PRP Diagnostic Imaging
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Patient Name:	FRANCIS, REBECCA	**Accession Number:**	PR-9356891-CT
Patient ID:	PR-AJH781Y	**Requested Date:**	August 28, 2022 06:30
Gender:	Female	**Report Status:**	R
Date of Birth:	January 6, 1986	**Requested Procedure:**	10266968
Home Phone:		**Procedure Description:**	NOR-CT PULMONARY ANGIOGRAM
Referring Physician:	MADDEN, STEPHEN	**Modality:**	CT
Organisation:	NOR		

Findings

Reporting MD: AFTER HOURS -, REPORTING
Dictation Time:
Transcription Date:

PRELIMINARY REPORT

CT PULMONARY ANGIOGRAM AND AORTOGRAM

CLINICAL NOTES:

Chest pain radiating to back with shortness of breath.

? Aortic dissection? PE.

TECHNIQUE:

CT imaging has been performed through the chest and abdomen post intravenous contrast in the arterial phase.

There is cardiac pulsation artefact through the aortic root and ascending thoracic aorta.

1 mm axial with multiplanar reformatted images were provided.

No relevant prior imaging was provided for comparison.

FINDINGS:

Heart size is normal. There is no pleural or pericardial effusion.

Allowing for cardiac pulsation artefact, there are no features to suggest dissection of the thoracic or abdominal aorta. Please note as mentioned above, there is cardiac pulsation artefact at the aortic root and ascending thoracic aorta.

The great vessels appear normal as these arise from the thoracic aortic arch.

The abdominal aorta is of normal calibre with no filling defect or dissection flap identified within the branches.

There is no mediastinal haematoma. I cannot assess for intramural haematoma in the absence of non-contrast imaging, although there are no features to suggest this.

There is no mediastinal haematoma. There is soft tissue within the anterior mediastinum, likely thymic tissue.

There has been good opacification of the pulmonary arteries. There are no features to suggest pulmonary embolus with confidence down to subsegmental level.

There are no features to suggest right heart strain.

The lungs are clear with no consolidation or collapse.

There is no pleural or pericardial effusion.

There is no pneumothorax.

No incidental lung lesion is seen.

There is no incidental adenopathy within the chest.

No radiodense gallstones are seen within the gallbladder. There are no CT features to suggest cholecystitis. There is no pancreatic abnormality with no increased density within the surrounding peripancreatic soft tissues.

The liver is hypodense in keeping with hepatic steatosis.

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Diagnostic Imaging

No definite abnormality is seen within the upper abdomen to account for symptoms.

No acute or destructive bone process is seen.

CONCLUSION:

Allowing for cardiac pulsation artefact from a non-ECG gated study, I can see no evidence of aortic dissection.

There is no evidence of pulmonary embolus.

A cause for symptoms has not been found on this study.

Electronically Signed By:

Dr. Lisa Gallagher

MBBCh. FRCR. FRANZCR.

Reporter: - R. After Hours -

PRP Westmead New PET/CT service begins July 18, 2022. Improving our well established Oncology service for the region All PRP Staff are fully vaccinated.

Norwest
PRIVATE HOSPITAL

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Emergency
Department

Re: Rebecca Francis
DOB 06/01/1986

Rebecca presented to Norwest Emergency with a 12-hour history of nausea and vomiting where she then developed epigastric/chest pain. The chest pain was sharp and stabbing in nature and radiated through to her back. She had some associated shortness of breath which sounds anxiety/pain related. She was otherwise systemically well.

Her pain resolved with IV morphine and vomiting settled. She remained hemodynamically stable and afebrile. Her Heart sounds were dual, chest was clear, abdomen was soft and non-tender and calves were soft and non-tender.

Her investigations were normal including a normal CRP and troponin. She had a CTPA/Aortic angiogram which was normal.

It is likely her pain is either MSK or secondary to vomiting. Reassuringly it resolved and did not return. She was discharged home in a well condition on simple analgesia and was encouraged to represent if she has any concerns.

Kind Regards

Dr James Molloy
ED CMO
Norwest private Hospital