST, STEVEN

Electronically Signed On: January 19, 2016 10:51 AM by Dr. WEST, STEVEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095172762

Report Date/Time: 1/20/2016 8:49:00 AM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

CHF AAA

Indication

POSSIBLE OBSTRUCTION

Technique

Single supine view of the abdomen

Comparison

Abdominal radiograph dated 01/06/2016 .

Findings

There are no pathologically dilated bowel loops to suggest

obstruction. Evaluation for free air is limited in this single supine

view.No organomegaly or pathologic calcifications are identified.

AICD is in place. Right iliac stent is noted.

Impression

Nonobstructive bowel gas pattern.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: MAHONEY, DEBORAH

Order Date/Time: January 20, 2016 8:25 AM

Scan Initiation Date/Time: January 20, 2016 8:38 AM

Completion Date/Time: January 20, 2016 8:49 AM

Encounter Number: 010095172762

Accession Number: 6556726

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: January 20, 2016 11:50 AM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095175435

Report Date/Time: 1/6/2016 1:22:00 AM

Report Name: KNEE LEFT TRAUMA VIEW

Clinical History

Fracture. Pain.

Technique

Three-views of the left knee

Comparison

No prior

Findings

There is diffuse soft tissue swelling about the left knee. There is

severe bone-on-bone left medial femorotibial osteoarthrosis. There

is a moderate sized left knee joint effusion. There is insertional

quadriceps spurring. There are dense arterial vascular

calcification. There is osteopenia.

Impression

Left knee osteoarthritis. No gross fracture.

Attending Radiologist: FELDMANN, ERIC

Ordered By: CHOE, DONG

Order Date/Time: January 6, 2016 12:50 AM

Scan Initiation Date/Time: January 6, 2016 1:10 AM

Completion Date/Time: January 6, 2016 1:22 AM

Encounter Number: 010095175435

Accession Number: 6538979

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 6, 2016 1:49 AM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095175435

Report Date/Time: 1/6/2016 1:22:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Pneumonia. Shortness of breath.

Technique

AP chest

Comparison

5 months.

Findings

Cardiomegaly. Moderate pulmonary vascular congestion. Calcified

aorta. Vascular stent at the superior mediastinum. Trace left lower

lobe atelectasis and trace pleural effusion. Prominent lung volumes.

Rotator cuff arthropathy on the right.

Impression

Moderate pulmonary vascular congestion and severe cardiomegaly.

Attending Radiologist: FELDMANN, ERIC

Ordered By: CHOE, DONG

Order Date/Time: January 6, 2016 12:55 AM

Scan Initiation Date/Time: January 6, 2016 1:09 AM

Completion Date/Time: January 6, 2016 1:22 AM

Encounter Number: 010095175435

Accession Number: 6538981

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 6, 2016 1:48 AM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095175435

Report Date/Time: 1/7/2016 3:08:00 PM

Report Name: KNEE RIGHT 2 VIEWS PORTABLE

Clinical History

79-year-old woman with right knee pain and elevated ESR.

Technique

Right knee, 2 views.

Comparison

No prior right knee radiographs are available for comparison.

Findings

There is approximately moderate osteoarthrosis of the right knee with

mild lateral tibial translation. There is narrowing of the medial

femoral tibial joint compartment. Bones are somewhat osteopenic.

There is no displaced fracture or dislocation.

There is a moderate somewhat dense suprapatellar knee joint effusion

without an obvious fat fluid level. This may be related to a

hemorrhagic component. If there is concern for occult fracture would

recommend CT. There is questionable although not definitive

chondrocalcinosis.

Vascular calcifications are noted.

Impression

Moderate sized dense suprapatellar effusion. The density could be

related to a complex or perhaps a hemorrhagic effusion. There is no

obvious fat fluid level which can be seen with intra-articular

fracture. If the patient has history of injury would suggest CT.

Moderate osteoarthrosis of the right knee, medial compartment

narrowing, mild lateral tibial translation. No acute displaced

fracture.

If there is concern for infection aspiration analysis would be

recommended.

Attending Radiologist: GOULD, ELAINE

Ordered By: KHIANI, KOMAL

Order Date/Time: January 7, 2016 2:55 PM

Scan Initiation Date/Time: January 7, 2016 3:03 PM

Completion Date/Time: January 7, 2016 3:08 PM

Encounter Number: 010095175435

Accession Number: 6541499

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: January 7, 2016 3:40 PM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095175435

Report Date/Time: 1/8/2016 9:44:00 PM

Report Name: CT LOWER EXTREMITY WO IV CONTRAST RIGHT

Clinical History

Right proximal fibular lucency, suspicious for lesion.

Technique

Noncontrast CT of the right knee and lower leg was performed by

obtaining contiguous axial images from the level of the distal right

femur to the midfoot. Oral contrast sagittal, and 3D reformats were

processed and reviewed.

Comparison

Radiographs from 01/07/2016.

Findings

Evaluation is quite limited by significant osteopenia.

There is no appreciable acute fracture or dislocation. There is

elongated appearance of the patella, likely on the basis of old

trauma. There is severe medial femorotibial and patellofemoral

arthrosis of the right knee with joint space narrowing, osteophytes,

and subchondral cystic change in the medial femoral condyle and

medial tibial plateau, where there also is probable bone-on-bone

contact. There also is joint space narrowing and osteophytic spurring

about the lateral femorotibial compartment.

There is chondrocalcinosis about the knee.

There is a moderate knee joint effusion. There also is a 4.3 x 1.6 x

7.7 cm popliteal cyst which tracks to the proximal aspect of the

lower leg.

Extensive vascular calcifications are present. There is fatty atrophy

of the semimembranosus and peroneal muscles.

Calcifications are noted along the anteromedial aspect of the skin

surface, possibly venous/vascular in etiology.

There is minor enthesopathy at the Achilles tendon insertion. There

also is enthesopathy of the quadriceps and patellar tendons. Very

minor degenerative change about the foot.

Delayed film is intact and

Impression

No appreciable fracture, dislocation, or osseous lytic lesion on CT.

Tricompartmental degenerative arthrosis of the left knee, most

prominent in the medial femoral tibial and patellofemoral

compartments, with probable bone on bone contact at the medial

compartment.

Fatty atrophy of the semimembranosus and peroneal muscles.

Moderate knee joint effusion with 4.3 x 1.6 x 7.7 cm popliteal cyst.

Attending Radiologist: BAKER, KEVIN S

Ordered By: ELBAYAR, JUSTEN

Order Date/Time: January 8, 2016 7:30 AM

Scan Initiation Date/Time: January 8, 2016 9:26 PM

Completion Date/Time: January 8, 2016 9:44 PM

Encounter Number: 010095175435

Accession Number: 6542091

Images were reviewed and interpreted by Attending Radiologist: Dr. BAKER, KEVIN S

Electronically Signed On: January 11, 2016 9:12 AM by Dr. BAKER, KEVIN S

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095175658

Report Date/Time: 1/6/2016 1:21:00 AM

Report Name: FOOT LEFT (ROUTINE)

Clinical History

Fracture. Pain.

Technique

Three-views of the left foot

Comparison

No prior.

Findings

Fracture of the terminal tuft of the left 3rd toe with fragmentation.

There is diffuse soft tissue swelling. Tiny plantar fascia origin

spur.

Impression

Fracture of the terminal tuft of the left 3rd toe with fragmentation.

Attending Radiologist: FELDMANN, ERIC

Ordered By: YU, CONNIE

Order Date/Time: January 6, 2016 12:40 AM

Scan Initiation Date/Time: January 6, 2016 1:17 AM

Completion Date/Time: January 6, 2016 1:21 AM

Encounter Number: 010095175658

Accession Number: 6538976

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 6, 2016 1:46 AM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095175658

Report Date/Time: 1/6/2016 3:06:00 PM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: GREGORIO DELACRUZ Exam Date: 1/6/2016 at 2:47:42 PM Heart

Rate:

MR #: 30794030 Report Date: 1/6/2016 Rhythm:

ACC #: 6539430 Height: BP:

173/86

DOB: 11/28/1959 Weight: 84.82 kg

Location: 12S

Age/Sex: 56 years / M BSA: 1.93 m²

Ref. Physician: Chaudhry Sarwar, cc:

Sonographer: CD

Fellow: PKS

Indications: CHF

History: Foot infection, CKD, IDDM, HTN

Procedure: Complete Echocardiogram - 93306.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.73 cm 2.0 - 3.8 LA Diam 5.00 cm 3.0-4.0

IVS 0.82 cm 0.6 - 1.0 LA Area 27.1cm² <=20

LVID 4.82 cm 4.2 - 5.9 3.44 cm LA Vol 108.50 ml 18-58

LVPW 0.81 cm 0.6 - 1.0 LA Vol/BSA 56.19ml/m² 22+ / -6

RA Diam 4.52cm 2.9-4.5

Ao at the sinuses 3.08 cm

Ao Ascending 3.22 cm

Ao Arch 3.20 cm

LVEF 66 % (biplane method of discs)

LV FS 28.6

LV SV 76.3 ml

LV SI 39.5 ml/m²

Aov Cusp Sep 2.40 cm

(Systole)

Aov VTI 0.330 m LVOT VTI 0.242 m LVOT diameter

2.00

cm

Aov VMax 1.37 m/s LVOT Vmax 1.02 m/s Dimensionless

Index 0.75

Aov Pk Pressure 7.5 mmHg Aov Mn 3.5 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 2.30 cm² Aov Area Index 1.19 cm²/m²

(VTI)

MV Pk Gradient mmHg MV Mn Gradient 1.0

MV VTI 0.236 m MV DT 291 msec

MV E Vmax 0.68 m/s MV A Vmax 0.38 m/s E/A 1.78

MV Area press 1/2 Time 2.61

IVRT 120 E/E ' 12.63

Septal E ' 0.052 m/s Prop Velocity

Lateral E ' 0.05 m/s LA Pressure 17.85 mmHg

Average E' 0.053 m/s

MV Average E/E' 12.87

TR Vmax 2.58 m/s TR Pk Grad 26.6 mmHg RA Pressure 3 mmHg RVSP

29.6 mmHg

TV E Max TV Mn Grad mmHg PHT 84.24 msec TV VTI

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

normal. The relative wall thickness is normal (0.34). Global left

ventricular systolic function is normal. The ejection fraction is 66%

by biplane method of discs. No regional wall motion abnormalities are

seen.

Left Ventricle - Diastole:The left ventricular isovolumetric

relaxation time is prolonged at 120 msec. The Doppler derived

transmitral left ventricular inflow velocity pattern is E wave

dominant. The Doppler derived early diastolic deceleration time is

prolonged at 291 msec. The flow in the pulmonary vein is diastolic

dominant. The velocity of the early diastolic septal mitral annular

movement, as determined by tissue Doppler imaging is reduced at 0.052

m/s. The velocity of the early diastolic lateral mitral annular

movement, as determined by tissue Doppler imaging is reduced at 0.05

m/s. The overall diastolic function is moderately impaired (grade II,

pseudonormal pattern) with elevated left ventricular filling

pressures.

Left Atrium: The left atrium is severely dilated in size.

Right Atrium: The right atrium is normal in size.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal. The tricuspid annular plane

systolic excursion is 2.62 cm consistent with normal right

ventricular systolic function.

Aortic Valve: The aortic valve is trileaflet with normal excursion.

Normal Doppler interrogation flow patterns without stenosis or

insufficiency.

Mitral Valve: The mitral valve is structurally normal. No evidence of

mitral stenosis is seen. Mild mitral regurgitation is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Mild

tricuspid regurgitation is present. The degree of tricuspid

regurgitation was not sufficient for accurate calculation of

pulmonary artery systolic pressure.

Pulmonic Valve: The pulmonic valve is normal. Trace pulmonary

regurgitation is seen.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.08 cm. The ascending aorta is normal at 3.22 cm. The

aortic arch is normal at 3.20 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.58 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is normal at 29.6 mmHg.

Pericardium: There is a trivial circumferential pericardial effusion.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Normal left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Normal global left ventricular systolic function.

4. No regional left ventricular wall motion abnormalities.

5. Moderate diastolic dysfunction with elevated left ventricular

filling pressures.

6. Normal right ventricular systolic function.

7. Severely dilated left atrial size.

8. Trileaflet aortic valve with normal excursion.

9. No aortic stenosis or insufficiency.

10. Mild mitral regurgitation.

11. Mild tricuspid regurgitation.

12. Normal atrial septum by 2D and color Doppler.

13. Normal aortic root diameter for body size.

14. Trivial circumferential pericardial effusion.

014970 Smadar Kort MD, FACC, FASE

Electronically signed by 014970 Smadar Kort MD, FACC, FASE on

1/6/2016 at 3:33:56 PM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: KAMADOLI, RIYAZ

Order Date/Time: January 6, 2016 11:30 AM

Scan Initiation Date/Time:

Completion Date/Time: January 6, 2016 3:06 PM

Encounter Number: 010095175658

Accession Number: 6539430

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: January 6, 2016 3:33 PM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095175658

Report Date/Time: 1/8/2016 9:46:00 PM

Report Name: MRI FOOT LEFT WO IV CONTRAST

Examination

MRI of the Foot.

Technique

Multiplanar, multisequences MRI images of the left forefoot forefoot

was performed without intravenous contrast.

History: A 56-year-old man with ulcer along left 3rd toe with fever.

Evaluate for osteomyelitis.

Comparison

No prior MRI is available for comparison. Plain films of 01/06/2016

are available.

Findings

There are confluent regions of decreased signal intensity in the

left 3rd proximal and distal phalanges seen on T1 with corresponding

high signal on T2. There is subcutaneous edema is seen in the

overlying soft tissues with either a wound or ulcer and possible

overlying bandage. There is swelling about the 3rd toe. There is some

mild edema within the 3rd proximal phalanx, possibly reactive or

stress related. 5 this abnormal signal is highly concerning for

underlying osteomyelitis. Given reported fracture on plain films

fracture can give a similar abnormal signal. There is a 0.6 x 0.6 cm

focus of increased T2 signal just medial to the 3rd toe DIP joint as

seen on series 10 image 15. This is concerning for either a small

fluid collection, outpocketing from the joint or hematoma. The

infected nature cannot be determined.

There is some swelling along the 2nd toe without definitive abnormal

marrow signal. There are mild degenerative changes at the 1st

metatarsophalangeal joint. There is no evidence for Freiberg's

infraction.

There is subcutaneous edema somewhat more prominent along the dorsum

of the forefoot which should be correlated for cellulitis. There is

also some some deep edema as well as T2 signal hyperintensity in the

musculature which could be related to diabetic neuropathy. There is

mild fluid in the ankle joint and within the subtalar joint as well

as in the recess posterior to the subtalar joint. There is a small,

nonspecific effusion at the 1st metatarsophalangeal joint. 1 there is

mild fluid there remainder of the MTP articulations.

There is abnormal fusiform thickening of the medial bundle of the

plantar aponeurosis at the level of the proximal metatarsal regions

as seen on series 11 image 13 . this is also seen on series 12 image

40 . This thickening is concerning for a plantar fibromatosis.

Correlate for palpable abnormality.

Impression

Abnormal signal involving the distal and middle phalanx of the 3rd

toe with overlying soft tissue edema, soft tissue irregularity

suggesting possible ulcer or sinus tract. Findings highly concerning

for underlying infection /osteomyelitis.

Approximately 6 millimeter x 6 mm focus of T2 signal hyperintensity

adjacent to the left 3rd PIP joint which is small for definitive

characterization without intravenous contrast. This could represent

extending from the joint, small localized fluid collection, hematoma

or tiny abscess.

Significant thickening of the distal portion of the plantar

aponeurosis highly concerning for plantar fibromatosis. Correlate

clinically.

Cellulitis.

T2 signal hyperintensity in the deep plantar musculature which can be

on the basis of diabetes.

Additional findings, as described above.

Attending Radiologist: GOULD, ELAINE

Ordered By: PILATO, LAUREN

Order Date/Time: January 8, 2016 3:20 PM

Scan Initiation Date/Time: January 8, 2016 9:02 PM

Completion Date/Time: January 8, 2016 9:46 PM

Encounter Number: 010095175658

Accession Number: 6543094

Images were reviewed and interpreted by Attending Radiologist: Dr. GOULD, ELAINE

Electronically Signed On: January 11, 2016 9:45 AM by Dr. GOULD, ELAINE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095175658

Report Date/Time: 1/11/2016 5:26:00 PM

Report Name: CHEST AP(PORT) CENTRAL LINE PL

Clinical History

Right upper extremity PICC line

Technique

portable frontal view of the chest

Comparison

None

Findings

There is a right-sided PICC line in place with distal tip in the

cavoatrial junction. There is no associated radiopaque foreign body.

There is no focal consolidation or effusion. The mediastinal and

cardiac silhouette is unremarkable.

Impression

Right-sided PICC line in place with tip in the cavoatrial junction.

No associated radiopaque foreign body.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: SCOTT, JOSHUA

Order Date/Time: January 11, 2016 4:20 PM

Scan Initiation Date/Time: January 11, 2016 5:24 PM

Completion Date/Time: January 11, 2016 5:26 PM

Encounter Number: 010095175658

Accession Number: 6545865

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 11, 2016 5:31 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095190913

Report Date/Time: 1/6/2016 3:14:00 PM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

ABDOMINAL PAIN

Technique

Routine study. Post Processed reconstructions included.

Contrast

No contrast.

Comparison

Comparison is made to CT of the abdomen from 12/14/2015

Findings

LUNG BASES: There are bilateral effusions with adjacent atelectasis,

more prominent on the left. The blood pool is hypodense to the

myocardium which may be secondary to anemia.

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: Gallbladder is unremarkable. No intra or extrahepatic

ductal dilatation.

PANCREAS: Diffuse coarse calcification of the pancreas is noted with

dilated main pancreatic duct without appreciable interval change

consistent with chronic pancreatitis. .

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. Stable right upper pole renal cyst

measuring up to 1 cm. No evidence of hydronephrosis or renal calculi.

BOWEL: Normal caliber. No wall thickening. Left-sided colostomy is

again noted.

PERITONEUM: No free air. There is interval development of small

perihepatic ascites.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta. Arthrosclerotic calcifications are

noted throughout the arterial vasculature.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Under distended which limits the evaluation for wall

thickening.

BONES: The patient is status post right-sided intra medullary rod

with dynamic hip screw placement. There is cortical step-off with

lucent line through the base of the left greater trochanter at the

intertrochanteric region without displacement. There is bony spurring

versus heterotopic ossification and questionable cortical

discontinuation of the iliac crest, likely from prior trauma.

Impression

1. Findings consistent with chronic pancreatitis as above.

2. Nondisplaced fracture through the base of the left greater

trochanter adjacent to the intertrochanteric region.

3. Interval development of small perihepatic ascites.

4. Bilateral pleural effusions, greater on the left.

Attending Radiologist: BANGIYEV, LEV

Ordered By: GOLDENBERG, WILLIAM D

Order Date/Time: January 6, 2016 12:25 PM

Scan Initiation Date/Time: January 6, 2016 2:45 PM

Completion Date/Time: January 6, 2016 3:14 PM

Encounter Number: 010095190913

Accession Number: 6539535

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 6, 2016 4:00 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095190913

Report Date/Time: 1/6/2016 3:15:00 PM

Report Name: CT LOWER EXTREMITY WO IV CONTRAST LEFT

Clinical History

Left hip pain

Technique

Multiplanar reformats of the pelvis were performed in bone algorithm.

2 and 3 dimensional post processing reconstructions created and

interpreted

Comparison

CT dated 12/14/2015

Findings

There is a minimally displaced impacted fracture of the left greater

trochanter. The fracture lucency is best appreciated on series 100,

image 71. Evaluation of extent of the fracture is difficult. No

definitive extension to the left femoral neck, however if there is

concern for fracture extension to the neck, consider MRI if there are

no contraindications. The lesser trochanter is intact.

There is a moderate left hip joint effusion. The femoral head is well

located within the acetabulum. No fracture of the visualized pelvis

is identified. There is degenerative change of the left hip joint

with joint space narrowing, subchondral sclerosis and subchondral

cystic changes.

The left sacroiliac joint is preserved. No evidence of widening.

Pubic symphysis joint is also preserved.

Visualized muscles are normal bulk. No evidence of muscle swelling or

suggestion of intramuscular hematoma.

Anastomotic sutures are noted in the sigmoid colon. Partial

visualization of left lower quadrant diverting colostomy.

Impression

Minimally displaced impacted fracture through the base of the greater

trochanter. No definitive extension to the left femoral neck, however

evaluation for fracture extent is limited on this CT. If there is

concern for extension, consider MRI if there are no

contraindications.

Moderate left hip joint effusion.

Attending Radiologist: KOLANKO, NICHOLAS

Ordered By: GOLDENBERG, WILLIAM D

Order Date/Time: January 6, 2016 12:25 PM

Scan Initiation Date/Time:

Completion Date/Time: January 6, 2016 3:15 PM

Encounter Number: 010095190913

Accession Number: 6539536

Images were reviewed and interpreted by Attending Radiologist: Dr. KOLANKO, NICHOLAS

Electronically Signed On: January 6, 2016 5:07 PM by Dr. KOLANKO, NICHOLAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095190913

Report Date/Time: 1/6/2016 5:47:00 PM

Report Name: HIP LEFT TRAUMA WITH PELVIS 2 OR 3 VWS

Clinical History

Possible fracture.

Technique

3 radiographs of the left knee.

4 radiographs of the left femur.

2 radiographs of the left hip.

Single radiograph of the pelvis.

Comparison

CT of the abdomen and pelvis and CT of the left hip from the same

date at 2:45 p.m.

Findings

Knee and femur: There is no acute fracture or dislocation. There are

mild degenerative changes f the femorotibial joint. Vascular

calcifications are noted. There is no significant joint effusion.

Left hip: There is no acute fracture or dislocation. There are mild

degenerative changes of the left hip joint.

Pelvis: There is dynamic compression screw and intramedullary nail

through the proximal right femur. No periprosthetic lucency to

suggest hardware malfunction. Multiple pelvic phleboliths are noted.

Mild degenerative changes of the lower lumbar spine and bilateral

sacroiliac joints.

Impression

1. No acute fracture or dislocation.

2. Mild degenerative changes as described above.

3. Dynamic compression screw and intramedullary nail through the

proximal right femur without evidence of complication.

Attending Radiologist: EISENBERG, JASON

Ordered By: GOLDENBERG, WILLIAM D

Order Date/Time: January 6, 2016 5:20 PM

Scan Initiation Date/Time: January 6, 2016 5:47 PM

Completion Date/Time: January 6, 2016 5:47 PM

Encounter Number: 010095190913

Accession Number: 6540216

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: January 6, 2016 6:45 PM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095190913

Report Date/Time: 1/6/2016 5:47:00 PM

Report Name: KNEE LEFT TRAUMA VIEW

Clinical History

Possible fracture.

Technique

3 radiographs of the left knee.

4 radiographs of the left femur.

2 radiographs of the left hip.

Single radiograph of the pelvis.

Comparison

CT of the abdomen and pelvis and CT of the left hip from the same

date at 2:45 p.m.

Findings

Knee and femur: There is no acute fracture or dislocation. There are

mild degenerative changes f the femorotibial joint. Vascular

calcifications are noted. There is no significant joint effusion.

Left hip: There is no acute fracture or dislocation. There are mild

degenerative changes of the left hip joint.

Pelvis: There is dynamic compression screw and intramedullary nail

through the proximal right femur. No periprosthetic lucency to

suggest hardware malfunction. Multiple pelvic phleboliths are noted.

Mild degenerative changes of the lower lumbar spine and bilateral

sacroiliac joints.

Impression

1. No acute fracture or dislocation.

2. Mild degenerative changes as described above.

3. Dynamic compression screw and intramedullary nail through the

proximal right femur without evidence of complication.

Attending Radiologist: EISENBERG, JASON

Ordered By: GOLDENBERG, WILLIAM D

Order Date/Time: January 6, 2016 5:20 PM

Scan Initiation Date/Time: January 6, 2016 5:42 PM

Completion Date/Time: January 6, 2016 5:47 PM

Encounter Number: 010095190913

Accession Number: 6540217

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: January 6, 2016 6:45 PM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095190913

Report Date/Time: 1/6/2016 5:47:00 PM

Report Name: FEMUR LEFT MINIMUM OF 2 VIEWS

Clinical History

Possible fracture.

Technique

3 radiographs of the left knee.

4 radiographs of the left femur.

2 radiographs of the left hip.

Single radiograph of the pelvis.

Comparison

CT of the abdomen and pelvis and CT of the left hip from the same

date at 2:45 p.m.

Findings

Knee and femur: There is no acute fracture or dislocation. There are

mild degenerative changes f the femorotibial joint. Vascular

calcifications are noted. There is no significant joint effusion.

Left hip: There is no acute fracture or dislocation. There are mild

degenerative changes of the left hip joint.

Pelvis: There is dynamic compression screw and intramedullary nail

through the proximal right femur. No periprosthetic lucency to

suggest hardware malfunction. Multiple pelvic phleboliths are noted.

Mild degenerative changes of the lower lumbar spine and bilateral

sacroiliac joints.

Impression

1. No acute fracture or dislocation.

2. Mild degenerative changes as described above.

3. Dynamic compression screw and intramedullary nail through the

proximal right femur without evidence of complication.

Attending Radiologist: EISENBERG, JASON

Ordered By: GOLDENBERG, WILLIAM D

Order Date/Time: January 6, 2016 5:20 PM

Scan Initiation Date/Time: January 6, 2016 5:42 PM

Completion Date/Time: January 6, 2016 5:47 PM

Encounter Number: 010095190913

Accession Number: 6540215

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: January 6, 2016 6:45 PM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095190913

Report Date/Time: 1/6/2016 6:03:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR TRAUMATIC INJURY

History and Indication

S/P TRAUMA

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

Prior study dated 12/14/2015.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

The ventricles, cisterns and sulci are age-appropriate in size.

There is no mass effect, or midline shift. There is moderate

periventricular white matter hypodensity most compatible with

microvascular ischemic disease.

There is no intracranial hemorrhage or extra-axial collection. There

are atherosclerotic calcifications of the bilateral carotid siphons.

The calvarium is intact. There is midline posterior fossa arachnoid

cyst or mega cisterna magna.

There is a persistently opacified right ethmoid air cell. There is no

other significant disease in the visualized paranasal sinuses and

mastoids.

Impression

No evidence of acute lobar infarction, intraparenchymal hemorrhage,

or extra-axial hematoma. Moderate microvascular ischemic disease and

involutional change.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: GOLDENBERG, WILLIAM D

Order Date/Time: January 6, 2016 5:20 PM

Scan Initiation Date/Time: January 6, 2016 6:01 PM

Completion Date/Time: January 6, 2016 6:03 PM

Encounter Number: 010095190913

Accession Number: 6540213

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: January 6, 2016 7:00 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095190913

Report Date/Time: 1/16/2016 12:25:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

New cough while admitted. Evaluate for pneumonia.

Technique

AP portable chest radiograph

Comparison

Chest radiograph from 12/14/2015 and CT of the abdomen and pelvis

from 01/06/2016.

Findings

There is a moderate-sized left-sided pleural effusion. Superimposed

infectious process cannot be ruled out. Left upper and right lungs

are clear. No sizeable pneumothorax.

Cardiomediastinal silhouette is unchanged. There is no pulmonary

vascular congestion.

Advanced degenerative changes of the left humeral head are again

identified. Multiple chronic rib fracture deformities are again

identified as it is an nonunited medial left clavicle fracture.

Multiple surgical clips noted over the medial aspect of the left

upper extremity.

Impression

Moderate left-sided pleural effusion. Superimposed infectious process

cannot be ruled out in this area, although is not suggested.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 16, 2016 11:20 AM

Scan Initiation Date/Time: January 16, 2016 12:11 PM

Completion Date/Time: January 16, 2016 12:25 PM

Encounter Number: 010095190913

Accession Number: 6552510

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: January 16, 2016 1:40 PM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095190913

Report Date/Time: 1/18/2016 8:08:00 AM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: RONNIE EVANS Exam Date: 1/18/2016 at 7:43:17 AM Heart Rate:

MR #: 00167140 Report Date: 1/18/2016 Rhythm:

ACC #: 6552683 Height: 170.18 cm BP: 128/65

DOB: 5/6/1955 Weight: 47.63 kg Location:

15N

Age/Sex: 60 years / M BSA: 1.54 m²

Ref. Physician: Dr. Robert ABDULAH, cc:

Sonographer: BJ

Indications: CHF

History: chronic falls, CP, chronic pancreatitis, HIV, PNA

Procedure: Complete Echocardiogram - 93306.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 2.96 cm 2.0 - 3.8 LA Diam 2.80 cm 3.0-4.0

IVS 1.10 cm 0.6 - 1.0 LA Area 20.6cm² <=20

LVID 5.06 cm 4.2 - 5.9 3.58 cm LA Vol 65.00 ml 18-58

LVPW 1.13 cm 0.6 - 1.0 LA Vol/BSA 42.27ml/m² 22+ / -6

RA Diam 4.4cm 2.9-4.5

Ao at the sinuses 3.70 cm

LVEF 50-55 % (visual estimation)

LV FS 29.2

LV SV 30.3 ml

LV SI 19.7 ml/m²

Aov Cusp Sep 1.90 cm

(Systole)

Aov VTI 0.254 m LVOT VTI 0.210 m LVOT diameter

2.10

cm

Aov VMax 1.20 m/s LVOT Vmax 1.06 m/s Dimensionless

Index 0.88

Aov Pk Pressure 5.8 mmHg Aov Mn 3.5 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 2.85 cm² Aov Area Index 1.85 cm²/m²

(VTI)

MV VTI MV DT 239 msec

MV E Vmax 0.58 m/s MV A Vmax 0.37 m/s E/A 1.54

MV Area press 1/2 Time 3.17

IVRT E/E ' 5.76

Septal E ' 0.073 m/s Prop Velocity

Lateral E ' 0.10 m/s LA Pressure 10.14 mmHg

Average E' 0.087 m/s

MV Average E/E' 6.65

TR Vmax 1.94 m/s TR Pk Grad 15.1 mmHg RA Pressure 8 mmHg RVSP

23.1 mmHg

TV E Max TV Mn Grad mmHg PHT 69.31 msec TV VTI

PV Vmax 0.74 m/s PV Pk Grad 2.2 mmHg PV Mn Grad 2.0 mmHg RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

mildly increased. Global left ventricular systolic function is low

normal. The ejection fraction is 50-55% by visual estimation. Left

ventricular basal fractional shortening is decreased.

Left Ventricle - Diastole:The overall diastolic function is normal

with normal left ventricular filling pressures.

Left Atrium: The left atrium is mildly dilated in size.

Right Atrium: The right atrium is normal in size.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal. The right ventricular

systolic pressure, as estimated using the tricuspid regurgitation

velocity, is 23.1 mmHg.

Aortic Valve: The aortic valve is trileaflet with normal excursion.

Mitral Valve: The mitral valve leaflets are thickened. Systolic

anterior motion of the mitral valve is not seen. Prolapse of the

mitral valve is not seen. Trace mitral regurgitation is present.

Tricuspid Valve: Mild tricuspid regurgitation is present.

Pulmonic Valve: Trace pulmonary regurgitation is seen.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.70 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 1.94 m/s, and

with an assumed right atrial pressure of 8 mmHg, the estimated

pulmonary artery systolic pressure is normal at 23.1 mmHg.

Pericardium: No pericardial effusion seen.

Miscellaneous: Left pleural effusion noted.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 1/4/13. There is no significant change in the findings since the

last echocardiogram.

Summary:

1. Normal left ventricular cavity size.

2. Mildly dilated left atrial size.

3. Mildly increased left ventricular wall thickness.

4. Low normal global left ventricular systolic function.

5. Normal diastolic function with normal left ventricular filling

pressures.

6. Normal right ventricular systolic function.

7. Trileaflet aortic valve with normal excursion.

8. Thickened mitral valve leaflets.

9. Trace mitral regurgitation.

10. Mild tricuspid regurgitation.

11. Left pleural effusion.

12. No pericardial effusion.

13. Normal aortic root diameter for body size.

012480 Howard Novotny MD, FACC

Electronically signed by 012480 Howard Novotny MD, FACC on 1/18/2016

at 9:21:38 AM

\*\*\* Final \*\*\*

Attending Cardiologist: NOVOTNY, HOWARD

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 16, 2016 4:00 PM

Scan Initiation Date/Time:

Completion Date/Time: January 18, 2016 8:08 AM

Encounter Number: 010095190913

Accession Number: 6552683

Images were reviewed and interpreted by Attending Cardiologist: Dr. NOVOTNY, HOWARD

Electronically Signed On: January 18, 2016 9:21 AM by Dr. NOVOTNY, HOWARD

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095190913

Report Date/Time: 1/18/2016 10:43:00 AM

Report Name: CT CHEST WO IV CONTRAST

Examination

CT of CHEST.

Clinical History

60-year-old male with shortness of breath, cough, left-sided effusion

and increased pro calcitonin, for further evaluation

Technique

Routine study. Post processed reconstructions included.

Contrast

No contrast

Comparison

CT dated 12/14/2015

Findings

BASE OF NECK: Unremarkable thyroid.

LUNGS: The lungs demonstrate a background of moderate centrilobular

emphysema with apical predominance. Mild subpleural reticular

opacity/ground-glass opacity is identified bilateral upper lobes, for

example as seen on series 4 image 50. Near complete passive

atelectasis of the left lower lobe and lingula.

LARGE AIRWAYS: Patent.

PLEURA: Large simple fluid attenuating left pleural effusion. No

right-sided pleural effusion. No pneumothorax.

VESSELS: Normal caliber thoracic aorta. Decreased attenuation of the

blood pool suggesting anemia. Main pulmonary arteries are normal in

caliber measuring 2.7 centimeter.

HEART: Cardiac chambers are unremarkable in size. No pericardial

effusion.

MEDIASTINUM and HILA: Few subcentimeter mediastinal lymph nodes

AXILLAE: Subcentimeter bilateral axillary lymph nodes.

BONES: Healing rib fractures of the anterolateral aspect of the

right 6th and 7th ribs. Additional old healed rib fractures are noted

bilaterally.

UPPER ABDOMEN: Partially imaged pancreas demonstrates diffuse

punctate calcification consistent with chronic pancreatitis.

Impression

1 . Large left pleural effusion with compressive atelectasis of the

left lower lobe and lingula.

2 . Moderate centrilobular emphysema with upper lobe predominance.

Scattered subpleural ground-glass opacity in bilateral upper lobes.

Recommend followup CT chest in 3 months to re-evaluate the pulmonary

parenchyma after resolution of the effusions.

3. Partially imaged pancreas, multifocal calcifications suggestive of

chronic pancreatitis.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 17, 2016 5:45 PM

Scan Initiation Date/Time: January 18, 2016 10:37 AM

Completion Date/Time: January 18, 2016 10:43 AM

Encounter Number: 010095190913

Accession Number: 6553335

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: January 18, 2016 4:22 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/6/2016 6:24:00 PM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Examination

PA and lateral radiographs of the chest.

Clinical History

Sepsis.

Comparison

Radiograph of the chest 12/26/2015

Findings

Right internal jugular approach a power port is noted with its tip

overlying the cavoatrial junction. No unintended radiopaque foreign

body is noted.

There is no focal consolidation, large pleural effusion, pneumothorax

or pulmonary vascular congestion. The cardiac silhouette is within

normal size limits.

Impression

Right approach power port in satisfactory position.

No focal consolidation or pleural effusion.

Attending Radiologist: EISENBERG, JASON

Ordered By: LEIBNER, EVAN

Order Date/Time: January 6, 2016 5:40 PM

Scan Initiation Date/Time: January 6, 2016 6:24 PM

Completion Date/Time: January 6, 2016 6:24 PM

Encounter Number: 010095201306

Accession Number: 6540235

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: January 6, 2016 6:48 PM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/6/2016 7:21:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

HEADACHE

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

Comparison is made to CT of the head from 09/04/2015

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There is a hyperdense subdural hematoma along the left frontoparietal

lobe measuring up to 3 mm in thickness with minimal mass effect on

the adjacent brain parenchyma. The collection is mildly heterogeneous

suggesting hemorrhage of different ages. Stable prominence of the

extra-axial space along the right frontal convexity which measures

CSF density.

The ventricles, cisterns and sulci are prominent in size and normal

in configuration compatible with involutional change. There is a

stable punctate calcification at the foramen of Monro.

There is no midline shift. There is superior cerebellar atrophy.

There is a partially empty sella.

There is no intraparenchymal hemorrhage.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

Acute on chronic left frontoparietal subdural hematoma measuring up

to 3 mm in width as described. No midline shift or hydrocephalus at

this time.

Findings were discussed with Dr. Leibner and 8 p.m. 01/06/2016

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: LEIBNER, EVAN

Order Date/Time: January 6, 2016 5:40 PM

Scan Initiation Date/Time: January 6, 2016 7:15 PM

Completion Date/Time: January 6, 2016 7:21 PM

Encounter Number: 010095201306

Accession Number: 6540236

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: January 6, 2016 8:22 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/7/2016 4:51:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

CVA SYMPTOMS

History and Indication

78 YO M WITH HISTORY OF SUBDURAL HEMATOMA

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

Prior study of 01/06/2016.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There is stable hyperdense subdural hematoma along the left

frontoparietal lobe measuring up to 3 mm in thickness with minimal

mass effect on the adjacent brain parenchyma. The collection is

mildly heterogeneous suggesting hemorrhage of different ages. Stable

prominence of the extra-axial space along the right frontal convexity

which measures CSF density.

The ventricles, cisterns and sulci are prominent in size and normal

in configuration compatible with involutional change. There is a

stable punctate calcification at the foramen of Monro. There is

periventricular white matter hypodensity most compatible with

microvascular ischemic disease.

There is no midline shift. There is superior cerebellar atrophy.

There is a partially empty sella.

There is no intraparenchymal hemorrhage.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

Stable left frontoparietal subdural hematoma measuring up to 3 mm in

width as described. No midline shift or hydrocephalus at this time.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: MEHTA, RISHI

Order Date/Time: January 7, 2016 3:50 PM

Scan Initiation Date/Time: January 7, 2016 4:48 PM

Completion Date/Time: January 7, 2016 4:51 PM

Encounter Number: 010095201306

Accession Number: 6541618

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: January 7, 2016 5:15 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/9/2016 3:25:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATION FOR STROKE

History and Indication

ACUTE ON CHRONIC SDH

Technique

Contiguous axial slices were obtained from the skull base to the

vertex. Sagittal and coronal reformatted images were also obtained.

Comparison

01/07/2016

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

No interval change in the relatively isodense left subdural hematoma

measuring up to 4 mm in size is noted. There is no associated mass

effect.

There is mild small vessel disease in the cerebral white matter.

There is mild dilatation of the lateral and 3rd and 4th ventricles

consistent with central atrophy. There is moderate cerebral cortical

atrophy. There is very prominent atrophy of the superior cerebellar

vermis which is advanced for age. Correlate with medical and social

history.

There is no mass effect, midline shift or other focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No interval change. No evidence of acute infarct.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: TERESSA, GETU

Order Date/Time: January 9, 2016 2:05 PM

Scan Initiation Date/Time: January 9, 2016 3:08 PM

Completion Date/Time: January 9, 2016 3:25 PM

Encounter Number: 010095201306

Accession Number: 6542608

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: January 9, 2016 3:55 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/9/2016 3:25:00 PM

Report Name: CT ORBITS WITH IV CONTRAST

Examination

CT ORBITS WITH CONTRAST

Clinical History

Technique

Axial sections through the orbit were obtained with contrast.

Following this, sagittal and coronal computer reformatted images were

obtained. of Ultravist 300 was administered.

Contrast

Contrast Agent OMNIPAQUE 300 100 milliliters 01/09/2016 INTRAVENOUS

Comparison

No images were available for comparison.

Findings

The bony orbits are intact. The globes, extraocular muscles, optic

nerves and other visualized soft tissue structures are unremarkable.

There is no evidence of orbital mass. There is no evidence of

exophthalmos. No abnormal contrast enhancement is present. The

paranasal sinuses are unremarkable.

Impression

Normal study.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: HEUSCHNEIDER, STACY

Order Date/Time: January 9, 2016 11:00 AM

Scan Initiation Date/Time: January 9, 2016 3:11 PM

Completion Date/Time: January 9, 2016 3:25 PM

Encounter Number: 010095201306

Accession Number: 6543672

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: January 9, 2016 3:59 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/11/2016 5:24:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATION FOR STROKE

History and Indication

NHL AND INTRACRANIAL HEMORHAGE

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

Prior study dated 01/09/2016.

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There are involutional changes without hydrocephalus. There is small

vessel disease. There are multiple vascular calcifications.

There is a grossly stable extra-axial subdural collection within the

left frontal and left parietal regions which appears mixed

attenuation. There is minimal mass effect upon the underlying brain

parenchyma. There is no midline shift. There is a partially empty

sella.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No significant change. Grossly stable left-sided mixed attenuation

subdural collection.

Attending Radiologist: DUNKIN, JARED

Ordered By: CAIATI, ROBERT

Order Date/Time: January 11, 2016 4:10 PM

Scan Initiation Date/Time: January 11, 2016 5:13 PM

Completion Date/Time: January 11, 2016 5:24 PM

Encounter Number: 010095201306

Accession Number: 6545846

Images were reviewed and interpreted by Attending Radiologist: Dr. DUNKIN, JARED

Electronically Signed On: January 11, 2016 6:37 PM by Dr. DUNKIN, JARED

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/13/2016 3:10:00 PM

Report Name: ULTRASOUND OF ABDOMEN

Clinical History

Cholecystitis status post percutaneous cholecystostomy. Evaluate

biliary tree.

Technique

An abdominal sonogram is performed with color Doppler interrogation.

Comparison

Prior right upper quadrant ultrasound 12/23/2013 renal ultrasound

12/17/2015.

Findings

Study is limited due to overlying bowel gas and bandages and drain in

right upper quadrant which limits sonographic window.

The liver is within normal limits in size and demonstrates no focal

abnormality. The echotexture of the liver is within normal limits.

Cholecystostomy tube is demonstrated within the relatively contracted

gallbladder. Contraction limits evaluation. Gallbladder wall

thickening demonstrated at least partially due to the degree of

contraction. No pericholecystic fluid is demonstrated. There is no

evidence for gallbladder wall thickening or pericholecystic fluid. No

intrahepatic or extrahepatic ductal dilatation is identified. The

proximal common duct measures 5 mm in diameter. The distal duct is

obscured. The sonographic Murphy' sign is negative.

The spleen is within normal limits in size measuring 8.8 cm in

craniocaudal dimension.

The visualized portions of the pancreas are unremarkable. The head

and tail are obscured by overlying bowel gas.

No free fluid is present in the upper abdomen.

The visualized proximal intraabdominal aorta is unremarkable. The

visualized portions of the upper IVC are unremarkable. There is

normal hepatopetal flow in the main portal vein.

The right kidney measures approximately 12.0 cm in length and the

left kidney measures 12.6 cm in length. There is no evidence for

hydronephrosis or definite shadowing calculus of either kidney. Renal

cortical echogenicity is within normal limits. There is

redemonstration of a lobulated multiseptated parapelvic left renal

cyst which measures 4.2 x 3.8 x 4.0 cm. No internal color flow is

demonstrated. The urinary bladder is not fully distended limiting

evaluation however no abnormality is seen.

Impression

Redemonstration of cholecystostomy drain within the contracted

gallbladder. Thickened wall again likely at least partially

secondary to contraction. No duct dilatation.

Multi-septated and lobulated parapelvic left renal cyst not

significantly changed from recent study. Advise follow up. Consider

further evaluation with renal mass protocol CT to evaluate for

significantly enhancing septae.

Attending Radiologist: CUNNINGHAM, ROBIN

Ordered By: YEUNG, POMIN

Order Date/Time: January 13, 2016 1:05 AM

Scan Initiation Date/Time: January 13, 2016 2:37 PM

Completion Date/Time: January 13, 2016 3:10 PM

Encounter Number: 010095201306

Accession Number: 6547829

Images were reviewed and interpreted by Attending Radiologist: Dr. CUNNINGHAM, ROBIN

Electronically Signed On: January 13, 2016 3:35 PM by Dr. CUNNINGHAM, ROBIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/15/2016 3:23:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR CHANGE IN CONSCIOUSNESS

History and Indication

CONFUSION , RECENT SDH

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

CT head from 01/ 11 /2016

Findings

There is no loss of gray-white matter distinction or other sign of

acute transcortical infarction. There is a stable left frontoparietal

iso attenuating subdural hematoma exerting essentially no mass effect

on the adjacent brain parenchyma, measuring approximately 3

millimeters in the left parietal region, perhaps slightly thinner on

the current study, and 2 millimeters in left frontal region. There is

no midline shift.

There are patchy foci of hypoattenuation within the periventricular

and subcortical white matter most compatible with microvascular

ischemic changes given the appearance of atherosclerotic vascular

calcifications.

The sulci are prominent and there is mild cerebral atrophy.

The calvarium is intact. There is a partially empty sella.

There is prominence of the right inferior nasal turbinate secondary

to mucosal thickening. There is no significant disease in the

remaining visualized paranasal sinuses and mastoids.

Bilateral proptosis.

Impression

1. No CT evidence of acute transcortical infarction. No new

intracranial hemorrhage.

2. Left frontoparietal iso attenuating subdural hematoma,

perhaps minimally thinner on the current study.

Attending Radiologist: FILATOV, ALEXANDER

Ordered By: HOELZER, MAUREEN

Order Date/Time: January 15, 2016 8:35 AM

Scan Initiation Date/Time: January 15, 2016 3:15 PM

Completion Date/Time: January 15, 2016 3:23 PM

Encounter Number: 010095201306

Accession Number: 6551113

Images were reviewed and interpreted by Attending Radiologist: Dr. FILATOV, ALEXANDER

Electronically Signed On: January 15, 2016 4:26 PM by Dr. FILATOV, ALEXANDER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/16/2016 1:38:00 AM

Report Name: MRA HEAD WO IV CONTRAST

Examination

MRA Head without contrast

Clinical History

EVALUATE FOR ANEURYSM

History and Indication

78 /M WITH A HISTORY OF REFRACTORY NON HODKINS LYMPHOMA (DIFFUSE B

CELL LYMPHOMA) AND CLL S/P CHEMOTHERAPY NOW WITH COMPLETE INABILITY

TO ABDUCT THE LEFT EYE AND ALSO WITH ASYMMETRIC PUPILLARY RESPONSE

Technique

3D TOF

Comparison

No prior studies are available for comparison.

Findings

There is no occlusive disease, aneurysm or AVM noted. Bilateral

posterior communicating arteries are visualized.

Impression

No evidence of intracranial vascular occlusion, aneurysm, or vascular

malformation.

Attending Radiologist: BANGIYEV, LEV

Ordered By: YEUNG, POMIN

Order Date/Time: January 15, 2016 9:50 PM

Scan Initiation Date/Time: January 16, 2016 12:08 AM

Completion Date/Time: January 16, 2016 1:38 AM

Encounter Number: 010095201306

Accession Number: 6552255

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 16, 2016 8:58 AM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/16/2016 1:20:00 AM

Report Name: MRI BRAIN WO AND WITH IV CONTRAST

Examination

MRI BRAIN WO AND WITH IV CONTRAST/STAT

Clinical History

R/MASS EFFECT UPON OCULOMOTOR NERVE

History and Indication

78 /M WITH A HISTORY OF REFRACTORY NON HODKINS LYMPHOMA (DIFFUSE B

CELL LYMPHOMA) AND CLL S/P CHEMOTHERAPY NOW WITH COMPLETE INABILITY

TO ABDUCT THE LEFT EYE AND ALSO WITH ASYMMETRIC PUPILLARY RESPONSE

Technique

Multiple sequences were obtained through the brain without and with

intravenous gadolinium.

Contrast

Contrast Agent GADAVIST 7.4 milliliters 01/16/2016 INTRAVENOUS

Comparison

Non contrast head CT dated 01/11/2016.

Findings

There is unchanged in thickness subacute trace subdural hematoma

along the left parietal convexity. There is no abnormal diffusion

restriction to suggest acute or subacute infarct. There is no mass

or appreciable mass effect. There is prominence of the ventricles,

sulci, and fissures consistent with age related volume loss.

Scattered punctate foci of subcortical, periventricular, and deep

white matter T2/FLAIR hyperintensity in consistent with mild chronic

microvascular disease. The pituitary gland is normal in size.

The major intracranial vascular structures demonstrate T2 flow voids.

The orbits and visualized soft tissues are unremarkable. The

visualized paranasal sinuses and right mastoid air cells are clear.

There is partial opacification of the left mastoid air cells.

Impression

Unchanged trace subacute subdural hematoma along the left parietal

convexity.

Mild chronic microvascular disease with age related volume loss.

Attending Radiologist: BANGIYEV, LEV

Ordered By: YEUNG, POMIN

Order Date/Time: January 15, 2016 9:50 PM

Scan Initiation Date/Time: January 16, 2016 12:08 AM

Completion Date/Time: January 16, 2016 1:20 AM

Encounter Number: 010095201306

Accession Number: 6552254

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 16, 2016 9:19 AM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/20/2016 4:20:00 PM

Report Name: FLUORO LUMBAR PUNCTURE BY NEURO RAD

Clinical History

Left cranial nerve III palsy

Technique

Lumbar puncture under fluoroscopic guidance.

H\T\P, labs and imaging reviewed. Informed consent was obtained.

The patient was placed in the prone position and the L2-3 interspace

was localized under realtime fluoroscopy. Sedation was administered

by anesthesia team. The overlying soft tissues were prepped and

draped in the usual sterile fashion. Local anesthesia was achieved

with 2% Xylocaine without epinephrine.

A 20 gauge 3.5 inch spinal needle was advanced into the thecal sac

using a right interlaminar approach under fluoroscopic guidance, and

the stylette removed.

Upon conclusion of the procedure, the stylette was replaced, the

spinal needle withdrawn, and the tract obliterated. A sterile

dressing was applied.

The patient tolerated the procedure well and there were no immediate

complications. The patient was taken to the recovery room by

anesthesia for postprocedure monitoring.

Comparison

None

Findings

Straw-colored CSF was encountered and 17 cc were collected for

laboratory analysis.

Impression

Status post successful fluoroscopically guided lumbar puncture.

Attending Radiologist: FILATOV, ALEXANDER

Ordered By: MASSASATI, LAMAH

Order Date/Time: January 18, 2016 6:00 AM

Scan Initiation Date/Time: January 20, 2016 2:53 PM

Completion Date/Time: January 20, 2016 4:20 PM

Encounter Number: 010095201306

Accession Number: 6553213

Images were reviewed and interpreted by Attending Radiologist: Dr. FILATOV, ALEXANDER

Electronically Signed On: January 20, 2016 4:39 PM by Dr. FILATOV, ALEXANDER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095201306

Report Date/Time: 1/25/2016 7:07:00 PM

Report Name: MRI BRAIN WO AND WITH IV CONTRAST

Examination

MRI BRAIN WO AND WITH IV CONTRAST/URGENT

Clinical History

SDH VS LYMPHOMA

History and Indication

PRESENTED WITH SDH AND COURSE COMPLICATED BY CNIII PALSY, LP

CONSISTENT WITH CARCINOMATOSIS, WOULD LIKE TO ASSESS IF SDH IS

LYMPHOMATOUS PROCESS INSTEAD

Technique

Multiple sequences were obtained through the brain without and with

intravenous gadolinium.

Contrast

Contrast Agent GADAVIST 7.5 milliliters 01/25/2016 INTRAVENOUS

Comparison

No images available for comparison.

Findings

Stable tiny subacute left frontoparietal convexity subdural hematoma

measuring 0.3 cm in maximal thickness. There is thickening and

enhancement of the left frontoparietal pachymeninges (series 105,

image 155). No associated mass effect or midline shift. There are

small foci of leptomeningeal enhancement in the left occipital lobe

and along the inferior aspect of the left cerebellum.

There is no area of abnormal restricted diffusion to suggest acute

infarction.

Stable tiny focus of susceptibility artifact seen within the left

superior parietal lobe with associated T2 hypointensity, consistent

with cavernous hemangioma. Scattered tiny deep cortical white matter

and periventricular nodular FLAIR hyperintensities are consistent

with chronic microvascular changes.

The ventricles are prominent in size, stable from prior examination.

Involutional changes are within normal limits for patient's age.

The pituitary gland is normal in size.

Normal flow void is noted in the major arteries of the circle of

Willis. Persistent fetal origin of the right posterior cerebral

circulation.

There is no significant disease in the paranasal sinuses.

The orbits are grossly unremarkable.

Impression

Stable tiny subacute left frontoparietal convexity subdural hematoma.

Thickening and enhancement of the left frontoparietal convexity

pachymeninges, given the results of lumbar puncture may represent

lymphomatous involvement versus reactive change related to subdural

hematoma.

Small punctate foci of leptomeningeal enhancement in the left

occipital lobe and along the inferior aspect of the left cerebellum.

Attending Radiologist: BANGIYEV, LEV

Ordered By: MASSASATI, LAMAH

Order Date/Time: January 25, 2016 4:25 PM

Scan Initiation Date/Time: January 25, 2016 6:25 PM

Completion Date/Time: January 25, 2016 7:07 PM

Encounter Number: 010095201306

Accession Number: 6563395

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 26, 2016 9:21 AM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095205265

Report Date/Time: 1/6/2016 7:44:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Chest pain.

Technique

AP portable radiograph of the chest.

Comparison

Radiograph of the chest from 07/22/15 .

Findings

The left costophrenic angle is not included in the study.

Cervical fusion hardware is re- demonstrated. There is relative

paucity of vascular markings in the left hemithorax as well as

overall lucency. This is unchanged when compared with the prior chest

radiographs on unenhanced CT 11/17/2015. This in part may be due to

muscular atrophy on the left side as demonstrated on the prior chest

CT.

There is no focal consolidation, large pleural effusion, pneumothorax

or pulmonary vascular congestion. Cardiac silhouette is within normal

size limits.

Partially visualized left lower healed rib fractures. No acute

fractures.

Impression

No acute cardiopulmonary process.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: NG, JENNIFER

Order Date/Time: January 6, 2016 7:20 PM

Scan Initiation Date/Time: January 6, 2016 7:27 PM

Completion Date/Time: January 6, 2016 7:44 PM

Encounter Number: 010095205265

Accession Number: 6540306

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 6, 2016 8:14 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095205265

Report Date/Time: 1/6/2016 9:32:00 PM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Examination

CHEST ROUTINE PA/AP AND LATERAL/STAT/ER

Clinical History

POSSIBLE PNEUMONIA

Presenting Diagnosis

POSSIBLE INFILTRATE

Technique

Two views of the chest are presented.

Comparison

Radiograph from the same date. At 7:27 p.m.

Findings

The bilateral costophrenic angles not included in the study.

Cervical fusion hardware is noted.

As described in the previous radiograph, there is a relative paucity

of vascular markings within the left hemithorax. This may be due to

atrophy of the pectoral muscles which is better characterized on the

CT from 11/17/2015.

There is no focal consolidation, large pleural effusion, pneumothorax

or pulmonary vascular congestion. The cardiac silhouette is within

normal size limits.

Impression

No acute cardiopulmonary process.

Attending Radiologist: FELDMANN, ERIC

Ordered By: NG, JENNIFER

Order Date/Time: January 6, 2016 7:35 PM

Scan Initiation Date/Time: January 6, 2016 9:17 PM

Completion Date/Time: January 6, 2016 9:32 PM

Encounter Number: 010095205265

Accession Number: 6540318

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 6, 2016 10:01 PM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095205265

Report Date/Time: 1/6/2016 9:32:00 PM

Report Name: ELBOW LEFT 3 VIEWS

Clinical History

Possible fracture.

Technique

2 radiographs of the left forearm.

3 radiographs of the left elbow.

2 radiographs of the left humerus.

3 radiographs of the left shoulder.

Comparison

Radiographs of the left shoulder, humerus, elbow, and forearm from

07/22/2015

Findings

There is no acute fracture or dislocation.

There are mild degenerative changes of the left acromioclavicular

joint. Evaluation is intact.

There is no elbow joint effusion. Small avian spur noted at the

distal left humeral shaft.

Impression

No acute fracture or dislocation.

Degenerative changes as described above.

Attending Radiologist: FELDMANN, ERIC

Ordered By: NG, JENNIFER

Order Date/Time: January 6, 2016 7:30 PM

Scan Initiation Date/Time: January 6, 2016 9:22 PM

Completion Date/Time: January 6, 2016 9:32 PM

Encounter Number: 010095205265

Accession Number: 6540319

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 6, 2016 10:00 PM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095205265

Report Date/Time: 1/6/2016 9:32:00 PM

Report Name: FOREARM LEFT (RADIUS AND ULNA)

Clinical History

Possible fracture.

Technique

2 radiographs of the left forearm.

3 radiographs of the left elbow.

2 radiographs of the left humerus.

3 radiographs of the left shoulder.

Comparison

Radiographs of the left shoulder, humerus, elbow, and forearm from

07/22/2015

Findings

There is no acute fracture or dislocation.

There are mild degenerative changes of the left acromioclavicular

joint. Evaluation is intact.

There is no elbow joint effusion. Small avian spur noted at the

distal left humeral shaft.

Impression

No acute fracture or dislocation.

Degenerative changes as described above.

Attending Radiologist: FELDMANN, ERIC

Ordered By: NG, JENNIFER

Order Date/Time: January 6, 2016 7:35 PM

Scan Initiation Date/Time: January 6, 2016 9:29 PM

Completion Date/Time: January 6, 2016 9:32 PM

Encounter Number: 010095205265

Accession Number: 6540320

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 6, 2016 10:00 PM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095205265

Report Date/Time: 1/6/2016 9:32:00 PM

Report Name: SHOULDER LEFT TRAUMA VIEW

Clinical History

Possible fracture.

Technique

2 radiographs of the left forearm.

3 radiographs of the left elbow.

2 radiographs of the left humerus.

3 radiographs of the left shoulder.

Comparison

Radiographs of the left shoulder, humerus, elbow, and forearm from

07/22/2015

Findings

There is no acute fracture or dislocation.

There are mild degenerative changes of the left acromioclavicular

joint. Evaluation is intact.

There is no elbow joint effusion. Small avian spur noted at the

distal left humeral shaft.

Impression

No acute fracture or dislocation.

Degenerative changes as described above.

Attending Radiologist: FELDMANN, ERIC

Ordered By: NG, JENNIFER

Order Date/Time: January 6, 2016 7:35 PM

Scan Initiation Date/Time: January 6, 2016 9:18 PM

Completion Date/Time: January 6, 2016 9:32 PM

Encounter Number: 010095205265

Accession Number: 6540321

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 6, 2016 10:00 PM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095205265

Report Date/Time: 1/6/2016 9:32:00 PM

Report Name: HUMERUS LEFT

Clinical History

Possible fracture.

Technique

2 radiographs of the left forearm.

3 radiographs of the left elbow.

2 radiographs of the left humerus.

3 radiographs of the left shoulder.

Comparison

Radiographs of the left shoulder, humerus, elbow, and forearm from

07/22/2015

Findings

There is no acute fracture or dislocation.

There are mild degenerative changes of the left acromioclavicular

joint. Evaluation is intact.

There is no elbow joint effusion. Small avian spur noted at the

distal left humeral shaft.

Impression

No acute fracture or dislocation.

Degenerative changes as described above.

Attending Radiologist: FELDMANN, ERIC

Ordered By: NG, JENNIFER

Order Date/Time: January 6, 2016 7:35 PM

Scan Initiation Date/Time: January 6, 2016 9:20 PM

Completion Date/Time: January 6, 2016 9:32 PM

Encounter Number: 010095205265

Accession Number: 6540323

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 6, 2016 10:00 PM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095205265

Report Date/Time: 1/7/2016 9:08:00 AM

Report Name: CT CHEST ANGIO WO AND WITH IV CONTRAST

Clinical History

58-year-old male with history of GBM. Desaturation.

Findings

PA and lateral scout images were not acquired. Infiltration of

patient's IV access site in the right mid humerus/upper arm. The

patient was asymptomatic without risk factors of compartment

syndrome.

The examination was deferred.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: NG, JENNIFER

Order Date/Time: January 6, 2016 9:50 PM

Scan Initiation Date/Time: January 6, 2016 11:52 PM

Completion Date/Time: January 7, 2016 9:08 AM

Encounter Number: 010095205265

Accession Number: 6540409

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 7, 2016 9:25 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095205265

Report Date/Time: 1/7/2016 8:27:00 PM

Report Name: CT CHEST ANGIO WO AND WITH IV CONTRAST

Examination

CT angiography of Chest (PE).

Clinical History

IMMOBILITY, HYPOXIA

GBM

Technique

Routine study utilizing thin sections. Post processed

reconstructions.

Contrast

Contrast Agent OMNIPAQUE 350 75 milliliters 01/07/2016 INTRAVENOUS

Comparison

Contrast-enhanced chest and abdominal pelvic CT dated 01/15/2014.

Findings

BASE OF NECK: Unremarkable thyroid.

LUNGS: No discrete infiltrates. Diffuse bronchial wall thickening

predominantly in the dependent portions of both lower lobes.

Clinical correlation is recommended as chronic aspiration pneumonitis

and early pneumonia given their location. Patchy parenchymal opacity

in the right middle lobe on image 226 which may represent a focal

area of atelectasis and or pneumonia in the appropriate clinical

setting.

LARGE AIRWAYS: Patent.

PLEURA: No effusion or pneumothorax.

VESSELS: No filling defects in pulmonary arteries to indicate

pulmonary embolus. Normal caliber thoracic aorta.

HEART: Normal size. Small pericardial effusion.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

BONES: No acute fractures.

UPPER ABDOMEN: No pathology.

Impression

No evidence of pulmonary embolus.

Small pericardial effusion.

Dependent bibasilar bronchial wall thickening. Clinical correlation

is recommended as to aspiration pneumonitis and early pneumonia.

Focal parenchymal opacity in the right middle lobe which may

represent atelectasis and or infiltrate in the appropriate clinical

setting.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: SHEMI, TIVERE

Order Date/Time: January 7, 2016 11:45 AM

Scan Initiation Date/Time: January 7, 2016 8:16 PM

Completion Date/Time: January 7, 2016 8:27 PM

Encounter Number: 010095205265

Accession Number: 6541100

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 7, 2016 8:58 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095205265

Report Date/Time: 1/13/2016 11:31:00 AM

Report Name: SPEECH PATHOLOGY VIDEO SWALLOW

Clinical History

GMB, ASPIRATION PNEUMONITIS. Status post anterior cervical spine

fusion.

History and Indication

EVALUATE FOR ASPIRATION

Technique

Scout radiograph was not performed.

Swallow study performed by speech pathologist under fluoroscopic

guidance.

Dose \T\ Comments

2.39 FL TIME DR TANK, AUDREY

Comparison

No comparison available

Findings

Per policy, scout films were not obtained or were previously

performed.

Evaluation of the video fluoroscopic images demonstrated partially

visualized lower cervical spine hardware. .

Please refer to speech pathologist report for swallowing/aspiration

findings and feeding recommendations.

Impression

Please refer to the official speech pathology report for evaluation

of aspiration and feeding recommendations/restrictions.

Partially visualized lower cervical spine postoperative changes.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: JAGLALL, NEIL

Order Date/Time: January 12, 2016 11:55 AM

Scan Initiation Date/Time: January 13, 2016 11:16 AM

Completion Date/Time: January 13, 2016 11:31 AM

Encounter Number: 010095205265

Accession Number: 6546855

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 13, 2016 3:48 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095214291

Report Date/Time: 1/6/2016 5:15:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Possible pneumonia.

Technique

AP portable radiograph of the chest.

Comparison

Chest radiograph from 03/11/2015

Findings

There is mild to moderate pulmonary vascular congestion and enlarged

cardiac silhouette. The left costophrenic angle is not completely

visualized. There is no definite focal consolidation or large pleural

effusion.

Impression

Moderate pulmonary vascular congestion and cardiomegaly. .

No definite focal consolidation.

Attending Radiologist: EISENBERG, JASON

Ordered By: HO, DIEU-HUONG

Order Date/Time: January 6, 2016 4:45 PM

Scan Initiation Date/Time: January 6, 2016 5:07 PM

Completion Date/Time: January 6, 2016 5:15 PM

Encounter Number: 010095214291

Accession Number: 6540152

Images were reviewed and interpreted by Attending Radiologist: Dr. EISENBERG, JASON

Electronically Signed On: January 6, 2016 6:26 PM by Dr. EISENBERG, JASON

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095214291

Report Date/Time: 1/6/2016 8:33:00 PM

Report Name: CT CHEST ANGIO WO AND WITH IV CONTRAST

Examination

CT angiography of Chest (PE).

Clinical History

POSSIBLE PULMONARY EMBOLUS

Technique

Routine study utilizing thin sections. Post processed

reconstructions.

Contrast

Contrast Agent OMNIPAQUE 350 115 milliliters 01/06/2016

Comparison

Comparison is made to CTA of the chest from 12 12/2014

Findings

BASE OF NECK: Unremarkable thyroid.

LUNGS: Multiple foci of ground-glass opacities involving bilateral

upper and lower lobes, greater on the right.

LARGE AIRWAYS: Patent.

PLEURA: No effusion or pneumothorax.

VESSELS: There are multiple filling defects involving bilateral main

pulmonary arteries with extension into lobar and segmental pulmonary

arteries. The main pulmonary artery is dilated measuring 4

centimeters is likely secondary to pulmonary arterial hypertension.

Normal caliber thoracic aorta.

HEART: Normal size. No pathologic pericardial effusion. There is

backflow of contrast into the IVC which suggest right-sided heart

strain.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

BONES: Within normal limits for age. No focal lesion.

UPPER ABDOMEN: No pathology.

Impression

1. Bilaterally pulmonary emboli involving both the right and

left main pulmonary arteries and their branches consisting of a high

clot burden. Secondary sign of right-sided heart strain with

backflow of contrast into the IVC is noted.

2. There are multiple foci of ground-glass opacities involving

bilateral upper and lower lobes, greater on the right (axial images

43 through 58 in particular) highly concerning for pulmonary

infarction given the clot burden. Areas of pneumonitis or pneumonia

cannot be excluded.

3. The findings were discussed with Dr. Gentile at 8:37 p.m.

01/06/2016

Attending Radiologist: ZAWIN, MARLENE

Ordered By: HO, DIEU-HUONG

Order Date/Time: January 6, 2016 5:00 PM

Scan Initiation Date/Time: January 6, 2016 8:16 PM

Completion Date/Time: January 6, 2016 8:33 PM

Encounter Number: 010095214291

Accession Number: 6540176

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 6, 2016 8:56 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095214291

Report Date/Time: 1/7/2016 9:00:00 AM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: ROBERT ASANTO Exam Date: 1/7/2016 at 8:19:08 AM Heart

Rate: 84

MR #: 30573125 Report Date: 1/7/2016 Rhythm:

Sinus Rhythm

ACC #: 6540360 Height: 177.80 cm BP: 129/88

DOB: 1/2/1975 Weight: 263.09 kg Location:

17S MICU

Age/Sex: 41 years / M BSA: 3.28 m²

Ref. Physician: WRIGHT, cc:

Sonographer: CF

Fellow: ML

Indications: ASSESS LV/RV

History: PULMONARY EMBOLISM, OBESE, HTN, DVT

Procedure: Comp. Echo w/contrast - C8929, Patient intubated, Patient

Supine and

Portable. The use of contrast was indicated for

enhancement of

endocardial border definition. There were no

contraindications for

the use of contrast in this patient. Verbal consent was

given by the

patient who is aware of the possible adverse reactions

associated

with the use of contrast. No adverse reactions or

hemodynamic

compromise identified.

Study Quality: This was a technically difficult study.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.12 cm 2.0 - 3.8 LA Diam 3.10 cm 3.0-4.0

IVS 1.29 cm 0.6 - 1.0 LA Area 23.3cm² <=20

LVID 4.96 cm 4.2 - 5.9 3.93 cm LA Vol 68.00 ml 18-58

LVPW 1.23 cm 0.6 - 1.0 LA Vol/BSA 20.72ml/m² 22+ / -6

RA Diam 5.3cm 2.9-4.5

Ao at the sinuses 3.40 cm

Ao Ascending 3.30 cm

Ao Arch 3.4 cm

LV FS 20.8

Aov Cusp Sep 1.90 cm

(Systole)

Aov VTI 0.142 m LVOT VTI 0.090 m LVOT diameter

2.30

cm

Aov VMax 0.95 m/s LVOT Vmax 0.50 m/s Dimensionless

Index 0.53

Aov Pk Pressure 3.6 mmHg Aov Mn 2.0 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 2.62 cm² Aov Area Index 0.80 cm²/m²

(VTI)

MV E Vmax 0.58 m/s MV A Vmax 0.82 m/s E/A 0.71

TR Vmax 3.89 m/s TR Pk Grad 60.5 mmHg RA Pressure 8 mmHg RVSP 68.5

mmHg

PV Vmax 1.05 m/s PV Pk Grad 4.4 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

mildly increased. The relative wall thickness is moderately increased

(0.51). Global systolic function is probably normal based on limited

images. Left ventricular basal fractional shortening is decreased. No

regional wall motion abnormalities are seen.

Left Ventricle - Diastole:The Doppler derived transmitral left

ventricular inflow velocity pattern is A wave dominant. The overall

diastolic function is mildly impaired (grade I, impaired relaxation

pattern) with normal left ventricular filling pressures.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is not well seen. The right atrium is

moderately dilated in size. Inferior vena cava diameter is dilated

(>2.1cm) with normal respiratory variability consistent with a right

atrial pressure of 8 mmHg.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricle is not well seen. Global right

ventricular systolic function is low normal. The tricuspid annular

plane systolic excursion is 1.4 cm consistent with reduced right

ventricular systolic function. The right ventricular systolic

pressure, as estimated using the tricuspid regurgitation velocity, is

68.5 mmHg.

Aortic Valve: The aortic valve was not well seen. Trace aortic valve

insufficiency is present.

Mitral Valve: The mitral valve leaflets are thickened. Mitral leaflet

mobility is normal. Trace mitral regurgitation is present.

Tricuspid Valve: The tricuspid valve is not well seen. Mild-moderate

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is not well visualized.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.40 cm. The ascending aorta is normal at 3.30 cm. The

aortic arch is normal at 3.4 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 3.89 m/s, and

with an assumed right atrial pressure of 8 mmHg, the estimated

pulmonary artery systolic pressure is moderately elevated at 68.5

mmHg.

Pericardium: No pericardial effusion seen.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 12/23/14. There is no significant change in the findings since

the last echocardiogram.

Summary:

1. Technically difficult study despite use of Definity due to poor

echo windows.

2. Normal left ventricular cavity size.

3. Mildly increased left ventricular wall thickness.

4. Moderately increased relative wall thickness.

5. Probably normal left ventricular systolic function.

6. No regional left ventricular wall motion abnormalities.

7. Not all segments of the left ventricle were well imaged.

8. Mild diastolic dysfunction with normal left ventricular filling

pressures.

9. Low normal right ventricular systolic function.

10. Moderately dilated right atrial size.

11. Normal atrial septum by 2D and color Doppler.

12. The aortic valve was not well seen.

13. Trace aortic insufficiency.

14. Thickened mitral valve leaflets.

15. Normal mitral mobility.

16. Trace mitral regurgitation.

17. Mild-moderate tricuspid regurgitation.

18. Moderately elevated pulmonary artery systolic pressure.

19. Normal aortic root diameter for body size.

20. No pericardial effusion.

014970 Smadar Kort MD, FACC, FASE

Electronically signed by 014970 Smadar Kort MD, FACC, FASE on

1/7/2016 at 11:03:41 AM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: GENTILE, STEPHANIE

Order Date/Time: January 6, 2016 8:40 PM

Scan Initiation Date/Time:

Completion Date/Time: January 7, 2016 9:00 AM

Encounter Number: 010095214291

Accession Number: 6540360

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: January 7, 2016 11:03 AM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095258876

Report Date/Time: 1/7/2016 5:04:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Shortness of breath.

Technique

AP portable radiograph of the chest.

Comparison

Chest radiograph from 12/12/2015

Findings

Patient is status post median sternotomy and left subclavian approach

unipolar AICD. Patient status post mitral valve annuloplasty.

The cardiac silhouette is enlarged and there is pulmonary edema.

There are small bilateral pleural effusions with subsegmental

atelectasis at the bases. There is no pneumothorax.

Impression

Pulmonary edema and cardiomegaly with small pleural effusions and

subsegmental atelectasis at the bases, increased from prior study.

Correlate for CHF decompensation.

Attending Radiologist: BLUESTONE, AVRAHAM

Ordered By: LEIBNER, EVAN

Order Date/Time: January 7, 2016 4:45 PM

Scan Initiation Date/Time: January 7, 2016 4:59 PM

Completion Date/Time: January 7, 2016 5:04 PM

Encounter Number: 010095258876

Accession Number: 6541702

Images were reviewed and interpreted by Attending Radiologist: Dr. BLUESTONE, AVRAHAM

Electronically Signed On: January 7, 2016 5:18 PM by Dr. BLUESTONE, AVRAHAM

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095258876

Report Date/Time: 1/8/2016 10:19:00 AM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: ROD E HARRIS Exam Date: 1/8/2016 at 9:26:32 AM Heart Rate:

MR #: 00234103 Report Date: 1/8/2016 Rhythm:

ACC #: 6542004 Height: 165.10 cm BP: 130/64

DOB: 6/24/1970 Weight: 89.81 kg Location:

4L ER

Age/Sex: 45 years / M BSA: 1.97 m²

Ref. Physician: WADHWA, cc:

Sonographer: SAJ

Indications: CHF

History: MECHANICAL MV 2/15, SOB, CAD, CABG, ESRD, PVD, DM, AICD

Procedure: Comp. Echo w/contrast - C8929, Definity Contrast - Q9957

and Patient

Sitting Upright. The use of contrast was indicated for

enhancement of

endocardial border definition. There were no

contraindications for

the use of contrast in this patient. Verbal consent was

given by the

patient who is aware of the possible adverse reactions

associated

with the use of contrast. No adverse reactions or

hemodynamic

compromise identified.

Study Quality: Due to technical issues, the quality of the study was

limited.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.26 cm 2.0 - 3.8 LA Diam 4.60 cm 3.0-4.0

IVS 0.93 cm 0.6 - 1.0 LA Area 19.6cm² <=20

LVID 5.31 cm 4.2 - 5.9 3.98 cm LA Vol 54.50 ml 18-58

LVPW 0.93 cm 0.6 - 1.0 LA Vol/BSA 27.67ml/m² 22+ / -6

RA Diam 4.32cm 2.9-4.5

Ao at the sinuses 2.40 cm

Ao Ascending 2.75 cm

Ao Arch 2.24 cm

LVEF 52 % (biplane method of discs)

LV FS 25.0

LV SV 82.0 ml

LV SI 41.6 ml/m²

Aov Cusp Sep 1.50 cm

(Systole)

Aov VTI 0.352 m LVOT VTI 0.216 m LVOT diameter

1.80 cm

Aov VMax 1.82 m/s LVOT Vmax 1.18 m/s Dimensionless

Index 0.65

Aov Pk Pressure 13.3 mmHg Aov Mn 7.2 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 1.56 cm² Aov Area Index 0.79 cm²/m²

(VTI)

MV Pk Gradient mmHg MV Mn Gradient 4.8

MV VTI MV DT 180 msec

MV E Vmax 1.85 m/s MV A Vmax 0.65 m/s E/A 2.83

MV Area press 1/2 Time 4.22

IVRT E/E ' 46.25

Septal E ' 0.030 m/s Prop Velocity

Lateral E ' 0.04 m/s LA Pressure 67.44 mmHg

Average E' 0.035 m/s

MV Average E/E' 52.86

TR Vmax 2.72 m/s TR Pk Grad 29.6 mmHg RA Pressure 15 mmHg RVSP

44.6 mmHg

TV E Max TV Mn Grad mmHg PHT 52.08 msec TV VTI

PV Vmax 1.43 m/s PV Pk Grad 8.2 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

normal. The relative wall thickness is normal (0.35). Global left

ventricular systolic function is mildly reduced. The ejection

fraction is 52% by biplane method of discs. Left ventricular basal

fractional shortening is decreased. The basal inferior wall is

severely hypokinetic. The mid inferior wall is severely hypokinetic.

There is abnormal (paradoxical) septal motion consistent with

post-operative status.

Left Atrium: The left atrium is mildly dilated in size.

Right Atrium: The right atrium is normal in size. Inferior vena cava

diameter is dilated (>2.1cm) without normal respiratory variability

consistent with a right atrial pressure of 15 mmHg.

Atrial Septum: Atrial septum is not well visualized. Atrial septum is

structurally normal and intact on 2D and color Doppler interrogation.

Right Ventricle: The right ventricle is not well seen. The right

ventricular size is mildly enlarged. The right ventricular fractional

area change is 36.14% which is normal. The tricuspid annular plane

systolic excursion is 2.08 cm consistent with normal right

ventricular systolic function. The right ventricular systolic

pressure, as estimated using the tricuspid regurgitation velocity, is

44.6 mmHg.

Right Heart Catheters/Leads: Catheter consistent with pacemaker or

defibrillator lead seen in the right heart.

Aortic Valve: The aortic valve leaflets are not well seen. Normal

Doppler interrogation flow patterns without stenosis or

insufficiency. No evidence of aortic valve insufficiency is present.

Mitral Valve: A mechanical prosthetic valve is present in the mitral

position. The mitral prosthesis appears to be well seated. There is

no evidence of a paravalvular leak. The mean pressure gradient across

the prosthesis is within normal limits. The peak early diastolic

velocity across the prosthetic mitral valve is 1.85 m/s. The mean

gradient across the prosthetic mitral valve is 4.8 mmHg. The pressure

half time is normal at 52 msec. Based on these parameters no stenosis

of the mitral valve prosthesis is present. Trace mitral regurgitation

is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Trace

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is not well visualized.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 2.40 cm. The ascending aorta is normal at 2.75 cm. The

aortic arch is normal at 2.24 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.72 m/s, and

with an assumed right atrial pressure of 15 mmHg, the estimated

pulmonary artery systolic pressure is mildly elevated at 44.6 mmHg.

Pericardium: No pericardial effusion seen.

Miscellaneous: Left pleural effusion noted.

Comparison: Prior examinations are available and were reviewed for

comparison purposes. The most recent available prior study is from

12/1/2015. There is no significant change in the findings since the

last echocardiogram.

Summary:

1. Normal left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Mildly reduced global left ventricular systolic function.

4. Abnormal septal motion consistent with a post-operative status.

5. Segmental wall motion abnormalities (see above).

6. Mildly enlarged right ventricle.

7. Mildly dilated left atrial size.

8. Aortic leaflets are not well seen.

9. No aortic stenosis or insufficiency.

10. Normally functioning mitral valve prosthesis.

11. Mechanical prosthetic valve in the mitral position.

12. No evidence of mitral prosthetic paravalvular leak.

13. No evidence of stenosis of the prosthetic mitral valve.

14. Trace mitral regurgitation.

15. Trace tricuspid regurgitation.

16. Mildly elevated pulmonary artery systolic pressure.

17. No pericardial effusion.

18. Normal aortic root diameter for body size.

19. Normal atrial septum by 2D and color Doppler.

20. Left pleural effusion.

015260 Kathleen Stergiopoulos MD, PhD, FASE, FACC

Electronically signed by 015260 Kathleen Stergiopoulos MD, PhD, FASE,

FACC on 1/8/2016 at 11:14:06 AM

\*\*\* Final \*\*\*

Attending Cardiologist: STERGIOPOULOS, KATHLEEN

Ordered By: SHEHZAD, USMAN

Order Date/Time: January 8, 2016 2:10 AM

Scan Initiation Date/Time:

Completion Date/Time: January 8, 2016 10:19 AM

Encounter Number: 010095258876

Accession Number: 6542004

Images were reviewed and interpreted by Attending Cardiologist: Dr. STERGIOPOULOS, KATHLEEN

Electronically Signed On: January 8, 2016 11:14 AM by Dr. STERGIOPOULOS, KATHLEEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095258876

Report Date/Time: 1/8/2016 2:40:00 PM

Report Name: ULTRASOUND KIDNEY TRANSPLANT EVAL

Examination

ULTRASOUND KIDNEY TRANSPLANT EVAL/URGENT

Clinical History

45 YO S/ TRANSPLANT

History and Indication

EVALUATE TRANSPLANTED KIDNEY EVALUATE FOR OBSTRUCTION, MASS, STONE

Technique

Grayscale ultrasound, color Doppler aspect of Doppler interrogation

were utilized to evaluate the transplant kidney.

Comparison

07/03/2008

Findings

The left transplant kidney measures 13.1 x 5.6 x 4.8 cm in size.

Mild fullness of the renal collecting system is noted without

evidence of hydronephrosis. There is no evidence for perinephric

fluid collection. Specifically, no definite hypoechoic peri

transplant collections are identified, although isoechoic collections

may be inconspicuous sonographically.

The renal parenchyma appears of normal echogenicity.

Resistive indices are upper normal limits with intrarenal RI's

ranging from 0.73 to 0.84.

The iliac artery demonstrates normal triphasic waveform with

approximate velocity of 159 cm/sec.

The main renal artery, feeding iliac artery and arterial anastomosis

have normal waveforms.

The main renal artery velocity is approximately 228 cm/second at the

anastomosis, estimated at 145 cm/sec proximally near the anastomosis,

89 cm/sec in the midportion and 108 cm/sec distally near the

transplant hilum.

Velocity exceeding 200cm/s or velocity ratio >2 is consistent with a

hemodynamically significant stenosis.

The main renal vein and iliac vein draining the transplant are patent

with normal waveforms.

The urinary bladder is distended and appears grossly unremarkable.

Impression

1. Mild fullness of the collecting system without evidence of

hydronephrosis.

2. Resistive indices upper normal limits.

This is a nonspecific finding occurring most frequently in the

setting of rejection, although the differential includes ATN, drug

toxicity, to name a few possibilities. Clinical correlation is

recommended.

Attending Radiologist: ABBASI, ALMAS

Ordered By: GARRIDO SANABRIA, EMILIO

Order Date/Time: January 8, 2016 12:45 PM

Scan Initiation Date/Time: January 8, 2016 2:05 PM

Completion Date/Time: January 8, 2016 2:40 PM

Encounter Number: 010095258876

Accession Number: 6542707

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: January 8, 2016 2:49 PM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095262936

Report Date/Time: 1/7/2016 11:29:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Seizure disorder.

Technique

AP chest

Comparison

1 year ago

Findings

Right internal jugular line tip overlies the superior vena cava

atrial junction. There is severe pulmonary vascular congestion and

low lung volumes. Superimposed lower lobe consolidation/atelectasis

is also possible. Bones are unchanged. Heart size is grossly normal.

Impression

As above.

Attending Radiologist: FELDMANN, ERIC

Ordered By: YUAN, DEREK

Order Date/Time: January 7, 2016 10:15 PM

Scan Initiation Date/Time: January 7, 2016 11:23 PM

Completion Date/Time: January 7, 2016 11:29 PM

Encounter Number: 010095262936

Accession Number: 6541915

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 7, 2016 11:36 PM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095262936

Report Date/Time: 1/8/2016 3:17:00 PM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/STAT

Clinical History

HX OF MULTIPLE SEIZURE, NEED TUBE PLACEMENT FOR MEDS

Additional History

LINE OR TUBE PLACEMENT

Technique

2 dedicated radiographs for NG tube placement

Comparison

1/7/2016

Findings

There is interval advancement of the enteric tube which on the

radiograph performed at 2:53 p.m. shows the distal tip well within

the stomach. In the visualized lungs, there are airspace opacities at

the lung bases. The cardiomediastinal silhouette is within normal

limits. Partially visualized ia a right IJ central venous catheter

with distal tip in the cavoatrial junction. The visualized abdomen is

unremarkable without evidence of obstruction or secondary signs of

free intraperitoneal air.

Impression

Interval advancement of the enteric tube which is seen overlying the

proximal stomach on the last available radiograph.

No significant change in the bibasilar airspace opacities.

Attending Radiologist: REITER, MICHAEL

Ordered By: RAO, QIN

Order Date/Time: January 8, 2016 2:45 PM

Scan Initiation Date/Time: January 8, 2016 3:00 PM

Completion Date/Time: January 8, 2016 3:17 PM

Encounter Number: 010095262936

Accession Number: 6542991

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 8, 2016 4:23 PM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095262936

Report Date/Time: 1/10/2016 11:09:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Confirm NG tube placement.

Technique

AP portable radiograph of the chest.

Comparison

Chest radiograph 01/08/2016

Findings

An NG tube is noted with its tip just distal to the GE junction.

Recommend slight advancement.

Right IJ approach central line has been removed.

Electronic device noted again in the soft tissues of the left chest

wall.

Moderate vascular congestion seen on the prior examination is almost

completely resolved.

There are perihilar/bibasilar airspace opacities consistent with

bibasilar pneumonia, which are unchanged when compared to the prior

study.

Impression

1. NG tube noted with its tip just distal to the GE junction.

Recommend slight advancement.

2. Right IJ approach central line, possibly a Quentin catheter,

has been removed.

3. Interval marked improvement in vascular congestion seen on

the prior.

4. Persistent bilateral airspace opacities consistent with

bibasilar pneumonia are without significant change.

Attending Radiologist: BALSAM, DVORAH

Ordered By: ALESSI, CATHERINE

Order Date/Time: January 10, 2016 8:15 AM

Scan Initiation Date/Time: January 10, 2016 10:56 AM

Completion Date/Time: January 10, 2016 11:09 AM

Encounter Number: 010095262936

Accession Number: 6544220

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: January 10, 2016 11:26 AM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095262936

Report Date/Time: 1/12/2016 8:07:00 AM

Report Name: F/U 2D ECHO W/WO M MODE

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: MAXMILLIAN NAGEL Exam Date: 1/12/2016 at 7:38:28 AM Heart

Rate:

MR #: 30735180 Report Date: 1/12/2016 Rhythm:

ACC #: 6545082 Height: 177.80 cm BP:

115/80

DOB: 11/12/1985 Weight: 99.79 kg

Location: 13N

Age/Sex: 30 years / M BSA: 2.17 m²

Ref. Physician: Andrew Goldfine, cc:

Sonographer: DQ

Indications: R/O Endocarditis

History: non verbal autism, seizures, pneumonia, cerebral palsy

Procedure: Limited Echo - 93308 and Patient Supine.

Measurements and Calculations

Diast Nl Nl

RV 2.64 cm 2.0 - 3.8 LA Diam 3.27 cm 3.0-4.0

Left Ventricle - Structure and Systolic Function: Global systolic

function is probably normal based on limited images. No regional wall

motion abnormalities are seen.

Mitral Valve: The mitral valve is structurally normal.

Summary:

1. Probably normal left ventricular systolic function.

2. No regional left ventricular wall motion abnormalities.

3. Not all segments of the left ventricle were well imaged.

014970 Smadar Kort MD, FACC, FASE, FAHA

Electronically signed by 014970 Smadar Kort MD, FACC, FASE, FAHA on

1/12/2016 at 9:13:10 AM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: TISOVIC, KELLY

Order Date/Time: January 11, 2016 10:25 AM

Scan Initiation Date/Time:

Completion Date/Time: January 12, 2016 8:07 AM

Encounter Number: 010095262936

Accession Number: 6545082

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: January 12, 2016 9:13 AM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095262936

Report Date/Time: 1/18/2016 2:41:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

EVALUATE FOR PNEUMONIA

Technique

AP portable

Comparison

01/10/2016

Findings

Cardiomediastinal silhouette is within normal limits. Again noted is

a vagal nerve stimulator device on the left side of the chest with

tip ending in the left side of the neck. Shallow inspiration with

crowding of vascular markings. Heterogenous opacity in the left lung

base may represent atelectasis. Small focal consolidation cannot be

excluded. No evidence of pneumothorax. Limited evaluation of lung

apices due to patient's chin overlying.

Impression

heterogenous opacity left lung base may represent atelectasis. Small

focal consolidation cannot be excluded. No significant interval

change.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: CAMERON, LAUREN

Order Date/Time: January 18, 2016 10:55 AM

Scan Initiation Date/Time: January 18, 2016 2:09 PM

Completion Date/Time: January 18, 2016 2:41 PM

Encounter Number: 010095262936

Accession Number: 6553895

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: January 18, 2016 6:36 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095262936

Report Date/Time: 1/27/2016 12:53:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

PNEUMONIA, RESOLVED ? SEIZING

Indication

EVALUATE FOR PNEUMOTHORAX

Technique

CHEST AP PORTABLE/STAT

Comparison

01/18/2016

Findings

Left upper lung is is obscured by patient's chin. The

cardiomediastinal silhouette is within normal limits. Bibasilar

atelectatic changes are seen. There is no pulmonary vascular

congestion or pleural effusion.

Impression

Bibasilar atelectatic changes.

Attending Radiologist: ABBASI, ALMAS

Ordered By: CAMERON, LAUREN

Order Date/Time: January 27, 2016 12:30 PM

Scan Initiation Date/Time: January 27, 2016 12:49 PM

Completion Date/Time: January 27, 2016 12:53 PM

Encounter Number: 010095262936

Accession Number: 6566054

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: January 27, 2016 1:58 PM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/7/2016 11:24:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Evaluated for pneumonia. Cough.

Technique

AP chest

Comparison

6 days ago

Findings

Prominent left lower lobe consolidation consistent with pneumonia.

Patchy airspace disease throughout the right lung consistent with

pneumonia. Tortuous calcified aorta. Cardiomegaly. Bronchitis /

COPD like changes. The known pulmonary nodules are not well seen.

Bones are unchanged. Heart size is prominent.

Impression

Multifocal pneumonia.

Attending Radiologist: FELDMANN, ERIC

Ordered By: LU, CHRISTINA

Order Date/Time: January 7, 2016 9:45 PM

Scan Initiation Date/Time: January 7, 2016 11:19 PM

Completion Date/Time: January 7, 2016 11:24 PM

Encounter Number: 010095263801

Accession Number: 6541906

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 7, 2016 11:33 PM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/8/2016 1:13:00 AM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Clinical History

64-year-old female with multiple medical problems including urethral

stones, status post stent placement. Patient now with complaint of

hematuria.

Technique

Routine study. Post Processed reconstructions included.

Comparison

Study on 01/06/2016.

Findings

Sensitivity for evaluation of the solid organ injury/hemorrhage is

decreased due to lack of IV contrast.

UNG BASES: Persistent bilateral pleural effusions, small on the left

and moderate sized on the right, with adjacent bibasilar atelectasis

are again noted.

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: No dilatation. Status postcholecystectomy.

PANCREAS: Atrophic pancreas noted.

SPLEEN: Normal size.

ADRENALS: 1.7 cm left adrenal nodule, unchanged compared to prior

study.

KIDNEYS: Area of hyperdensity within the right renal pelvis which may

represent blood. There is interval development of severe of left

renal hydronephrosis. Left double-J uretreal stent is unchanged in

position, with its proximal tip is in the left proximal ureter with

distal tip in the urinary bladder is noted. Multiple tiny left

intraparenchymal renal calculi are seen.

Status post right nephrectomy. Again, postsurgical changes are

visualized in the right renal bed.

BOWEL: Patient is status post right hemicolectomy. No evidence of a

small bowel obstruction. Diverticulosis without evidence of

diverticulitis is noted.

PERITONEUM: Trace amount of free intraperitoneal fluid is noted.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Atherosclerotic vascular calcifications of a normal caliber

aorta.

Pelvis:

REPRODUCTIVE ORGANS: Patient is status post hysterectomy bilateral

salpingo-oophorectomy.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: There is layering of debris/ within the bladder, likely

representing blood. Foley catheter is seen within the bladder.

SOFT TISSUES: Anasarca

BONES: Multilevel degenerative changes with osteophyte formation are

noted. Anasarca. .

Impression

1. Severe left hydronephrosis with blood within the renal pelvis

and A large amount of thrombus within urinary bladder, encasing the

Foley catheter balloon.

2. Left ureteral stent unchanged in position.

3. Tiny left intraparenchymal renal calculi.

4. Persistent bilateral is partially imaged, at least small to

moderate sized pleural effusions with adjacent bibasilar atelectasis.

5. Trace ascites.

6. Anemia.

7. Severe gastric wall thickening diffusely, correlate with

history.

8. Anasarca.

9. Findings discussed with Dr. Rittenberg at 1:30 a.m. by Dr.

Kermani..

Attending Radiologist: FELDMANN, ERIC

Ordered By: YU, CONNIE

Order Date/Time: January 8, 2016 12:50 AM

Scan Initiation Date/Time: January 8, 2016 1:06 AM

Completion Date/Time: January 8, 2016 1:13 AM

Encounter Number: 010095263801

Accession Number: 6541969

Images were reviewed and interpreted by Attending Radiologist: Dr. FELDMANN, ERIC

Electronically Signed On: January 8, 2016 2:02 AM by Dr. FELDMANN, ERIC

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/8/2016 10:47:00 AM

Report Name: ART ABDOMINAL

Clinical History

Request for emergent renal arteriogram, embolization. The patient

patient's nephrostomy external drain was removed three days ago, now

dropping hematocrit, large clots evacuated from her bladder. Solitary

left kidney.

Technique

Risks, benefits, and alternatives to renal arteriogram and branch

artery embolization as well as moderate IV sedation were discussed

with the patient and informed written consent was obtained. She was

brought to fluoroscopy and placed supine. Right femoral head was

identified under fluoroscopy and skin overlying its lower margin was

marked. The right groin was prepped with 2 percent chlorhexidine

solution and draped. 1 percent lidocaine was given subcutaneously.

Access to the right common femoral artery was obtained using

micropuncture technique. Micropuncture sheath was exchanged for a 5

French vascular sheath over a Bentson wire. Attempts were made to

manipulate the wire into the iliac artery, then with the aid of an

angled catheter, unsuccessful. Arteriogram reveals the right common

iliac artery to be completely occluded. The left groin was prepped

with 2 percent chlorhexidine solution and draped. Left femoral head

was identified under fluoroscopy and skin overlying its lower margin

was marked. 1 percent lidocaine was given subcutaneously. Access to

the left common femoral artery was obtained using micropuncture

technique. Micropuncture sheath was exchanged for a 5 French vascular

sheath over a Bentson wire. Benson wire and cobra catheter were

manipulated into the left renal artery and initial arteriogram was

obtained. After discussion with Dr. Adler, decision was made to

further interrogate mid and lower pole branches. The catheter was

manipulated into the posterior segmental division which supplied mid

and lower poles, territory where the drain was placed. Arteriograms

were obtained. Catheter and sheath were removed. Hemostasis was

obtained using manual compression. The patient was sent back to her

hospital room having tolerated this procedure well.

Comparison

CT abdomen and pelvis 01/08/2016.

Findings

No extravasation, however extremely sluggish arterial inflow.

Interlobar branches from the anterior trunk opacified, but not from

the posterior trunk. Arcuate arteries not opacified at all.

Nephrogram never appears. No visible venous outflow.

Severe femoral artery atherosclerosis and iliac occlusive disease on

the right.

Impression

No radiographic evidence of renal artery bleeding, however evaluation

is severely limited by very low arterial inflow to this poorly

functioning kidney. Dr. Adler of urology present for this procedure.

Findings and impressions also discussed with Abe D'Amato of urology.

Fluoroscopy time 13.7 min.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: RITTENBERG, DANIEL

Order Date/Time: January 8, 2016 12:50 AM

Scan Initiation Date/Time: January 8, 2016 7:49 AM

Completion Date/Time: January 8, 2016 10:47 AM

Encounter Number: 010095263801

Accession Number: 6541970

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: January 11, 2016 2:49 PM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/9/2016 11:49:00 AM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

64-year-old female with solitary kidney with kidney stone status post

nephrostomy tube removal with hematuria angiogram inconclusive.

Evaluate for hematoma, stones

Technique

Routine non contrast study. Post Processed reconstructions included.

Contrast

No intravenous or oral contrast

Comparison

1/08/2016

Findings

LUNG BASES: Moderate bilateral pleural effusions with adjacent

compressive atelectasis. 2 mm nodule is noted within the right middle

lobe on image 3, nonspecific

Study is limited in evaluating the visceral abdominal and pelvic

organs without the use of intravenous contrast

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: Status post cholecystectomy. Surgical clips are noted

within the gallbladder fossa. No dilatation.

PANCREAS: Pancreas is atrophic. No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: A left adrenal 1.3 x 1.5 cm nodule is again noted does not

fulfill the strict CT criteria an adenoma, unchanged.

KIDNEYS: Absent right kidney. Ill-defined soft tissue density and

calcifications and or clips in the right renal bed is unchanged. A

large left subcapsular hematoma is noted nearly circumscribing the

entire left kidney sparing at the level of the hilum measuring

approximately 7.8 TR x 11.1 AP x 14.1cc cm as well as hemorrhage

within the left anterior pararenal space extending into the left hemi

pelvis. The hemorrhage causes slight mass effect and displacement

upon the left adrenal, tail of the pancreas, small bowel loops .A

left double-pigtail ureteral stent

is again noted. The proximal tip however appears to be within the

left proximal ureter and the distal tip is noted within the urinary

bladder. No left renal mass, or hydronephrosis. Punctate

calcifications are noted within the left renal collecting system

difficult to ascertain whether this may represent vascular

calcifications or residual tiny calculi. Additionally increased

attenuation is noted within the left renal pelvis may represent

hemorrhage.

BOWEL: Limited due to non opacification fluid-filled small bowel

loops without obstruction No wall thickening or obstruction. There

is evidence of a right hemi colectomy with surgical anastomosis in

the right lower quadrant. .

PERITONEUM: Minimal ascites is noted more marked in the presacral

space slightly increased. Stranding is seen around the peritoneum.

May be secondary edema. No free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta caliber with atherosclerotic

calcifications. .

Pelvis:

REPRODUCTIVE ORGANS: Status post hysterectomy.

PELVIC SIDEWALLS AND GROIN: The right femoral venous catheter is

noted with its tip at the level of the right external iliac vein. No

lymphadenopathy.

BLADDER: Foley catheter is noted within the urinary bladder urinary

bladder is somewhat decompressed. Areas noted within the urinary

bladder from Foley catheter placement.

BONES and soft tissues: Multilevel degenerative change of the spine

is noted most marked at L5-S1 with disc space narrowing, endplate

osteophytes and sclerosis. . . No focal lesion. Anasarca is again

noted

Impression

Large left renal subcapsular hematoma as well as hemorrhage within

the left anterior perirenal space extending into the left hemipelvis

as above . These findings were discussed with Dr. Smestad on

01/09/2016 at 12:30 p.m.

Left double-pigtail ureteral stent with the proximal tip in the

proximal ureter and distal tip in the urinary bladder , unchanged.

Increased attenuation is noted within the left renal pelvis may be

secondary to hemorrhage, unchanged.

No evidence of hydronephrosis.

Anasarca and minimal ascites, mildly increased

Moderate bilateral pleural effusions and adjacent compressive

atelectasis.

Absent right kidney, post nephrectomy.

Status post right hemicolectomy. No evidence of bowel obstruction

Attending Radiologist: MASON, MARYANNA

Ordered By: SHAH, TEJAS

Order Date/Time: January 9, 2016 11:25 AM

Scan Initiation Date/Time: January 9, 2016 11:41 AM

Completion Date/Time: January 9, 2016 11:49 AM

Encounter Number: 010095263801

Accession Number: 6543692

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 9, 2016 12:33 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/12/2016 6:16:00 PM

Report Name: CHEST AP ONLY

Clinical History

Midline placement

Technique

Portable AP chest x-ray

Comparison

01/07/2016

Findings

Interval placement of a right IJ approach central venous catheter

with tip seen within the SVC.

The trachea is midline. The cardiomediastinal silhouette is

unchanged in size there is mild atherosclerotic calcification of the

aorta. There are patchy opacities throughout bilateral lower lobes

and increased interstitial prominence consistent with multifocal

pneumonia. There is likely a small left-sided pleural effusion. There

is no evidence of pneumothorax. .

Impression

Right IJ central venous catheter with its tip in SVC. No evidence of

pneumothorax.

Multifocal pneumonia, left effusion.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: KHALILI, MICHAEL

Order Date/Time: January 12, 2016 5:45 PM

Scan Initiation Date/Time: January 12, 2016 6:06 PM

Completion Date/Time: January 12, 2016 6:16 PM

Encounter Number: 010095263801

Accession Number: 6547596

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 12, 2016 6:41 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/19/2016 3:21:00 PM

Report Name: QUINTON CATHETER (NON-TUNNELED)

Clinical History

64-YEAR-OLD WOMAN WITH LOW HGB, 4.8, TRANSFUSING, GFR LOW, WILL NEED

EMERGENT DIALYSIS

PRESENTS FOR QUINTON CATHETER PLACEMENT.

Technique

RIGHT QUINTON

Please note that the attending physician, Dr. Suprenant, was present

for the entirety of the procedure.

PROCEDURE:

Placement of a duel lumen 12 French x 15 cm Quinton catheter via the

right internal jugular vein approach.

Procedure and possible complications was explained to the patient and

informed consent was obtained. The patient was brought into the

radiology suite and was kept in her stretcher.

The right neck and chest were prepped and draped in usual sterile

fashion. 1% lidocaine was used for local anesthetic.

Ultrasound evaluation of a potential access site was performed. After

successfully identifying a patent vessel, with the use of the

ultrasound guidance, the internal jugular vein was accessed with a

micropuncture needle. A permanent recording was created for the

patient's record.

The micropuncture needle was then exchanged for a 4 French dilator,

through which the guidewire was removed and exchanged for an Amplatz

wire.

Following a series of exchanges the track was dilated and a 12 French

x 15 cm dual-lumen Quinton catheter was advanced over the Amplatz.

The inner stiffener and Amplatz were removed.

Both lumens aspirated and flushed easily. Catheter was secured in

place and sterile dressing was applied.

The patient was transferred to the floor in stable condition.

There were no immediate complications associated with the procedure.

A postprocedural chest radiograph was ordered to confirm tip

location.

Impression

SUCCESSFUL PLACEMENT OF A 12 FRENCH X 15 CM DUAL-LUMEN QUINTON

CATHETER VIA THE RIGHT INTERNAL JUGULAR VEIN APPROACH.

POSTPROCEDURE CHEST RADIOGRAPH ORDERED TO CONFIRM TIP LOCATION.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: ZARRABI, KEVIN

Order Date/Time: January 19, 2016 10:45 AM

Scan Initiation Date/Time: January 19, 2016 3:08 PM

Completion Date/Time: January 19, 2016 3:21 PM

Encounter Number: 010095263801

Accession Number: 6555383

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: January 21, 2016 10:54 AM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/19/2016 4:41:00 PM

Report Name: CHEST AP PORTABLE

Examination

Chest

Clinical History

S/P QUINTON PLACEMENT

Technique

A single AP view the chest.

Comparison

01/12/2016

Findings

There has been interval increasing perihilar prominent central

markings likely due to mildly increased pulmonary vascular

congestion. There is a layering left-sided pleural effusion which is

not significantly changed. Cannot exclude a small right pleural

effusion. The trachea is midline.

Stable right IJ catheter. There is a 2nd catheter now seen which

appears to be from an right IJ approach with its tip at the caval

atrial junction. This likely represents the Quentin catheter that

has been placed. No pneumothorax.

Impression

Stable right IJ catheter. There is a 2nd catheter now seen which

appears to be from an right IJ approach with its tip at the caval

atrial junction. This likely represents the Quentin catheter that has

been placed. No pneumothorax.

Interval increase in pulmonary vascular congestion. Layering

left-sided pleural effusion again seen which is likely mildly

increased when compared. Small right pleural effusion likely.

Attending Radiologist: AREMAN, DAVID

Ordered By: RAMIREZ, KENNETH

Order Date/Time: January 19, 2016 3:25 PM

Scan Initiation Date/Time: January 19, 2016 4:38 PM

Completion Date/Time: January 19, 2016 4:41 PM

Encounter Number: 010095263801

Accession Number: 6556074

Images were reviewed and interpreted by Attending Radiologist: Dr. AREMAN, DAVID

Electronically Signed On: January 19, 2016 4:49 PM by Dr. AREMAN, DAVID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/20/2016 3:26:00 AM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/ROUT

Clinical History

HYPOXIA

Indication

EVALUATE FOR CHF

Technique

AP portable of the chest

Comparison

Prior film dated 01/19/2016

Findings

Right IJ temporary dialysis catheter is noted, tip in the mid to

upper SVC, as well as a right internal jugular introducer. . Lungs

demonstrate no significant interval change with again well-defined

airspace disease in the left lower lobe with obscuration of the left

costophrenic angle. Stable probable associated moderate to large left

pleural effusion is noted. Slight worsening in degree of airspace

disease in the right lower lung zone. There is evidence of moderate

pulmonary vascular congestion, unchanged. No evidence for

pneumothorax. Cardiac enlargement is unchanged.

Impression

Findings as above may reflect asymmetric CHF versus infectious

process. Slight worsening in degree of right the lower lung zone

airspace disease. Stable dense left lower lobe consolidation and

parapneumonic effusion.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: CHESONI, SANDRA

Order Date/Time: January 20, 2016 3:15 AM

Scan Initiation Date/Time: January 20, 2016 3:20 AM

Completion Date/Time: January 20, 2016 3:26 AM

Encounter Number: 010095263801

Accession Number: 6556625

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: January 20, 2016 12:00 PM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/20/2016 2:50:00 PM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

64 YO F WITH HISTORY OF SUBCAPSULAR HEMATOMA. History of solitary

kidney with kidney stone status post nephrostomy tube removal with

hematuria angiogram inconclusive.

Technique

Routine study. Post Processed reconstructions included.

Contrast

No IV contrast.

Comparison

01/09/2016.

Findings

LUNG BASES: Moderate bilateral pleural effusion with adjacent

compressive atelectasis.

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: Status post cholecystectomy. No biliary duct

dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: There is absence of right kidney. There is redemonstration

of hematoma in the left renal fossa, measuring 14.4 x 10.6 x 17.5 cm,

compared to 12 x 9 x 14.1 cm on prior study. There is associated mass

effect and displacement of adjacent bowel, left adrenal , tail of

pancreas, and the urinary bladder. There is interval removal of

left-sided double-J stent.

BOWEL: Normal caliber. No wall thickening. S/p right hemicolectomy

with anastomotic sutures seen in the right lower quadrant of the

abdomen. Sigmoid diverticulosis without evidence of diverticulitis.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Normal caliber aorta. Arthrosclerotic calcifications of the

aorta are present..

Pelvis:

REPRODUCTIVE ORGANS: Status post hysterectomy.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Air is seen in the bladder secondary to instrumentation.

BONES: Within normal limits for age. No focal lesion.

Impression

Hematoma in the left renal fossa increased in size compared to prior

study.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: MEHTA, RISHI

Order Date/Time: January 20, 2016 10:20 AM

Scan Initiation Date/Time: January 20, 2016 2:39 PM

Completion Date/Time: January 20, 2016 2:50 PM

Encounter Number: 010095263801

Accession Number: 6556955

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: January 20, 2016 3:54 PM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095263801

Report Date/Time: 1/25/2016 5:04:00 PM

Report Name: PERMACATH PLACEMENT (TUNNELED)

Clinical History

Request for placement of tunneled dialysis catheter, patient requires

longer term hemodialysis access. She already has a non-tunneled R

internal jugular dialysis catheter.

Technique

Risks, benefits and alternatives to placement of a tunneled dialysis

catheter as well as moderate IV sedation were discussed with the

patient and informed written consent was obtained. She was brought to

fluoroscopy and placed supine. Initial image was obtained. Decision

was made to convert the non-tunneled catheter to a tunneled dialysis

catheter. Exposed Quinton and skin were prepped with 2 percent

chlorhexidine solution and draped. 1% lidocaine was given

subcutaneously. Moderate IV sedation was given and vital signs were

monitored for one half hour. Quinton catheter was exchanged for a

peel away sheath over an Amplatz wire. 16 french x 19 cm tunneled

dialysis catheter was tunneled from the skin exit site to the

venotomy, then placed through the sheath. Peel away was removed. Both

ports flushed and aspirated easily. Final image was stored. The

patient was sent back to her hospital room having tolerated this

procedure well.

Maximal Sterile Barrier Technique was used during CVC Insertion

Cap/mask/sterile gown/gloves/large sterile sheet. Hand hygiene/2 %

chlorhexidine for cutaneous antisepsis

Comparison

Quinton catheter placement 1/19/2016

Findings

New tunneled dialysis catheter ends in the RA/SVC

Impression

Technically successful conversion of non tunneled dialysis catheter

to a tunneled device. Catheter is ready for use. No immediate post

procedure complications. Fluoroscopy time 1.5 min.

Attending Radiologist: SUPRENANT, VALMORE

Ordered By: SMESTAD, ANDIE LEIGH

Order Date/Time: January 25, 2016 3:57 PM

Scan Initiation Date/Time: January 25, 2016 3:48 PM

Completion Date/Time: January 25, 2016 5:04 PM

Encounter Number: 010095263801

Accession Number: 6561794

Images were reviewed and interpreted by Attending Radiologist: Dr. SUPRENANT, VALMORE

Electronically Signed On: January 28, 2016 9:55 AM by Dr. SUPRENANT, VALMORE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095294863

Report Date/Time: 1/8/2016 7:14:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Possible pneumonia.

Technique

AP portable radiograph of the chest.

Comparison

Chest radiograph from 12/30/2015

Findings

Study markedly limited due to low lung volumes. There is elevation

of the right hemidiaphragm. There is right basilar atelectasis.

There is no pulmonary vascular congestion. Cardiac size is likely

within normal limits.

Impression

Markedly limited study due to low lung volumes.

Persistent elevation of the right hemidiaphragm. Right basilar

atelectasis. No pulmonary vascular congestion or pneumothorax.

Attending Radiologist: BADIA, JAMES

Ordered By: WEISS, SARAH

Order Date/Time: January 8, 2016 5:35 PM

Scan Initiation Date/Time: January 8, 2016 6:42 PM

Completion Date/Time: January 8, 2016 7:14 PM

Encounter Number: 010095294863

Accession Number: 6543291

Images were reviewed and interpreted by Attending Radiologist: Dr. BADIA, JAMES

Electronically Signed On: January 8, 2016 7:40 PM by Dr. BADIA, JAMES

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095294863

Report Date/Time: 1/20/2016 1:13:00 PM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

Hypoactive bowel sounds

Technique

Supine views of the abdomen

Comparison

None

Findings

Slightly distended gastric air bubble is noted. No signs of

significant small bowel dilatation seen. Residual fecal material

noted in the rectum and sigmoid colon. Left total hip replacement and

advanced collapse of the right femoral head noted.No organomegaly or

abnormal calcifications are seen within the abdomen or pelvis.

Impression

Non-obstructive bowel gas pattern. Slightly distended gastric air

bubble .

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: CHAKRAVARTY, RAMANUJ

Order Date/Time: January 20, 2016 12:45 PM

Scan Initiation Date/Time: January 20, 2016 1:09 PM

Completion Date/Time: January 20, 2016 1:13 PM

Encounter Number: 010095294863

Accession Number: 6557292

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: January 20, 2016 1:39 PM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095294863

Report Date/Time: 1/20/2016 2:06:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR AMS

History and Indication

COPD, SEIZURE DISORDER, RESP FAILURE

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

CT head from 11/12/2015

Findings

Motion results in streak artifact and significant image degradation,

limiting evaluation. Images through the middle and posterior cranial

fossae are particularly severely degraded.

Given limitations, there is no definite CT evidence of acute cortical

infarction, obvious intracranial hemorrhage or gross extra-axial

collection. There is redemonstration of chronic lacunar infarcts

within the bilateral centrum semiovale and corona radiata.

Patchy foci of hypoattenuation within the periventricular and

subcortical white matter without mass effect are most compatible with

moderate to advanced microvascular ischemic changes given presence of

atherosclerotic calcifications at the skullbase.

Moderate to advanced age-related volume loss ex vacuo ventricular

prominence.

No depressed calvarial fracture.

There is no significant disease in the visualized paranasal sinuses

and mastoids. Soft tissue attenuation material within the left

external auditory canal, correlate for cerumen.

Impression

No obvious CT evidence of acute intracranial abnormality given marked

motion degradation.

Moderate to advanced microvascular ischemic disease and multiple

lacunae infarcts. Diffusion-weighted MRI is significantly more

sensitive for subtle acute ischemia.

Attending Radiologist: FILATOV, ALEXANDER

Ordered By: PILATO, LAUREN

Order Date/Time: January 20, 2016 10:15 AM

Scan Initiation Date/Time: January 20, 2016 1:43 PM

Completion Date/Time: January 20, 2016 2:06 PM

Encounter Number: 010095294863

Accession Number: 6556950

Images were reviewed and interpreted by Attending Radiologist: Dr. FILATOV, ALEXANDER

Electronically Signed On: January 20, 2016 2:43 PM by Dr. FILATOV, ALEXANDER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095304670

Report Date/Time: 1/11/2016 6:03:00 PM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

70-year-old female with urothelial cancer status post chemotherapy.

Evaluate for metastases.

Technique

Routine study. Post processed reconstructions included.

Contrast

No intravenous or oral contrast

Comparison

CT abdomen and pelvis 11/20/2015 and CT chest 11/03/2015

Findings

BASE OF NECK: Again noted is a 3.4 x 2.4 cm right thyroid nodule

extending to the superior mediastinum unchanged. A 1.0 cm ovoid

nodule is noted within the left lobe of the thyroid. These are

nonspecific. Correlate with laboratory values and thyroid ultrasound

as indicated.

Chest:

LUNGS: . Biapical scarring/fibrosis. New small focal ground-glass

opacity is noted in the left upper lobe apical posterior segment and

right apex, nonspecific may be inflammatory or infectious in

etiology.Trace bibasilar atelectasis right slightly greater than left

Left lung:

2 mm nodule left upper lobe anteriorly image 51, unchanged prior

image 49

1 mm nodule left upper lobe anteriorly image 53, unchanged prior

image 49

3 mm nodule left upper lobe anteriorly image 85

LARGE AIRWAYS: Patent.

PLEURA: Trace right pleural effusion No left effusion. Significantly

improved from prior exam. No pneumothorax.

HEART and vessels: Normal size. Minimal coronary artery

calcifications. No pathologic pericardial effusion. Normal-caliber

thoracic aorta with trace atherosclerotic calcifications.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

The study is limited in evaluating the visceral abdominal and pelvic

organs without the use of intravenous contrast.

Abdomen:

LIVER: Normal size. A 2.8 cm low attenuation lesion is noted within

the right lobe of the liver, markedly increased in size from prior

exam, previously measuring 1.2 cm .interval development of

ill-defined mass medially within the posterior segment right lobe

measuring approximately 3.4 cm and additional lesions within the

posterior segment right lobe; ill-defined measuring 1.9 x 2.7 cm

image 62, 1.8 x 2.6 cm image 66 likely represents worsening

metastatic disease. . An additional 3.2 cm lesion is noted within the

posterior segment right lobe also markedly increased in size

previously measuring 1.7 cm

BILIARY TRACT: No dilatation.

PANCREAS: Pancreas is atrophic. No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: The right adrenal gland is poorly delineated. The left

adrenal gland is prominent in size with possible 1.5 x 1.3 cm nodule.

KIDNEYS: Status post right nephrectomy. Within the right renal fossa

is ill-defined low-attenuation with thick surrounding soft tissue rim

abutting the hepatic capsule of the inferior edge of the liver and

right psoas muscle. This measures approximately 3.6 x 4.0 x 10.3 cm.

Centrally the low attenuation measures simple fluid. A broad bands

of density courses obliquely in the right posterior para renal space

to the right lower quadrant. May represent evolving/resolving

hematoma however there is significant nodularity at its inferior

aspect and adjacent to the inferior surgical clips measuring 1.1x 1.

0 cm and 2.7 x 1.6 cm seen on image 80 and 83 respectively.

Additional nodularity is seen in the right posterior perirenal space

measuring 0.8 cm image 75 along the lateral Conal fascia measuring

1.2 cm image 78 and anterior to the right quadratus lumborum muscle

measuring 1.4 cm image 85 and 1.2 cm image 84 The possibility of

recurrent neoplasm and/ir tumor implants cannot be excluded. Trace

complex fluid is seen posteriorly in the right renal fossa and along

the inferior hepatic edge may represent complex fluid. No left renal

contour deforming mass, calculus or hydronephrosis.

BOWEL: Small hiatal hernia is again noted. Normal caliber. No wall

thickening.

PERITONEUM: No, free air, or fluid collection. 0.8 cm soft tissue

density is seen involving the anterior abdominal peritoneal surface

right upper quadrant image 64 and additional nodularity anterior

abdomen measuring 2.0 x 1 point 3 cm image 69 an additional 1.6 x 1.3

cm soft tissue nodule is seen involving the right rectus muscle image

80 these likely represent tumor implants.

RETROPERITONEUM: Subcentimeter left periaortic lymph nodes not

enlarged by CT criteria. No lymphadenopathy. IVC filter is noted.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy. Questionable trace

fluid within the right lower quadrant.

BLADDER: Unremarkable.

BONES and soft tissues: Degenerative change at L4-5 and L5-S1 with

disc space narrowing, endplate sclerosis and osteophytes. . No focal

lesion. Two 0.7 cm soft tissue nodules are noted within the anterior

subcutaneous tissues of the upper abdomen right paramedian location

image 64 and 66 tumor implants cannot be excluded. Resolved

subcutaneous edema

Impression

Limited study.

Status post right nephrectomy. Complex collection within the right

renal fossa with central low attenuation and thick surrounding soft

tissue rim . May represent evolving hematoma however adjacent

significant nodularity at its inferior aspect and adjacent to the

surgical clips, recurrent or residual neoplasm must be considered.

Peritoneal soft tissue nodular densities, right rectus muscle and

subcutaneous nodules as described above likely representing tumor

implants.

Large hepatic hypodense lesions, worsened from prior exam consistent

with worsening metastases.

Left pulmonary nodules largest measuring 3 mm iwithout significant

change, nonspecific, recommend continued followup.

Interval development of small focus of ground-glass opacity within

the bilateral apices, nonspecific may be inflammatory or infectious

in etiology.

Trace residual right pleural effusion, improved. Resolved left

pleural effusion. Resolved subcutaneous edema

Questionable trace residual complex fluid right perihepatic location

Please read above

Attending Radiologist: MASON, MARYANNA

Ordered By: SIRCAR, SHARLAINA CARMELLE

Order Date/Time: January 11, 2016 2:15 PM

Scan Initiation Date/Time: January 11, 2016 5:56 PM

Completion Date/Time: January 11, 2016 6:03 PM

Encounter Number: 010095304670

Accession Number: 6545613

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 12, 2016 10:25 AM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095304670

Report Date/Time: 1/11/2016 6:03:00 PM

Report Name: CT CHEST WO IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

70-year-old female with urothelial cancer status post chemotherapy.

Evaluate for metastases.

Technique

Routine study. Post processed reconstructions included.

Contrast

No intravenous or oral contrast

Comparison

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Findings

BASE OF NECK: Again noted is a 3.4 x 2.4 cm right thyroid nodule

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the bilateral apices, nonspecific may be inflammatory or infectious

in etiology.

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Please read above

Attending Radiologist: MASON, MARYANNA

Ordered By: SIRCAR, SHARLAINA CARMELLE

Order Date/Time: January 11, 2016 2:15 PM

Scan Initiation Date/Time:

Completion Date/Time: January 11, 2016 6:03 PM

Encounter Number: 010095304670

Accession Number: 6545612

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 12, 2016 10:25 AM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095304670

Report Date/Time: 1/13/2016 7:08:00 PM

Report Name: ABSCESS DRAIN PERI-RENAL

Clinical History

Status post right nephrectomy now with fluid collection in surgical

bed and leukocytosis.

Technique

PROCEDURE:

Risks, benefits, and alternatives of the procedure were discussed

with the patientwho granted informed consent. The patient was

positioned prone on the CT table. Limited axial CT images were

obtained. A suitable access site was marked using a localizing grid,

then prepped and draped in sterile fashion. 1 percent lidocaine was

used for local anesthesia. Fentanyl was administered intravenously

under continuous nurse monitoring. Under CT guidance from a right

posterolateral approach, an 18 gauge trocar needle was advanced into

the right nephrectomy bed collection. An Amplatz wire was advanced

through the needle into the collection. Following tract dilation, a

10 French locking multipurpose drainage catheter was advanced over

the wire into the collection and the locking loop formed. Following

decompression, final CT images were obtained. A specimen was sent to

the laboratory for analysis. The catheter was secured to the skin

with a 2-0 Ethilon suture, then covered with a Biopatch and sterile

dressing. The catheter was placed to gravity drainage.

DLP: 894 mGy-cm

Medications: Fentanyl 50 mcg IV

FINDINGS:

Initial CT demonstrates a complex fluid collection in the right

nephrectomy bed with considerable hyperdense material likely

representing blood. There was successful CT-guided placement of a 10

French multipurpose drainage catheter into this collection from a

right posterolateral approach as described above. Dark purple

material was removed, nonpurulent in appearance, consistent with a

liquefying hematoma.

Impression

Successful placement of a 10 French locking multipurpose drainage

catheter into the right nephrectomy bed collection. Findings

consistent with a liquefying hematoma, grossly nonpurulent.

Attending Radiologist: MALESON, ANDREW

Ordered By: SIRCAR, SHARLAINA CARMELLE

Order Date/Time: January 13, 2016 2:10 PM

Scan Initiation Date/Time: January 13, 2016 6:28 PM

Completion Date/Time: January 13, 2016 7:08 PM

Encounter Number: 010095304670

Accession Number: 6548657

Images were reviewed and interpreted by Attending Radiologist: Dr. MALESON, ANDREW

Electronically Signed On: January 13, 2016 7:46 PM by Dr. MALESON, ANDREW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095304670

Report Date/Time: 1/18/2016 11:24:00 AM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

RIGHT NEPHROURETERECTOMY FOR UROTHELIAL CARCINOMA. Reassess fluid

collection status post percutaneous drainage.

Technique

Routine study. Post Processed reconstructions included.

Contrast

None.

Comparison

CT studies from 01/11/2016 at 11/20/2015.

Findings

LUNG BASES: Trace right pleural effusion than basilar peripheral

atelectasis, right greater than left, are again noted.

Abdomen:

LIVER: Normal size. There has been progression of hepatic metastases

as compared to the study of 1 week ago with the largest mass

measuring approximately 7 cm as demonstrated on image 30 of series 2.

.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: Right adrenal gland is not well visualized. Left adrenal

gland appears unremarkable.

KIDNEYS and RETROPERITONEUM: Status post right nephroureterectomy.

Residual abnormal density in the right renal fossa appears unchanged

in size and shape. Right percutaneous drainage catheter is noted.

Enlarging masses are seen in the right retroperitoneum (see image 51

of series 2 where an ovoid mass measures 2.9 cm in maximum

dimension).

Left kidney appears unremarkable.

BOWEL: Normal caliber. No wall thickening.

PERITONEUM: Multiple peritoneal deposits are identified which have

progressed from the study of 1 week earlier and are new as compared

to the study from November, 2015. Several of these nodules appear to

be invading the abdominal wall musculature as seen on image 47 of

series 2. No abscess or extraluminal gas.

VESSELS: Normal caliber aorta. IVC filter is in place.

Pelvis:

REPRODUCTIVE ORGANS: Uterus is difficult to define.

PELVIC SIDEWALLS AND GROIN: Extensive abnormal soft tissue densities

seen along the right pelvic sidewall as demonstrated on images 67-75

of series 2.

BLADDER: Unremarkable.

BONES: Within normal limits for age. No focal lesion.

Impression

1. Percutaneous drainage catheter noted within the

low-attenuation portion of extensive abnormal density in the right

renal fossa without significant interval change in the overall

appearance of the right renal fossa except for evidence of enlarging

tumor deposits.

2. Progression of hepatic and peritoneal metastases (as compared

to study of 1 week earlier).

3. Large abnormal density along the right pelvic sidewall - it

is uncertain if this represents resolving hematoma or another large

tumor deposit.

Attending Radiologist: MANKES, SETH

Ordered By: DING, YONGZENG

Order Date/Time: January 18, 2016 9:55 AM

Scan Initiation Date/Time: January 18, 2016 11:14 AM

Completion Date/Time: January 18, 2016 11:24 AM

Encounter Number: 010095304670

Accession Number: 6553782

Images were reviewed and interpreted by Attending Radiologist: Dr. MANKES, SETH

Electronically Signed On: January 18, 2016 11:55 AM by Dr. MANKES, SETH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095304670

Report Date/Time: 1/19/2016 12:29:00 PM

Report Name: ABSCESS DRAINAGE PERCUTANEOUS

Clinical History

70-year-old female who has a history of urothelial tumor status post

right nephroureterectomy with right retroperitoneal phlegmon/

abscess. Plan is to up-size the existing abscess drainage catheter,

as well as placed a 2nd drainage catheter superiorly.

Please note the attending radiologist Dr. Ferretti was present for

the entire procedure.

Technique

Limited CAT scan of the abdomenwas performed for localization

purposes.

The patient was prepared and draped using standard aseptic technique.

First, attention was turned towards up sizing the existing drainage

catheter.

The existing 10 French locking multipurpose drainage catheter was

exchanged over a wire for a 12 French locking multipurpose pigtail

drainage catheter.

Attention was then turned towards inserting a second drainage

catheter slightly superior to the existing catheter.

Following local lidocaine infusion, a 5 French Yueh needle was

inserted into the right retroperitoneal collection. Following

multiple guidewire and catheter exchanges a 12 French pigtail

catheter was advanced into the collection. External port was left to

gravity drainage.

The patient tolerated the procedure well and no immediate post

abscess drainage complications observed. Moderate sedation was used.

The patient was transported to the floor in stable condition.

Comparison

CT abdomen pelvis 01/18/2016

Findings

As above

Impression

1. Upsizing of existing 10 French right retroperitoneal

collection drainage catheter to a 12 French catheter.

2. New 12 French catheter into the right retroperitoneal

collection superiorly.

3. No immediate complications.

Attending Radiologist: FERRETTI, JOHN

Ordered By: DING, YONGZENG

Order Date/Time: January 19, 2016 9:56 AM

Scan Initiation Date/Time: January 19, 2016 11:43 AM

Completion Date/Time: January 19, 2016 12:29 PM

Encounter Number: 010095304670

Accession Number: 6554607

Images were reviewed and interpreted by Attending Radiologist: Dr. FERRETTI, JOHN

Electronically Signed On: January 20, 2016 1:44 PM by Dr. FERRETTI, JOHN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095312574

Report Date/Time: 1/10/2016 12:43:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SOB

Indication

POSSIBLE INFILTRATE

Technique

CHEST AP PORTABLE/STAT/ER

Comparison

04/03/2013 .

Findings

Elevation of the right hemidiaphragm. Likely right basilar

atelectasis or scarring. No focal consolidation. No pleural effusion

or pneumothorax. Cardiomediastinal silhouette is stable. No

concerning osseous lesion.

Impression

No acute cardiopulmonary process.

Attending Radiologist: REITER, MICHAEL

Ordered By: MOHAMMADY, NAJIM

Order Date/Time: January 9, 2016 11:10 PM

Scan Initiation Date/Time: January 10, 2016 12:12 AM

Completion Date/Time: January 10, 2016 12:43 AM

Encounter Number: 010095312574

Accession Number: 6544087

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 10, 2016 1:38 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095312574

Report Date/Time: 1/10/2016 12:43:00 AM

Report Name: FOOT LEFT (ROUTINE)

Clinical History

Pain

Technique

3 views of each foot.

Comparison

None

Findings

There is hallux valgus deformity on the right. Otherwise alignment

is anatomic. Diffuse osteopenia. No fracture or dislocation.

Left-sided calcaneal enthesophyte noted. There is prominent soft

tissue swelling of the dorsum of the left foot.

Impression

No acute fracture. Marked dorsal soft tissue swelling of the left

foot.

Attending Radiologist: REITER, MICHAEL

Ordered By: MOHAMMADY, NAJIM

Order Date/Time: January 9, 2016 11:10 PM

Scan Initiation Date/Time: January 10, 2016 12:15 AM

Completion Date/Time: January 10, 2016 12:43 AM

Encounter Number: 010095312574

Accession Number: 6544089

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 10, 2016 1:43 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095312574

Report Date/Time: 1/10/2016 12:43:00 AM

Report Name: FOOT RIGHT (ROUTINE)

Clinical History

Pain

Technique

3 views of each foot.

Comparison

None

Findings

There is hallux valgus deformity on the right. Otherwise alignment

is anatomic. Diffuse osteopenia. No fracture or dislocation.

Left-sided calcaneal enthesophyte noted. There is prominent soft

tissue swelling of the dorsum of the left foot.

Impression

No acute fracture. Marked dorsal soft tissue swelling of the left

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Attending Radiologist: REITER, MICHAEL

Ordered By: MOHAMMADY, NAJIM

Order Date/Time: January 9, 2016 11:10 PM

Scan Initiation Date/Time: January 10, 2016 12:19 AM

Completion Date/Time: January 10, 2016 12:43 AM

Encounter Number: 010095312574

Accession Number: 6544090

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 10, 2016 1:43 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095312574

Report Date/Time: 1/11/2016 10:01:00 AM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: JOSEPH P DUNNE Exam Date: 1/11/2016 at 9:01:10 AM Heart

Rate:

MR #: 30267367 Report Date: 1/11/2016 Rhythm:

ACC #: 6544197 Height: 175.26 cm BP:

124/62

DOB: 8/30/1939 Weight: 86.64 kg

Location: 15N

Age/Sex: 76 years / M BSA: 2.03 m²

Ref. Physician: Alice Greene, cc:

Sonographer: CD

Indications: R/O ischemia

History: Gangrene of foot, DVT

Procedure: Comp. Echo w/contrast - C8929 and Definity Contrast -

Q9957. The use

of contrast was indicated for enhancement of endocardial

border

definition. There were no contraindications for the use of

contrast

in this patient. Verbal consent was given by the patient

who is aware

of the possible adverse reactions associated with the use

of

contrast. No adverse reactions or hemodynamic compromise

identified.

Study Quality: This was a technically difficult study.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.59 cm 2.0 - 3.8 LA Diam 4.10 cm 3.0-4.0

IVS 0.71 cm 0.6 - 1.0 LA Area 27.22cm² <=20

LVID 5.56 cm 4.2 - 5.9 3.81 cm LA Vol 91.00 ml 18-58

LVPW 0.75 cm 0.6 - 1.0 LA Vol/BSA 44.92ml/m² 22+ / -6

RA Diam 3.89cm 2.9-4.5

Ao at the sinuses 3.42 cm

Ao Ascending 2.99 cm

LVEF 65 % (biplane method of discs)

LV FS 31.4

LV SV 63.7 ml

LV SI 31.4 ml/m²

Aov Cusp Sep 2.47 cm

(Systole)

Aov VTI 0.273 m LVOT VTI 0.248 m LVOT diameter

2.12 cm

Aov VMax 1.43 m/s LVOT Vmax 1.18 m/s Dimensionless

Index 0.82

Aov Pk Pressure 8.2 mmHg Aov Mn 4.1 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 3.21 cm² Aov Area Index 1.58 cm²/m²

(VTI)

AI DT 3232 msec

MV VTI 0.196 m MV DT 200 msec

MV E Vmax 0.56 m/s MV A Vmax 0.42 m/s E/A 1.32

MV Area press 1/2 Time 3.79

IVRT 96 E/E ' 4.66

Septal E ' 0.065 m/s Prop Velocity

Lateral E ' 0.12 m/s LA Pressure 9.39 mmHg

Average E' 0.092 m/s

MV Average E/E' 6.04

TR Vmax 2.43 m/s TR Pk Grad 23.6 mmHg RA Pressure 3 mmHg RVSP

26.6 mmHg

TV E Max TV Mn Grad mmHg PHT 57.99 msec TV VTI

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

normal. The relative wall thickness is normal (0.26). Global left

ventricular systolic function is normal. The ejection fraction is 65%

by biplane method of discs. Left ventricular basal fractional

shortening is normal. No regional wall motion abnormalities are seen.

Left Ventricle - Diastole:The left ventricular isovolumetric

relaxation time is prolonged at 96 msec. The Doppler derived

transmitral left ventricular inflow velocity pattern is E wave

dominant. The Doppler derived early diastolic deceleration time is

normal at 200 msec. The velocity of the early diastolic septal mitral

annular movement, as determined by tissue Doppler imaging is reduced

at 0.065 m/s. The velocity of the early diastolic lateral mitral

annular movement, as determined by tissue Doppler imaging is normal

at 0.12 m/s. The overall diastolic function is normal with normal

left ventricular filling pressures.

Left Atrium: The left atrium is severely dilated in size.

Right Atrium: The right atrium is normal in size.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. The right

ventricular diastolic area is 27.53 cm which is normal. The right

ventricular systolic area is 14.80 cm which is normal. Global right

ventricular systolic function is normal. The right ventricular

fractional area change is 46.24% which is normal. The tricuspid

annular plane systolic excursion is 3.76 cm consistent with normal

right ventricular systolic function. The right ventricular systolic

pressure, as estimated using the tricuspid regurgitation velocity, is

26.6 mmHg.

Aortic Valve: The aortic valve was not well seen. Based on these

parameters no aortic stenosis is present. Mild aortic valve

insufficiency is present. The pressure half-time of the aortic

insufficiency jet is 937 msec. The vena contracta is 0.19 cm. The

ratio of the aortic regurgitation jet width to the left ventricular

outflow tract width is 26%.

Mitral Valve: The mitral valve is structurally normal. Trace mitral

regurgitation is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Mild

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is not well visualized.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.42 cm. The ascending aorta is normal at 2.99 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.43 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is normal at 26.6 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Normal left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Normal global left ventricular systolic function.

4. No regional left ventricular wall motion abnormalities.

5. Normal diastolic function with normal left ventricular filling

pressures.

6. Normal right ventricular systolic function.

7. Severely dilated left atrial size.

8. Normal atrial septum by 2D and color Doppler.

9. The aortic valve was not well seen.

10. No aortic stenosis.

11. Mild aortic insufficiency.

12. Trace mitral regurgitation.

13. Mild tricuspid regurgitation.

14. Normal aortic root diameter for body size.

15. No pericardial effusion.

014970 Smadar Kort MD, FACC, FASE

Electronically signed by 014970 Smadar Kort MD, FACC, FASE on

1/11/2016 at 11:24:04 AM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: GRANATI, GLEN

Order Date/Time: January 10, 2016 5:40 AM

Scan Initiation Date/Time:

Completion Date/Time: January 11, 2016 10:01 AM

Encounter Number: 010095312574

Accession Number: 6544197

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: January 11, 2016 11:24 AM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095312574

Report Date/Time: 1/12/2016 4:09:00 PM

Report Name: MRI FOOT RIGHT WO AND WITH IV CONTRAST

Examination

MRI of the Right Foot.

Indication

76-year-old male with clinical suspicion for a lung ganglion

bilateral hallux and 2nd toes. For full evaluation of the right foot

Technique

Multiplanar, multisequences MRI images of the Right forefoot and

midfoot were obtained. Postcontrast images were obtained after the

administration of 17 mL of Magnevist.

Comparison

None

Findings

No T1 hypointense signal identified in the visualized bones to

suggest osteomyelitis. Mild T2 hyperintense signal is identified in

the phalanges of the 1st and 2nd toes which may represent mild edema.

Diffuse T2 hyperintense signal is identified within the subcutaneous

tissues of the dorsum of the foot and medial plantar aspect of the

foot with postcontrast enhancement suggestive of cellulitis. T1 and

T2 hypointense signal is identified superficial to the head of the

5th metatarsal, likely representing callus formation. No focal

collection identified to suggest abscess.

Small joint effusion is identified at the 1st metatarsophalangeal

joint. Minimal joint effusion is identified 2nd through 4th MTP

joints. An intact 1st plantar plate is not identified, likely torn.

Impression

No evidence of osteomyelitis. Mild osteitis / edema is identified in

the phalanges of the 1st and 2nd toes. Diffuse T2 hyperintensity

involving the subcutaneous tissues predominantly of the dorsum of the

foot with postcontrast enhancement suggestive of cellulitis.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: GINGERICH, JACOB

Order Date/Time: January 10, 2016 11:05 AM

Scan Initiation Date/Time: January 12, 2016 3:09 PM

Completion Date/Time: January 12, 2016 4:09 PM

Encounter Number: 010095312574

Accession Number: 6544296

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: January 12, 2016 7:03 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095312574

Report Date/Time: 1/13/2016 12:31:00 PM

Report Name: MYO PERF SPECT MULTI W/WALL EJ

Report :

MYOCARDIAL PERFUSION IMAGING:

Please refer to the combined Cardiology/Nuclear Medicine report for

complete patient results.

Study was interpreted by Dr. Katz and Dr. Franceschi.

IMPRESSION:

Please refer to the combined Cardiology/Nuclear Medicine report for

complete patient results.

Attending Radiologist: FRANCESCHI, DINKO

Ordered By: GRANATI, GLEN

Order Date/Time: January 11, 2016 10:00 AM

Scan Initiation Date/Time: January 11, 2016 12:52 PM

Completion Date/Time: January 13, 2016 12:31 PM

Encounter Number: 010095312574

Accession Number: 6544873

Images were reviewed and interpreted by Attending Radiologist: Dr. FRANCESCHI, DINKO

Electronically Signed On: January 13, 2016 6:12 PM by Dr. FRANCESCHI, DINKO

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095312574

Report Date/Time: 1/13/2016 9:17:00 AM

Report Name: REGADENOSON STRESS TEST

Results

Test Type: Regadenoson/Sestamibi/SPECT Imaging

Stony Brook University Hospital

Ht:(in.): 69 Wt:(lbs.): 191 Previous study: No

Clinical indication: Dyspnea on exertion.

History: DVTs, cellulitis, B12 deficiency, Lyme disease, anemia,

homelessness

CAD risk factors: Obesity, positive family history-mother, past

tobacco use

Medications: Lipitor, aspirin, enoxaparin, vancomycin, oxycodone,

metoprolol, Zosyn, Tylenol

Site location: University Hospital

Stress lab staff: Angela Abbott CVT, J.Swartz NP

Nuclear Technologist: Peter Novotny CNMT

Date of stress imaging: 01/13/2016 Date of rest

imaging: 01/11/2016

Pre-stress ECG interpretation

Rate: 56 beats/minute PR: 0.24 sec. QRS: 0.08 sec. QT:

0.40 sec.

Sinus bradycardia, first degree heart block, otherwise normal ECG

Protocol: Intravenous Regadenoson

0.4 mg of regadenoson was administered as a rapid intravenous

injection followed by 5 ml of an intravenous saline flush. The

resting heart rate and blood pressure were 56 beats/minute and 141/66

mmHg. The heart rate and blood pressure at maximal vasodilation were

70 beats/minute and 84/45 mmHg.

Low level treadmill exercise during regadenoson administration: No.

ECG changes: There were no significant new electrocardiographic ST

segment changes.

Arrhythmias: Occasional isolated APCs and PVCs.

Symptoms: Nausea and weakness.

Transient physical findings: None.

The patient underwent SPECT myocardial perfusion imaging following

the intravenous injection of 31.0 millicuries of technetium-99m

sestamibi at peak pharmacologic stress and 29.7 millicuries of

technetium-99m sestamibi at rest. Stress cardiac images were acquired

utilizing a gated tomographic technique.

Nuclear Imaging Results

The overall quality of the study was: Fair.

Study artifacts: None identified.

Left ventricular cavity size: Normal size.

Transient ischemic dilation (TID): No.

TID ratio: 1.02

Myocardial perfusion images: A reversible mid to basal inferior and

basal inferoseptal defect of small to moderate size and mild

intensity was present.

Left ventricular ejection fraction: 59%.

Post-stress gated SPECT wall motion analysis: Normal left ventricular

myocardial wall thickening and excursion.

Impression

1. Abnormal regadenoson technetium-99m sestamibi perfusion

scintigraphy demonstrating reversible mid to basal inferior and basal

inferoseptal defects which are compatible with mild ischemia. There

was no evidence of myocardial infarction.

2. Hypotensive blood pressure response to regadenoson.

3. No significant new electrocardiographic ST segment changes after

regadenoson administration.

4. The post-stress gated cardiac images revealed normal left

ventricular myocardial wall thickening and excursion.

5. The calculated left ventricular ejection fraction was 59%.

The study was supervised by Dr. Jordan Katz.

The study was interpreted by Dr. Jordan Katz and Dr. Dinko

Franceschi.

Dr. Dinko Franceschi personally provided the nuclear myocardial

perfusion imaging services for this exam.

Addendum: Dr. Alice Greene was notified of study results on 1/13/2016

at 5:08 pm.

Attending Cardiologist: KATZ, JORDAN

Ordered By: GRANATI, GLEN

Order Date/Time: January 10, 2016 5:40 AM

Scan Initiation Date/Time: January 11, 2016 12:52 PM

Completion Date/Time: January 13, 2016 9:17 AM

Encounter Number: 010095312574

Accession Number: 6544198

Images were reviewed and interpreted by Attending Cardiologist: Dr. KATZ, JORDAN

Electronically Signed On: January 13, 2016 5:14 PM by Dr. KATZ, JORDAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095312574

Report Date/Time: 1/13/2016 10:05:00 PM

Report Name: MRI FOOT LEFT WO AND WITH IV CONTRAST

Clinical History

1st and 2nd digit dry gangrene.

Technique

Multiplanar and multisequence MRI of the left foot pre- and post

administration of 17 mL of Magnevist.

Comparison

Comparison prior radiographs from 01/10/2016.

Findings

There is no skin irregularity at the dorsal aspect of the 2nd toe.

While there is mild abnormal T2 signal noted in the metatarsal heads

and proximal phalanges diffusely, this is felt likely artifactual in

nature. There is no abnormal T1 signal of the 2nd digit to suggest

underlying osteomyelitis. The bones maintain a normal T1 signal.

There are areas of mild marrow edema at the dorsal aspect of the 4th

metatarsal head (series 7, image 20), and possibly at the distal tip

of the 1st distal phalanx (sagittal image 8 of series 7). There is

probable ankylosis of the 5th DIP joint.

There are hammertoe deformities. The great toe is held in extension.

There is degeneration of the 1st plantar plate.

There are small joint effusions at the 1st, 2nd, 3rd and and 4th MTP

joints.

There is diffuse edema and fatty atrophy of the intrinsic foot

musculature, likely from diabetic myopathy. There is soft tissue

edema in the dorsum of the foot. There is also increased enhancement

of the skin, clinical correlation with physical exam is recommended

to assess for cellulitis.

There is relative lack of enhancement of the distal aspects of the

great toe and to a greater extent, the 2nd toe, which are in keeping

with the history of gangrene.

There is fluid in the 1st web space (series 5, image 16) and fluid in

the 3rd web space (series 5, image 17) compatible with

intermetatarsal bursitis. No definitive Morton's neuroma.

Mild edema and cystic changes are noted in the tibial sesamoid.

The Lisfranc ligament is intact.

Impression

No definitive MRI evidence of underlying osteomyelitis, as there is

no significant T1 hypointensity. Relative lack of enhancement of the

distal aspects of the 1st, and to a greater extent, 2nd toes is

compatible with history of gangrene.

Hammertoe deformities with diffuse small MTP joint effusions.

Moderate soft tissue edema and enhancement of dorsal subcutaneous

tissues. Correlation with physical exam is recommended to exclude

cellulitis.

Mild intermetatarsal bursitis in the 1st and 3rd web spaces.

Edema and fatty atrophy of the musculature about the left forefoot,

likely representing diabetic myopathy.

Attending Radiologist: BAKER, KEVIN S

Ordered By: GINGERICH, JACOB

Order Date/Time: January 10, 2016 11:05 AM

Scan Initiation Date/Time: January 13, 2016 9:28 PM

Completion Date/Time: January 13, 2016 10:05 PM

Encounter Number: 010095312574

Accession Number: 6544297

Images were reviewed and interpreted by Attending Radiologist: Dr. BAKER, KEVIN S

Electronically Signed On: January 14, 2016 11:57 AM by Dr. BAKER, KEVIN S

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095312574

Report Date/Time: 1/16/2016 6:08:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Osteomyelitis

Technique

Frontal view of the chest.

Comparison

1/10/16 .

Findings

Cardiomediastinal silhouette is stable. Elevation of the right

hemidiaphragm with apparent colonic interposition is again noted.

There are low lung volumes bilaterally. No definite airspace opacity.

Impression

No definite evidence for pneumonia. Low lung volumes suggest weak

inspiration or atelectasis.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: ROHATGI, ABHINAV

Order Date/Time: January 16, 2016 5:55 AM

Scan Initiation Date/Time: January 16, 2016 5:59 AM

Completion Date/Time: January 16, 2016 6:08 AM

Encounter Number: 010095312574

Accession Number: 6552369

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: January 16, 2016 9:51 AM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/10/2016 2:05:00 PM

Report Name: CHEST AP PORTABLE

Examination

CHEST AP PORTABLE/STAT/ER

Clinical History

TACHYCARDIC, TACHYPNIC W/ BILAT LEG SWELLING

Indication

POSSIBLE INFILTRATE

Technique

Chest AP portable.

Technologist Comments

Comparison

06/02/2013.

Findings

Aorta is dilated and calcified. The heart is mildly enlarged.

There is no evidence of pulmonary vascular congestion, consolidation,

or significant effusion.

Impression

No vascular congestion, consolidation, or pleural effusion.

Attending Radiologist: BALSAM, DVORAH

Ordered By: WACKEROW, PAUL

Order Date/Time: January 10, 2016 1:50 PM

Scan Initiation Date/Time: January 10, 2016 2:02 PM

Completion Date/Time: January 10, 2016 2:05 PM

Encounter Number: 010095314174

Accession Number: 6544396

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: January 10, 2016 2:11 PM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/10/2016 4:34:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

MULTIPLE TRAUMA

History and Indication

MULTIPLE TRAUMA VICTIM

Technique

Contiguous axial slices were obtained from the skull base to the

vertex. Sagittal and coronal reformats were obtained.

Comparison

CT of the head dated 06/03/2013 .

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction. There is edema in the right inferior frontal lobe.

The ventricles, cisterns and sulci are age-appropriate in size.

There is no mass effect, midline shift or focal parenchymal

abnormality.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact. There is re- demonstration of a large soft

tissue mass with central calcifications occupying the surgical bed

suspicious for possible recurrence.

There is re- demonstration of a large right-sided facial mass with

calcifications and bony destruction discussed on the CT scan of the

facial bones performed on the same day.

Impression

No CT evidence of hydrocephalus, hemorrhage, or midline shift. Large

right-sided facial mass previously discussed.

Attending Radiologist: BADIA, JAMES

Ordered By: WACKEROW, PAUL

Order Date/Time: January 10, 2016 2:45 PM

Scan Initiation Date/Time: January 10, 2016 4:13 PM

Completion Date/Time: January 10, 2016 4:34 PM

Encounter Number: 010095314174

Accession Number: 6544426

Images were reviewed and interpreted by Attending Radiologist: Dr. BADIA, JAMES

Electronically Signed On: January 10, 2016 7:52 PM by Dr. BADIA, JAMES

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/10/2016 4:34:00 PM

Report Name: CT FACIAL BONE MANDIBLE WO IV CONTRAST

Clinical History

77 now presenting with multiple trauma

History and Indication

MULITIPLE TRAUMA

Technique

MULTIPLE TRAUMA VICTIM

Very thin axial sections were obtained through the facial bones.

Following this, axial, coronal and sagittal computer reformatted

images were obtained.

Comparison

PET-CT dated 11/25/2013 . There is a provided history of right-sided

sinus subtle carcinoma with prior surgical resection and radiation

therapy.

Findings

There has been interval development of a mass occupying the prior

surgical bed epicenter likely at the level of the right maxillary

sinus at the level measuring approximately 6.3 x 7.1 cm with soft

tissue density containing multiple central calcifications. There is

extensive bone destruction involving the right maxillary sinus mean

including the medial wall of the lateral wall and posterior wall.

There is invasion of the orbital rim in the maxilla. There is edema

at the right inferior frontal lobe.

There is enucleation of bone right orbit. There are multiple plates

fixating the bilateral frontal craniotomy.

Impression

Interval development of a large soft tissue calcified mass occupying

the prior surgical bed measuring approximately 6.3 x 7.1 cm with soft

tissue density and multiple central calcifications. The

calcifications may be secondary to prior radiation. All findings are

new since the prior PET-CT of 11/25/2013.

Attending Radiologist: BADIA, JAMES

Ordered By: WACKEROW, PAUL

Order Date/Time: January 10, 2016 2:45 PM

Scan Initiation Date/Time: January 10, 2016 4:19 PM

Completion Date/Time: January 10, 2016 4:34 PM

Encounter Number: 010095314174

Accession Number: 6544427

Images were reviewed and interpreted by Attending Radiologist: Dr. BADIA, JAMES

Electronically Signed On: January 10, 2016 7:50 PM by Dr. BADIA, JAMES

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/10/2016 4:34:00 PM

Report Name: CT SPINE CERVICAL WO IV CONTRAST

Examination

CT SPINE CERVICAL WITHOUT CONTRAST

Clinical History

MULTIPLE TRAUMA

History and Indication

MULTIPLE TRAUMA VICTIM

Technique

1.25 mm. thick helical axial slices were obtained from skull base to

the upper thoracic spine and then sagittal and coronal reformatted

images were obtained.

Comparison

PET-CT dated 11/25/2013 .

Findings

There are no acute fractures or traumatic listhesis. There is no

prevertebral soft tissue swelling. Multilevel degenerative changes of

the cervical spine with intervertebral disc space narrowing most

severe at the C6-7 level. Posterior disk osteophyte at C3-4 and C6-7

levels.

Soft tissue information is limited. No evidence of large disc

protrusion or critical spinal stenosis is noted.

MRI should be obtained, if the patient is MRI compatible, if further

information regarding disc protrusion, hematoma or spinal cord

pathology is required.

Impression

No acute fracture or traumatic listhesis.

Attending Radiologist: BADIA, JAMES

Ordered By: WACKEROW, PAUL

Order Date/Time: January 10, 2016 2:45 PM

Scan Initiation Date/Time: January 10, 2016 4:17 PM

Completion Date/Time: January 10, 2016 4:34 PM

Encounter Number: 010095314174

Accession Number: 6544428

Images were reviewed and interpreted by Attending Radiologist: Dr. BADIA, JAMES

Electronically Signed On: January 11, 2016 12:08 AM by Dr. BADIA, JAMES

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/10/2016 4:35:00 PM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

77-year-old male with multiple trauma worsening bilateral lower

extremity swelling facial swelling at old surgical site.

As per prior radiology report, patient has history of head and neck

cancer, right sinonasal carcinoma status post surgical resection and

radiation therapy.

Technique

Routine study. Post processed reconstructions included.

Contrast

No intravenous or oral contrast

Comparison

PET CT 11/25/2013

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: No pulmonary infiltrate. Linear atelectasis left lung base.

Mild bronchiectasis. .

Right lung:

7 mm nodule right upper lobe anteriorly image 83, new from prior

exam.

8 mm nodule right upper lobe posteriorly image 113, new from prior

exam

7 mm nodule right middle lobe image 149, new from prior exam

These are nonspecific however metastatic lesions must be considered.

Consider PET CT imaging.

LARGE AIRWAYS: Patent.

PLEURA: No effusion or pneumothorax.

HEART and vessel: Mildly enlarged. Coronary artery calcifications

are noted. No pathologic pericardial effusion. The ascending thoracic

aorta is dilated measuring maximum of 5.3 cm in AP dimension this is

without change from prior exam. The aortic origin descending thoracic

aorta measure a maximum of 3.0 cm and tapers to the diaphragmatic

hiatus normal in caliber measuring 2.8 cm. . Scattered

atherosclerotic calcifications are noted.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

The study is limited in evaluating the visceral abdominal contrast.

and pelvic organs without the use of intravenous contrast .

Abdomen:

LIVER: Normal size. Several Scattered hepatic hypodensities are again

seen within the liver the largest in the right lobe near the dome

measuring 4.0 x 3.3 cm measuring 7 Hounsfield U likely represents a

cyst. The largest lesions measures fluid by Hounsfield U consistent

with cysts and are without significant change in number or size.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. A 2.8 cm hypodense lesion is noted

within the right upper pole measuring 9 Hounsfield U likely

represents a cyst without significant change. A 1.0 cm hyperdense

lesion arises from the left lower pole, unchanged may represent a

hyperdense cyst. Full characterization however is limited without

intravenous contrast. Not reported to be FDG avid. Further

characterization with ultrasound with dedicated renal CT can be

obtained for No calculus or hydronephrosis. Bilateral extrarenal

pelvis is noted.

BOWEL: Limited due to non opacification Normal caliber. No wall

thickening or obstruction. The appendix is normal in appearance.

PERITONEUM: No ascites, free air, or fluid collection. Evidence of

prior right anterior abdominal hernia repair

RETROPERITONEUM: No lymphadenopathy. Normal caliber abdominal aorta

however with atherosclerotic calcifications.

Pelvis:

REPRODUCTIVE ORGANS: The prostate is markedly enlarged measuring 6.8

x 7.1 x 6.8 cm and causes indentation on the bladder base possibly a

median lobe. Correlate with PSA levels.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Physis distended the contains a 0.4 cm calculus at its base.

There is a possible tiny urachal diverticulum at the bladder dome

containing a 2-3 mm calculus, unchanged from prior exam.

BONES: Multilevel degenerative change of the spine is noted. No focal

lesion.

Impression

New right pulmonary nodules, nonspecific however metastatic lesions

must be considered. Consider PET CT imaging.

Aneurysmal dilatation of the ascending thoracic aorta measuring 5.3

cm is unchanged.

No significant mediastinal adenopathy.

Markedly enlarged prostate. Correlate with PSA levels. No

underlying bladder calculus. Possible tiny urachal diverticulum

containing 2-3 mm calculus, unchanged.

Hepatic cysts, unchanged.

Probable right renal upper pole 2.8 cm cyst, unchanged. Possible left

lower pole 1. 0 cm hyperdense cyst unchanged.

No significant retroperitoneal or pelvic adenopathy.

Please read above.

Attending Radiologist: MASON, MARYANNA

Ordered By: WACKEROW, PAUL

Order Date/Time: January 10, 2016 2:45 PM

Scan Initiation Date/Time: January 10, 2016 4:21 PM

Completion Date/Time: January 10, 2016 4:35 PM

Encounter Number: 010095314174

Accession Number: 6544431

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 10, 2016 5:44 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/10/2016 4:35:00 PM

Report Name: CT CHEST WO IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

77-year-old male with multiple trauma worsening bilateral lower

extremity swelling facial swelling at old surgical site.

As per prior radiology report, patient has history of head and neck

cancer, right sinonasal carcinoma status post surgical resection and

radiation therapy.

Technique

Routine study. Post processed reconstructions included.

Contrast

No intravenous or oral contrast

Comparison

PET CT 11/25/2013

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: No pulmonary infiltrate. Linear atelectasis left lung base.

Mild bronchiectasis. .

Right lung:

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exam.

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AXILLAE: No lymphadenopathy.

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and pelvic organs without the use of intravenous contrast .

Abdomen:

LIVER: Normal size. Several Scattered hepatic hypodensities are again

seen within the liver the largest in the right lobe near the dome

measuring 4.0 x 3.3 cm measuring 7 Hounsfield U likely represents a

cyst. The largest lesions measures fluid by Hounsfield U consistent

with cysts and are without significant change in number or size.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. A 2.8 cm hypodense lesion is noted

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BOWEL: Limited due to non opacification Normal caliber. No wall

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PERITONEUM: No ascites, free air, or fluid collection. Evidence of

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RETROPERITONEUM: No lymphadenopathy. Normal caliber abdominal aorta

however with atherosclerotic calcifications.

Pelvis:

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x 7.1 x 6.8 cm and causes indentation on the bladder base possibly a

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PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Physis distended the contains a 0.4 cm calculus at its base.

There is a possible tiny urachal diverticulum at the bladder dome

containing a 2-3 mm calculus, unchanged from prior exam.

BONES: Multilevel degenerative change of the spine is noted. No focal

lesion.

Impression

New right pulmonary nodules, nonspecific however metastatic lesions

must be considered. Consider PET CT imaging.

Aneurysmal dilatation of the ascending thoracic aorta measuring 5.3

cm is unchanged.

No significant mediastinal adenopathy.

Markedly enlarged prostate. Correlate with PSA levels. No

underlying bladder calculus. Possible tiny urachal diverticulum

containing 2-3 mm calculus, unchanged.

Hepatic cysts, unchanged.

Probable right renal upper pole 2.8 cm cyst, unchanged. Possible left

lower pole 1. 0 cm hyperdense cyst unchanged.

No significant retroperitoneal or pelvic adenopathy.

Please read above.

Attending Radiologist: MASON, MARYANNA

Ordered By: WACKEROW, PAUL

Order Date/Time: January 10, 2016 2:45 PM

Scan Initiation Date/Time:

Completion Date/Time: January 10, 2016 4:35 PM

Encounter Number: 010095314174

Accession Number: 6544432

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 10, 2016 5:44 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/10/2016 4:46:00 PM

Report Name: CT SPINE THORACIC WO IV CONTRAST

Examination

CT SPINE THORACIC WITHOUT CONTRAST

Clinical History

77 male status post multiple trauma.

Technique

CT of the thoracic spine was performed with thin contiguous axial

slices. Subsequently, computer reformations were obtained in the

coronal and sagittal planes.

Comparison

PET-CT study dated 11/25/2013 .

Findings

This study was obtained to evaluate for fracture. There is no

evidence of vertebral fracture or bone destruction. No large disc

protrusion or critical spinal stenosis is noted.

Impression

No acute fracture or traumatic listhesis.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: WACKEROW, PAUL

Order Date/Time: January 10, 2016 2:45 PM

Scan Initiation Date/Time: January 10, 2016 4:21 PM

Completion Date/Time: January 10, 2016 4:46 PM

Encounter Number: 010095314174

Accession Number: 6544429

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: January 10, 2016 5:17 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/10/2016 4:46:00 PM

Report Name: CT SPINE LUMBAR WO IV CONTRAST

Examination

CT SPINE LUMBAR WITHOUT CONTRAST

Clinical History

MULTIPLE TRAUMA

History and Indication

MULTIPLE TRAUMA VICTIM

Technique

Thin axial slices were obtained through the lumbar spine.

Subsequently, oblique axial, sagittal and coronal reformatted images

were obtained.

Comparison

No images available for comparison.

Findings

No acute fracture or traumatic listhesis. Multilevel degenerative

changes of the lumbosacral spine most severe at the L3-4 and L4-5

level.

There is no disc protrusion or spinal stenosis.

No fracture, bone destruction or subluxation is seen.

Impression

No acute fracture or traumatic listhesis.

Attending Radiologist: BADIA, JAMES

Ordered By: WACKEROW, PAUL

Order Date/Time: January 10, 2016 2:45 PM

Scan Initiation Date/Time:

Completion Date/Time: January 10, 2016 4:46 PM

Encounter Number: 010095314174

Accession Number: 6544430

Images were reviewed and interpreted by Attending Radiologist: Dr. BADIA, JAMES

Electronically Signed On: January 10, 2016 7:56 PM by Dr. BADIA, JAMES

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/11/2016 1:01:00 AM

Report Name: ULTRASOUND KIDNEYS COMPLETE

Examination

ULTRASOUND KIDNEYS COMPLETE/STAT

Clinical History

ACUTE RENAL FAILURE, BUN 100

Critical Results

EVAL FOR HYDRONEPHROSI

Technique

Grayscale ultrasound and color Doppler interrogation were utilized to

evaluate the kidneys.

Comparison

CT of the abdomen performed on 01/10/2016.

Findings

The right kidney measures 12.0 x 5.8 x 5.2 cm. There is no evidence

for hydronephrosis. Renal parenchyma appears echogenic. There is

cortical atrophy. A predominantly simple cyst in the upper pole is

noted, measuring 2.9 x 2.5 x 2.8 cm.

The left kidney measures 11.1 x 5.6 x 6.9 cm. There is no

hydronephrosis . Renal parenchyma appears echogenic. Cortical atrophy

is noted. There is a simple cyst within the midpole of the left

kidney measuring 0.9 x 0.8 x 0.7 cm. In addition multiple small

subcentimeter exophytic cysts are also noted. Note is made 1.0 x

1.4 cm lobulated isoechoic lesion in the lower pole.

Urinary bladder is distended and appears grossly unremarkable.

Bilateral ureteral jets were demonstrated indicating no evidence for

obstruction. Note is made of echogenic debris in the urinary bladder

.

Impression:

1. No sonographic evidence of hydronephrosis.

2. Bilateral renal cysts.

3. Bilateral echogenic renal parenchyma likely secondary to

medical renal disease. Follow up with BUN/creatinine in is

recommended.

4. A 1.4 cm isoechoic possibly solid lesion in the lower pole of

left kidney. Further evaluation with dedicated CT/MR is recommended.

5. Echogenic debris in the urinary bladder. Correlation for UTI

is suggested.

Attending Radiologist: ABBASI, ALMAS

Ordered By: WACKEROW, PAUL

Order Date/Time: January 10, 2016 10:10 PM

Scan Initiation Date/Time: January 11, 2016 12:39 AM

Completion Date/Time: January 11, 2016 1:01 AM

Encounter Number: 010095314174

Accession Number: 6544636

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: January 11, 2016 10:08 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/12/2016 10:00:00 AM

Report Name: CT KIDNEY UROGRAM

Examination

CT of Abdomen and Pelvis.

Clinical History

77 YEAR OLD MAN W/LEFT RENAL MASS

History and Indication

EVALUATE LEFT RENAL MASS

Technique

Routine study. CT scan of the abdomen and pelvis was performed in the

axial plane from lung bases through the symphysis pubis both prior to

and following administration intravenous contrast.Delayed imaging in

the excretory phase also performed. No oral contrast was utilized as

per dedicated renal protocol. Post Processed Coronal and sagittal

reconstructed images were generated from the source data and also

submitted and reviewed.

Contrast

Contrast Agent OMNIPAQUE 350 100 milliliters 01/12/2016 INTRAVENOUS

Comparison

CT of abdomen pelvis performed on 10/31/2016.

Findings

Lung Base:

New small bilateral pleural effusion with adjacent compressive

atelectasis. Multichamber cardiomegaly is partially visualized.

Coronary atherosclerotic calcifications are noted.

Abdomen:

LIVER: Normal size. Multiple nonenhancing fluid attenuating lesions

are present, with the largest in the segment 7 of the right liver

lobe, measuring 4.43 x 3.5 cm, unchanged consistent with cysts. .

BILIARY TRACT: Unremarkable gallbladder No biliary dilatation

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No calculus or hydronephrosis. Within the

right upper pole is a 2.9 x 3.0 cm simple cyst measuring 8 Hounsfield

units without enhancement. Within the left lower pole is a 1.0 cm

hyperdense lesion on non contrast images which measures 46 Hounsfield

units. This becomes low-attenuation on post-contrast imaging without

enhancement measuring 46 Hounsfield units and represents a hyperdense

cyst/proteinaceous cyst. Subcentimeter hypodensities are noted

within the right mid and lower poles as well as within the left mid

and upper poles, too small to accurately characterize. No CT evidence

of urothelial lesion.

BOWEL: Normal caliber. No wall thickening or obstruction. The

appendix is normal in appearance. Few sigmoid diverticula are noted.

No CT evidence of diverticulitis. Evidence of prior right anterior

abdominal wall hernia repair. .

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

ABDOMINAL WALL: No hernia or masses.

VESSELS: Normal caliber aorta with arthrosclerotic calcifications

Pelvis:

REPRODUCTIVE ORGANS: Prostate is enlarged, measuring 7.5 x 7.0 x 7.1

cm with heterogeneous enhancement and with 1.7 cm focal area of low

attenuation in the right aspect of the prostate and additional 1.6 cm

hypodensity in the left aspect of the prostate. This is a

nonspecific correlate with PSA levels further evaluation with

transrectal ultrasound or MR imaging can be obtained.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Interval placement of a Foley catheter. The urinary bladder

is somewhat decompressed compared to the prior exam. There is

apparent wall thickening. This may be partially artifactual due to

limited distension however maybe secondary to bladder outlet

obstruction. Air is seen in the bladder, secondary to

instrumentation. Again noted is a 4 mm calculus within the urinary

bladder. An additional 3 mm calcification is seen at the bladder dome

unchanged.

BONES: Multilevel degenerative changes of the thoracolumbar spine are

noted.

Impression

Left renal 1.0 cm a hyperdense cyst. 2.9 cm right simple renal cyst.

Additional subcentimeter bilateral renal hypodensities too small to

characterize.

No CT evidence of urothelial lesions.

Multiple hepatic cysts, unchanged from prior study.

Markedly enlarged prostate as described above. Correlate with PSA

levels. Further evaluation a transrectal prostate ultrasound or MR

imaging can be obtained.

Bladder calculi as described above. Status post Foley catheter

placement. Mild bladder wall thickening. A degree of this may be

artifactual due to limited distension however may be secondary to

bladder outlet obstruction.

Please read above.

Attending Radiologist: MASON, MARYANNA

Ordered By: NGUYEN, DON

Order Date/Time: January 11, 2016 1:50 PM

Scan Initiation Date/Time: January 12, 2016 9:35 AM

Completion Date/Time: January 12, 2016 10:00 AM

Encounter Number: 010095314174

Accession Number: 6545576

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 12, 2016 12:23 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/14/2016 9:53:00 AM

Report Name: CHEST AP PORTABLE

Examination

Portable chest radiograph

Clinical History

RRT - FEVER

Technique

Single AP view of chest is presented.

Comparison

01/10/2016 .

Findings

Lines, tubes, and devices: None.

Lungs and Pleura: No pulmonary edema.No overt consolidative

opacity.No large pleural effusion or pneumothorax.

Cardiomediastinal structures: Cardiomediastinal silhouette can not

be well assessed upon due to technique (antero-posterior projection).

The ascending aorta appears mildly dilated. There is mild tortuosity

of the descending thoracic aorta. Atherosclerotic calcifications

again noted in the aortic knob.

Bones/Soft tissues: No acute osseous abnormality.

Impression

No focal consolidation to suggest pneumonia. No pleural effusion.

mildly dilated descending thoracic aorta. Mild tortuosity of the

descending thoracic aorta.

Attending Radiologist: GUPTA, AMIT

Ordered By: JAGLALL, NEIL

Order Date/Time: January 14, 2016 9:05 AM

Scan Initiation Date/Time: January 14, 2016 9:51 AM

Completion Date/Time: January 14, 2016 9:53 AM

Encounter Number: 010095314174

Accession Number: 6549442

Images were reviewed and interpreted by Attending Radiologist: Dr. GUPTA, AMIT

Electronically Signed On: January 14, 2016 12:54 PM by Dr. GUPTA, AMIT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095314174

Report Date/Time: 1/18/2016 2:48:00 PM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: VINCENZO BARILLA Exam Date: 1/18/2016 at Heart Rate:

100-160

2:24:02 PM

MR #: 00283037 Report Date: 1/18/2016 Rhythm:

Atrial

Fibrillation

ACC #: 6554240 Height: 172.72 cm BP: 154/75

DOB: 8/27/1938 Weight: 79.83 kg Location:

16N

Age/Sex: 77 years / M BSA: 1.94 m²

Ref. Physician: Dr. Neil JAGLALL, cc:

Sonographer: BJ

Indications: SOB

History: CHF, A-Fib, HTN, LE edema, NSTEMI

Procedure: Complete Echocardiogram - 93306.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.07 cm 2.0 - 3.8 LA Diam 4.20 cm 3.0-4.0

IVS 1.15 cm 0.6 - 1.0 LA Area 16.7cm² <=20

LVID 4.61 cm 4.2 - 5.9 3.61 cm LA Vol 59.00 ml 18-58

LVPW 1.29 cm 0.6 - 1.0 LA Vol/BSA 30.48ml/m² 22+ / -6

RA Diam 3.4cm 2.9-4.5

Ao at the sinuses 4.00 cm

LVEF 45 % (biplane method of discs)

LV FS 21.7

LV SV 31.6 ml

LV SI 16.3 ml/m²

Aov Cusp Sep 2.40 cm

(Systole)

Aov VTI 0.208 m LVOT VTI 0.120 m LVOT diameter

2.40

cm

Aov VMax 1.17 m/s LVOT Vmax 0.67 m/s Dimensionless

Index 0.57

Aov Pk Pressure 5.5 mmHg Aov Mn 3.0 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 2.60 cm² Aov Area Index 1.34 cm²/m²

(VTI)

MV VTI MV DT 144 msec

MV E Vmax 1.28 m/s MV A Vmax E/A

MV Area press 1/2 Time 5.27

IVRT E/E ' 12.40

Septal E ' 0.105 m/s Prop Velocity

Lateral E ' m/s LA Pressure 17.02 mmHg

TR Vmax 2.43 m/s TR Pk Grad 23.7 mmHg RA Pressure 8 mmHg RVSP

31.7 mmHg

TV E Max TV Mn Grad mmHg PHT 41.76 msec TV VTI

PV Vmax 0.93 m/s PV Pk Grad 3.5 mmHg PV Mn Grad 2.0 mmHg RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

mildly increased. The relative wall thickness is severely increased

(0.53). Global left ventricular systolic function is mildly reduced.

The ejection fraction is 45% by biplane method of discs. Left

ventricular basal fractional shortening is decreased. The basal

inferolateral wall is akinetic. The basal inferior wall is akinetic.

Left Ventricle - Diastole:The Doppler derived early diastolic

deceleration time is short at 144 msec. The overall diastolic

function is moderately impaired (grade II, pseudonormal pattern) with

elevated left ventricular filling pressures.

Left Atrium: The left atrium is mildly dilated in size.

Right Atrium: The right atrium is normal in size.

Right Ventricle: The right ventricular diastolic area is 14.20 cm

which is normal. The right ventricular systolic area is 8.10 cm which

is normal. The right ventricular fractional area change is 42.96%

which is normal. The right ventricular systolic pressure, as

estimated using the tricuspid regurgitation velocity, is 31.7 mmHg.

Aortic Valve: The aortic valve is trileaflet and is calcified with

normal excursion. Mild aortic valve insufficiency is present.

Mitral Valve: Mild mitral regurgitation is present.

Tricuspid Valve: Mild tricuspid regurgitation is present.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.43 m/s, and

with an assumed right atrial pressure of 8 mmHg, the estimated

pulmonary artery systolic pressure is normal at 31.7 mmHg.

Pericardium: There is a trivial circumferential pericardial effusion.

Miscellaneous: Left pleural effusion noted.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 5/2/13. There is a mild decrease in the left ventricular

systolic function as compared to the prior study.

Summary:

1. Normal left ventricular cavity size.

2. Mildly increased left ventricular wall thickness.

3. Severely increased relative wall thickness.

4. Mildly reduced global left ventricular systolic function.

5. Segmental wall motion abnormalities (see above).

6. Moderate diastolic dysfunction with elevated left ventricular

filling pressures.

7. Mildly dilated left atrial size.

8. Trileaflet aortic valve and aortic sclerosis.

9. Mild aortic insufficiency.

10. Mild mitral regurgitation.

11. Mild tricuspid regurgitation.

12. Trivial circumferential pericardial effusion.

13. Left pleural effusion.

14. Mild decrease in left ventricular systolic function since the

prior study.

014970 Smadar Kort MD, FACC, FASE, FAHA

Electronically signed by 014970 Smadar Kort MD, FACC, FASE, FAHA on

1/18/2016 at 3:58:33 PM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: RIQUELME, LUIS A

Order Date/Time: January 18, 2016 1:20 PM

Scan Initiation Date/Time:

Completion Date/Time: January 18, 2016 2:48 PM

Encounter Number: 010095314174

Accession Number: 6554240

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: January 18, 2016 3:58 PM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/11/2016 11:53:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

CVA.

Technique

Single frontal view of the chest

Comparison

None.

Findings

The trachea is midline. The cardiomediastinal silhouette is normal.

No airspace consolidation, sizable effusion, or pneumothorax. There

is severe osteoarthritis involving the right acromioclavicular

joint.

Impression

No airspace consolidation, sizable effusion, or pneumothorax.

Severe osteoarthritis of the right AC joint.

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: LEIBNER, EVAN

Order Date/Time: January 11, 2016 11:15 AM

Scan Initiation Date/Time: January 11, 2016 11:48 AM

Completion Date/Time: January 11, 2016 11:53 AM

Encounter Number: 010095329487

Accession Number: 6545233

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: January 11, 2016 2:23 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/11/2016 3:14:00 PM

Report Name: MRA NECK WO IV CONTRAST

Examination

MRA NECK WITHOUT CONTRAST

Clinical History

BRAIN ATTACK PROTOCOL

History and Indication

POSSIBLE CVA

Technique

3D time-of-flight for the arteries in the neck. Following this MIP

images were created. NASCET methodology was employed to evaluate the

degree of stenosis.

Comparison

No images available for comparison.

Findings

There is no evidence of stenosis of the right and left carotid

arteries and right and left vertebral arteries. The origin and the

right vertebral artery is not well visualized, however the remainder

of the right vertebral artery demonstrates slightly hypoplastic

configuration without stenosis or evidence for dissection.

There is no evidence of dissection.

Impression

No evidence of stenosis or dissection.

Attending Radiologist: BANGIYEV, LEV

Ordered By: LEIBNER, EVAN

Order Date/Time: January 11, 2016 11:15 AM

Scan Initiation Date/Time: January 11, 2016 1:59 PM

Completion Date/Time: January 11, 2016 3:14 PM

Encounter Number: 010095329487

Accession Number: 6545236

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 11, 2016 4:32 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/11/2016 3:14:00 PM

Report Name: MRI BRAIN WO AND WITH IV CONTRAST

Examination

MRI BRAIN WO AND WITH IV CONTRAST/STAT

Clinical History

1 MONTH WORSEN BALANCE AND FINE MOTOR N\T\V

History and Indication

POSSIBLE CVA

Technique

Multiple sequences were obtained through the brain without and with

intravenous gadolinium.

Contrast

Contrast Agent GADAVIST 9 milliliters 01/11/2016 INTRAVENOUS

Comparison

No images available for comparison.

Findings

There is masslike T2/FLAIR hyperintense enhancing lesion centered in

the right brachium pontis extending superiorly involving superior

cerebellar peduncle and right dorsal pons, inferiorly involving

dorsal medulla and likely inferior cerebellar peduncle. The lesion

also extends anterolaterally to the level of the right trigeminal

nerve root entry. There is minimal associated mass effect with subtle

effacement of the right aspect of the 4th ventricle. There are

multiple nonenhancing T2/FLAIR hyperintense lesions in the

periventricular white matter that demonstrates somewhat perpendicular

orientation in relation to the ventricles. There are punctate

lesions in the corpus callosum involving genu and mid body. There is

additional T2/Flair hyperintense lesion in the left inferior

cerebellum. Additional subcortical and deep white matter of

white-matter lesions are also noted. There is no definite

juxtacortical white matter.

Evaluation of MR perfusion demonstrates no evidence for

hyperperfusion.

The ventricles, sulci, and fissures are prominent consistent with

age-related volume loss. There is no abnormal diffusion restriction

to suggest acute or subacute infarct, acute intracranial hemorrhage,

or extra-axial collection. There is no midline shift or evidence for

transtentorial herniation. The major intracranial vascular structures

demonstrate T2 flow voids.

There is a punctate focus of enhancement within the left internal

auditory canal measuring approximately 1-2 mm. There is a right

frontal convexity extra-axial dural-based nodular enhancement

measuring 4-5 mm.

The orbits and visualized soft tissues are normal. The visualized

paranasal sinuses and mastoid air cells are clear.

Impression

Masslike T2/FLAIR hyperintense enhancing lesion centered in the right

brachium pontis extending into the dorsal pons and medulla with

extension to the right trigeminal nerve root entry zone with

additional multiple nonenhancing white matter lesions in the

supratentorial and infratentorial brain. Primary consideration

includes tumefactive demyelination, alternatively primary CNS

neoplasm should be considered.

Punctate focus of enhancement within left internal auditory canal may

represent a small vestibular schwannoma versus leptomeningeal

enhancement. As clinically indicated correlation with CSF analysis

can be obtained for further evaluation.

Right frontal convexity dural based nodular enhancement likely

meningioma.

Findings were discussed with neurology attending Dr. Harth at 4 p.m.

on 11/21/2016

Attending Radiologist: BANGIYEV, LEV

Ordered By: LEIBNER, EVAN

Order Date/Time: January 11, 2016 11:15 AM

Scan Initiation Date/Time: January 11, 2016 1:59 PM

Completion Date/Time: January 11, 2016 3:14 PM

Encounter Number: 010095329487

Accession Number: 6545234

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 11, 2016 4:28 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/11/2016 3:14:00 PM

Report Name: MRA HEAD WO IV CONTRAST

Examination

MRA Head without contrast

Clinical History

EVALUATE FOR CENTRAL THROMBOSIS

History and Indication

POSSIBLE CVA

Technique

3D TOF

Comparison

No prior studies are available for comparison.

Findings

There is no occlusive disease, aneurysm or AVM noted. There is

hypoplastic right intracranial vertebral artery terminating

predominantly in PICA.

Impression

Unremarkable intracranial MRA.

Attending Radiologist: BANGIYEV, LEV

Ordered By: LEIBNER, EVAN

Order Date/Time: January 11, 2016 11:15 AM

Scan Initiation Date/Time: January 11, 2016 1:59 PM

Completion Date/Time: January 11, 2016 3:14 PM

Encounter Number: 010095329487

Accession Number: 6545235

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 11, 2016 4:34 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/13/2016 2:46:00 PM

Report Name: MRI SPECTROSCOPY

Clinical History

Brain lesion

Technique

3D FLAIR sequence without contrast. Single voxel spectroscopy at was

performed utilizing short TE 30 centered over the abnormality and

normal-appearing brain parenchyma with long TE 135.

Comparison

Correlation is made with brain MRI dated 01/11/2016

Findings

There is unchanged in extent FLAIR hyperintense lesion in the right

brachium pontis extending into adjacent cerebellum, also extending to

the right trigeminal nerve root entry zone, in addition lesion

extends superiorly and along the right dorsal aspect of the pons

involving superior cerebellar peduncle, and inferiorly along the

dorsal medulla also involving left inferior cerebellar peduncle.

Evaluation of single voxel short and long TE spectroscopy centered

over the abnormality demonstrates slightly increased choline peak

with relatively decreased NAA peak and prominent lactate/lipid

complex in comparison to normal-appearing spectra on the

contralateral side.

Impression

Given imaging characteristics and spectroscopy finding the lesion

likely represents a tumefactive demyelination rather than a CNS

neoplasm.

Attending Radiologist: BANGIYEV, LEV

Ordered By: CHAN, JILLIAN

Order Date/Time: January 11, 2016 6:00 PM

Scan Initiation Date/Time: January 13, 2016 1:51 PM

Completion Date/Time: January 13, 2016 2:46 PM

Encounter Number: 010095329487

Accession Number: 6545980

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 13, 2016 5:02 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/13/2016 2:46:00 PM

Report Name: MRI BRAIN WO IV CONTRAST

Clinical History

Brain lesion

Technique

3D FLAIR sequence without contrast. Single voxel spectroscopy at was

performed utilizing short TE 30 centered over the abnormality and

normal-appearing brain parenchyma with long TE 135.

Comparison

Correlation is made with brain MRI dated 01/11/2016

Findings

There is unchanged in extent FLAIR hyperintense lesion in the right

brachium pontis extending into adjacent cerebellum, also extending to

the right trigeminal nerve root entry zone, in addition lesion

extends superiorly and along the right dorsal aspect of the pons

involving superior cerebellar peduncle, and inferiorly along the

dorsal medulla also involving left inferior cerebellar peduncle.

Evaluation of single voxel short and long TE spectroscopy centered

over the abnormality demonstrates slightly increased choline peak

with relatively decreased NAA peak and prominent lactate/lipid

complex in comparison to normal-appearing spectra on the

contralateral side.

Impression

Given imaging characteristics and spectroscopy finding the lesion

likely represents a tumefactive demyelination rather than a CNS

neoplasm.

Attending Radiologist: BANGIYEV, LEV

Ordered By: TISOVIC, KELLY

Order Date/Time: January 13, 2016 8:50 AM

Scan Initiation Date/Time:

Completion Date/Time: January 13, 2016 2:46 PM

Encounter Number: 010095329487

Accession Number: 6547967

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 13, 2016 5:02 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/14/2016 12:44:00 PM

Report Name: MRI SPINAL CORD CERVICAL WITH IV CONTRAST

Examination

MRI CERVICAL SPINE WITH CONTRAST

Clinical History

EVALUATE FOR LESIONS

Additional History

NEW BRAIN LESION

Technique

Following intravenous contrast administration, sagittal T1 and STIR

sequences and axial T1 and Merge sequences were obtained through the

cervical spine.

Contrast

Contrast Agent GADAVIST 10 milliliters 01/14/2016 INTRAVENOUS

Comparison

No images available for comparison.

Findings

Evaluation of the cervical spinal cord demonstrates normal contour,

caliber, and signal characteristics. There is no abnormal intradural

or intramedullary enhancement or mass lesion.

There is anatomic alignment of the cervical spine. There is no

evidence of subluxation or facet joint dislocation. The vertebral

bodies demonstrate normal height and morphology. There is multilevel

disc desiccation corrected by decreased T2 signal. There is mild

diffuse loss of intervertebral disc height. The visualized

prevertebral and paravertebral soft tissues are unremarkable.

At C3-4 there is disc osteophyte complex indenting thecal sac

effacement also is without spinal cord compression or cord signal

abnormality. There is mild bilateral neural foraminal stenosis

related to facet and uncovertebral hypertrophy.

At C4-5 there is a shallow disc osteophyte complex indenting thecal

sac partially effacing ventral CSF. There is no spinal cord

compression or cord signal abnormality. There is mild bilateral

neural foraminal stenosis related to facet and uncovertebral

hypertrophy.

At C5-6 there is disc osteophyte complex indenting thecal sac

partially effacing ventral CSF. There is no spinal cord compression

or cord signal abnormality. There is mild to moderate bilateral

neural foraminal stenosis related to facet and uncovertebral

hypertrophy.

At C6-7 there is disc osteophyte complex indenting thecal sac partial

effacement of CSF. There is no spinal cord compression or cord

signal abnormality. There is mild to moderate bilateral neural

foraminal stenosis related to facet and uncovertebral hypertrophy.

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Impression

No evidence of cervical spinal cord lesion or abnormal enhancement.

Multilevel degenerative disc disease.

Attending Radiologist: BANGIYEV, LEV

Ordered By: CHAN, JILLIAN

Order Date/Time: January 11, 2016 5:35 PM

Scan Initiation Date/Time: January 14, 2016 11:46 AM

Completion Date/Time: January 14, 2016 12:44 PM

Encounter Number: 010095329487

Accession Number: 6545954

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 14, 2016 1:50 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/14/2016 12:46:00 PM

Report Name: MRI THORACIC SPINE WITH IV CONTRAST

Examination

MRI THORACIC SPINE WITH CONTRAST

Clinical History

Brain lesion.

Technique

Following intravenous contrast administration, sagittal T1 and

T2-weighted and proton density sequences and axial T1 and T2 weighted

sequences were performed. cc of Magnevist was administered.

Contrast

Contrast Agent GADAVIST 10 milliliters 01/14/2016 INTRAVENOUS

Comparison

No images available for comparison.

Findings

Irradiation and the visualized spinal cord demonstrates normal

contour, caliber, and signal characteristics. There is no abnormal

intradural or intramedullary enhancement or mass lesion. There is no

evidence of spinal cord compression.

There is mild dextro convex thoracic scoliosis. There is otherwise

anatomic alignment of the thoracic spine. The vertebral bodies

demonstrate normal height and morphology.

At T9-10 there is a shallow disc bulge with superimposed prominent

epidural plexus indenting thecal sac effacing ventral CSF and

contacts the ventral aspect of the spinal cord without evidence of

spinal cord compression.

There is no neural foraminal stenosis.

Impression

No definite spinal cord signal abnormality or abnormal enhancement.

Attending Radiologist: BANGIYEV, LEV

Ordered By: CHAN, JILLIAN

Order Date/Time: January 11, 2016 5:35 PM

Scan Initiation Date/Time: January 14, 2016 11:46 AM

Completion Date/Time: January 14, 2016 12:46 PM

Encounter Number: 010095329487

Accession Number: 6545955

Images were reviewed and interpreted by Attending Radiologist: Dr. BANGIYEV, LEV

Electronically Signed On: January 14, 2016 1:32 PM by Dr. BANGIYEV, LEV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/14/2016 9:02:00 PM

Report Name: CT ABD AND PELVIS WITH IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

Brain lesion

Technique

Routine study. Post processed reconstructions included.

Contrast

Contrast Agent OMNIPAQUE 300 110 milliliters 01/14/2016 INTRAVENOUS

Comparison

None

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: Background emphysematous change is noted in the upper lobes.

Subsegmental atelectatic segments seen in the lower lungs

predominantly on the left side. No signs of suspicious mass lesions

seen in the lungs.

LARGE AIRWAYS: Patent.

PLEURA: No effusion or pneumothorax.

HEART: Normal size. No pathologic pericardial effusion.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: Evidence of chronic diverticulitis in the sigmoid colon with

pericolonic sinus tracts and adhesions between the ileum and the

sigmoid colon. No sign of active abscess is seen in the mesenteric

fat.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy. Calcific atherosclerotic change

is seen in the normal caliber aorta and its branches.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy. Evidence of Perianal

sinus tracts and the adjacent skin thickening seen in the right

gluteal region likely reflecting chronic perianal fistulous disease.

Current activity could not be determined.

BLADDER: Unremarkable.

BONES: Within normal limits for age. No focal lesion.

Impression

No mass lesion is identified in the chest, abdomen or pelvis.

Evidence of remote sigmoid diverticulitis with pericolonic adhesions

and sinus tracts as well as chronic perianal fistulous disease.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: CHAN, JILLIAN

Order Date/Time: January 14, 2016 3:30 PM

Scan Initiation Date/Time:

Completion Date/Time: January 14, 2016 9:02 PM

Encounter Number: 010095329487

Accession Number: 6550310

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: January 15, 2016 8:20 AM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/14/2016 9:02:00 PM

Report Name: CT CHEST WITH IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

Brain lesion

Technique

Routine study. Post processed reconstructions included.

Contrast

Contrast Agent OMNIPAQUE 300 110 milliliters 01/14/2016 INTRAVENOUS

Comparison

None

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: Background emphysematous change is noted in the upper lobes.

Subsegmental atelectatic segments seen in the lower lungs

predominantly on the left side. No signs of suspicious mass lesions

seen in the lungs.

LARGE AIRWAYS: Patent.

PLEURA: No effusion or pneumothorax.

HEART: Normal size. No pathologic pericardial effusion.

MEDIASTINUM and HILA: No lymphadenopathy.

AXILLAE: No lymphadenopathy.

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: Evidence of chronic diverticulitis in the sigmoid colon with

pericolonic sinus tracts and adhesions between the ileum and the

sigmoid colon. No sign of active abscess is seen in the mesenteric

fat.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy. Calcific atherosclerotic change

is seen in the normal caliber aorta and its branches.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy. Evidence of Perianal

sinus tracts and the adjacent skin thickening seen in the right

gluteal region likely reflecting chronic perianal fistulous disease.

Current activity could not be determined.

BLADDER: Unremarkable.

BONES: Within normal limits for age. No focal lesion.

Impression

No mass lesion is identified in the chest, abdomen or pelvis.

Evidence of remote sigmoid diverticulitis with pericolonic adhesions

and sinus tracts as well as chronic perianal fistulous disease.

Attending Radiologist: CHIMPIRI, ANNAPURNESWARA

Ordered By: CHAN, JILLIAN

Order Date/Time: January 14, 2016 3:30 PM

Scan Initiation Date/Time: January 14, 2016 8:53 PM

Completion Date/Time: January 14, 2016 9:02 PM

Encounter Number: 010095329487

Accession Number: 6550309

Images were reviewed and interpreted by Attending Radiologist: Dr. CHIMPIRI, ANNAPURNESWARA

Electronically Signed On: January 15, 2016 8:20 AM by Dr. CHIMPIRI, ANNAPURNESWARA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095329487

Report Date/Time: 1/18/2016 3:33:00 PM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: LEE STEINBACH Exam Date: 1/18/2016 at 2:48:18 PM Heart

Rate:

MR #: 30636187 Report Date: 1/18/2016 Rhythm:

ACC #: 6554232 Height: 167.64 cm BP: 137/81

DOB: 2/9/1963 Weight: 79.38 kg Location:

13N

Age/Sex: 52 years / M BSA: 1.89 m²

Ref. Physician: GUIDO, MICHAEL, cc:

Sonographer: CF

Indications: HTN

History: MS, HTN

Procedure: Comp. Echo w/contrast - C8929 and Definity Contrast -

Q9957. The use

of contrast was indicated for enhancement of endocardial

border

definition. There were no contraindications for the use of

contrast

in this patient. Verbal consent was given by the patient

who is aware

of the possible adverse reactions associated with the use

of

contrast. No adverse reactions or hemodynamic compromise

identified.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 2.51 cm 2.0 - 3.8 LA Diam 2.70 cm 3.0-4.0

IVS 1.08 cm 0.6 - 1.0 LA Area 10.5cm² <=20

LVID 4.90 cm 4.2 - 5.9 3.17 cm LA Vol 23.50 ml 18-58

LVPW 0.95 cm 0.6 - 1.0 LA Vol/BSA 12.44ml/m² 22+ / -6

RA Diam 3.8cm 2.9-4.5

Ao at the sinuses 3.60 cm

Ao Ascending 3.10 cm

Ao Arch 2.2 cm

Ao Descending 1.8cm

LVEF 72 % (biplane method of discs)

LV FS 35.3

LV Mass 210.3 g LV Mass Index/BSA 111.3 g/m²

LV SV 58.5 ml

LV SI 30.9 ml/m²

Aov Cusp Sep 2.20 cm

(Systole)

Aov VTI 0.278 m LVOT VTI 0.184 m LVOT diameter

2.00

cm

Aov VMax 1.57 m/s LVOT Vmax 1.03 m/s Dimensionless

Index 0.66

Aov Pk Pressure 9.9 mmHg Aov Mn 5.0 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 2.08 cm² Aov Area Index 1.10 cm²/m²

(VTI)

MV VTI MV DT 143 msec

MV E Vmax 0.95 m/s MV A Vmax 1.01 m/s E/A 0.94

MV Area press 1/2 Time 5.32

IVRT E/E ' 8.62

Septal E ' 0.100 m/s Prop Velocity

Lateral E ' 0.11 m/s LA Pressure 13.10 mmHg

Average E' 0.105 m/s

MV Average E/E' 9.03

TV E Max TV Mn Grad PHT 41.32 msec TV VTI

PV Vmax 1.16 m/s PV Pk Grad 5.3 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

normal. Left ventricular mass by the area-length technique, is

normal, at 210.3 g.(111.3 g/m²). The relative wall thickness is

normal (0.41). Global left ventricular systolic function is normal.

The ejection fraction is 72% by biplane method of discs. Left

ventricular basal fractional shortening is normal.

Left Ventricle - Diastole:The overall diastolic function is normal

with normal left ventricular filling pressures.

Left Atrium: The left atrium is normal in size. No left atrial mass

seen.

Right Atrium: The right atrium is normal in size.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. Global right

ventricular systolic function is normal. The tricuspid annular plane

systolic excursion is 2.6 cm consistent with normal right ventricular

systolic function.

Aortic Valve: The aortic valve is trileaflet with normal excursion.

Mitral Valve: The mitral valve is structurally normal. No evidence of

mitral insufficiency is seen.

Tricuspid Valve: The tricuspid valve is structurally normal. No

tricuspid insufficiency is seen.

Pulmonic Valve: The pulmonic valve is not well visualized.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.60 cm. The ascending aorta is normal at 3.10 cm. The

aortic arch is normal at 2.2 cm. The descending aorta is normal in

size at 1.8 cm.

Pericardium: No pericardial effusion seen.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Normal left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Normal global left ventricular systolic function.

4. Normal diastolic function with normal left ventricular filling

pressures.

5. Normal right ventricular systolic function.

6. Trileaflet aortic valve with normal excursion.

7. No left atrial mass.

8. No pericardial effusion.

9. Normal aortic root diameter for body size.

10. Normal atrial septum by 2D and color Doppler.

012480 Howard Novotny MD, FACC

Electronically signed by 012480 Howard Novotny MD, FACC on 1/18/2016

at 3:47:15 PM

\*\*\* Final \*\*\*

Attending Cardiologist: NOVOTNY, HOWARD

Ordered By: CAMERON, LAUREN

Order Date/Time: January 18, 2016 1:15 PM

Scan Initiation Date/Time:

Completion Date/Time: January 18, 2016 3:33 PM

Encounter Number: 010095329487

Accession Number: 6554232

Images were reviewed and interpreted by Attending Cardiologist: Dr. NOVOTNY, HOWARD

Electronically Signed On: January 18, 2016 3:47 PM by Dr. NOVOTNY, HOWARD

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095346630

Report Date/Time: 1/11/2016 4:17:00 PM

Report Name: CHEST AP PORTABLE

Given history is a 84-year-old male status post left-sided pacemaker

implantation

Technique:

AP portable view of the chest were submitted .

Comparison:

No prior study

Findings:

A left subclavian approach pacemaker is noted with distal leads in

the region of the right atrium and right ventricle. The trachea is

midline. The aorta is calcified and mildly tortuous otherwise the

mediastinal silhouette is normal in appearance. The cardiac size

appears mildly enlarged. The lungs are without consolidation,

congestion or pleural effusion. There is no evidence of pneumothorax.

The diaphragms are normal in position and smooth in contour. The

visualized osseous structures are unremarkable.

Impression:

Status post pacemaker placement. No evidence of pneumothorax.

Mild cardiomegaly.

No evidence of pulmonary consolidation or effusion

Attending Radiologist: MASON, MARYANNA

Ordered By: SINGH, ABHIJEET

Order Date/Time: January 11, 2016 4:00 PM

Scan Initiation Date/Time: January 11, 2016 4:11 PM

Completion Date/Time: January 11, 2016 4:17 PM

Encounter Number: 010095346630

Accession Number: 6545840

Images were reviewed and interpreted by Attending Radiologist: Dr. MASON, MARYANNA

Electronically Signed On: January 11, 2016 4:24 PM by Dr. MASON, MARYANNA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095346630

Report Date/Time: 1/12/2016 10:44:00 AM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Examination

CHEST ROUTINE PA/AP AND LATERAL/ROUT

Clinical History

S/P LEFT SIDED PPM IMPLANTATION

Presenting Diagnosis

LEAD PLACEMENT POST IMPLANT, PENDING DISCHARGE

Technique

Two views of the chest are presented.

Comparison

Prior portable chest radiograph dated 01/11/2016.

Findings

Limited inspiratory effort. Apparent stable mediastinal widening

likely secondary to ectatic or dilated vessels. Persistent

cardiomegaly. Left subclavian sequential pacemaker is present with 1

lead overlying the right atrium and the other the right ventricle.

For the localization is not possible on this frontal film. No

pneumothorax is identified. There is no radiographic evidence of

pulmonary edema.

No new discrete infiltrates are present. Crowding of vessels in both

lung bases likely secondary to the limited inspiratory effort.

Subparagraph is the osseous structures are unchanged.

Impression

No pneumothorax.

Limited inspiratory effort.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: SINGH, ABHIJEET

Order Date/Time: January 12, 2016 6:00 AM

Scan Initiation Date/Time: January 12, 2016 10:29 AM

Completion Date/Time: January 12, 2016 10:44 AM

Encounter Number: 010095346630

Accession Number: 6545841

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 12, 2016 12:08 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095346630

Report Date/Time: 1/12/2016 10:02:00 AM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: ZDZISLAW Exam Date: 1/12/2016 at Heart

Rate:

PIETRASIEWICZ 9:18:11 AM 110-120

MR #: 30795004 Report 1/12/2016 Rhythm:

Sinus

Date:

Tachycardia

ACC #: 6545938 Height: 170.18 cm BP:

158/68

DOB: 7/16/1931 Weight: 79.83 kg

Location: 5L CACU

Age/Sex: 84 years / M BSA: 1.92 m²

Sonographer: CF

Indications: SYNCOPE

History: ICD, HTN,SYCNCOPE, DYSPNEA

Procedure: Comp. Echo w/contrast - C8929, Definity Contrast - Q9957

and Patient

Supine. The use of contrast was indicated for enhancement

of

endocardial border definition. There were no

contraindications for

the use of contrast in this patient. Verbal consent was

given by the

patient who is aware of the possible adverse reactions

associated

with the use of contrast. No adverse reactions or

hemodynamic

compromise identified.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Nl Nl

IVS 0.6 - 1.0 LA Area 15.65cm² <=20

LVID 4.2 - 5.9 LA Vol 32.05 ml 18-58

LVPW 0.6 - 1.0 LA Vol/BSA 16.74ml/m² 22+ / -6

RA Diam 5.0cm 2.9-4.5

Ao Arch 2.5 cm

Ao Descending 2.0cm

Aov VTI 0.261 m LVOT VTI LVOT diameter

Aov VMax 1.68 m/s LVOT Vmax 1.24 m/s Dimensionless

Index 0.74

Aov Pk Pressure 11.3 mmHg Aov Mn Pressure 6.6 mmHg

Gradient Gradient

MV VTI MV DT 340 msec

MV E Vmax 0.79 m/s MV A Vmax E/A

MV Area press 1/2 Time 2.23

IVRT E/E ' 9.93

Septal E ' 0.065 m/s Prop Velocity

Lateral E ' 0.08 m/s LA Pressure 15.49 mmHg

Average E' 0.073 m/s

MV Average E/E' 10.96

TR Vmax 2.63 m/s TR Pk Grad 27.7 mmHg RA Pressure 3 mmHg RVSP

30.7 mmHg

TV E Max TV Mn Grad mmHg PHT 98.52 msec TV VTI

Left Ventricle - Structure and Systolic Function: Global systolic

function is probably moderately reduced based on limited images.

Left Ventricle - Diastole:The Doppler derived early diastolic

deceleration time is prolonged at 340 msec. The velocity of the early

diastolic septal mitral annular movement, as determined by tissue

Doppler imaging is reduced at 0.065 m/s. The velocity of the early

diastolic lateral mitral annular movement, as determined by tissue

Doppler imaging is reduced at 0.08 m/s. The overall diastolic

function is mildly impaired (grade I, impaired relaxation pattern)

with elevated left ventricular filling pressures.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is moderately dilated in size.

Right Ventricle: The right ventricular size is moderately enlarged.

The right ventricular diastolic area is 35.11 cm which is moderately

dilated. The right ventricular systolic area is 23.30 cm which is

severely dilated. Global right ventricular systolic function is

normal. The right ventricular fractional area change is 33.64% which

is normal. The tricuspid annular plane systolic excursion is 1.5 cm

consistent with normal right ventricular systolic function.

Mitral Valve: Mild mitral regurgitation is present.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.63 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is normal at 30.7 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Probably moderately reduced left ventricular systolic function.

2. Mild diastolic dysfunction with elevated filling pressures.

3. Moderately enlarged right ventricle.

4. Normal right ventricular systolic function.

5. Moderately dilated right atrial size.

6. Mild mitral regurgitation.

7. No pericardial effusion.

014970 Smadar Kort MD, FACC, FASE, FAHA

Electronically signed by 014970 Smadar Kort MD, FACC, FASE, FAHA on

1/12/2016 at 10:59:28 AM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: CUMMINGS, KELLY

Order Date/Time: January 11, 2016 5:25 PM

Scan Initiation Date/Time:

Completion Date/Time: January 12, 2016 10:02 AM

Encounter Number: 010095346630

Accession Number: 6545938

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: January 12, 2016 10:59 AM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095346630

Report Date/Time: 1/15/2016 3:36:00 PM

Report Name: ULTRASOUND KIDNEYS COMPLETE

Clinical History

84-year-old male with acute kidney injury versus chronic kidney

disease. Evaluate for obstruction, mass or stone.

Technique

A renal sonogram is performed with color Doppler interrogation.

Comparison

No images available for comparison.

Findings

The study is limited due to patient inability to cooperate for the

exam and overlying bowel gas.

The right kidney measures 9.8 cm and the left kidney measures 9.4 cm

in length. There is no evidence for hydronephrosis or definite

shadowing calculus of either kidney. Renal cortical echogenicity is

isoechoic to liver and favored to be within normal limits however

there is diffuse mild cortical thinning. There is a lobular contour

on the left. A simple appearing cyst is demonstrated in the mid to

upper pole left kidney measuring 2.5 x 2.6 x 2.6 cm. Note that the

upper pole of the left kidney is obscured by bowel gas.

The urinary bladder is not fully distended limiting evaluation.

Impression

Limited study.

No hydronephrosis.

Diffuse mild cortical thinning.

Note that solid masses are not excluded on the basis of this limited

study.

Attending Radiologist: CUNNINGHAM, ROBIN

Ordered By: ASIF, AINUL

Order Date/Time: January 15, 2016 12:10 PM

Scan Initiation Date/Time: January 15, 2016 3:20 PM

Completion Date/Time: January 15, 2016 3:36 PM

Encounter Number: 010095346630

Accession Number: 6551590

Images were reviewed and interpreted by Attending Radiologist: Dr. CUNNINGHAM, ROBIN

Electronically Signed On: January 15, 2016 3:45 PM by Dr. CUNNINGHAM, ROBIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095346630

Report Date/Time: 1/20/2016 1:24:00 PM

Report Name: LUMBAR PUNCTURE UNDER FLUOROSCOPY

Examination

LUMBAR PUNCTURE UNDER FLUOROSCOPY

Clinical History

84 YEAR OLD POLISH SPEAKING MALE WITH NO KNOWN PAST MEDICAL HISTORY

TRANSFERRED FROM PBMC FOR AV BLOCK. INITIALLY ADMITTED TO CACU FOR

PPM PLACEMENT. HOSPITAL COURSE COMPLICATED BY DELIRIUM AND LYME AB

POSIT

Technique

H\T\P, labs and imaging were reviewed. Informed consent was obtained

from the patient's Healthcare proxy.

The patient was placed in the prone position and the L3-4 interspace

was localized under realtime fluoroscopy. Sedation was provided by

anesthesia staff.

The overlying soft tissues were prepped and draped in the usual

sterile fashion. Local anesthesia was achieved with 2% Xylocaine

without epinephrine.

A 20 gauge 3.5 inch spinal needle was advanced into the thecal sac

using a left interlaminar approach under fluoroscopic guidance, and

the stylette removed.

Upon conclusion of the procedure, the stylette was replaced, the

spinal needle withdrawn, and the tract obliterated. A sterile

dressing was applied.

The patient tolerated the procedure well and there were no immediate

complications.

Findings

Clear fluid was encountered. 7 cc of fluid was collected. Access was

subsequently lost due technical difficulty. CSF was sent to

laboratory for analysis.

Impression

Status post successful lumbar puncture without complication noted.

Attending Radiologist: FILATOV, ALEXANDER

Ordered By: RIQUELME, LUIS A

Order Date/Time: January 15, 2016 12:05 PM

Scan Initiation Date/Time: January 20, 2016 10:47 AM

Completion Date/Time: January 20, 2016 1:24 PM

Encounter Number: 010095346630

Accession Number: 6551571

Images were reviewed and interpreted by Attending Radiologist: Dr. FILATOV, ALEXANDER

Electronically Signed On: January 20, 2016 1:43 PM by Dr. FILATOV, ALEXANDER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095394861

Report Date/Time: 1/12/2016 1:48:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

DYSPNEA

Additional History

POSSIBLE INFILTRATE

Technique

Portable AP view of the chest.

Comparison

Portable AP chest X-Ray from 12/02/2015.

Findings

The trachea is midline. The cardiomediastinal silhouette appears

within normal limits for size. Again seen is coarsening of

bronchovascular markings. There is evidence of vascular crowding

secondary to low lung findings. No focal consolidation, large pleural

effusion, pneumothorax, or pulmonary vascular congestion.

Visualized osseous structures show no evidence of acute fracture.

Impression

No acute cardiopulmonary disease.

Attending Radiologist: YAN, ZENGMIN

Ordered By: KAPUR, SUSHMA

Order Date/Time: January 12, 2016 1:30 PM

Scan Initiation Date/Time: January 12, 2016 1:40 PM

Completion Date/Time: January 12, 2016 1:48 PM

Encounter Number: 010095394861

Accession Number: 6547040

Images were reviewed and interpreted by Attending Radiologist: Dr. YAN, ZENGMIN

Electronically Signed On: January 12, 2016 3:08 PM by Dr. YAN, ZENGMIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095394861

Report Date/Time: 1/12/2016 10:21:00 PM

Report Name: ULTRASOUND OF ABDOMEN

Examination

ULTRASOUND OF ABDOMEN/ROUT

Clinical History

ASCITES, LIVER CIRRHOSIS

Critical Results

ASCITES

Technique

Gray scale ultrasoundand color Doppler were utilized to evaluate the

abdomen.

Comparison

Abdomen ultrasound dated 10/28/2015

Findings

Study is limited due to significant amount of bowel gas.

The upper abdominal aorta and IVC are partially visualized.

Hepatic parenchyma is echogenic and coarsed compatible with patient's

history of cirrhosis. The liver measures 12.3 centimeter. There are

no visible focal liver masses. There is no intrahepatic ductal

dilatation. Evaluation of the portal vein is severely limited due to

overlying ascites.

There is gallbladder wall thickening which is new compared to the

prior study. Gallbladder wall measures 0.9 cm. There is again seen

cholelithiasis and sludge within the gallbladder. No pericholecystic

fluid seen. Negative Murphy's sign. The common bile duct is not

dilated measuring 0.5 cm.

Pancreas could not be adequately visualized.

The right kidney measures 10.2 x 4.8 x 4.5 cm. There is a cyst within

the midpole of the right kidney measuring 1.8 x 1.3 centimeter.

The left kidney measures 9.6 x 5.0 x 4.7 cm. There is a cyst within

the midpole of the left kidney measuring 2.9 x 2.9 centimeter.

There is no hydronephrosis. There are no visualized renal calculi.

The renal parenchyma is normal in echogenicity.

The spleen measures 11.3 x 2.6 x 4.3 cm. There are no focal splenic

lesions.

There is moderate amount of ascites which has been increased compared

to the prior study.

Impression

Limited study.

Liver cirrhosis.

Abdominal ascites, increased compared to the prior study.

Cholelithiasis and sludge and new gallbladder wall thickening,

nonspecific. Negative Murphy's sign.

Attending Radiologist: REITER, MICHAEL

Ordered By: DING, YONGZENG

Order Date/Time: January 12, 2016 7:15 PM

Scan Initiation Date/Time: January 12, 2016 9:28 PM

Completion Date/Time: January 12, 2016 10:21 PM

Encounter Number: 010095394861

Accession Number: 6547654

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 13, 2016 2:45 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095394861

Report Date/Time: 1/15/2016 4:45:00 PM

Report Name: PARACENTESIS W/IMAGE INC ALL

Clinical History

Ascites

Technique

PROCEDURE:

Risks, benefits, and alternatives were discussed with the patient,

who appeared to understand and granted informed consent. Patient

placed in the supine position while in the stretcher. Nurse

monitoring was performed throughout the entire procedure. Limited

initial ultrasound of the abdomen was performed and images were

stored. A suitable entry site was marked, prepped and draped in the

usual sterile fashion. Following administration of 1% lidocaine

anesthetic, and using real-time ultrasound guidance, a 5 French

Saf-T-Centesis catheter needle was advanced into the peritoneal

cavity. The catheter was advanced, connected to suction, and fluid

was removed in the usual manner. The catheter was removed and a

sterile dressing was applied. The patient tolerated the procedure

wellwithout immediate complication.

FINDINGS:

Limited initial ultrasound reveals moderate ascites. There was

successful ultrasound-guided paracentesis as described. 3 liters of

clear yellow fluid readily drained.

Impression

Successful ultrasound-guided paracentesis. 3 liters removed.

Attending Radiologist: MALESON, ANDREW

Ordered By: HOELZER, MAUREEN

Order Date/Time: January 15, 2016 11:45 AM

Scan Initiation Date/Time: January 15, 2016 4:03 PM

Completion Date/Time: January 15, 2016 4:45 PM

Encounter Number: 010095394861

Accession Number: 6551522

Images were reviewed and interpreted by Attending Radiologist: Dr. MALESON, ANDREW

Electronically Signed On: January 15, 2016 4:54 PM by Dr. MALESON, ANDREW

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095394861

Report Date/Time: 1/18/2016 2:36:00 PM

Report Name: CHEST AP(PORT) CENTRAL LINE PL

Clinical History

Right upper extremity PICC placement

Technique

AP portable for right upper extremity PICC placement.

Comparison

01/12/2016

Findings

Interval placement of right upper extremity PICC with tip in SVC. No

unintended radiopaque foreign body along the length of the PICC.

Cardiomediastinal silhouette is within normal limits. Prominent

ascending and descending thoracic aorta, likely ectatic. Moderate

pulmonary venous congestion is identified. Heterogenous airspace

opacities in the right mid zone may represent atelectasis or focal

consolidation. No evidence of pneumothorax.

Impression

Interval placement of right upper extremity PICC line with the no

unintended radiopaque foreign body along the length of the PICC.

Moderate pulmonary venous congestion with airspace opacity in the

right mid zone which may represent atelectasis or small focal

consolidation.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: DUARTE, CAROL

Order Date/Time: January 18, 2016 1:10 PM

Scan Initiation Date/Time: January 18, 2016 2:14 PM

Completion Date/Time: January 18, 2016 2:36 PM

Encounter Number: 010095394861

Accession Number: 6554222

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: January 18, 2016 6:06 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095426986

Report Date/Time: 1/13/2016 4:22:00 PM

Report Name: SPINE CERVICAL (AP/ LATERAL/ ODONTOID)

Clinical History

Neck pain. Possible fracture

Additional History

POSSIBLE FRACTURE

Technique

AP, lateral and odontoid views of the cervical spine, for a total of

5 images.

Comparison

No prior radiographs available for direct comparison.

Correlation is made with cervical spine CT dated 11/17/15.

Findings

Cervical spine is portions of C7 on the lateral film, including

swimmer's view. Base of the odontoid is grossly intact. Lateral

masses of C1 are well seated on C2. Predental space is maintained.

Bone mineralization is within normal. Alignment and vertebral body

heights are maintained. Intervertebral disc spaces are maintained. No

evidence of prevertebral soft tissue swelling/thickening. Bilateral,

relatively symmetric calcifications in the neck are most likely

vascular, presumably at the level of the carotid bifurcations.

Impression

Alignment of the cervical spine is maintained without compression

fracture.

Attending Radiologist: WOROCH, LUBOSLAV

Ordered By: HENDLER, ROBERT

Order Date/Time: January 13, 2016 12:55 PM

Scan Initiation Date/Time: January 13, 2016 4:16 PM

Completion Date/Time: January 13, 2016 4:22 PM

Encounter Number: 010095426986

Accession Number: 6548504

Images were reviewed and interpreted by Attending Radiologist: Dr. WOROCH, LUBOSLAV

Electronically Signed On: January 13, 2016 5:13 PM by Dr. WOROCH, LUBOSLAV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095426986

Report Date/Time: 1/13/2016 4:22:00 PM

Report Name: SPINE THORACIC AP AND LATERAL

Clinical History

Back pain.

Technique

3 views of the thoracic spine

Comparison

none

Findings

Evaluation of the upper thoracic spine is limited on the lateral film

due to overlapping soft tissue and bone. Alignment and vertebral

body heights are maintained in the thoracic spine. The pedicles of

the thoracic vertebra are intact and symmetric. There is mild levo

convex tilt of the midthoracic spine. There is mild disc space

narrowing with endplate osteophytes in the lower thoracic spine from

T9 and T10- T12-L1.

Impression

Alignments of the thoracic spine is maintained without compression

fracture.

Attending Radiologist: WOROCH, LUBOSLAV

Ordered By: HENDLER, ROBERT

Order Date/Time: January 13, 2016 12:55 PM

Scan Initiation Date/Time: January 13, 2016 4:18 PM

Completion Date/Time: January 13, 2016 4:22 PM

Encounter Number: 010095426986

Accession Number: 6548505

Images were reviewed and interpreted by Attending Radiologist: Dr. WOROCH, LUBOSLAV

Electronically Signed On: January 13, 2016 5:11 PM by Dr. WOROCH, LUBOSLAV

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095426986

Report Date/Time: 1/13/2016 4:22:00 PM

Report Name: SPINE LUMBO-SACRAL

Clinical History

Possible Fracture

Technique

3 views of lumbosacral spine.

Comparison

None

Findings

No acute compression fracture deformity. No subluxation. Multilevel

degenerative changes with osteophytosis and facet arthropathy.

Sacroiliac joints appear symmetric. No widening of the symphysis

pubis.

Calcific atherosclerosis of the abdominal aorta. Large amount of

stool in the rectal vault, suggestive of constipation.

Impression

1. No acute fracture compression fracture deformity or

subluxation.

2. Multilevel degenerative changes.

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: HENDLER, ROBERT

Order Date/Time: January 13, 2016 12:55 PM

Scan Initiation Date/Time: January 13, 2016 4:19 PM

Completion Date/Time: January 13, 2016 4:22 PM

Encounter Number: 010095426986

Accession Number: 6548506

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: January 13, 2016 5:01 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095426986

Report Date/Time: 1/13/2016 4:22:00 PM

Report Name: HIP BILATERAL WITH PELVIS MIN OF 5 VWS

Clinical History

Possible fracture

Technique

A single frontal view of the pelvis was obtained, 2 views of right

hip, 2 views of left hip

Comparison

None

Findings

No acute fracture or dislocation. Bilateral hips are located without

evidence of dislocation. Sacroiliac joints are intact without

evidence of disruption. No widening of the symphysis pubis.

Large amount of stool in the rectal vault, suggestive of

constipation.

Impression

No evidence of acute fracture or dislocation of pelvis or bilateral

hip.

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: HENDLER, ROBERT

Order Date/Time: January 13, 2016 1:00 PM

Scan Initiation Date/Time: January 13, 2016 4:26 PM

Completion Date/Time: January 13, 2016 4:22 PM

Encounter Number: 010095426986

Accession Number: 6548507

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: January 13, 2016 4:59 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095426986

Report Date/Time: 1/13/2016 4:22:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Trauma

Technique

Portable AP chest x-ray

Comparison

Chest x-ray 11/17/2015

Findings

The trachea is midline. Cardiomediastinal silhouette is prominent but

stable. Mild atherosclerotic calcification of the thoracic aorta. No

focal consolidation or large pleural effusion. Mild degenerative

changes of thoracic spine.

Impression

No focal consolidation or large pleural effusion.

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: HENDLER, ROBERT

Order Date/Time: January 13, 2016 12:55 PM

Scan Initiation Date/Time: January 13, 2016 4:25 PM

Completion Date/Time: January 13, 2016 4:22 PM

Encounter Number: 010095426986

Accession Number: 6548502

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: January 13, 2016 5:12 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095426986

Report Date/Time: 1/17/2016 9:59:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Cough and low grade fever

Technique

Portable AP film of the chest

Comparison

Comparison is made to 01/13/2016

Findings

Cardiomediastinal silhouette is within normal limits. The aorta is

dilated and tortuous.

The basilar airspace opacities on the prior examination, especially

on the left, have resolved. No large pleural effusion. No

pneumothorax. No pulmonary vascular congestion. Linear atelectasis

left base.

Visualized osseous structures are unremarkable.

Impression

Interval resolution of parenchymal opacities on the prior

examination. The lungs are now clear except for minor linear

atelectasis.

Attending Radiologist: BALSAM, DVORAH

Ordered By: MATHEW, ALEX

Order Date/Time: January 17, 2016 8:50 AM

Scan Initiation Date/Time: January 17, 2016 9:40 AM

Completion Date/Time: January 17, 2016 9:59 AM

Encounter Number: 010095426986

Accession Number: 6553039

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: January 17, 2016 11:30 AM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095439906

Report Date/Time: 1/13/2016 2:21:00 PM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Clinical History

LLL PNA

History and Indication

POSSIBLE INFILTRATE

Technique

PA and lateral views of the chest

Comparison

CXR from 12/28/15

Findings

A tunneled right IJ approach central venous catheter is again seen

with tip overlying the atrial-caval junction. The trachea is

midline. The cardiomediastinal silhouette appears within normal

limits for size. Atherosclerotic calcification of aortic knob. A

vascular stent is identified in the left suprahilar region. Interval

increase of nonspecific opacities in the left lower lung zone and

lingula. No focal consolidation in right lung. No large pleural

effusion. Multilevel degenerative changes in thoracic spine.

Impression

Interval increase of nonspecific opacities in left lower lung zone

and lingula; may reflect atelectasis and/or pneumonia.

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: HERNANDEZ, CRISTINA

Order Date/Time: January 13, 2016 1:40 PM

Scan Initiation Date/Time: January 13, 2016 2:26 PM

Completion Date/Time: January 13, 2016 2:21 PM

Encounter Number: 010095439906

Accession Number: 6548596

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: January 13, 2016 2:42 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095439906

Report Date/Time: 1/16/2016 12:21:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

81-year-old male with a past medical history of COPD presents with

RSV pneumonia.

Technique

AP portable chest radiograph

Comparison

Chest radiograph from 01/13/2016

Findings

Right subclavian approach Perma-Cath is identified with its tip at

the cavoatrial junction.

Retrocardiac opacity likely represents atelectasis. There is a trace

left-sided pleural effusion. No pneumothorax.

Cardiomediastinal silhouette is unchanged. There is calcification of

the aortic knob. Vascular stent is noted projecting over the left

upper mediastinum.

Multilevel degenerative changes of thoracic spine.

Impression

1. Trace left-sided pleural effusion.

2. Retrocardiac opacity likely representing atelectasis.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: CHAKRAVARTY, RAMANUJ

Order Date/Time: January 16, 2016 8:50 AM

Scan Initiation Date/Time: January 16, 2016 11:39 AM

Completion Date/Time: January 16, 2016 12:21 PM

Encounter Number: 010095439906

Accession Number: 6552425

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: January 16, 2016 1:26 PM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095439906

Report Date/Time: 1/20/2016 10:40:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

81M WITH PNA NOW WITH WORSENING SOB

Indication

EVALUATE FOR PNEUMONIA

Technique

CHEST AP PORTABLE/STAT

Comparison

Study on the previous day.

Findings

Dual-lumen right IJ catheter is unchanged in position. Linear

opacity in the left lung base likely represents atelectasis. No

focal consolidation or pneumothorax. Cardiac silhouette is normal in

size. Stent again noted within the left superior mediastinum.

Impression

Left basilar atelectasis. No consolidation or large pleural effusion.

Attending Radiologist: REITER, MICHAEL

Ordered By: NEERUKONDA, ANU

Order Date/Time: January 20, 2016 10:00 PM

Scan Initiation Date/Time: January 20, 2016 10:35 PM

Completion Date/Time: January 20, 2016 10:40 PM

Encounter Number: 010095439906

Accession Number: 6558092

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 20, 2016 10:46 PM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095439906

Report Date/Time: 1/24/2016 4:46:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Possible pneumonia

Technique

Single portable view of the chest

Comparison

Single portable view of the chest dated 01/20/2016

Findings

There is a right subclavian approach infusion catheter visualized

with its tip overlying the right atrium. Trachea is midline. The

cardiomediastinal silhouette is within normal limits. The left

costophrenic angle is omitted from the field of view. There is no

large right-sided pleural effusion. There is no focal lung

consolidation component of congestion or pneumothorax. There are no

acute osseous fractures.

Impression

No acute cardiopulmonary process on this limited exam.

Attending Radiologist: FISHER, PAUL

Ordered By: SAVLA, GEETA

Order Date/Time: January 24, 2016 3:55 PM

Scan Initiation Date/Time: January 24, 2016 4:43 PM

Completion Date/Time: January 24, 2016 4:46 PM

Encounter Number: 010095439906

Accession Number: 6561987

Images were reviewed and interpreted by Attending Radiologist: Dr. FISHER, PAUL

Electronically Signed On: January 24, 2016 5:10 PM by Dr. FISHER, PAUL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095440599

Report Date/Time: 1/13/2016 3:46:00 PM

Report Name: ULTRASOUND SCROTUM/TESTICULAR

Examination

ULTRASOUND SCROTUM/TESTICULAR/STAT

Clinical History

TESTICULAR PAIN

Additional History

EVAL FOR TESTICULAR TORSION/EPIDIDYMITIS from patient is paraplegic.

Technique

Grayscale ultrasound, color Doppler and spectral Doppler

interrogation were utilized to evaluate the scrotum.Spectral Doppler

utilized to evaluate for testicular perfusion and to exclude torsion.

Comparison

09/10/2012

Findings

The right testicle measures 1.7 x 2.7 x 3.8 cm and demonstrates

homogeneous echotexture without evidence for focal mass. There is

at least 1 punctate callus microcalcification in the right testicle.

The prominent vasculature is seen within the testicle with findings

to suggest mild intratesticular varicocele. Normal testicular

arterial and venous waveforms are documented. The right epididymal

head measures 0.7 x 1.2 x 1.0 cm.

The left testicle measures 1.5 x 2.0 x 4.2 cm in size. There is

normal homogeneous echotexture without focal mass. Normal color flow

is demonstrated. There are few clustered micro calcifications

identified without an overall pattern of testicular microlithiasis,

very likely postinflammatory. Normal testicular arterial and venous

waveforms are documented. The left epididymal head measures 1.0 x 1.3

x 1.1 cm. There is a mild left hydrocele.

There is mild to moderate left varicocele demonstrated on color

Doppler patent with Valsalva maneuver.

Impression

No evidence for testicular torsion or epididymitis.

Mild to moderate left varicocele and probable mild probable

intratesticular varicocele on the right side.

Mild left hydrocele.

Several testicular microcalcifications without definite overall

pattern of testicular microlithiasis, very likely postinflammatory.

Attending Radiologist: CUNNINGHAM, ROBIN

Ordered By: HERNANDEZ, CRISTINA

Order Date/Time: January 13, 2016 2:50 PM

Scan Initiation Date/Time: January 13, 2016 3:16 PM

Completion Date/Time: January 13, 2016 3:46 PM

Encounter Number: 010095440599

Accession Number: 6548737

Images were reviewed and interpreted by Attending Radiologist: Dr. CUNNINGHAM, ROBIN

Electronically Signed On: January 13, 2016 4:12 PM by Dr. CUNNINGHAM, ROBIN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095440599

Report Date/Time: 1/15/2016 9:26:00 AM

Report Name: MRI FOOT LEFT WO IV CONTRAST

Clinical History

Soft tissue wound on dorsal foot. Concern for underlying

osteomyelitis.

Technique

Multiplanar and multisequence noncontrast MRI of the left forefoot.

Comparison

No prior studies are available for comparison.

Findings

There is a large soft tissue wound at the dorsal aspect of the

midfoot, difficult to measure, however approximately 5.3 x 4.2 cm in

area. There is exposure to the underlying soft tissue structures

including the extensor tendons, as well as the underlying

subcutaneous tissues. While some of this may be exaggerated by MRI

technique, this should likely be clearly evident on physical exam.

There is diffuse patchy marrow edema, predominantly about the midfoot

bones (for example, series 9, image 12) which is adjacent to this

large soft tissue wound. However, there is no confluent convincing

abnormal T1 marrow signal to suggest underlying osteomyelitis. As

such, the findings are likely reflective of reactive marrow edema or

the very beginning of osteitis. There is no drainable fluid

collection.

There is edema and atrophy of the intrinsic foot musculature which is

likely related to the patient's paraplegic status and denervation.

There is significant soft tissue swelling at the dorsal subcutaneous

fat at the level of the metatarsals.

There is mild 3rd web space intermetatarsal bursitis. No convincing

Morton's neuroma. Plantar plates appear grossly intact.

LisFranc ligament is intact.

Impression

Large dorsal soft tissue wound with exposure of underlying soft

tissue structures including muscles and tendons, may be exaggerated

by MRI technique, but should be clearly evident on physical exam.

Diffuse mild patchy marrow edema about the midfoot, without overly

convincing loss of T1 signal, likely representing reactive marrow

edema or the very beginning of osteitis.

Mild intermetatarsal bursitis at the 3rd web space.

Attending Radiologist: BAKER, KEVIN S

Ordered By: DEMISSIE, TINSAE

Order Date/Time: January 14, 2016 8:05 PM

Scan Initiation Date/Time: January 15, 2016 8:56 AM

Completion Date/Time: January 15, 2016 9:26 AM

Encounter Number: 010095440599

Accession Number: 6550631

Images were reviewed and interpreted by Attending Radiologist: Dr. BAKER, KEVIN S

Electronically Signed On: January 15, 2016 10:14 AM by Dr. BAKER, KEVIN S

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095440599

Report Date/Time: 1/15/2016 3:52:00 PM

Report Name: FOOT LEFT 2 VWS PORTABLE

Clinical History

Pre-op evaluation.

Technique

2 radiographs of the left foot were acquired.

Comparison

No prior radiographs of the left foot are available for comparison.

Correlation is made with MRI performed earlier on the same day.

Findings

There is no acute fracture or dislocation appreciated. There is mild

hallux valgus. Very slight spurring at the 1st MTP joint. There is a

large dorsal soft tissue defect, better evaluated on physical exam.

Significant soft tissue swelling is also noted about the foot. The

osseous structures are osteopenic.

Impression

1. No acute fracture or dislocation appreciated.

2. Mild hallux valgus.

3. Large dorsal soft tissue defect, better evaluated on physical

exam.

4. Significant soft tissue swelling about the foot.

5. Osteopenia.

Attending Radiologist: BAKER, KEVIN S

Ordered By: DEMISSIE, TINSAE

Order Date/Time: January 15, 2016 2:00 PM

Scan Initiation Date/Time: January 15, 2016 3:30 PM

Completion Date/Time: January 15, 2016 3:52 PM

Encounter Number: 010095440599

Accession Number: 6551792

Images were reviewed and interpreted by Attending Radiologist: Dr. BAKER, KEVIN S

Electronically Signed On: January 15, 2016 4:36 PM by Dr. BAKER, KEVIN S

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095440979

Report Date/Time: 1/13/2016 4:42:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Chest pain

Technique

Portable AP chest x-ray

Comparison

01/09/2016

Findings

There is an AICD in the right upper chest with leads projecting over

the cardiomediastinal silhouette is unchanged in position from prior

exam. Basket the kidneys seen overlying the cardiomediastinal

silhouette is unchanged in position from prior exam. Cervical spinal

fusion hardware is partially visualized.

The trachea is midline. Cardiomediastinal silhouette is enlarged,

stable from prior study. There is prominence of perihilar vasculature

evidence of cephalization compatible with moderate pulmonary vascular

congestion. There is a small to moderate left pleural effusion

increase prior exam with underlying opacity favored to represent

compressive atelectasis however underlying infectious process cannot

be excluded.

Impression

Moderate pulmonary vascular congestion.

Small to moderate sized left pleural effusion increased prior exam,

with underlying opacity may represent atelectasis however underlying

infectious process cannot be excluded.

Cardiomegaly

Attending Radiologist: HUANG, MINGQIAN

Ordered By: GENTILE, STEPHANIE

Order Date/Time: January 13, 2016 3:40 PM

Scan Initiation Date/Time: January 13, 2016 4:39 PM

Completion Date/Time: January 13, 2016 4:42 PM

Encounter Number: 010095440979

Accession Number: 6548857

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 13, 2016 5:09 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095440979

Report Date/Time: 1/14/2016 9:23:00 AM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: RANDOLPH H MANNING Exam Date: 1/14/2016 at 8:26:52 AM

Heart Rate:

MR #: 00148504 Report Date: 1/14/2016

Rhythm:

ACC #: 6548886 Height: 185.42 cm BP:

96/64

DOB: 12/18/1947 Weight: 90.26 kg

Location: 16N

Age/Sex: 68 years / M BSA: 2.15 m²

Ref. Physician: NEWTON ERIKA, cc:

Sonographer: TS

Indications: Palpitations

History: A-Fib, S/P PPM/Defib recent placement, NIDCM, A-Fib,

Hypotension,

Hyperkalemia, Weakness, CAD, ESRD S/P Renal transplant

Procedure: Complete Echocardiogram - 93306.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 4.23 cm 2.0 - 3.8 LA Diam 4.97 cm 3.0-4.0

IVS 1.44 cm 0.6 - 1.0 LA Area 28.90cm² <=20

LVID 5.53 cm 4.2 - 5.9 5.28 cm LA Vol 113.95 ml 18-58

LVPW 1.44 cm 0.6 - 1.0 LA Vol/BSA 53.07ml/m² 22+ / -6

RA Diam 5.60cm 2.9-4.5

Ao at the sinuses 3.42 cm

Ao Ascending 3.35 cm

Ao Arch 2.78 cm

Ao Descending 2.84cm

LVEF 15 % (visual estimation)

LV FS 4.5

LV Mass 307.5 g LV Mass Index/BSA 143.2 g/m²

Aov Cusp Sep 1.76 cm

(Systole)

Aov VTI 0.194 m LVOT VTI 0.128 m LVOT diameter

2.28

cm

Aov VMax 1.16 m/s LVOT Vmax 0.80 m/s Dimensionless

Index 0.69

Aov Pk Pressure 5.4 mmHg Aov Mn 3.4 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 2.70 cm² Aov Area Index 1.26 cm²/m²

(VTI)

MV VTI MV DT 132 msec

MV E Vmax 1.13 m/s MV A Vmax 0.48 m/s E/A 2.37

MV Area press 1/2 Time 5.74

IVRT E/E ' 14.06

Septal E ' 0.050 m/s Prop Velocity

Lateral E ' 0.08 m/s LA Pressure 23.36 mmHg

Average E' 0.065 m/s

MV Average E/E' 17.31

TR Vmax 3.26 m/s TR Pk Grad 42.4 mmHg RA Pressure 15 mmHg RVSP

57.4 mmHg

TV E Max TV Mn Grad mmHg PHT 38.32 msec TV VTI

PV Vmax 0.72 m/s PV Pk Grad 2.1 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

moderately increased. Left ventricular mass by the area-length

technique, is increased, at 307.5 g.(143.2 g/m²). The relative wall

thickness is severely increased (0.52). Severely reduced global left

ventricular systolic function with diffuse hypokinesis. The ejection

fraction is 15% by visual estimation. Left ventricular basal

fractional shortening is decreased.

Left Ventricle - Diastole:The overall diastolic function is severely

impaired (grade III, restrictive pattern) with marked elevation of

left ventricular filling pressures.

Left Atrium: The left atrium is severely dilated in size.

Right Atrium: The right atrium is severely dilated in size.

Atrial Septum: Atrial septum is not well visualized. Atrial septum is

structurally normal and intact on 2D and color Doppler interrogation.

Right Ventricle: The right ventricular size is mildly enlarged.

Global right ventricular systolic function is mildly reduced. The

tricuspid annular plane systolic excursion is 1.20 cm consistent with

reduced right ventricular systolic function. The right ventricular

systolic pressure, as estimated using the tricuspid regurgitation

velocity, is 57.4 mmHg.

Right Heart Catheters/Leads: Catheter consistent with pacemaker or

defibrillator lead seen in the right heart.

Aortic Valve: The aortic valve is trileaflet and is thickened with

normal excursion. Normal Doppler interrogation flow patterns without

stenosis or insufficiency.

Mitral Valve: The mitral valve leaflets appear tethered consistent

with papillary muscle displacement or annular dilatation. Prolapse of

the mitral valve is not seen. No evidence of mitral stenosis is seen.

Mild-moderate mitral regurgitation is present. The jet is

centrally-directed.

Tricuspid Valve: The tricuspid valve is structurally normal.

Moderate-severe tricuspid regurgitation is present. The color Doppler

jet is directed centrally.

Pulmonic Valve: The pulmonic valve is not well visualized. Trace

pulmonary regurgitation is seen.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 3.42 cm. The ascending aorta is normal at 3.35 cm. The

aortic arch is normal at 2.78 cm. The descending aorta is normal in

size at 2.84 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 3.26 m/s, and

with an assumed right atrial pressure of 15 mmHg, the estimated

pulmonary artery systolic pressure is moderately elevated at 57.4

mmHg.

Pericardium: No pericardial effusion seen.

Miscellaneous: Ascites noted. Left pleural effusion noted.

Comparison: Prior examinations are available and were reviewed for

comparison purposes. The most recent available prior study is from

1/5/2016. There is no significant change in the findings since the

last echocardiogram. There is a mild worsening in the parameters of

left ventricular diastolic filling as compared to the prior study.

Summary:

1. Normal left ventricular cavity size.

2. Moderately increased left ventricular wall thickness.

3. Severely increased relative wall thickness.

4. Severely reduced global left ventricular systolic function with

diffuse hypokinesis.

5. Severely dilated left atrial size.

6. Severely dilated right atrial size.

7. Severe diastolic dysfunction with elevated left ventricular

filling pressures.

8. Mildly reduced right ventricular systolic function.

9. Mildly enlarged right ventricle.

10. Trileaflet aortic valve and thickened leaflets with no aortic

stenosis.

11. No aortic stenosis or insufficiency.

12. Tethering of the mitral valve leaflets.

13. Mild-moderate mitral regurgitation.

14. Moderate-severe tricuspid regurgitation.

15. Moderately elevated pulmonary artery systolic pressure.

16. Normal aortic root diameter for body size.

17. No pericardial effusion.

18. Normal atrial septum by 2D and color Doppler.

19. Ascites present.

20. Left pleural effusion.

21. Mild worsening in left ventricular diastolic filling since the

prior study.

015260 Kathleen Stergiopoulos MD, PhD, FASE, FACC

Electronically signed by 015260 Kathleen Stergiopoulos MD, PhD, FASE,

FACC on 1/14/2016 at 10:30:43 AM

\*\*\* Final \*\*\*

Attending Cardiologist: STERGIOPOULOS, KATHLEEN

Ordered By: GENTILE, STEPHANIE

Order Date/Time: January 13, 2016 4:00 PM

Scan Initiation Date/Time:

Completion Date/Time: January 14, 2016 9:23 AM

Encounter Number: 010095440979

Accession Number: 6548886

Images were reviewed and interpreted by Attending Cardiologist: Dr. STERGIOPOULOS, KATHLEEN

Electronically Signed On: January 14, 2016 10:30 AM by Dr. STERGIOPOULOS, KATHLEEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095442330

Report Date/Time: 1/14/2016 3:33:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

S/P CENTRAL LINE

Additional History

CHECK LINE PLACEMENT

Technique

Portable AP view of the chest.

Comparison

Portable AP chest X-Ray from 01/12/2014.

Findings

Interval right IJ approach central venous catheter placement with tip

overlying the cavoatrial junction. Again seen is a left subclavian

approach AICD/ pacemaker in the left upper chest with leads overlying

the cardiomediastinal silhouette.

The trachea is midline. The cardiomediastinal silhouette appears

within normal limits for size. No focal consolidation, large pleural

effusion or pneumothorax.

Imaged bony structures appear unremarkable.

Impression

1. Status post right IJ approach CVAD placement with tip

overlying cavoatrial junction.

2. No focal consolidation, large pleural effusion or

pneumothorax.

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: SEDA, JESUS

Order Date/Time: January 14, 2016 3:20 PM

Scan Initiation Date/Time: January 14, 2016 3:26 PM

Completion Date/Time: January 14, 2016 3:33 PM

Encounter Number: 010095442330

Accession Number: 6550272

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: January 14, 2016 4:02 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095442330

Report Date/Time: 1/14/2016 4:50:00 PM

Report Name: CT CHEST WITH IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

Overdose

Technique

Routine study. Post processed reconstructions included.

Contrast

Contrast Agent OMNIPAQUE 350 125 milliliters 01/14/2016 INTRAVENOUS

No oral contrast was given limiting evaluation of the bowel.

Comparison

Prior CT 09/03/2013

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: No parenchymal consolidation. Bibasilar dependent atelectasis.

LARGE AIRWAYS: Patent.

PLEURA: No effusion or pneumothorax.

HEART: Borderline enlarged. No pathologic pericardial effusion.

Single lead AICD is unchanged in configuration. There is a

right-sided central venous catheter with its tip at the cavoatrial

junction.

MEDIASTINUM and HILA: No lymphadenopathy. Rebound thymus is noted

within the anterior mediastinum.

AXILLAE: No lymphadenopathy.

Abdomen:

Evaluation is limited due to streak artifact associated with the

patient's radiographically unfavorable body habitus.

LIVER: Normal size. No focal lesion.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: Small hiatal hernia. No bowel obstruction. No wall thickening.

There is distention of the esophagus. There is a small fat containing

umbilical hernia.

PERITONEUM: There is no pneumoperitoneum. Trace free fluid within the

pelvis likely physiologic in nature. No CT evidence of acute

appendicitis.

RETROPERITONEUM: No lymphadenopathy.

ABDOMINAL WALL: Small fat containing umbilical hernia.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. There is a 1.5 cm Bartholin cyst

noted in the left labum major.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Within normal limits for age. No focal lesion.

Impression

Hepatic steatosis.

Rebound thymus within the anterior superior mediastinum.

Small hiatal hernia

Left Bartholin's cyst

Trace free fluid within the pelvis likely physiologic in nature.

Attending Radiologist: DUNKIN, JARED

Ordered By: SEDA, JESUS

Order Date/Time: January 14, 2016 3:40 PM

Scan Initiation Date/Time:

Completion Date/Time: January 14, 2016 4:50 PM

Encounter Number: 010095442330

Accession Number: 6550329

Images were reviewed and interpreted by Attending Radiologist: Dr. DUNKIN, JARED

Electronically Signed On: January 14, 2016 5:07 PM by Dr. DUNKIN, JARED

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095442330

Report Date/Time: 1/14/2016 4:50:00 PM

Report Name: CT ABD AND PELVIS WITH IV CONTRAST

Examination

CT of Chest, Abdomen and Pelvis.

Clinical History

Overdose

Technique

Routine study. Post processed reconstructions included.

Contrast

Contrast Agent OMNIPAQUE 350 125 milliliters 01/14/2016 INTRAVENOUS

No oral contrast was given limiting evaluation of the bowel.

Comparison

Prior CT 09/03/2013

Findings

BASE OF NECK: Unremarkable thyroid.

Chest:

LUNGS: No parenchymal consolidation. Bibasilar dependent atelectasis.

LARGE AIRWAYS: Patent.

PLEURA: No effusion or pneumothorax.

HEART: Borderline enlarged. No pathologic pericardial effusion.

Single lead AICD is unchanged in configuration. There is a

right-sided central venous catheter with its tip at the cavoatrial

junction.

MEDIASTINUM and HILA: No lymphadenopathy. Rebound thymus is noted

within the anterior mediastinum.

AXILLAE: No lymphadenopathy.

Abdomen:

Evaluation is limited due to streak artifact associated with the

patient's radiographically unfavorable body habitus.

LIVER: Normal size. No focal lesion.

BILIARY TRACT: No dilatation.

PANCREAS: No focal or diffuse pathology.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. No mass, calculus or hydronephrosis.

BOWEL: Small hiatal hernia. No bowel obstruction. No wall thickening.

There is distention of the esophagus. There is a small fat containing

umbilical hernia.

PERITONEUM: There is no pneumoperitoneum. Trace free fluid within the

pelvis likely physiologic in nature. No CT evidence of acute

appendicitis.

RETROPERITONEUM: No lymphadenopathy.

ABDOMINAL WALL: Small fat containing umbilical hernia.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. There is a 1.5 cm Bartholin cyst

noted in the left labum major.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Unremarkable.

BONES: Within normal limits for age. No focal lesion.

Impression

Hepatic steatosis.

Rebound thymus within the anterior superior mediastinum.

Small hiatal hernia

Left Bartholin's cyst

Trace free fluid within the pelvis likely physiologic in nature.

Attending Radiologist: DUNKIN, JARED

Ordered By: SEDA, JESUS

Order Date/Time: January 14, 2016 3:40 PM

Scan Initiation Date/Time: January 14, 2016 4:40 PM

Completion Date/Time: January 14, 2016 4:50 PM

Encounter Number: 010095442330

Accession Number: 6550330

Images were reviewed and interpreted by Attending Radiologist: Dr. DUNKIN, JARED

Electronically Signed On: January 14, 2016 5:07 PM by Dr. DUNKIN, JARED

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095442330

Report Date/Time: 1/16/2016 2:12:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

Patient with new fever. Possible pulmonary source.

Technique

AP portable chest radiograph

Comparison

Chest radiograph from 01/14/2016

Findings

Left chest wall pacemaker is noted with its tip projecting over the

right ventricle. Right IJ central venous catheter is noted with its

tip over the cavoatrial junction.

No focal consolidation or pleural effusion is identified. No sizeable

pneumothorax is noted.

Cardiomediastinal silhouette is unchanged. There is mild to moderate

pulmonary vascular congestion.

Osseous structures are unchanged.

Impression

No definite airspace consolidation.

Mild to moderate pulmonary vascular congestion.

Attending Radiologist: BERNSTEIN, CLIFF

Ordered By: YEUNG, POMIN

Order Date/Time: January 15, 2016 10:05 PM

Scan Initiation Date/Time: January 16, 2016 1:58 AM

Completion Date/Time: January 16, 2016 2:12 AM

Encounter Number: 010095442330

Accession Number: 6552259

Images were reviewed and interpreted by Attending Radiologist: Dr. BERNSTEIN, CLIFF

Electronically Signed On: January 16, 2016 1:19 PM by Dr. BERNSTEIN, CLIFF

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095442330

Report Date/Time: 1/17/2016 4:50:00 PM

Report Name: GASTRIC EMPTYING

Examination

GASTRIC EMPTYING

Clinical History

Type 1 diabetes with known gastroparesis, abdominal pain, suicidal

ideation.

Technique

On 1/17/16 the patient ingested 1.0 millicuries of Tc-99m sulfur

colloid in a standardized egg meal. Planar images were obtained from

the anterior and posterior directions initially and up to 4 hours.

The patient was only able to tolerate approximately half of the meal,

with emesis before the 4 hour imaging.

Comparison

No prior study was available for comparison.

Findings

Curves generated from the geometric mean of gastric counts show the

stomach to contain 31 % at 1 hour (1 hr normal 37-90 %), 4 % at 2

hours (2 hr normal 30-60 %), and 2 % at 4 hours (4 hr normal 0-10 %).

Images do not show any abnormalities.

Impression

No evidence of gastroparesis. Accelerated gastric emptying at 2 hour

time point.

Attending Radiologist: MATTHEWS, ROBERT

Ordered By: CHAKRAVARTY, RAMANUJ

Order Date/Time: January 16, 2016 8:20 AM

Scan Initiation Date/Time: January 17, 2016 12:18 PM

Completion Date/Time: January 17, 2016 4:50 PM

Encounter Number: 010095442330

Accession Number: 6552409

Images were reviewed and interpreted by Attending Radiologist: Dr. MATTHEWS, ROBERT

Electronically Signed On: January 18, 2016 9:17 AM by Dr. MATTHEWS, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095442330

Report Date/Time: 1/18/2016 8:47:00 AM

Report Name: ECHO COMPLETE

Stony Brook University Hospital

Stony Brook, New York

Female Adult Echocardiography Report

Name: ERICA Exam 1/18/2016 8:14:30 Heart Rate: 83

GANTT Date/Time: AM

MR #: 30063152 Report Date: 1/18/2016 Heart Rhythm:

Sinus

Rhythm

ACC #: 6553036 Ht: 162.56 cm BP: 151/81 mmHg

DOB: 6/7/1988 Wt: 108.86 kg Location: 12S

Age/Sex: 27 yearsF BSA: 2.11 m²

Ref. Physician: CHAKRAVARTY, cc:

Sonographer: CF

Indications: chest pain

History: OBESE, HTN, ICD, SUICIDAL, CHF, DM

Procedure: Complete Echocardiogram - 93306.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.32 cm 2.0 - 3.8 LA Diam 4.20 cm 3.0-4.0

IVS 0.77 cm 0.6 - 0.9 LA Area 17.8cm² <=20

LVID 5.49 cm 3.9 - 5.3 4.03 cm LA Vol 51.00 ml 18-58

LVPW 0.90 cm 0.6 - 1.0 LA Vol/BSA 24.13ml/m² 22+ / -6

RA Diam 4.8cm 2.9-4.5

Ao at the sinuses 2.50

Ao Ascending 2.70 cm

Ao Arch 2.6 cm

Ao Descending 1.7cm

LVEF 47 % (biplane method of discs)

LV FS 26.6

LV SV 53.6 ml

LV SI 25.4 ml/m²

Aov Cusp Sep 1.80 cm

(Systole)

Aov VTI 0.292 m LVOT VTI 0.154 m LVOT diameter

2.00 cm

Aov VMax 1.64 m/s LVOT Vmax 0.83 m/s Dimensionless

Index 0.51

Aov Pk Pressure 10.8 mmHg Aov Mn 6.0 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 1.66 cm² Aov Area Index 0.79 cm²/m²

(VTI)

MV VTI MV DT 144 msec

MV E Vmax 1.09 m/s MV A Vmax 0.44 m/s E/A 2.47

MV Area press 1/2 Time 5.27

IVRT 87 E/E ' 10.90

Septal E ' 0.070 m/s Prop Velocity

Lateral E ' 0.10 m/s LA Pressure 17.80 mmHg

Average E' 0.085 m/s

MV Average E/E' 12.82

TR Vmax 2.21 m/s TR Pk Grad 19.6 mmHg RA Pressure 3 mmHg RVSP

22.6 mmHg

TV E Max TV Mn Grad mmHg PHT 41.76 msec TV VTI

PV Vmax 1.10 m/s PV Pk Grad 4.9 mmHg PV Mn Grad RVEDP

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is mildly increased. Ventricular wall

thickness is normal. A false tendon is present which is a normal

variant. The relative wall thickness is normal (0.30). Global left

ventricular systolic function is mildly reduced. The ejection

fraction is 47% by biplane method of discs. Left ventricular basal

fractional shortening is decreased. The basal inferolateral wall is

moderately hypokinetic. The mid inferolateral wall is moderately

hypokinetic. The lateral apex is moderately hypokinetic.

Left Ventricle - Diastole:The left ventricular isovolumetric

relaxation time is normal at 87 msec. The Doppler derived transmitral

left ventricular inflow velocity pattern is E wave dominant. The

Doppler derived early diastolic deceleration time is short at 144

msec. The velocity of the early diastolic septal mitral annular

movement, as determined by tissue Doppler imaging is reduced at 0.070

m/s. The velocity of the early diastolic lateral mitral annular

movement, as determined by tissue Doppler imaging is normal at 0.10

m/s. The overall diastolic function is severely impaired (grade III,

restrictive pattern) with marked elevation of left ventricular

filling pressures.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is mildly dilated in size.

Atrial Septum: Atrial septum is structurally normal and intact on 2D

and color Doppler interrogation.

Right Ventricle: The right ventricular size is normal. The right

ventricular diastolic area is 25.00 cm which is normal. The right

ventricular systolic area is 17.70 cm which is mildly dilated. Global

right ventricular systolic function is mildly reduced. The right

ventricular fractional area change is 29.20% which is mildly

abnormal. The tricuspid annular plane systolic excursion is 1.5 cm

consistent with normal right ventricular systolic function. The right

ventricular systolic pressure, as estimated using the tricuspid

regurgitation velocity, is 22.6 mmHg.

Right Heart Catheters/Leads: Catheter consistent with pacemaker or

defibrillator lead seen in the right heart.

Aortic Valve: The aortic valve is trileaflet with normal excursion.

Normal Doppler interrogation flow patterns without stenosis or

insufficiency.

Mitral Valve: The mitral valve is structurally normal. Trace mitral

regurgitation is present.

Tricuspid Valve: The tricuspid valve is structurally normal. Mild

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is not well visualized. Trace

pulmonary regurgitation is seen.

Aorta: The aorta at the level of the sinuses of Valsalva is normal in

diameter at 2.50 cm. The ascending aorta is normal at 2.70 cm. The

aortic arch is normal at 2.6 cm. The descending aorta is normal in

size at 1.7 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.21 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is normal at 22.6 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: Prior examination reports are available and were reviewed

for comparison purposes. The most recent available prior study is

from 11/2/12. There is no significant change in the findings since

the last echocardiogram.

Summary:

1. Mildly increased left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Mildly reduced global left ventricular systolic function.

4. Segmental wall motion abnormalities (see above).

5. Severe diastolic dysfunction with elevated left ventricular

filling pressures.

6. Mildly dilated right atrial size.

7. Mildly reduced right ventricular systolic function.

8. Normal atrial septum by 2D and color Doppler.

9. Trileaflet aortic valve with normal excursion.

10. No aortic stenosis or insufficiency.

11. Trace mitral regurgitation.

12. Mild tricuspid regurgitation.

13. Normal aortic root diameter for body size.

14. No pericardial effusion.

014970 Smadar Kort MD, FACC, FASE, FAHA

Electronically signed by 014970 Smadar Kort MD, FACC, FASE, FAHA on

1/18/2016 at 9:35:28 AM

\*\*\* Final \*\*\*

Attending Cardiologist: KORT, SMADAR

Ordered By: CHAKRAVARTY, RAMANUJ

Order Date/Time: January 17, 2016 8:40 AM

Scan Initiation Date/Time:

Completion Date/Time: January 18, 2016 8:47 AM

Encounter Number: 010095442330

Accession Number: 6553036

Images were reviewed and interpreted by Attending Cardiologist: Dr. KORT, SMADAR

Electronically Signed On: January 18, 2016 9:35 AM by Dr. KORT, SMADAR

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095443916

Report Date/Time: 1/13/2016 2:43:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

HYPOXIA

Additional History

POSSIBLE INFILTRATE

Technique

Portable AP view of the chest.

Comparison

None.

Findings

A left subclavian approach dual lead pacemaker is in place.

The trachea is midline. Cardiac silhouette is borderline normal in

size. Atherosclerotic calcification of the aortic knob. Ill-defined

retrocardiac opacity which may represent infectious process. No large

pleural effusion. Multilevel degenerative changes in thoracic spine.

Dextroscoliosis at the thoracolumbar junction.

Impression

Nonspecific retrocardiac opacity; may reflect pneumonia and/or

atelectasis.

Attending Radiologist: CHERIAN, VARGHESE

Ordered By: MCINTOSH, BRADEN

Order Date/Time: January 13, 2016 2:10 PM

Scan Initiation Date/Time: January 13, 2016 2:48 PM

Completion Date/Time: January 13, 2016 2:43 PM

Encounter Number: 010095443916

Accession Number: 6548654

Images were reviewed and interpreted by Attending Radiologist: Dr. CHERIAN, VARGHESE

Electronically Signed On: January 13, 2016 4:07 PM by Dr. CHERIAN, VARGHESE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095443916

Report Date/Time: 1/18/2016 12:58:00 PM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

86F H/O VASCULAR DEMENTIA, ATRIAL FIBRILLATION ON COUMADIN,

HYPERTENSION, AND OSTEOPOROSIS, CHR ANEMIA .

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

No images available for comparison.

Findings

There is no CT evidence of acute transcortical infarction,

intracranial hemorrhage, or extra-axial collection. No mass effect or

midline shift.

Advanced cerebral and cerebellar volume loss with ex vacuo

ventricular prominence.

Patchy foci of hypoattenuation within the periventricular and

subcortical white matter without mass effect are most compatible with

microvascular ischemic changes given presence of atherosclerotic

calcifications at the skullbase. Chronic appearing lacunar infarct

within the left external capsule.

The calvarium is intact.

Moderate frothy opacification of the frontal sinus on the right

extending into the outflow tract, with layering fluid. Moderate

polypoid opacification of the bilateral ethmoid air cells.

Near-complete opacification of the bilateral sphenoid sinuses and

severe opacification of the bilateral maxillary sinuses.

Bilateral cataract surgery.

Impression

No CT evidence of acute intracranial abnormality. Microvascular

ischemic and atherosclerotic calcific disease. Left external capsule

lacunar infarct. Advanced volume loss. Diffusion-weighted MRI is

significantly more sensitive for subtle acute ischemia if there is

clinical concern.

Severe paranasal sinus mucosal disease with layering fluid within the

right frontal sinus, correlate for acute sinusitis.

Attending Radiologist: FILATOV, ALEXANDER

Ordered By: RIQUELME, LUIS A

Order Date/Time: January 18, 2016 11:35 AM

Scan Initiation Date/Time: January 18, 2016 12:37 PM

Completion Date/Time: January 18, 2016 12:58 PM

Encounter Number: 010095443916

Accession Number: 6554027

Images were reviewed and interpreted by Attending Radiologist: Dr. FILATOV, ALEXANDER

Electronically Signed On: January 18, 2016 1:25 PM by Dr. FILATOV, ALEXANDER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095443916

Report Date/Time: 1/19/2016 4:33:00 PM

Report Name: MRI BRAIN WO IV CONTRAST

Clinical History

EPISODES OF UNRESPONSIVENESS

History and Indication

HX OF DEMENTIA WITH AMS NOW

Technique

Axial diffusion-weighted, FLAIR and susceptibility weighted images

only

Comparison

Head CT 01/18/2016

Findings

There is no evidence of restricted diffusion to suggest acute

infarction.

There is very mild small vessel disease in the cerebral white matter.

There is mild dilatation of the lateral and 3rd ventricles, normal

for age, with a small 4th ventricle. There is no hydrocephalus.

There is marked cerebral cortical atrophy especially prominent at the

sylvian fissures. Very mild cerebellar atrophy is noted.

There is no mass, mass effect, midline shift or other focal

parenchymal abnormality.

There is no intracranial hemorrhage or extra-axial collection.

Severe mucosal disease is noted in the bilateral maxillary, ethmoid

and sphenoid sinuses. There is moderate mucosal disease in the right

frontal sinus. The left frontal sinus is unremarkable.

No gross abnormality is noted within the orbits.

Impression

Prominent atrophy. Minimal small vessel disease. No intracranial

hemorrhage or mass.

Extensive paranasal sinus disease.

Attending Radiologist: PEYSTER, ROBERT

Ordered By: MATHEW, ALEX

Order Date/Time: January 19, 2016 2:05 PM

Scan Initiation Date/Time: January 19, 2016 4:08 PM

Completion Date/Time: January 19, 2016 4:33 PM

Encounter Number: 010095443916

Accession Number: 6555892

Images were reviewed and interpreted by Attending Radiologist: Dr. PEYSTER, ROBERT

Electronically Signed On: January 19, 2016 4:39 PM by Dr. PEYSTER, ROBERT

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095452339

Report Date/Time: 1/13/2016 5:24:00 PM

Report Name: ABDOMEN SERIES (FLAT/ERECT)

Clinical History

Abdominal pain

Technique

Supine view of the abdomen.

Comparison

6/21/15.

Findings

There is gaseous distention of the large bowel which is seen

overlying the mid abdomen measuring up to 14.9 cm. Findings are

similar to that seen on prior exam. There is no evidence of

extraluminal free air examination is limited by overlying distended

bowel.

IVC filter is seen overlying the expected region of the inferior vena

cava unchanged from prior exam.

The patient is status post midline sternotomy and aortic valve

replacement. Dual lead pacemaker /AICD seen in the left upper chest

with leads overlying cardiomediastinal silhouette.

There are low lung volumes. The lungs appear clear without evidence

of consolidation or large pleural effusion. There is mild prominence

of the perihilar vasculature.

Impression

Gaseous distention of large bowel measuring up to 14.9 cm concerning

for chronic large bowel obstruction vs sigmoid volvulus.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: SHAH, RAHUL

Order Date/Time: January 13, 2016 4:50 PM

Scan Initiation Date/Time: January 13, 2016 5:19 PM

Completion Date/Time: January 13, 2016 5:24 PM

Encounter Number: 010095452339

Accession Number: 6548974

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 13, 2016 5:57 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095452339

Report Date/Time: 1/13/2016 10:02:00 PM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of the Abdomen and Pelvis

Clinical History

POSSIBLE SIGMOID VOLVULUS

Technique

Contiguous helical CT images of the abdomen and pelvis were obtained,

without intravenous contrast as below. Multiplanar reconstructions in

soft tissue windows were provided for interpretation following image

acquisition.

Contrast

With oral and rectal contrast.

Comparison

CT abdomen pelvis 05/2015

Findings

LUNG BASES: Again seen are nodular opacities within the left lower

lung field. The heart is enlarged. The patient is status post median

sternotomy and valve repair. There is partial visualization of a

pacemaker lead.

Abdomen:

LIVER: Normal size measuring 18.3 cm. No evidence of mass mass.

BILIARY TRACT: Gallbladder is distended with heterogeneous fluid

likely representing sludge. No evidence of cholelithiasis. No intra

or extrahepatic ductal dilatation.

PANCREAS: There is fatty replacement involving portions of the

pancreas.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology and contour. No evidence of cyst or mass.

Several bilateral nonobstructing punctate renal calculi, the largest

which measures 3 mm located in the lower pole of the left kidney. No

evidence of perinephric stranding. Symmetric enhancement.

BOWEL: Dilute oral contrast is seen throughout the decompressed

proximal small bowel. Percutaneous gastrostomy tube is noted with the

balloon within the stomach. There is oral contrast within the distal

esophagus which demonstrates wall thickening. A right lower quadrant

loop ileostomy is again noted. The patient is status post partial

sigmoidectomy with colonic remnant and discontinuity. The proximal

suture line seen in the left upper quadrant (series 106 image 68).

Rectal contrast is seen filling the rectum and the Hartmann's pouch

(series 106 image 60). There is distension of the colonic remnant

with a mixture of air and stool measuring up to 9.3 cm. There is some

bowel wall thickening involving the proximal sigmoid colon which is

remaining with slight infiltration of surrounding fat. There is

increased distention of the proximal mid sigmoid colon when compared

to the prior study. PERITONEUM: No ascites, free air, or fluid

collection.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: Limited evaluation without IV contrast Normal caliber aorta

without evidence of aneurysmal dilatation. There is mild-moderate

atherosclerotic calcification of the thoracic aorta extending into

the common iliac arteries. There is a filter within the inferior vena

cava.

ABDOMINAL WALL: Umbilical hernia is seen which contains a loop of

distal ileum and part of the colonic remnant without evidence of

obstruction (series 3 image 56).

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

PELVIC SIDEWALLS AND GROIN: No lymphadenopathy.

BLADDER: Underdistended with simple fluid.

BONES: Multilevel degenerative changes of the lower thoracolumbar

spine with anterior endplate syndesmotic formation. There is

osteopenia.

Impression

1. Status post partial sigmoidectomy with diverting ileostomy and

possible Hartmann's pouch but no apparent colostomy. Increased

distension involving the proximal /mid sigmoid colon with some wall

thickening involving the proximal sigmoid colon which may be

secondary to stercoral colitis.

2. Oral contrast within the distal esophagus which demonstrates wall

thickening. Correlate with colonoscopy to exclude underlying lesion.

Differential includes esophagitis and possibly from reflux.

3. Stable nodular opacities within the left lower lung field.

Nonemergent CT the chest is recommended for further evaluation.

4. Several bilateral nonobstructing subcentimeter renal calculi.

Attending Radiologist: DUNKIN, JARED

Ordered By: SHAH, RAHUL

Order Date/Time: January 13, 2016 5:10 PM

Scan Initiation Date/Time: January 13, 2016 9:28 PM

Completion Date/Time: January 13, 2016 10:02 PM

Encounter Number: 010095452339

Accession Number: 6549012

Images were reviewed and interpreted by Attending Radiologist: Dr. DUNKIN, JARED

Electronically Signed On: January 13, 2016 10:45 PM by Dr. DUNKIN, JARED

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095452339

Report Date/Time: 1/17/2016 10:00:00 AM

Report Name: ABDOMEN SERIES PORTABLE (FLAT/ERECT)

Clinical History

History of ileostomy, colon resection, status post PEG tube now with

abdominal pain

Technique

Hide portable upright and supine AP views of the abdomen

Comparison

Comparison is made to abdominal film dated 01/13/2016, CT of the

abdomen and pelvis dated 01/13/2016

Findings

Once again, there is a dilated loop of large bowel, unchanged in size

and appearance compared to the prior study. There is stool-filled

ascending, transverse, and descending colon.

There is no evidence of free air under the diaphragms on the upright

radiograph. There are no abnormal calcifications seen. No

radiographic evidence of organomegaly.

IVC filter is once again seen, unchanged in position. Patient is

status post median sternotomy. There is a left subclavian approach

pacing device, with distal leads unchanged in position.

Impression

Persistent dilatation of the sigmoid colon as seen on prior abdominal

film and CT of abdomen and pelvis. There has been no significant

change in caliber or appearance. Stool-filled ascending, transverse,

and descending colon.

Attending Radiologist: BALSAM, DVORAH

Ordered By: MATHEW, ALEX

Order Date/Time: January 17, 2016 8:30 AM

Scan Initiation Date/Time: January 17, 2016 9:24 AM

Completion Date/Time: January 17, 2016 10:00 AM

Encounter Number: 010095452339

Accession Number: 6553033

Images were reviewed and interpreted by Attending Radiologist: Dr. BALSAM, DVORAH

Electronically Signed On: January 17, 2016 11:51 AM by Dr. BALSAM, DVORAH

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095452339

Report Date/Time: 1/19/2016 12:45:00 PM

Report Name: ABSCESS DRAINAGE PERCUTANEOUS

Clinical History

79-YEAR-OLD WOMAN WITH END ILEOSTOMY, HARTMAN POUCH AND TERMINAL

ILEUM AND REST OF COLON IS LYING DEFUNCTIONALIZED IN THE BOWEL . THAT

DEFUNCTIONALIZED COLON IS DISTENDED

Technique

SIGMOIDOSTOMY

Please note that the attending physician, Dr. Ferretti, was present

for the entirety of the procedure.

PROCEDURE:

Placement of a 10 French drainage catheter into the sigmoid colon

under fluoroscopic guidance.

The procedure, possible complications and use of conscious sedation

were explained to the patient and informed consent was obtained.

The patient's ASA status is 3. The patient was brought to the

Radiology suite and placed supine on the table.

The patient's upper abdomen was prepped and draped in usual sterile

fashion.

The patient's sigmoid colon was already markedly distended, therefore

air insufflation was not required. Following administration of 1%

lidocaine local anesthetic, two Kimberly-Clark T-fasteners were used

to secure the sigmoid colon to the inner abdominal wall.

Then the sigmoid colon was percutaneously accessed under fluoroscopic

guidance with an 18-gauge needle, and a small amount of contrast

material was injected which opacified the sigmoid colon.

Through each needle T-fastener was then deployed into the sigmoid

colon and secured down with an accompanying thread.

A third 18 g needle was then percutaneously advanced through the

center of the T-fasteners and into the sigmoid colon. Contrast study

confirmed entrance into the stomach with opacification of the colon.

An Amplatz wire was then advanced through the needle and into the in

sigmoid colon. A 10 French drain was then advanced over the Amplatz

wire and into the sigmoid colon. The drainage catheter was then

secured and a sterile dressing was applied.

There were no complications and the patient was transferred back to

the floor in stable condition.

Fluoro Time: 1.5 minutes

Impression

SUCCESSFUL PLACEMENT OF A PERCUTANEOUS 10FR DRAINAGE CATHETER FOR

SIGMOIDOSTOMY AS DESCRIBED ABOVE.

Attending Radiologist: FERRETTI, JOHN

Ordered By: RIQUELME, LUIS A

Order Date/Time: January 19, 2016 10:40 AM

Scan Initiation Date/Time: January 19, 2016 11:47 AM

Completion Date/Time: January 19, 2016 12:45 PM

Encounter Number: 010095452339

Accession Number: 6553659

Images were reviewed and interpreted by Attending Radiologist: Dr. FERRETTI, JOHN

Electronically Signed On: January 20, 2016 1:43 PM by Dr. FERRETTI, JOHN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095452339

Report Date/Time: 1/21/2016 6:12:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Shortness of breath

Technique

Portable AP view of the chest

Comparison

Comparison is made with 08/30/2015

Findings

Patient status post median sternotomy, mitral valve replacement.

Cardiomediastinal silhouette is stable in size. There is a left

subclavian approach pacemaker with distal leads unchanged in

position.

Areas of linear atelectasis bilateral lung bases. Persistent

elevation of the right hemidiaphragm. No focal consolidation. No

large pleural effusion. No pneumothorax. Mild pulmonary vascular

congestion has resolved.

Patient status post left shoulder hemiarthroplasty.

Impression

1. Persistent elevation of the right hemidiaphragm.

2. Linear atelectasis bilateral lung bases.

3. Resolved Mild pulmonary vascular congestion.

Attending Radiologist: SARADOFF, CHRISTOPHER V

Ordered By: MATHEW, ALEX

Order Date/Time: January 21, 2016 6:00 PM

Scan Initiation Date/Time: January 21, 2016 6:10 PM

Completion Date/Time: January 21, 2016 6:12 PM

Encounter Number: 010095452339

Accession Number: 6559540

Images were reviewed and interpreted by Attending Radiologist: Dr. SARADOFF, CHRISTOPHER V

Electronically Signed On: January 21, 2016 7:33 PM by Dr. SARADOFF, CHRISTOPHER V

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095452339

Report Date/Time: 1/22/2016 3:36:00 AM

Report Name: FLAT PLATE OF ABDOMEN PORTABLE

Clinical History

OBESITY ILLEOSTOMY ACHALASIA OF ESOPHAGUS- NOW WITH COLONIC BOWEL

DILITATION S/P DRIAN PALCEMENT

Indication

EVALUATE COLONIC DILATATION

Technique

Single portable supine view of the abdomen.

Comparison

Abdominal radiograph dated 01/17/16 .

Findings

There has been interval improvement in the previously visualized

dilated large bowel loops. Nonspecific, nonobstructive bowel gas

pattern.Limited evaluation for free air on this single supine view.

No abnormal calcifications identified. There has been interval

placement of a pigtail drainage catheter terminating in the right

hemiabdomen. No radiographic evidence for organomegaly. IVC filter

is unchanged in position. The patient is status post median

sternotomy and mitral valve prosthesis.

Impression

Interval improvement in previously identified dilated bowel loops.

Nonobstructive bowel gas pattern. Partially opacified featureless

distal bowel.

Interval placement of a pigtail drainage catheter.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: ROCCO, VERONICA

Order Date/Time: January 22, 2016 6:00 AM

Scan Initiation Date/Time: January 22, 2016 12:45 AM

Completion Date/Time: January 22, 2016 3:36 AM

Encounter Number: 010095452339

Accession Number: 6559396

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 22, 2016 9:52 AM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095459284

Report Date/Time: 1/13/2016 7:19:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Possible pneumonia

Technique

Portable AP chest x-ray

Comparison

11/03/2015

Findings

There is again noted evidence for low lung volumes. The patient is

rotated and patient's chin obscures view of the superior mediastinum

and left lung apex limiting evaluation.

The cardiomediastinal silhouette is within normal limits for size.

There is evidence of vascular crowding secondary to low lung volumes.

There is no convincing evidence of consolidation, large pleural

effusions in a pneumothorax.

Impression

Limited evaluation.

No convincing evidence for consolidation or large pleural effusion.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: FRANCIS, ARIE

Order Date/Time: January 13, 2016 7:05 PM

Scan Initiation Date/Time: January 13, 2016 7:15 PM

Completion Date/Time: January 13, 2016 7:19 PM

Encounter Number: 010095459284

Accession Number: 6549102

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 13, 2016 7:23 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095459284

Report Date/Time: 1/13/2016 8:45:00 PM

Report Name: ABDOMEN TUBE INJ JEJUNOSTOMY

Examination

ABDOMEN TUBE INJ JEJUNOSTOMY/STAT/ER

Clinical History

HX OF ? DISLODGMENT OF G TUBE

Indication

EVALUATE FOR NASOGASTRIC/FEEDING TUBE WITH GASTROVIEW

Technique

Supine view of the abdomen status post Gastroview injection

Comparison

Flat plate of the abdomen 11/12/2015.

Findings

A percutaneous gastric tube is seen overlying the midabdomen. After

injection contrast to be seen within the fundus of the stomach. There

is a nonspecific bowel gas pattern with evidence of fecal loading of

the ascending colon. No evidence of contrast extravasation

Impression

Contrast seen within the fundus of the stomach status post Gastroview

injection. No extravasation.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: FRANCIS, ARIE

Order Date/Time: January 13, 2016 8:15 PM

Scan Initiation Date/Time: January 13, 2016 8:39 PM

Completion Date/Time: January 13, 2016 8:45 PM

Encounter Number: 010095459284

Accession Number: 6549147

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 13, 2016 9:15 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095459284

Report Date/Time: 1/13/2016 8:57:00 PM

Report Name: CT ABD AND PELVIS WO IV CONTRAST

Examination

CT of Abdomen and Pelvis.

Clinical History

Abdominal distention

Technique

Routine study. Post Processed reconstructions included.

Contrast

Oral contrast

Comparison

Comparison is made to CT of the abdomen and pelvis from 09/29/2015 .

Findings

LUNG BASES: Clear. No pleural effusion. Atherosclerotic

calcifications of the coronary arteries are noted.

Abdomen:

LIVER: Normal size. No mass.

BILIARY TRACT: Gallbladder is unremarkable. No intra or extrahepatic

ductal dilatation.

PANCREAS: Diffuse fatty atrophy of the pancreas is noted.

SPLEEN: Normal size. No focal lesions.

ADRENALS: No nodule or mass.

KIDNEYS: Normal morphology. There is slight improvement in bilateral

hydroureteronephrosis since the prior exam with residual

hydroureteronephrosis remaining. There is no calculi. Stable right

renal cyst is again noted.

BOWEL / pelvic sidewalls: G-tube is again noted with balloon inflated

in the body of the stomach. There is a left-sided inguinal hernia

containing a loop of small bowel without evidence of obstruction.

There is wall thickening from the rectum into the distal sigmoid

colon. There is a fat containing right inguinal hernia.

PERITONEUM: No ascites, free air, or fluid collection.

RETROPERITONEUM: No lymphadenopathy.

VESSELS: The infrarenal abdominal aorta remains small in caliber.

Atherosclerotic calcifications of the arterial vasculature is noted.

Pelvis:

REPRODUCTIVE ORGANS: Normal size. No focal lesion.

BLADDER: The urinary bladder is near completely collapsed and

demonstrates wall thickening and contains a small amount of air.

There is a Foley catheter balloon possibly with a portion in the

region of the prostatic urethra. Slight infiltration of fat

surrounding the urinary bladder extending into the region of the

distal ureters.

BONES: Multilevel degenerate changes of the lumbar spine is noted

with disk height loss and anterior osteophytosis. There is stable

subcentimeter sclerotic foci within both iliac bones.

Impression

1. PEG tube unchanged in position with balloon inflated in the

stomach.

2. Left-sided inguinal hernia containing a loop of small bowel

without evidence of bowel obstruction.

3. Minimally improved bilateral hydroureteronephrosis.

Thickening of the urinary bladder which is near completely collapsed

with a Foley catheter balloon possibly with a portion in the region

of the prostatic urethra. Correlate clinically for appropriate

positioning. Small amount of air within the urinary bladder which may

be from recent instrumentation. Correlation with cystoscopy is

recommended to exclude neoplasm.

4. Thickening of the rectal and sigmoid colon wall, correlate

for proctitis/colitis.

Attending Radiologist: DUNKIN, JARED

Ordered By: FRANCIS, ARIE

Order Date/Time: January 13, 2016 8:20 PM

Scan Initiation Date/Time: January 13, 2016 8:51 PM

Completion Date/Time: January 13, 2016 8:57 PM

Encounter Number: 010095459284

Accession Number: 6549150

Images were reviewed and interpreted by Attending Radiologist: Dr. DUNKIN, JARED

Electronically Signed On: January 13, 2016 9:15 PM by Dr. DUNKIN, JARED

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095459284

Report Date/Time: 1/15/2016 6:39:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Sepsis

Technique

Frontal view of the chest

Comparison

01/13/2016

Findings

Low lung volume. There is no focal consolidation, effusion or

pneumothorax. The mediastinal and cardiac silhouette is unchanged.

Impression

No focal consolidation.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: ALDERWISH, EDRIS

Order Date/Time: January 15, 2016 4:20 PM

Scan Initiation Date/Time: January 15, 2016 6:06 PM

Completion Date/Time: January 15, 2016 6:39 PM

Encounter Number: 010095459284

Accession Number: 6552037

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 15, 2016 8:25 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095460977

Report Date/Time: 1/14/2016 2:04:00 AM

Report Name: CHEST ROUTINE PA/AP AND LATERAL

Clinical History

Pain

Technique

PA and lateral chest radiographs and 3 views of the left ribs

Comparison

12/15/2015 .

Findings

Lungs are hyperinflated but clear. Cardiac silhouette is normal in

size. Status post sternotomy and aortic valve replacement. Old

healed fracture deformities of the left 2nd, 6th, and 10th ribs. No

acute displaced rib fracture.

Impression

No acute cardiopulmonary finding.

Old healed left-sided rib fractures as above. No acute displaced rib

fracture.

Attending Radiologist: REITER, MICHAEL

Ordered By: SAWAS, ANAS

Order Date/Time: January 13, 2016 11:45 PM

Scan Initiation Date/Time: January 14, 2016 2:05 AM

Completion Date/Time: January 14, 2016 2:04 AM

Encounter Number: 010095460977

Accession Number: 6549255

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 14, 2016 2:15 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095460977

Report Date/Time: 1/14/2016 2:04:00 AM

Report Name: SPINE LUMBO-SACRAL

Clinical History

Pain

Technique

4 views of the lumbar spine.

Comparison

05/07/2010

Findings

Anatomic alignment. Vertebral body heights are maintained. No acute

fracture or subluxation. Degenerative changes of the spine.

Atherosclerotic vascular calcifications of the abdominal aorta.

There is a left ureteral stent in place.

Impression

No acute osseous finding.

Attending Radiologist: REITER, MICHAEL

Ordered By: SAWAS, ANAS

Order Date/Time: January 13, 2016 11:50 PM

Scan Initiation Date/Time: January 14, 2016 2:09 AM

Completion Date/Time: January 14, 2016 2:04 AM

Encounter Number: 010095460977

Accession Number: 6549256

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 14, 2016 2:19 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095460977

Report Date/Time: 1/14/2016 2:04:00 AM

Report Name: RIBS LEFT

Clinical History

Pain

Technique

PA and lateral chest radiographs and 3 views of the left ribs

Comparison

12/15/2015 .

Findings

Lungs are hyperinflated but clear. Cardiac silhouette is normal in

size. Status post sternotomy and aortic valve replacement. Old

healed fracture deformities of the left 2nd, 6th, and 10th ribs. No

acute displaced rib fracture.

Impression

No acute cardiopulmonary finding.

Old healed left-sided rib fractures as above. No acute displaced rib

fracture.

Attending Radiologist: REITER, MICHAEL

Ordered By: SAWAS, ANAS

Order Date/Time: January 13, 2016 11:50 PM

Scan Initiation Date/Time: January 14, 2016 2:07 AM

Completion Date/Time: January 14, 2016 2:04 AM

Encounter Number: 010095460977

Accession Number: 6549257

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 14, 2016 2:15 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095460977

Report Date/Time: 1/14/2016 1:10:00 PM

Report Name: ABDOMEN SUPINE (KUB)

Clinical History

63 YEAR OLD MAN W/PMH NEPHROLITHIASIS S/P L URETERAL STENT, NOW WITH

ABDOMINAL PAIN.

Technique

Supine and erect views of the abdomen.

Comparison

CT dated 12/13/2015.

Findings

There is a left nephroureteral stent with the tips overlying the left

renal pelvis and urinary bladder. There is a nonspecific bowel gas

pattern. Air is present within the small bowel. There is moderate

stool burden throughout the colon. There is no bowel wall thickening

or pneumatosis. Evaluation of intraperitoneal free air is limited on

this supine evaluation.

The osseous structures are grossly unremarkable.

Impression

Left nephroureteral stent the tips of which overly the left renal

pelvis and urinary bladder.

Attending Radiologist: ZAWIN, MARLENE

Ordered By: NGUYEN, DON

Order Date/Time: January 14, 2016 12:45 PM

Scan Initiation Date/Time: January 14, 2016 1:19 PM

Completion Date/Time: January 14, 2016 1:10 PM

Encounter Number: 010095460977

Accession Number: 6549963

Images were reviewed and interpreted by Attending Radiologist: Dr. ZAWIN, MARLENE

Electronically Signed On: January 14, 2016 1:56 PM by Dr. ZAWIN, MARLENE

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095460977

Report Date/Time: 1/19/2016 3:32:00 PM

Report Name: CERVICAL-THORACIC ESOPHOGRAM

Clinical History

Persistent dysphagia. Patient feels food gets stuck in the mid chest.

Technique

A preliminary AP scout film of the chest and lateral view of the neck

soft tissue were obtained. Effervescent crystals were first given.

Then, thick barium was given for coating of the esophagus. Thin

barium sulfate was then given, and progression observed under

fluoroscopic guidance.

Fluoro time: 0.8 minutes.

Comparison

No images available for comparison.

Findings

Scout film of the chest demonstrates no focal consolidations, large

pleural effusions or pulmonary vascular congestion. The

cardiomediastinal silhouette is within normal limits. The lungs

appear slightly hyperinflated. The patient is status post sternotomy

and aortic valve replacement. Both hemidiaphragms are smooth in

contour and normal in position. Old healed fracture deformities are

again noted in the left 2nd, 6th and 7th ribs.

On the lateral view of the neck soft tissue, there is no radiographic

evidence of fracture or subluxation involve the C2-C4 vertebral

bodies and posterior elements. The visualized disc spaces are

preserved. No significant soft tissue abnormalities are present.

Barium outlines the cervical esophagus normally and the swallowing

mechanism appears to be normal with no evidence of aspiration. There

is no evidence of a filling defect or obstruction of the esophagus.

Barium outlines the thoracic esophagus normally. There is good

peristalsis noted and there is no evidence of a filling defect or

obstruction of the esophagus. There is no evidence of hiatus hernia

or reflux demonstrated.

Impression

No evidence for obstruction, hiatal hernia or reflux.

Attending Radiologist: HUSSAIN, SHAHID

Ordered By: ABDULLAH, ROBERT

Order Date/Time: January 19, 2016 11:15 AM

Scan Initiation Date/Time: January 19, 2016 3:01 PM

Completion Date/Time: January 19, 2016 3:32 PM

Encounter Number: 010095460977

Accession Number: 6555469

Images were reviewed and interpreted by Attending Radiologist: Dr. HUSSAIN, SHAHID

Electronically Signed On: January 19, 2016 4:16 PM by Dr. HUSSAIN, SHAHID

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461249

Report Date/Time: 1/13/2016 10:17:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

Pneumonia

Technique

Portable frontal view of the chest

Comparison

Study from earlier the same day.

Findings

Again appreciated the airspace opacities of both lower lobes,

concerning for multifocal pneumonia. There is small left pleural

effusion. There is mild pulmonary vascular congestion. There is

cardiomyopathy. Patient is status post CABG and median sternotomy.

Impression

Multiple airspace opacities bilaterally, concerning for multifocal

pneumonia.

Left pleural effusion.

Cardiomegaly. Pulmonary vascular congestion

Attending Radiologist: HUANG, MINGQIAN

Ordered By: MOHAMMADY, NAJIM

Order Date/Time: January 13, 2016 9:40 PM

Scan Initiation Date/Time: January 13, 2016 10:15 PM

Completion Date/Time: January 13, 2016 10:17 PM

Encounter Number: 010095461249

Accession Number: 6549198

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 13, 2016 10:27 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461249

Report Date/Time: 1/14/2016 2:23:00 PM

Report Name: ECHO COMPLETE W/CONTRAST

Stony Brook University Hospital

Stony Brook, New York

Male Adult Echocardiography Report

Name: JOHN KENNEDY Exam Date: 1/14/2016 at 1:05:32 PM Heart Rate:

MR #: 30668015 Report Date: 1/14/2016 Rhythm:

ACC #: 6549313 Height: 180.34 cm BP: 123/58

30668015

DOB: 4/3/1932 Weight: 63.96 kg Location:

9S

Age/Sex: 83 years / M BSA: 1.82 m²

Sonographer: CF

Indications: DYSPNEA

History: DEMENTIA, AFIB, HTN

Procedure: Comp. Echo w/contrast - C8929, Definity Contrast - Q9957

and Patient

Supine. The use of contrast was indicated for enhancement

of

endocardial border definition. There were no

contraindications for

the use of contrast in this patient. Verbal consent was

given by the

patient who is aware of the possible adverse reactions

associated

with the use of contrast. No adverse reactions or

hemodynamic

compromise identified.

Study Quality: The images were of adequate diagnostic quality.

Measurements and Calculations

Diast Nl Syst Nl

RV 3.06 cm 2.0 - 3.8 LA Diam 4.87 cm 3.0-4.0

IVS 1.05 cm 0.6 - 1.0 LA Area 31.8cm² <=20

LVID 5.72 cm 4.2 - 5.9 5.00 cm LA Vol 127.90 ml 18-58

LVPW 1.07 cm 0.6 - 1.0 LA Vol/BSA 70.36ml/m² 22+ / -6

RA Diam 4.2cm 2.9-4.5

Ao at the sinuses 3.50 cm

Ao Ascending 3.40 cm

Ao Arch 3.4 cm

Ao Descending 2.2cm

LVEF 35-40 % (visual estimation)

LV FS 12.5

Aov Cusp Sep 0.98 cm

(Systole)

Aov VTI 0.764 m LVOT VTI 0.202 m LVOT diameter

2.35 cm

Aov VMax 3.76 m/s LVOT Vmax 0.85 m/s Dimensionless

Index 0.23

Aov Pk Pressure 56.7 mmHg Aov Mn 32.1 mmHg

Gradient Pressure

Gradient

Aov Area (VTI) 1.15 cm² Aov Area Index 0.63 cm²/m²

(VTI)

AI DT 1002 msec

MV VTI MV DT 210 msec

MV E Vmax 1.25 m/s MV A Vmax E/A

MV Area press 1/2 Time 3.61

IVRT E/E ' 20.84

Septal E ' 0.040 m/s Prop Velocity

Lateral E ' 0.06 m/s LA Pressure 32.90 mmHg

Average E' 0.050 m/s

MV Average E/E' 25.00

TR Vmax 2.77 m/s TR Pk Grad 30.6 mmHg RA Pressure 3 mmHg RVSP

33.6 mmHg

TV E Max TV Mn Grad mmHg PHT 60.95 msec TV VTI

Left Ventricle - Structure and Systolic Function: The left

ventricular cavity size is normal. Ventricular wall thickness is

normal. The relative wall thickness is normal (0.37). Global left

ventricular systolic function is moderately reduced. The ejection

fraction is 35-40% by visual estimation. Left ventricular basal

fractional shortening is decreased. The basal inferolateral wall is

moderately hypokinetic. The mid inferolateral wall is moderately

hypokinetic. The basal inferior wall is severely hypokinetic. The mid

inferior wall is severely hypokinetic. The basal inferior septum is

severely hypokinetic. The mid inferior septum is severely

hypokinetic. The inferior apex is severely hypokinetic.

Left Ventricle - Diastole:The overall diastolic function is

moderately impaired (grade II, pseudonormal pattern) with elevated

left ventricular filling pressures.

Left Atrium: The left atrium is severely dilated in size.

Right Atrium: The right atrium is normal in size.

Atrial Septum: Atrial septum is not well visualized. Atrial septum is

structurally normal and intact on 2D and color Doppler interrogation.

Right Ventricle: The right ventricular size is mildly enlarged.

Global right ventricular systolic function is normal. The right

ventricular fractional area change is 43.06% which is normal. The

tricuspid annular plane systolic excursion is 1.8 cm consistent with

normal right ventricular systolic function. The right ventricular

systolic pressure, as estimated using the tricuspid regurgitation

velocity, is 33.6 mmHg.

Aortic Valve: The aortic valve is trileaflet and is calcified with

reduced excursion. The aortic valve peak velocity is 3.76 m/s, the

peak gradient is 56.7 mmHg, and the mean gradient is 32.1 mmHg. The

aortic valve area is 1.15 cm². The aortic valve area indexed to BSA

is 0.63 cm²/m². The dimensionless index is 0.23. Based on these

parameters moderate to severe aortic stenosis is present. Moderate to

severe aortic valve insufficiency is present. The pressure half-time

of the aortic insufficiency jet is 290 msec.

Mitral Valve: There is mild mitral annular calcification. The mitral

valve leaflets appear tethered consistent with papillary muscle

displacement or annular dilatation. Prolapse of the mitral valve is

not seen. No evidence of mitral stenosis is seen. Mild-moderate

mitral regurgitation is present. The jet is centrally-directed.

Tricuspid Valve: The tricuspid valve is structurally normal. Mild

tricuspid regurgitation is present.

Pulmonic Valve: The pulmonic valve is normal. Trace pulmonary

regurgitation is seen.

Aorta: There is calcification of the aortic wall. The aorta at the

level of the sinuses of Valsalva is normal in diameter at 3.50 cm.

The ascending aorta is normal at 3.40 cm. The aortic arch is normal

at 3.4 cm. The descending aorta is normal in size at 2.2 cm.

Pulmonary Artery: The tricuspid regurgitant velocity is 2.77 m/s, and

with an assumed right atrial pressure of 3 mmHg, the estimated

pulmonary artery systolic pressure is normal at 33.6 mmHg.

Pericardium: No pericardial effusion seen.

Comparison: There are no prior studies available on this patient for

comparison purposes.

Summary:

1. Normal left ventricular cavity size.

2. Normal left ventricular wall thickness.

3. Moderately reduced global left ventricular systolic function.

4. Segmental wall motion abnormalities (see above).

5. Severely dilated left atrial size.

6. Moderate diastolic dysfunction with elevated left ventricular

filling pressures.

7. Mildly enlarged right ventricle.

8. Normal right ventricular systolic function.

9. Trileaflet aortic valve and calcified aortic valve with reduced

excursion.

10. Moderate to severe aortic stenosis.

11. Moderate to severe aortic insufficiency.

12. Tethering of the mitral valve leaflets.

13. Mild-moderate mitral regurgitation.

14. Mild tricuspid regurgitation.

15. No pericardial effusion.

16. Normal aortic root diameter for body size.

17. Normal atrial septum by 2D and color Doppler.

18. Calcification of the aortic wall.

015260 Kathleen Stergiopoulos MD, PhD, FASE, FACC

Electronically signed by 015260 Kathleen Stergiopoulos MD, PhD, FASE,

FACC on 1/14/2016 at 2:29:46 PM

\*\*\* Final \*\*\*

Attending Cardiologist: STERGIOPOULOS, KATHLEEN

Ordered By: BHASHYAM, SANDEEP

Order Date/Time: January 14, 2016 6:05 AM

Scan Initiation Date/Time:

Completion Date/Time: January 14, 2016 2:23 PM

Encounter Number: 010095461249

Accession Number: 6549313

Images were reviewed and interpreted by Attending Cardiologist: Dr. STERGIOPOULOS, KATHLEEN

Electronically Signed On: January 14, 2016 2:29 PM by Dr. STERGIOPOULOS, KATHLEEN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461249

Report Date/Time: 1/15/2016 3:02:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

PNEUMONIA AND CHF

Indication

EVALUATE FOR CHF

Technique

CHEST AP PORTABLE/ROUT

Comparison

01/13/2016

Findings

The cardiomediastinal silhouette is unchanged. Interval improvement

of bilateral pulmonary opacities is noted. There is no pneumothorax

.

No large pleural effusion is visualized.

Impression

Interval improvement of bilateral pulmonary opacities.

Attending Radiologist: ABBASI, ALMAS

Ordered By: STAMORAN, VLADIMIR

Order Date/Time: January 15, 2016 5:00 AM

Scan Initiation Date/Time: January 15, 2016 2:19 AM

Completion Date/Time: January 15, 2016 3:02 AM

Encounter Number: 010095461249

Accession Number: 6550593

Images were reviewed and interpreted by Attending Radiologist: Dr. ABBASI, ALMAS

Electronically Signed On: January 15, 2016 9:48 AM by Dr. ABBASI, ALMAS

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461249

Report Date/Time: 1/17/2016 6:38:00 PM

Report Name: CHEST AP PORTABLE

Clinical History

CHF, shortness of breath, pneumonia

Technique

Portable AP film of the chest

Comparison

Comparison is made to 01/15/2016

Findings

Patient status post median sternotomy, CABG. Cardiomediastinal

silhouette is stable in size.

Small bilateral pleural effusions with bibasilar atelectasis. Diffuse

patchy airspace opacities, which may represent pulmonary edema versus

infectious process. No pneumothorax. Mild pulmonary vascular

congestion, increased from the prior exam.

Multilevel degenerative changes of the thoracic spine.

Impression

1. Small bilateral pleural effusions with bibasilar atelectasis.

2. Diffuse patchy airspace opacities, likely representing

pulmonary edema. Cannot rule out an infectious process.

3. Mild pulmonary vascular congestion, increased from the prior

exam.

Attending Radiologist: HUANG, MINGQIAN

Ordered By: DING, YONGZENG

Order Date/Time: January 17, 2016 5:40 PM

Scan Initiation Date/Time: January 17, 2016 6:31 PM

Completion Date/Time: January 17, 2016 6:38 PM

Encounter Number: 010095461249

Accession Number: 6553327

Images were reviewed and interpreted by Attending Radiologist: Dr. HUANG, MINGQIAN

Electronically Signed On: January 17, 2016 9:29 PM by Dr. HUANG, MINGQIAN

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461249

Report Date/Time: 1/18/2016 2:34:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

SOB

History and Indication

EVALUATE FOR CHF

Technique

AP portable view of the chest

Comparison

Radiograph dated 01/17/2016

Findings

Status post median sternotomy and CABG. Cardiac mediastinal

silhouette is enlarged, not significantly changed from prior

radiograph.

Scattered airspace opacities are identified in the right mid to lower

zone and left lower lobe, unchanged from prior radiographs. Small

left pleural effusion. Moderate pulmonary venous congestion. No

evidence of pneumothorax.

Impression

Patchy airspace opacities in the right mid to lower zone and left

lower lobe with underlying moderate pulmonary venous congestion and

small left pleural effusion. Primary differential consideration is

pulmonary edema, superimposed infection is not excluded. No

significant interval change.

Attending Radiologist: YADDANAPUDI, KAVITHA

Ordered By: DING, YONGZENG

Order Date/Time: January 18, 2016 6:00 AM

Scan Initiation Date/Time: January 18, 2016 1:42 AM

Completion Date/Time: January 18, 2016 2:34 AM

Encounter Number: 010095461249

Accession Number: 6553469

Images were reviewed and interpreted by Attending Radiologist: Dr. YADDANAPUDI, KAVITHA

Electronically Signed On: January 18, 2016 1:04 PM by Dr. YADDANAPUDI, KAVITHA

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461249

Report Date/Time: 1/20/2016 2:28:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

CHF, SOB

Technique

Single portable frontal view of the chest

Comparison

January 18, 2016

Findings

Again demonstrated are diffuse bilateral pulmonary opacities, favored

to represent pulmonary edema in the appropriate clinical setting.

Superimposed infectious process cannot be excluded. There is trace

left-sided pleural effusion. There is no pneumothorax.

Cardiomediastinal silhouette appears enlarged, but stable. Sequelae

of prior CABG again noted.

Impression

Again demonstrated are diffuse bilateral pulmonary opacities,

favored to represent pulmonary edema in the appropriate clinical

setting. Superimposed infectious process cannot be excluded. There is

trace left-sided pleural effusion.

Attending Radiologist: RIPTON-SNYDER, JENNIFER

Ordered By: DING, YONGZENG

Order Date/Time: January 20, 2016 6:00 AM

Scan Initiation Date/Time: January 20, 2016 12:48 AM

Completion Date/Time: January 20, 2016 2:28 AM

Encounter Number: 010095461249

Accession Number: 6556263

Images were reviewed and interpreted by Attending Radiologist: Dr. RIPTON-SNYDER, JENNIFER

Electronically Signed On: January 20, 2016 9:35 AM by Dr. RIPTON-SNYDER, JENNIFER

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461306

Report Date/Time: 1/14/2016 1:42:00 AM

Report Name: CHEST AP PORTABLE

Clinical History

COUGH

Indication

POSSIBLE INFILTRATE

Technique

CHEST AP PORTABLE/STAT/ER

Comparison

12/23/2015 .

Findings

Lungs are hyperinflated with coarsening of the interstitial markings,

consistent with COPD. No focal consolidation, pleural effusion or

pneumothorax. Cardiac silhouette is enlarged, stable. No aggressive

osseous lesion.

Impression

No acute cardiopulmonary process.

Attending Radiologist: REITER, MICHAEL

Ordered By: LEE, CHRISTOPHER

Order Date/Time: January 13, 2016 11:05 PM

Scan Initiation Date/Time: January 14, 2016 1:33 AM

Completion Date/Time: January 14, 2016 1:42 AM

Encounter Number: 010095461306

Accession Number: 6549236

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 14, 2016 2:08 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461306

Report Date/Time: 1/14/2016 1:42:00 AM

Report Name: PELVIS ROUTINE AP VIEW

Clinical History

Pain

Technique

2 views of each hip and single frontal view of the pelvis.

Comparison

12/07/2012

Findings

Anatomic alignment. No fracture or dislocation. Severe degenerative

changes of both hips. Soft tissues are unremarkable.

Impression

No fracture.

Attending Radiologist: REITER, MICHAEL

Ordered By: LEE, CHRISTOPHER

Order Date/Time: January 13, 2016 11:10 PM

Scan Initiation Date/Time: January 14, 2016 1:35 AM

Completion Date/Time: January 14, 2016 1:42 AM

Encounter Number: 010095461306

Accession Number: 6549244

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 14, 2016 2:11 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461306

Report Date/Time: 1/14/2016 1:42:00 AM

Report Name: HIP RIGHT TRAUMA WITH PELVIS 2 OR 3 VWS

Clinical History

Pain

Technique

2 views of each hip and single frontal view of the pelvis.

Comparison

12/07/2012

Findings

Anatomic alignment. No fracture or dislocation. Severe degenerative

changes of both hips. Soft tissues are unremarkable.

Impression

No fracture.

Attending Radiologist: REITER, MICHAEL

Ordered By: LEE, CHRISTOPHER

Order Date/Time: January 13, 2016 11:10 PM

Scan Initiation Date/Time: January 14, 2016 1:37 AM

Completion Date/Time: January 14, 2016 1:42 AM

Encounter Number: 010095461306

Accession Number: 6549245

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 14, 2016 2:11 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461306

Report Date/Time: 1/14/2016 1:42:00 AM

Report Name: HIP LEFT TRAUMA WITH PELVIS 2 OR 3 VWS

Clinical History

Pain

Technique

2 views of each hip and single frontal view of the pelvis.

Comparison

12/07/2012

Findings

Anatomic alignment. No fracture or dislocation. Severe degenerative

changes of both hips. Soft tissues are unremarkable.

Impression

No fracture.

Attending Radiologist: REITER, MICHAEL

Ordered By: LEE, CHRISTOPHER

Order Date/Time: January 13, 2016 11:10 PM

Scan Initiation Date/Time: January 14, 2016 1:39 AM

Completion Date/Time: January 14, 2016 1:42 AM

Encounter Number: 010095461306

Accession Number: 6549246

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 14, 2016 2:11 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461306

Report Date/Time: 1/14/2016 2:22:00 AM

Report Name: CT HEAD ROUTINE WO IV CONTRAST

Examination

CT HEAD ROUTINE WITHOUT CONTRAST

Clinical History

EVALUATE FOR TRAUMATIC INJURY

History and Indication

S/P TRAUMA

Technique

Contiguous axial slices were obtained from the skull base to the

vertex.

Comparison

12/05/2012

Findings

There is no loss of gray-white matter distinction or other sign of

acute infarction.

There is global cerebral atrophy.

There is moderate chronic small vessel ischemic disease. Old lacunar

right basal ganglia infarct.

There is no intracranial hemorrhage or extra-axial collection.

The calvarium is intact.

There is no significant disease in the visualized paranasal sinuses

and mastoids.

Impression

No acute intracranial finding.

Attending Radiologist: REITER, MICHAEL

Ordered By: LEE, CHRISTOPHER

Order Date/Time: January 13, 2016 11:10 PM

Scan Initiation Date/Time: January 14, 2016 2:11 AM

Completion Date/Time: January 14, 2016 2:22 AM

Encounter Number: 010095461306

Accession Number: 6549242

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 14, 2016 2:51 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300

Encounter #: 10095461306

Report Date/Time: 1/14/2016 2:22:00 AM

Report Name: CT SPINE CERVICAL WO IV CONTRAST

Examination

CT SPINE CERVICAL WITHOUT CONTRAST

Clinical History

EVAL FOR FRACTURE

History and Indication

FALL

Technique

1.25 mm. thick helical axial slices were obtained from skull base to

the upper thoracic spine and then sagittal and coronal reformatted

images were obtained.

Comparison

No images available for comparison.

Findings

No fracture, subluxation or bone destruction is noted. Multilevel

degenerative changes.

Soft tissue information is limited. No evidence of large disc

protrusion or critical spinal stenosis is noted.

Impression

NO FRACTURE.

Attending Radiologist: REITER, MICHAEL

Ordered By: LEE, CHRISTOPHER

Order Date/Time: January 13, 2016 11:10 PM

Scan Initiation Date/Time: January 14, 2016 2:14 AM

Completion Date/Time: January 14, 2016 2:22 AM

Encounter Number: 010095461306

Accession Number: 6549243

Images were reviewed and interpreted by Attending Radiologist: Dr. REITER, MICHAEL

Electronically Signed On: January 14, 2016 2:53 AM by Dr. REITER, MICHAEL

STONY BROOK UNIVERSITY HOSPITAL

DEPARTMENT OF RADIOLOGY

STONY BROOK, NY 11794-7300