

ΕΞΩΚΑΡΔΙΑΚΑ ΕΥΡΗΜΑΤΑ & CTCA

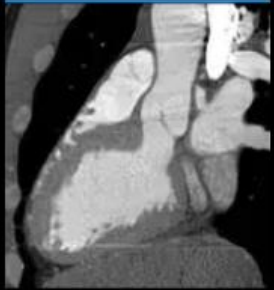
ΣΤΕΦΑΝΟΥ ΔΑΝΑΗ, MD, MSc

Lecture outline

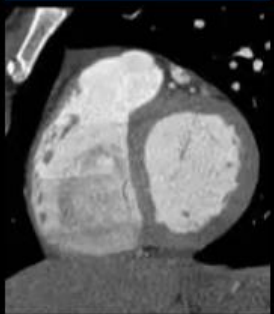
- **Εισαγωγή: Incidentaloma & Εξωκαρδιακά Ευρήματα**
- **Literature Review**
- **Ενδιαφέροντα περιστατικά**
- **Take home messages**

No conflicts of interest to report

VERTICAL LONG AXIS



SHORT AXIS

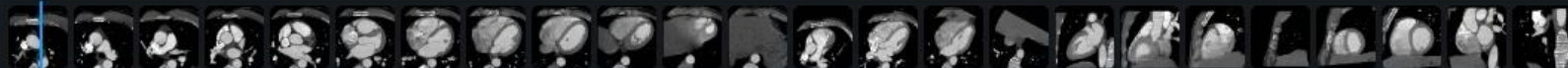
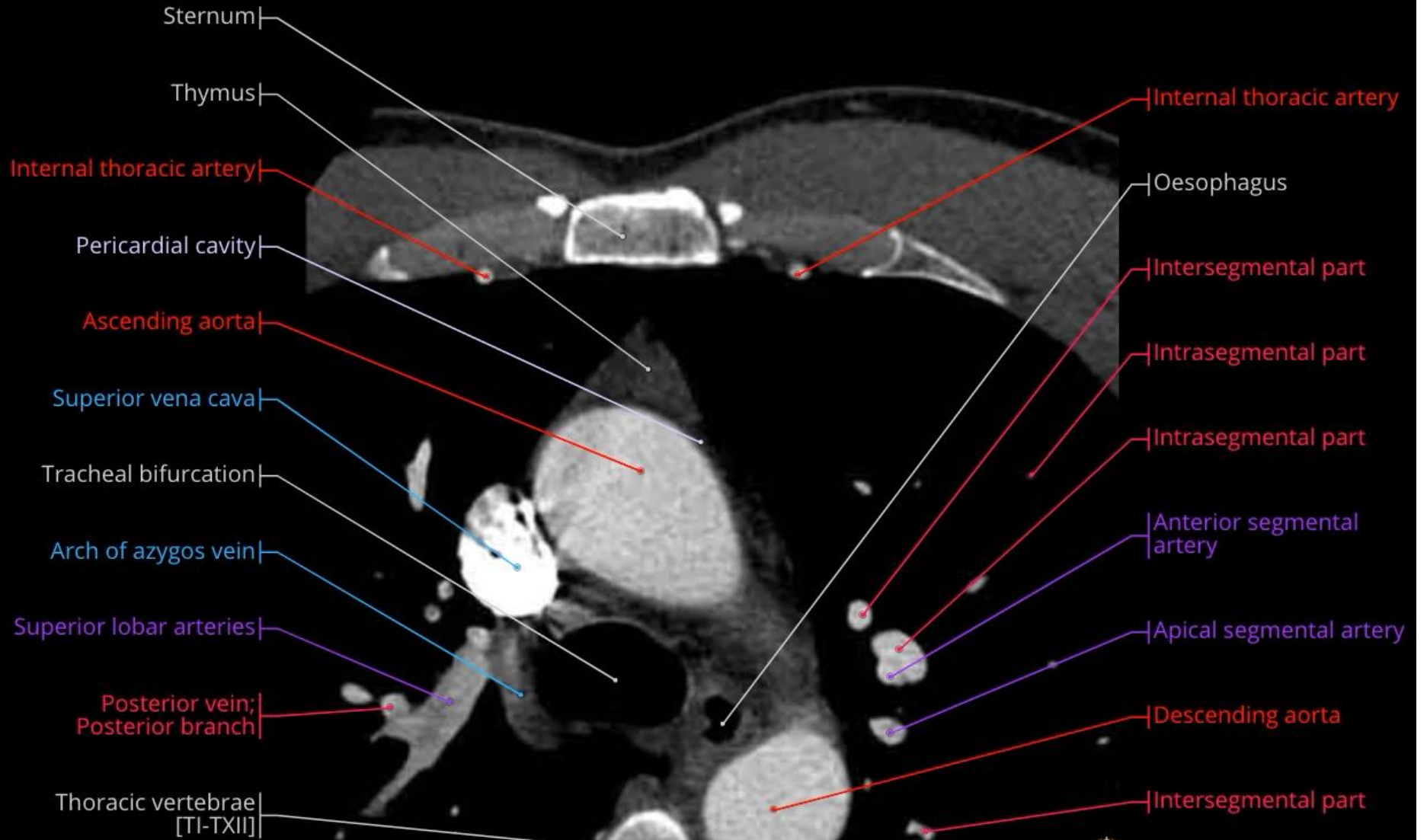


3D



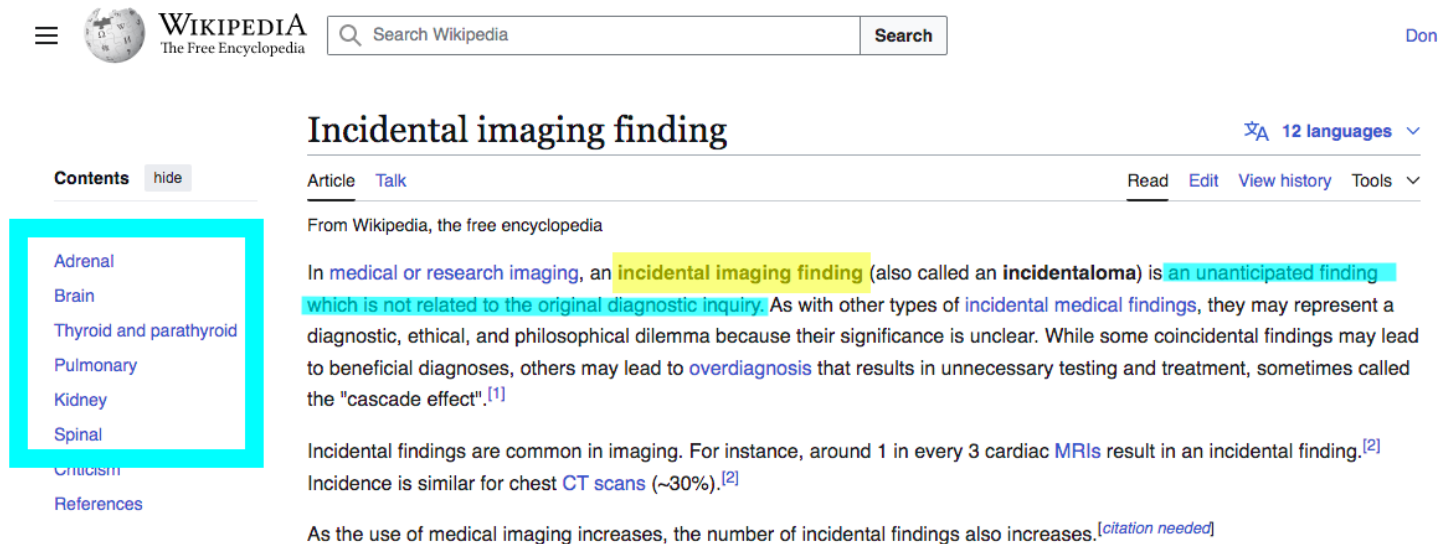
Search in this module

Heart - CT
(Axial)



ΤΥΧΑΙΩΜΑ-INCIDENTALOMA

- είναι ένας ακτινολογικός νεολογισμός που υποδηλώνει μια αλλοίωση που βρέθηκε τυχαία και είναι αμφιβόλου κλινικής σημασίας



- Τυχαία εξωκαρδιακά ευρήματα είναι πολύ συχνά στις CTCA, οι οποίες όλο και περισσότερο χρησιμοποιούνται ως απεικονιστικό εργαλείο
- το κλειδί στα τυχαία εξωκαρδιακά ευρήματα είναι να προσδιοριστεί η κλινική σημασία τους και η ανάγκη περαιτέρω αξιολόγησης —————> πως θα επικοινωνήσουν οι ακτινολόγοι το εύρημα σε εσάς

Clinically Relevant Extracardiac Findings at Cardiac Imaging: Insights from the European MR/CT Registry

Lukas J. Moser, MD • Matthias Gutberlet, MD, PhD • Rozemarijn Vliegenthart, MD, PhD • Marco Francone, MD, PhD • Ricardo P. J. Budde, MD, PhD • Rodrigo Salgado, MD • Maja Hrabak Paar, MD, PhD • Maja Pirnat, MD • Christian Loewe, MD • Konstantin Nikolaou, MD • Michelle C. Williams, MBCHB, PhD • Giuseppe Muscogiuri, MD, PhD • Luigi Natale, MD • Robin F. Gohmann, MD • Christian Lücke, MD • Matthias Eberhard, MD • Hatem Alkadhri, MD

From Diagnostic and Interventional Radiology, University Hospital Zurich, University of Zurich, Raemistrasse 100, CH-8091 Zurich, Switzerland (L.J.M., M.E., H.A.); Department of Diagnostic and Interventional Radiology, Herzzentrum Leipzig Universitätsklinik, Leipzig, Germany (M.G., R.F.G., C. Lücke); Department of Radiology, University Medical Center Groningen, Groningen, the Netherlands (R.V.); Department of Biomedical Sciences, Humanitas University, Pieve Emanuele, Humanitas Research Hospital, Rozzano, Italy (M.F.); IRCCS Humanitas Research Hospital, Milan, Italy (M.E.); Department of Radiology and Nuclear Medicine, Erasmus Medical Center, Rotterdam, the Netherlands (R.P.J.B.); Department of Radiology, Antwerp University Hospital and Antwerp University, Antwerp, Belgium (R.S.); Department of Diagnostic and Interventional Radiology, University Hospital Centre Zagreb, Zagreb, Croatia (M.H.P.); Department of Radiology, University Medical Centre Maribor, Maribor, Slovenia (M.P.); Department of Biomedical Imaging and Image-Guided Therapy, Division of Cardiovascular and Interventional Radiology, Medical University of Vienna, Vienna, Austria (C. Loewe); Department of Diagnostic and Interventional Radiology, University Hospital Tübingen, Tübingen, Germany (K.N.); British Heart Foundation Centre for Cardiovascular Science, University of Edinburgh, Edinburgh, United Kingdom (M.C.W.); School of Medicine and Surgery, University of Milano-Bicocca, Milan, Italy (G.M.); Department of Radiology, IRCCS Istituto Auxologico Italiano, San Luca Hospital, Milan, Italy (G.M.); and Department of Radiological Sciences-Institute of Radiology, Catholic University of Rome, A. Gemelli University Hospital, Rome, Italy (L.N.). Received April 2, 2024; revision requested May 7; revision received July 12; accepted September 10. Address correspondence to H.A. (email: hatem.alkadhri@usz.ch).

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Conflicts of interest are listed at the end of this article.

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Key Points

- The prevalence of clinically relevant extracardiac findings was 3.28% (6832 of 208 506) at cardiac CT examinations and 1.50% (3421 of 228 462) at cardiac MRI examinations from the multicenter, multinational European Society of Cardiovascular Radiology MR/CT Registry.
- Clinically relevant extracardiac findings were most common at cardiac CT examinations performed for transcatheter aortic valve replacement (incidence rate ratio [IRR], 2.07; $P < .001$) and cardiac MRI examinations performed for myocarditis (IRR, 1.36; $P < .001$).
- Older patient age was significantly associated with higher prevalence of extracardiac findings at both cardiac CT and MRI examinations (IRR, 1.02; $P < .001$).

Clinically Relevant:
Findings that require follow-up examinations and those that necessitate a change in clinical management

Purpose: To determine the prevalence of clinically relevant extracardiac findings at cardiac CT and MRI examinations from a multicenter, multinational MR/CT registry and the relationship of prevalence with examination indications and patient characteristics.

Materials and Methods: This was a retrospective analysis of data from the European Society of Cardiovascular Radiology MR/CT Registry. Data from 208 506 cardiac CT examinations (median patient age, 66 years [IQR, 55–77]; 121 617 [58.33%] male patients) and 228 462 cardiac MRI examinations (median patient age, 57 years [IQR, 42–69]; 145 792 [63.81%] male patients) entered into the registry between January 2011 and November 2023 were analyzed. Clinically relevant extracardiac findings were defined as findings requiring follow-up examinations or influencing clinical management. The association of examination indication and patient characteristics, including age, with prevalence of extracardiac findings was evaluated using incidence rate ratios (IRRs) derived from multivariable Poisson regression models.

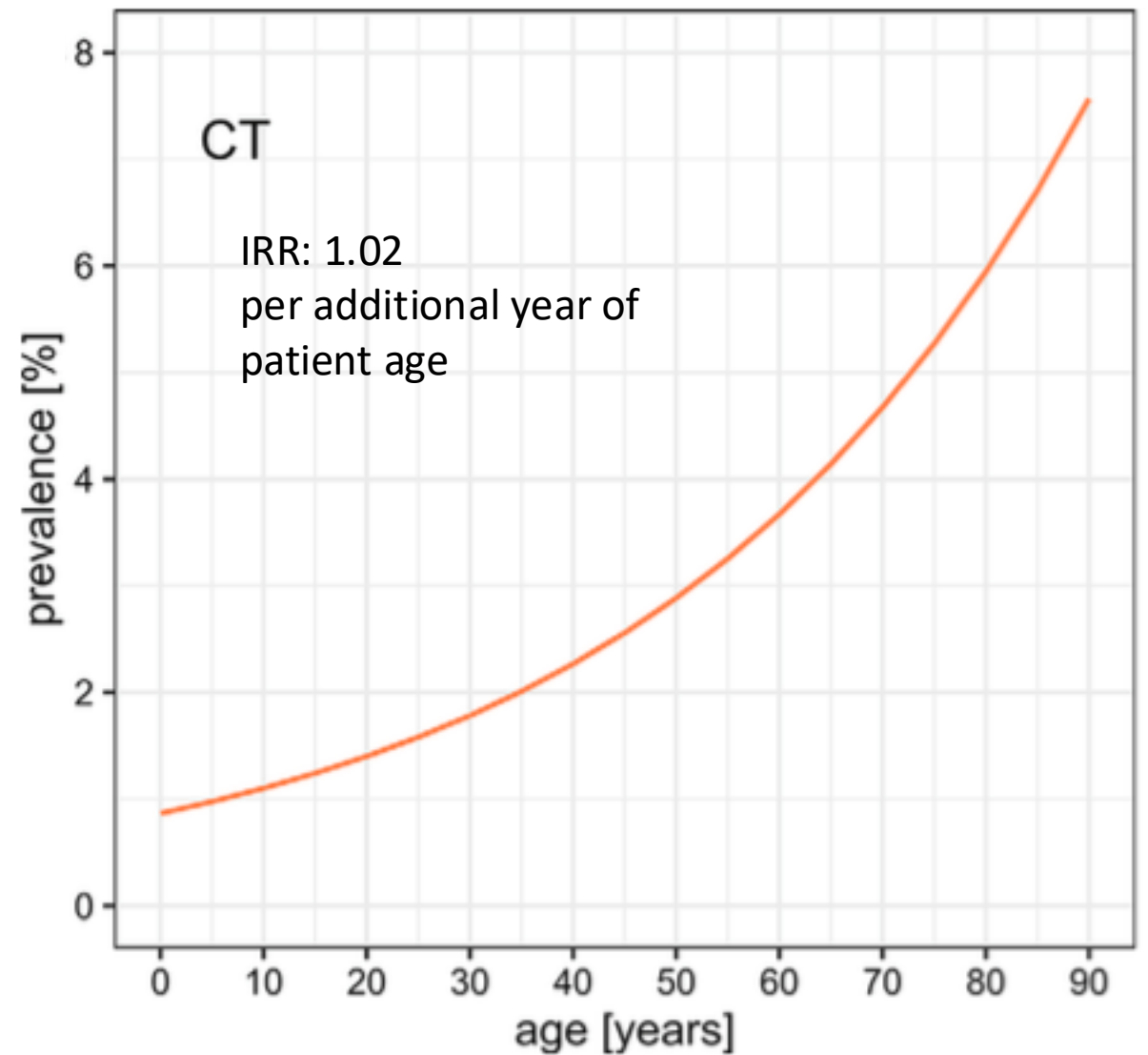
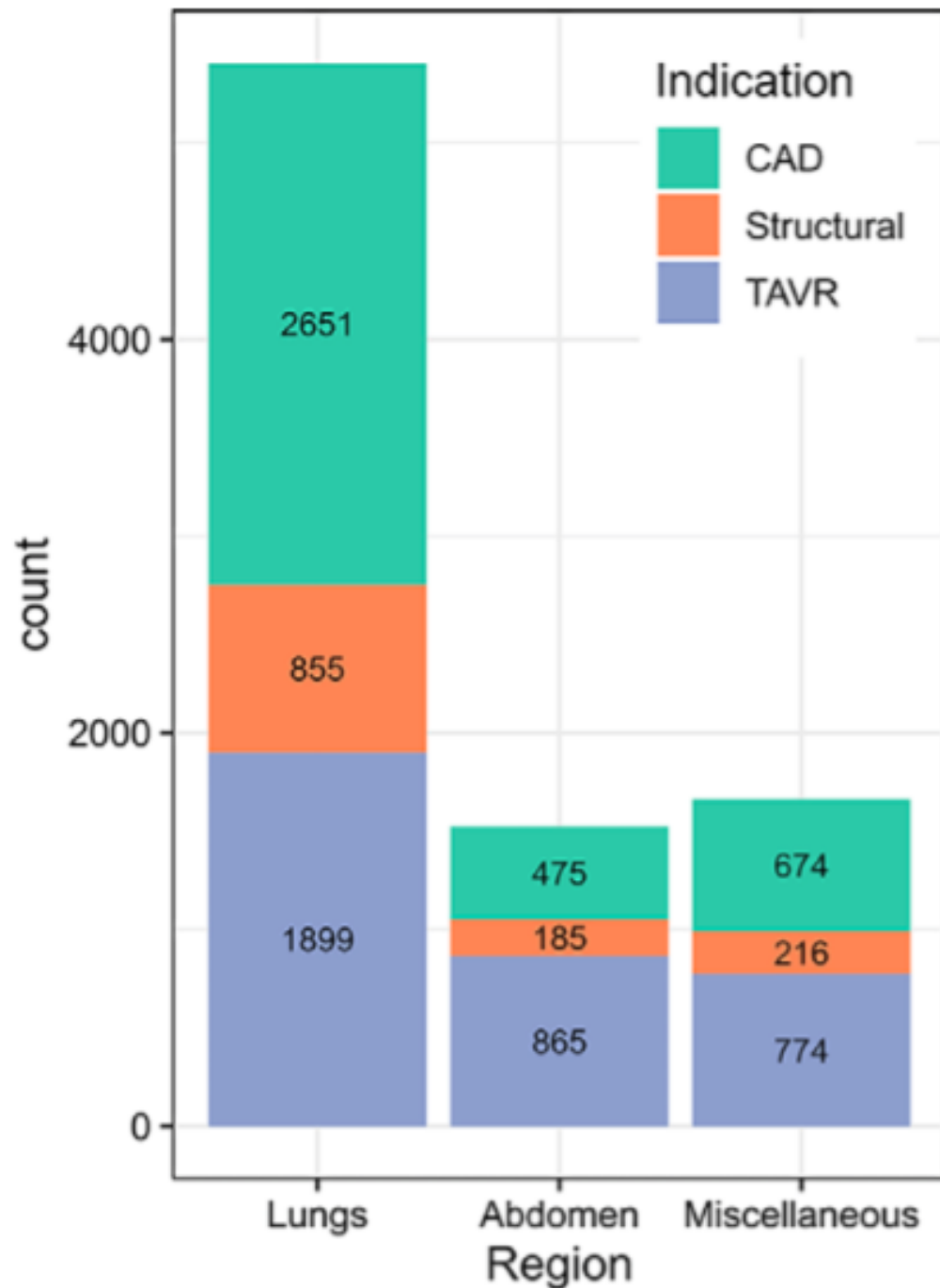
Results: The prevalence of clinically relevant extracardiac findings was 3.28% (6832 of 208 506) at cardiac CT and 1.50% (3421 of 228 462) at cardiac MRI examinations. Extracardiac findings were more common at CT examinations performed for transcatheter aortic valve replacement (IRR, 2.07; $P < .001$) and structural heart disease (IRR, 1.44; $P < .001$) compared with CT performed for coronary artery disease (IRR, 1; reference). Extracardiac findings were more common at MRI examinations performed for myocarditis (IRR, 1.36; $P < .001$) and structural heart disease (IRR, 1.16; $P < .001$) than for coronary artery disease. Older patient age was also significantly associated with higher prevalence of extracardiac findings, with an IRR for both CT and MRI examinations of 1.02 ($P < .001$).

Conclusion: Data from the multicenter, multinational MR/CT registry indicate that clinically relevant extracardiac findings are present at cardiovascular CT and MRI examinations, and the prevalence of these findings is associated with examination indication and patient age.

Table 2: Clinically Relevant Extracardiac Findings at Cardiac CT according to Body Region and Examination Indication

Extracardiac Finding	CAD	Structural	TAVR	Total	Relative Frequency (%)
Lung	2651	855	1899	5405	100.00
Pulmonary lesion or nodule	1405	303	761	2469	45.68
Pulmonary effusion	573	274	775	1622	30.01
Pulmonary infiltrate	421	188	259	868	16.06
Structural lung disease	195	35	57	287	5.31
Pneumothorax	22	38	16	76	1.41
Pulmonary embolism	26	13	17	56	1.04
Pleural lesion	9	4	14	27	0.50
Abdomen	475	185	865	1525	100.00
Suspicious abdominal lesions	330	138	797	1265	82.95
Hiatus hernia	78	22	13	113	7.41
Diffuse liver disease	46	9	24	79	5.18
Ascites	12	11	22	45	2.95
Acute abdominal pathology	9	5	9	23	1.51
Miscellaneous	674	216	774	1664	100.00
Enlarged lymph nodes	413	139	472	1024	61.54
Suspicious bony lesion	77	23	93	193	11.60
Aortic aneurysm	45	14	41	100	6.01
Extra-aortal vessel pathology	17	17	48	82	4.93
Suspicious mammary lesion	50	2	25	77	4.63
Thyroid lesion or nodule	15	8	52	75	4.51
Spine or rib fracture	24	7	26	57	3.43
Suspicious mediastinal lesion	21	3	14	38	2.28
Acute aortic syndrome	12	3	3	18	1.08

Moser LJ,et al Clinically Relevant Extracardiac Findings at Cardiac Imaging: Insights from the European MR/CT Registry. Radiol Cardiothorac Imaging. 2024 Oct;6(5):e240117.



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The Ten Studies Reporting Extracardiac Findings at Cardiovascular CT with the Largest Included Patient Populations

Reference	Year	N	Indications	Age [Years]	Male Sex	Study Design	Definitions (Number of Patients in Group)	Prevalence (%)
MRCT-registry (data to 11/2023)	2024	208506	Varying indications in inpatients	66 ^a	58%	retrospective registry analysis	Clinical significance: determined by study members (<i>n</i> = 6832). Nonsignificant: not included in analysis.	6832 (3.3)
Johnson et al (22)	2010	6920	Varying indications in outpatients	54	65%	retrospective reports	Study did not include "trivial abnormalities of no clinical importance"	1642 (24)
Kelion et al (23)	2022	4340	predominately suspicion of CAD	NA	NA	retrospective reports	Clinical significance: indicated in report (<i>n</i> = 687). Nonsignificant: indicated in report (not included)	687 (16)
Karius et al (17)	2019	3898	Suspicion of CAD—only negative studies	59	49%	retrospective reports	Relevant: recommendation for follow-up (<i>n</i> = 94). Urgent: recommendation for prompt change in management (<i>n</i> = 16). Malignancy (<i>n</i> = 3). Nonrelevant (<i>n</i> = 1004)	1117 (29)
Williams et al (18)	2018	1778	Suspicion of CAD	57	56%	retrospective reports (on prospective cohort)	Clinical significance: causing symptoms as indicated in report "Yes," "Probable," or requiring follow-up (<i>n</i> = 175). Nonsignificance: unlikely or not cause of symptoms (<i>n</i> = 500).	675 (38)
Koonce et al (20)	2009	1764	varying	58	61%	retrospective reports	Clinical significance: requiring treatment or follow-up (<i>n</i> = 325). Nonsignificance: requiring no follow-up (<i>n</i> = 116).	441 (25)
Bendix et al (39)	2011	1383	Suspicion of CAD	56	46%	retrospective unknown	Major: requiring clinical or imaging follow-up (<i>n</i> = 103*). Minor: requiring no follow-up (<i>n</i> = 378*).	393 (28)
Chia et al (40)	2009	1061	Variable indications	56	65%	retrospective images	Significant findings: requiring clinical or imaging follow-up (<i>n</i> = 33). Nonsignificant: requiring no follow-up (<i>n</i> = 52).	85 (8)
Trenkwalder et al (41)	2018	1050	pre-TAVR	80	53%	retrospective unknown	Clinically relevant: requiring clinical or imaging follow-up or change in management (<i>n</i> = 258). Nonrelevant: unsuspecting and requiring no follow-up (<i>n</i> = 741).	999 (95)
Lazoura et al (28)	2010	1044	Variable indications	61	74%	retrospective images	Severe: definite importance requiring follow-up or management (<i>n</i> = 174*). Indeterminate: requiring follow-up or correlation (<i>n</i> = 96*). Mild: no need for follow-up (<i>n</i> = 459*).	588 (56)
Machaalany et al (42)	2009	966	Variable indications	58	55%	retrospective reports (on prospective cohort)	Clinically significant: definite pathologic diagnosis (<i>n</i> = 12).	401 (42)

Clinical and economic impact of extracardiac lesions on coronary CT angiography

Heart

Andrew Kelion ¹, Nikant Sabharwal ¹, David Holdsworth,¹ Sam Dawkins,¹ Heiko Peschl,² Anny Sykes,³ Yaver Bashir¹

Abstract

Objective When reporting coronary CT angiography (CCTA), extracardiac structures are routinely assessed, usually on a wide field-of-view (FOV) reconstruction. We performed a retrospective observational cross-sectional study to investigate the impact of incidental extracardiac abnormalities on resource utilisation and treatment, and cost-effectiveness.

Methods All patients undergoing CCTA at a single institution between January 2012 and March 2020 were identified. The indication for CCTA was chest pain or dyspnoea in >90%. Patients with ≥ 1 significant extracardiac findings were selected. Clinical follow-up, investigations and treatment were documented, and costs were calculated.

Results 4340 patients underwent CCTA; 717 extracardiac abnormalities were identified in 687 individuals (15.8%; age 62 ± 12 years; male 336, 49%). The abnormality was already known in 162 (23.6%). Lung nodules and cysts were the most common abnormalities (296, 43.1%). Clinical and/or imaging follow-up was pursued in 292 patients (42.5%). Treatment was required by 14 patients (0.3% of the entire population), including lung resection for adenocarcinoma in six (0.1%). All but two abnormalities (both adenocarcinomas) were identifiable on the limited cardiac FOV. The cost of reporting (£20) and follow-up (£33) of extracardiac abnormalities was £53 per patient. The cost per discounted quality-adjusted life year was £23 930, increasing to £46 674 for reporting the wide FOV rather than the cardiac FOV alone.

Conclusions Extracardiac abnormalities are common on CCTA, but identification and follow-up are costly. The few requiring treatment are usually identifiable without review of the wide FOV. The way in which CCTAs are scrutinised for extracardiac abnormalities in a resource-limited healthcare system should be questioned.

Frequency of extracardiac findings on "negative" CT coronary angiography studies

Abstract

Aim: To evaluate the prevalence and nature of extracardiac findings identified on computed tomography (CT) coronary angiography (CTCA) in patients with chest pain but without evidence of coronary artery disease (CAD).

Materials and methods: CTCA studies in patients referred to the hospital between January 2017 to February 2021 with chest pain and a suspected diagnosis of CAD were reviewed retrospectively for the presence of extracardiac findings. Consensus review of CTCA studies was performed by two experienced thoracic radiologists. The presence and severity of extracardiac findings, together with the likelihood that chest pain might be attributed to these, was recorded. Patient records were reviewed to ascertain the recording of extracardiac findings on initial CTCA reports and, where applicable, the nature of the follow-up.

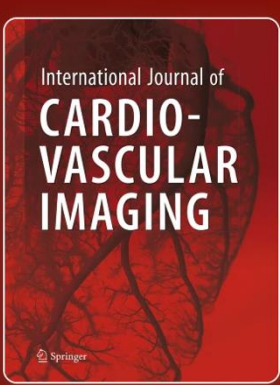
Results: Extracardiac findings (n=210) were present in 110/180 patients (61%) with a mean of 1.9 findings per patient. Extracardiac findings were more prevalent in patients aged ≥ 65 years compared to those < 65 years ($p < 0.001$). At least one extracardiac finding with the potential to cause chest pain was present in 40 patients (22%): degenerative disc disease (n=23 [13%]) and hiatus hernia (n=6 [3.3%]) were the most common extracardiac findings. Only 37.6% (79) of all retrospectively identified findings had been initially reported and, of these, 12.7% (10) required further follow-up.

Conclusion: Extracardiac findings are common in patients with no evidence of CAD on CTCA. The entire dataset should be evaluated for the presence of extracardiac findings that could explain chest pain symptoms on wide field of view reconstructions.

Beyond the heart: a pictorial review of extracardiac findings on cardiac CT

Review | Published: 26 February 2026

(2026) [Cite this article](#)



Abstract

Cardiac computed tomography (CT) is a cornerstone imaging modality for the diagnosis and management of cardiovascular disease, with widespread applications from the evaluation of chest pain to planning a wide range of minimally invasive procedures. The field of view obtained during imaging includes the heart and surrounding structures, including pericardium, thoracic great vessels, mediastinum, lungs, bones, and upper abdomen. Extracardiac findings have been reported in up to 61% of patients evaluated for chest pain, highlighting the importance of carefully analyzing and evaluating extracardiac structures. False positive interpretation leads to additional downstream testing, increasing health care costs and patient anxiety. Conversely, false negative interpretation, resulting in missed diagnoses, may pose even greater risk to patients. This review article provides a structured approach to evaluate for extracardiac findings on cardiac CT. With a rapid expansion of cardiac CT utilization, endorsed by multiple cardiovascular guidelines, it is imperative to establish and uphold standardized interpretation protocols for extracardiac findings that may have important clinical implications for patient care.

Beyond the heart: a pictorial review of extracardiac findings on cardiac CT

Siddarth Ragupathi¹ · Felipe I. Contreras Yametti² · Maria Qureshi² · Daniel Lorenzatti² · Leandro Slipczuk² · Jeffrey M. Levisky¹ · Matthew S. Lazarus¹

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Abstract

Cardiac computed tomography (CT) is a cornerstone imaging modality for the diagnosis and management of cardiovascular disease, with widespread applications from the evaluation of chest pain to planning a wide range of minimally invasive procedures. The field of view obtained during imaging includes the heart and surrounding structures, including pericardium, thoracic great vessels, mediastinum, lungs, bones, and upper abdomen. Extracardiac findings have been reported in up to 61% of patients evaluated for chest pain, highlighting the importance of carefully analyzing and evaluating extracardiac structures. False positive interpretation leads to additional downstream testing, increasing health care costs and patient anxiety. Conversely, false negative interpretation, resulting in missed diagnoses, may pose even greater risk to patients. This review article provides a structured approach to evaluate for extracardiac findings on cardiac CT. With a rapid expansion of cardiac CT utilization, endorsed by multiple cardiovascular guidelines, it is imperative to establish and uphold standardized interpretation protocols for extracardiac findings that may have important clinical implications for patient care.

Keywords Extracardiac · Cardiac · CT · Coronary · Chest pain

Abbreviations

CT	Computed tomography
CCTA	Coronary CT angiography
MRI	Magnetic Resonance Imaging
HU	Hounsfield units
SVC	Superior vena cava
IVC	Inferior vena cava
GGO	Ground glass opacities

Introduction

Cardiac CT has witnessed rapid growth in recent years. It has become a standard test in the evaluation of patients with chest pain since being assigned a Class 1 A recommendation in the 2021 ACC/AHA chest pain guidelines [1]. Additionally, cardiovascular CT is the standard tool for analysis of patients undergoing transcatheter structural cardiac interventions. These combined forces have led to an exponential increase in volume of cardiac CTs. This upward trend is expected to continue as more physicians recognize the utility of this examination. This growth of cardiac CT is accompanied by diverse interpretative models to report both cardiac and extra-cardiac findings, including cardiologists, general or subspecialized radiologists, co-read paradigms, or teleradiology assistance that vary by institution and region. Independent interpretation by cardiologists or radiologists is a common approach in the United States. Given this dynamic, interpretation of extracardiac findings requires special attention from readers without a radiology background.

✉ Matthew S. Lazarus
mlazarus@montefiore.org

¹ Montefiore Health System/Albert Einstein College of Medicine, Department of Radiology, Bronx, NY, USA

² Montefiore Health System/Albert Einstein College of Medicine, Division of Cardiology, Bronx, NY, USA

Incidental chest findings on coronary CT angiography: a pictorial essay and management proposal

[Erique Pinto](#)¹, [Diana Penha](#)^{1,2}, [Bruno Hochhegger](#)³, [Colin Monaghan](#)², [Edson Marchiori](#)^{4,5}, [Luís Taborda-Barata](#)¹, [Klaus Irion](#)²

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ABSTRACT

Many health systems have been using coronary CT angiography (CCTA) as a first-line examination for ischaemic heart disease patients in various countries. The rising number of CCTA examinations has led to a significant increase in the number of reported incidental extracardiac findings, mainly in the chest. Pulmonary nodules are the most common incidental findings on CCTA scans, as there is a substantial overlap of risk factors between the population seeking to exclude ischaemic heart disease and those at risk of developing lung cancer (i.e., advanced age and smoking habits). However, most incidental findings are clinically insignificant and actively pursuing them could be cost-prohibitive and submit the patient to unnecessary and potentially harmful examinations. Furthermore, there is little consensus regarding when to report or actively exclude these findings and how to manage them, that is, when to trigger an alert or to immediately refer the patient to a pulmonologist, a thoracic surgeon or a multidisciplinary team. This pictorial essay discusses the current literature on this topic and is illustrated with a review of CCTA scans. We also propose a checklist organised by organ and system, recommending actions to raise awareness of pulmonologists, thoracic surgeons, cardiologists and radiologists regarding the most significant and actionable incidental findings on CCTA scans.

Lung

Solid pulmonary nodule

- < 5 mm or < 80 mm³ with no suspicious features (e.g., granulomas, IPLNs)
 - Reporting is optional, and no follow-up is required
- > 5 mm, previously unknown or with suspicious features
 - Report and alert the respiratory team
 - 5-8 mm → Baseline LDCT and provide an LDCT follow-up schedule
 - 5-6 mm: LDCT within one year 6-8 mm: LDCT within three months
 - > 8 mm or > 300 mm³ → Assess the risk of cancer (Brock model)
 - < 10% risk of cancer: baseline LCDT and follow-up LDCT within one year
 - ≥ 10% risk of cancer: referral to lung cancer MDT

Subsolid pulmonary nodule

- ≥ 5 mm → Report to and alert the respiratory team
 - Baseline LDCT and provide a follow-up schedule within three months
 - Stable after ≥ 3 months: assess the risk of cancer (Brock model)
 - < 10% risk of cancer: follow-up LDCT within one year
 - ≥ 10% risk of cancer: referral to lung cancer MDT
 - Growing or altered morphology → Referral to lung cancer MDT

Pulmonary emboli → Report and urgent referral to the respiratory team

ILAs → Report to and alert the respiratory team

- In the presence of respiratory symptoms, physiological abnormalities, gas transfer abnormalities and extensive CT changes → Referral to the respiratory team/ILD MDT meeting
- In the presence of risk factors for progression → Follow-up may be appropriate even after exclusion of ILD (the optimal interval for follow-up CT scanning is unknown)

Infection/Consolidation

- Report and referral to the respiratory team if not already under their care
- CT reassessment after therapy

Pleura

Pneumothorax (rare) → Report and urgent referral to the medical emergency team

Pleural plaques → Report

- in lung cancer patients: differentiate pleural plaques from pleural metastases
- in asbestos exposure: assess signs suspicious for mesothelioma

Pleural effusion → Report

- in cardiac patients it may be related to heart failure: trigger an alert

Mediastinum

Pneumomediastinum (rare) → Report and urgent referral to the medical emergency team

Mediastinal nodule or mass → Report

- if presenting suspicious features → Referral to the cardiothoracic surgical team
- if benign-looking → Suggest annual CT follow-up or MRI characterisation

Aorta and pulmonary vessels → Report abnormalities in the context of the patient's cardiovascular disease

Lymphadenopathy → Report

- if suspicious features or absence of an explaining disease to justify lymphadenopathy → Consider providing a follow-up schedule or suggest further characterisation with PET-CT or biopsy

Oesophageal hiatus hernia → Report

- In the presence of heartburn (confounding symptom) → Referral to gastrointestinal evaluation

Chest wall

Bone

- 'Do not touch' lesions → Report but no follow-up required
- Degenerative bony changes → Report (may cause atypical chest pain)
- Suspicious bone lesions → Report and trigger an alert

Skin, subcutaneous and muscle lesions → Report new or previously undiagnosed lesions

Breast → Report new or previously undiagnosed lesions and alert breast team

Upper abdomen

Liver

Simple hepatic cysts → Reporting is optional, and no follow-up is required

Other focal parenchymal lesions → Report if previously undiagnosed and suggest further evaluation with triple-phase CT or MRI

Biliary system

Abnormal appearance of the gallbladder wall, biliary obstruction or pneumobilia → Report and suggest further evaluation

Gallstones → Reporting is optional, and no follow-up is required

Adrenal glands, pancreas, stomach and spleen

Any cystic or solid lesions, or splenomegaly → Report and suggest further evaluation if previously undiagnosed

Kidneys

Simple or minimally complex renal cysts (Bosniak I and II) → Reporting is optional, and no follow-up is required

Complex renal cysts → Report and suggest further evaluation

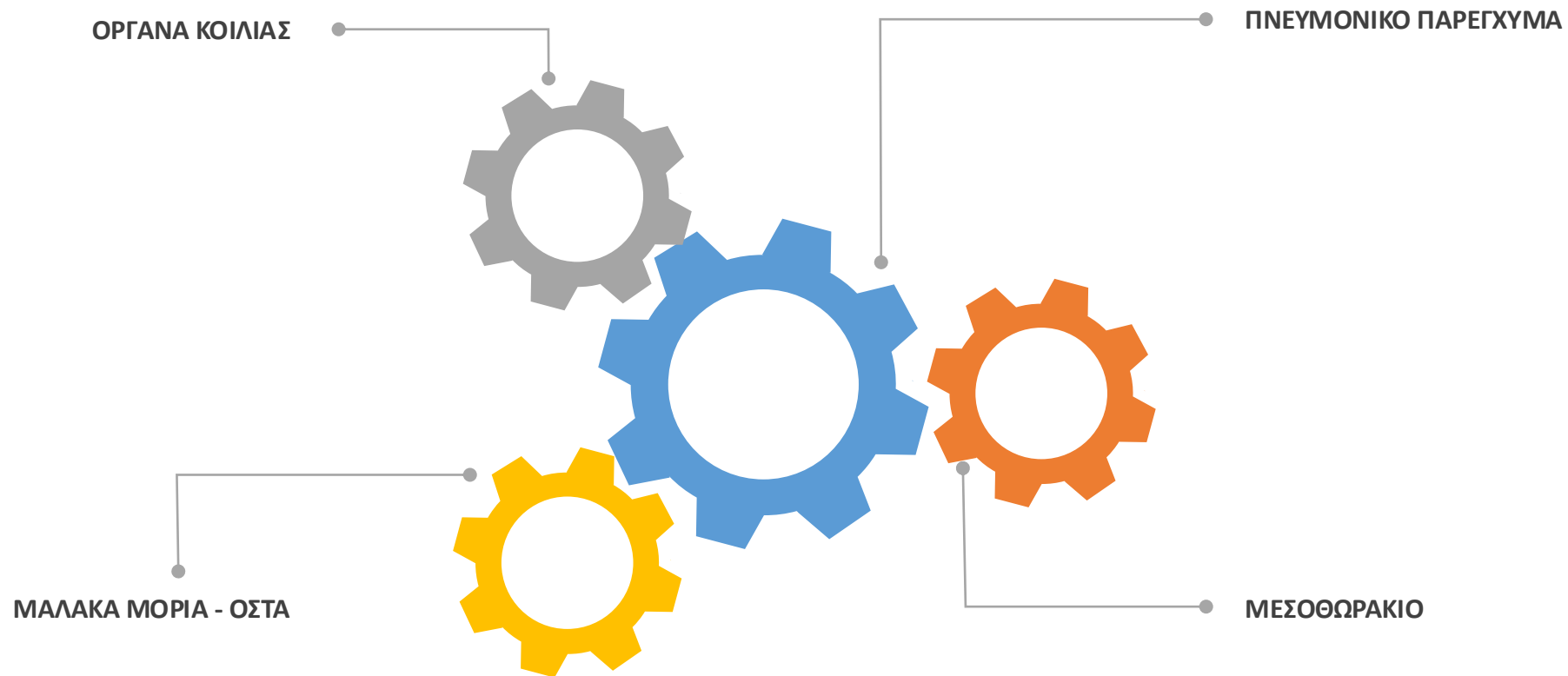
Solid renal masses → Report and trigger an alert

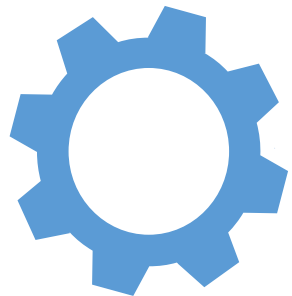
Peritoneum

Nodules, infiltrative masses, haziness, ascites, peritoneal thickening or implants → Report, alert and suggest further evaluation

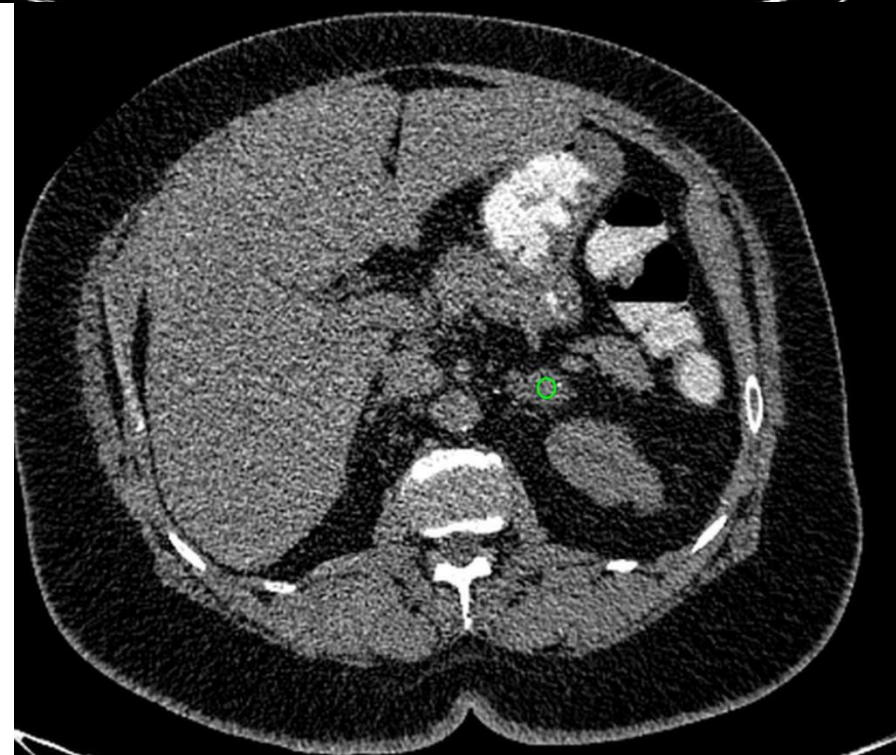
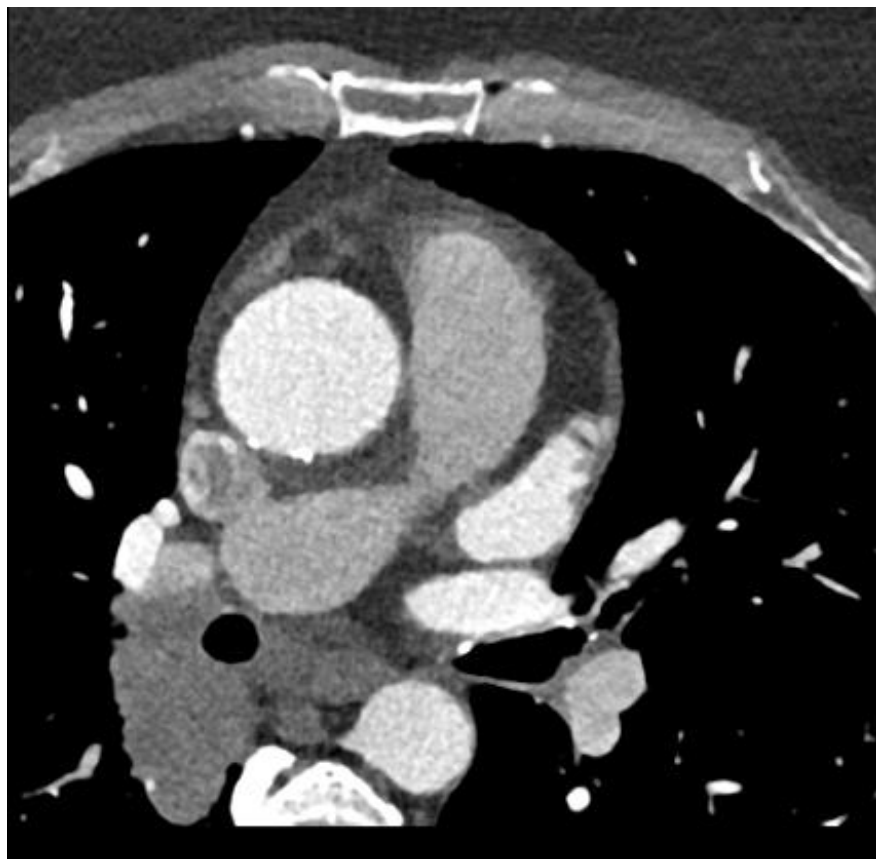
Lymphadenopathy → Report and suggest further evaluation

ΕΞΩΚΑΡΔΙΑΚΑ ΕΥΡΗΜΑΤΑ



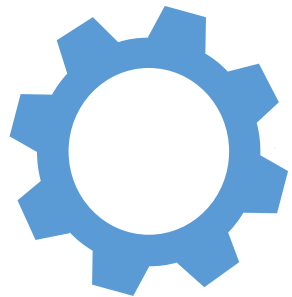


LUNG CASES

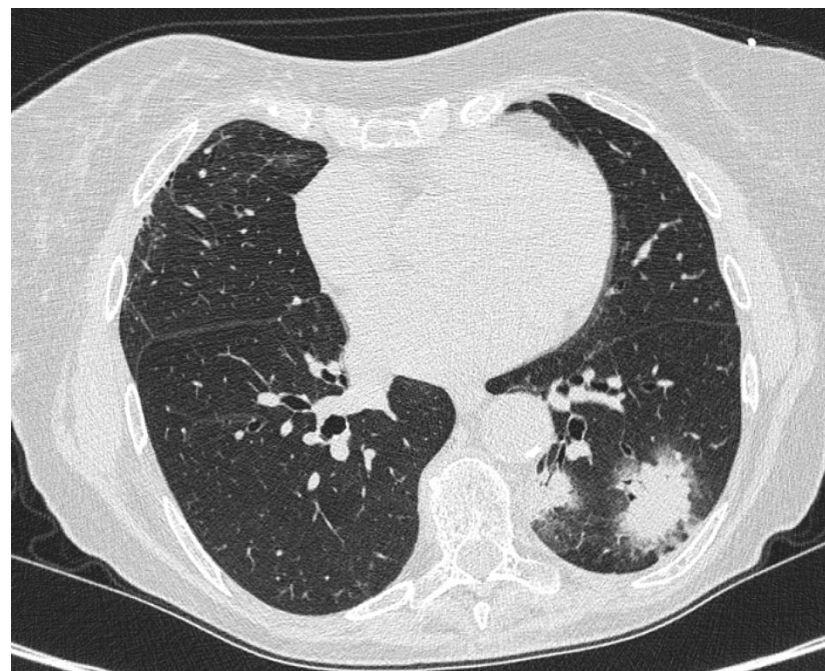
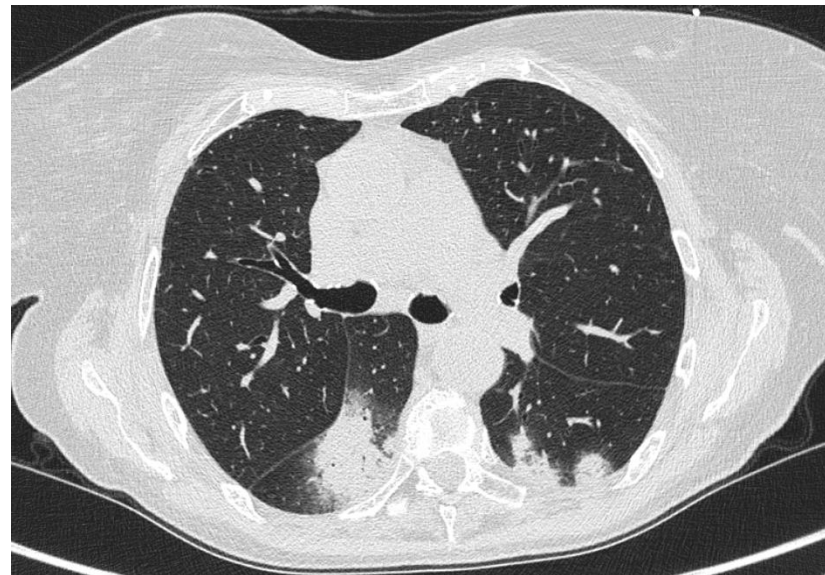


63 yo female for CTCA

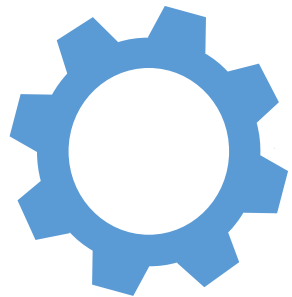
PET/CT & BRONCHOSCOPY



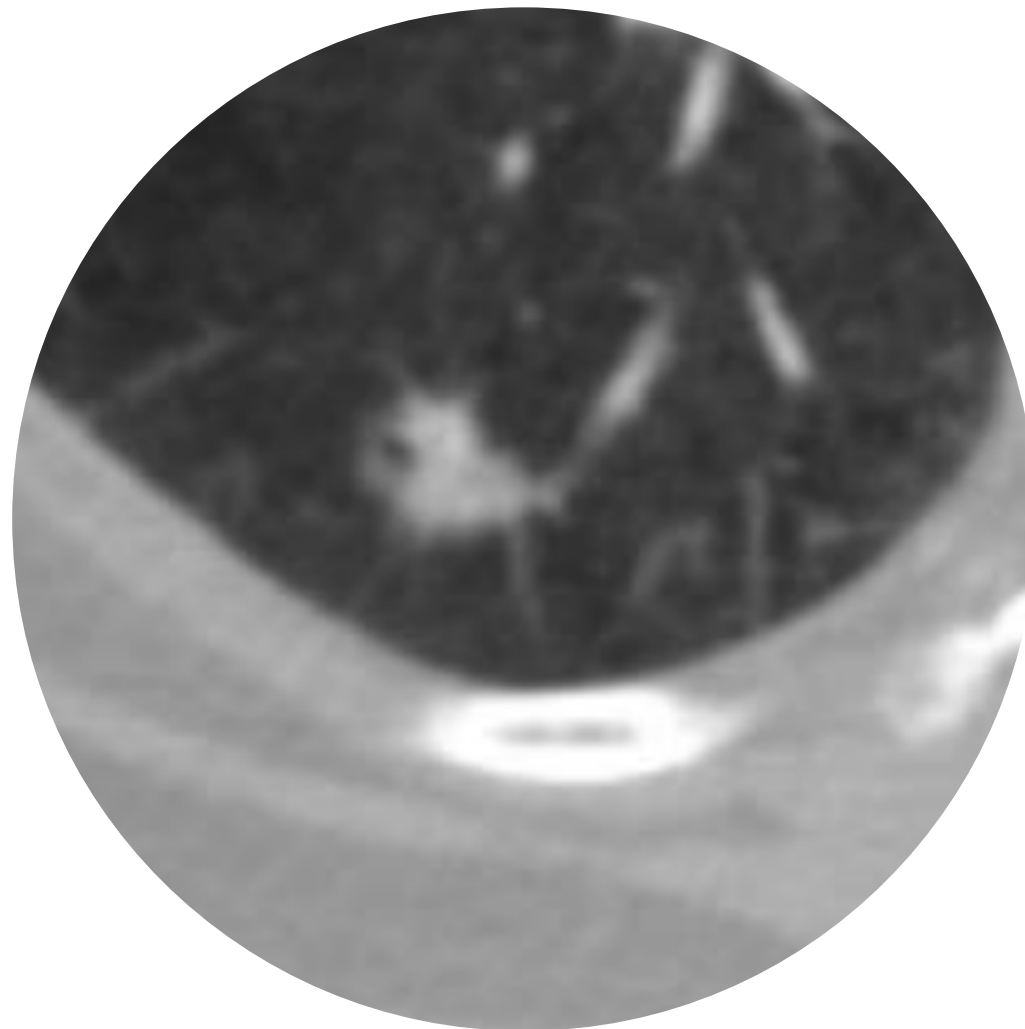
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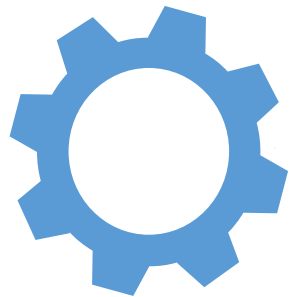


83 yo female for CTCA
Breast cancer history

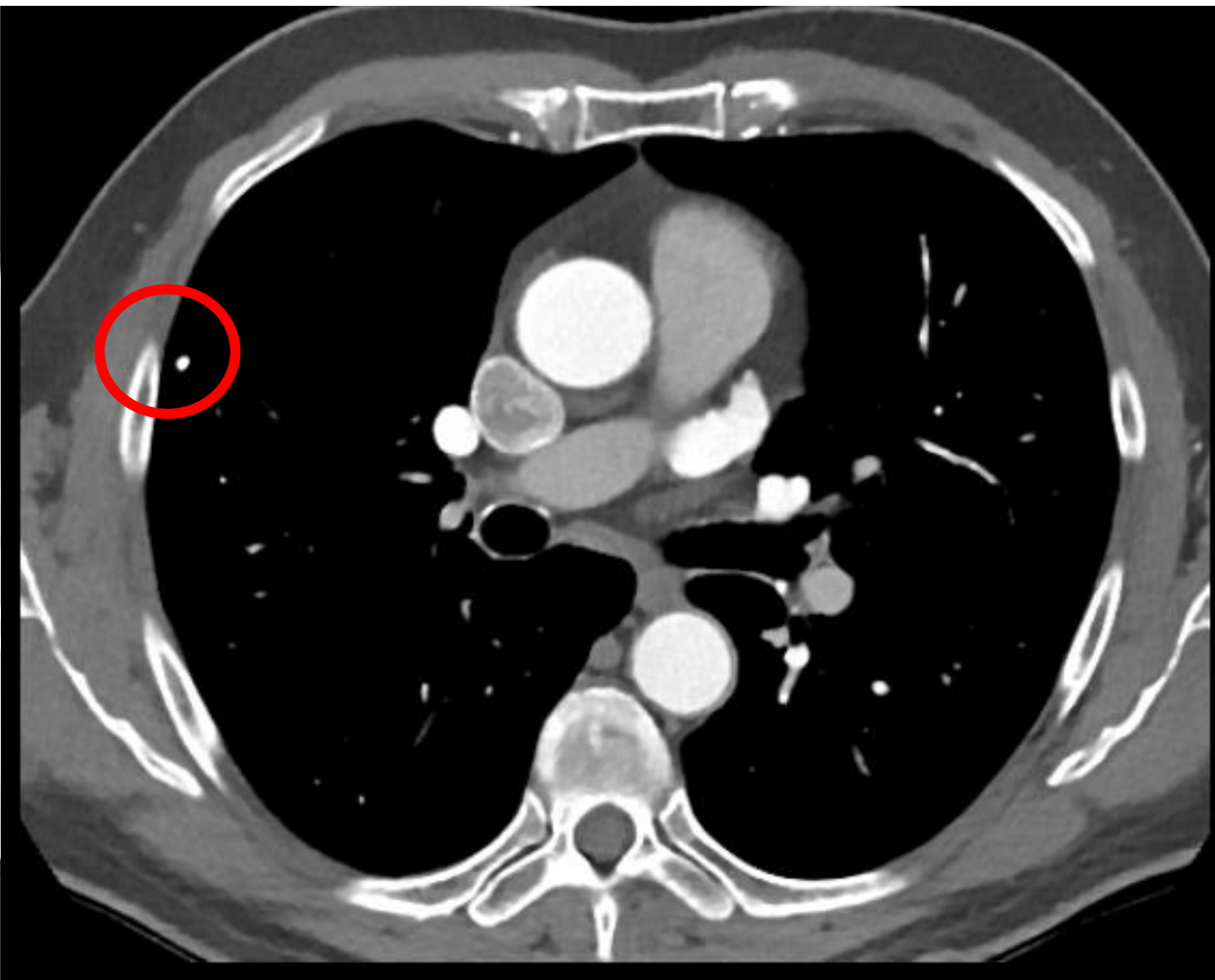
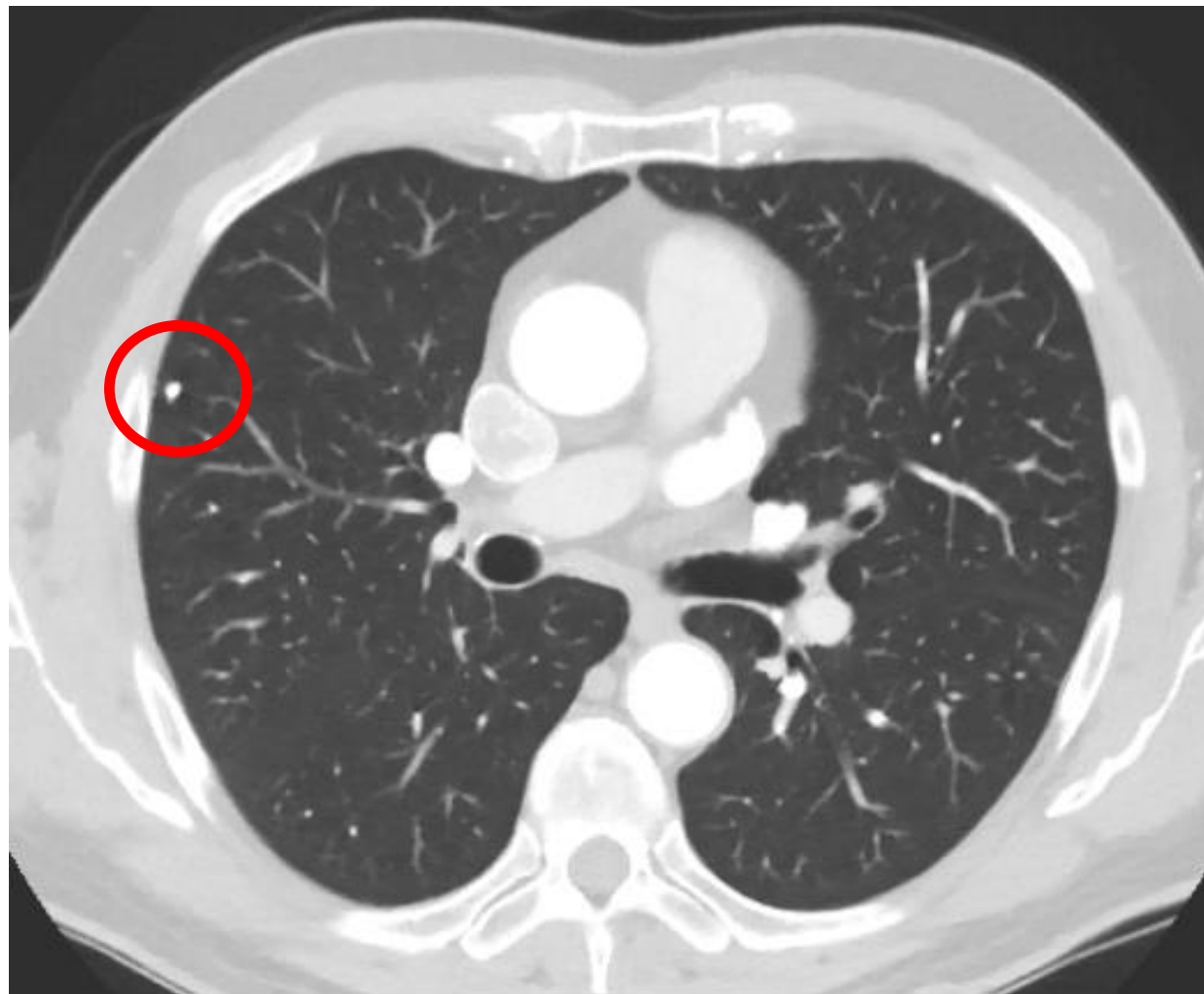


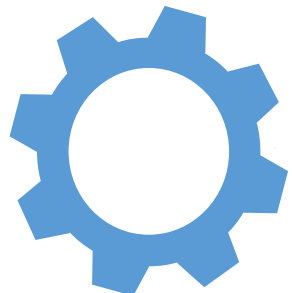
LUNG CASES





LUNG CASES





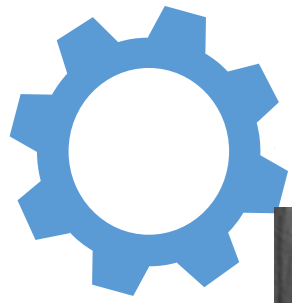
LUNG CASES



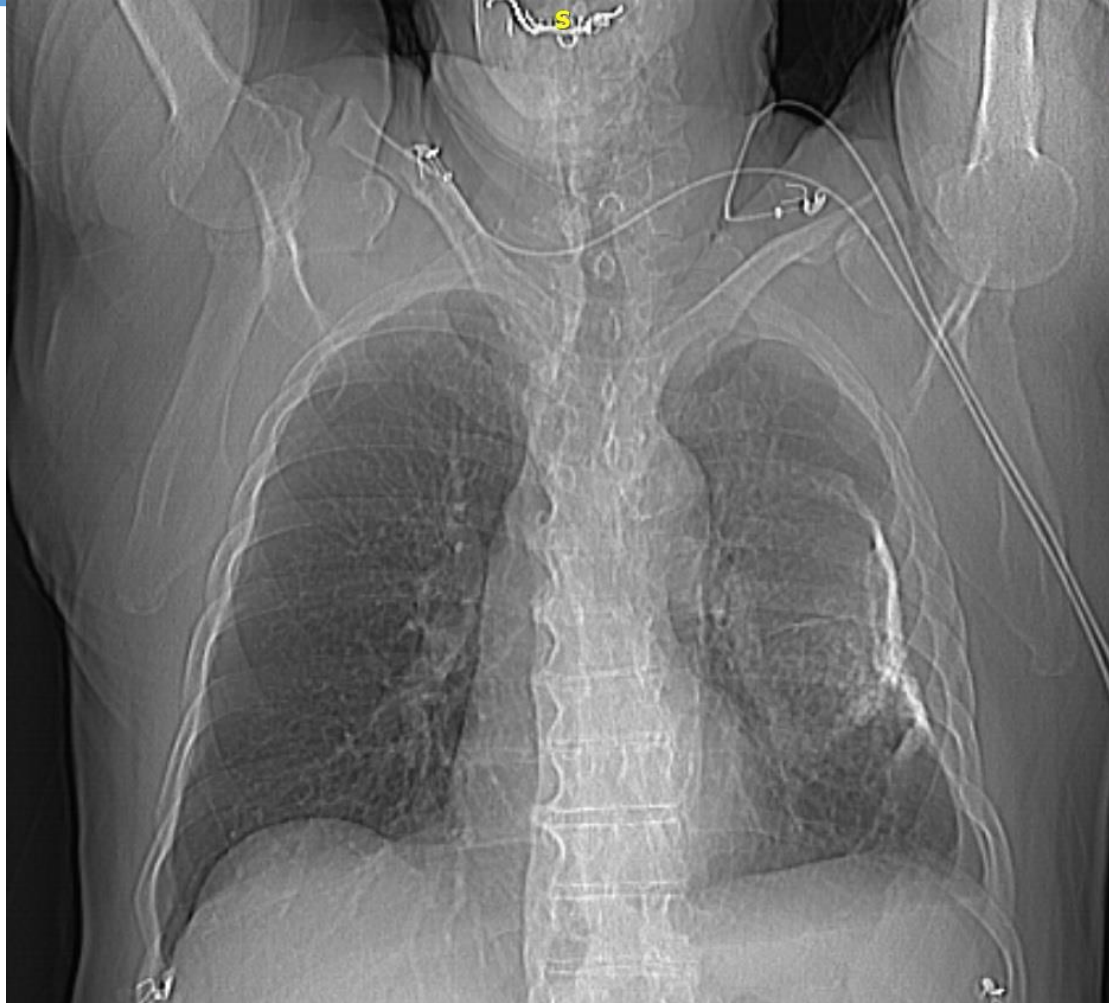
male for CTCA - smokers



Interstitial lung disease

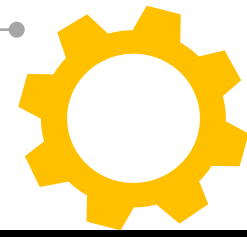


LUNG CASES

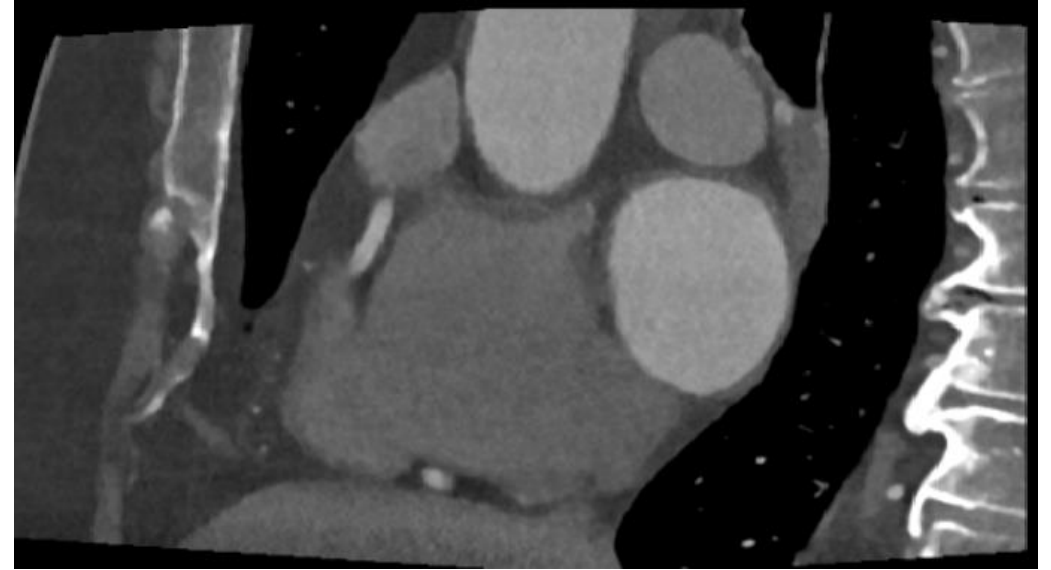
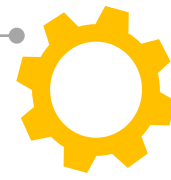


male for CTCA – asbestos exposure

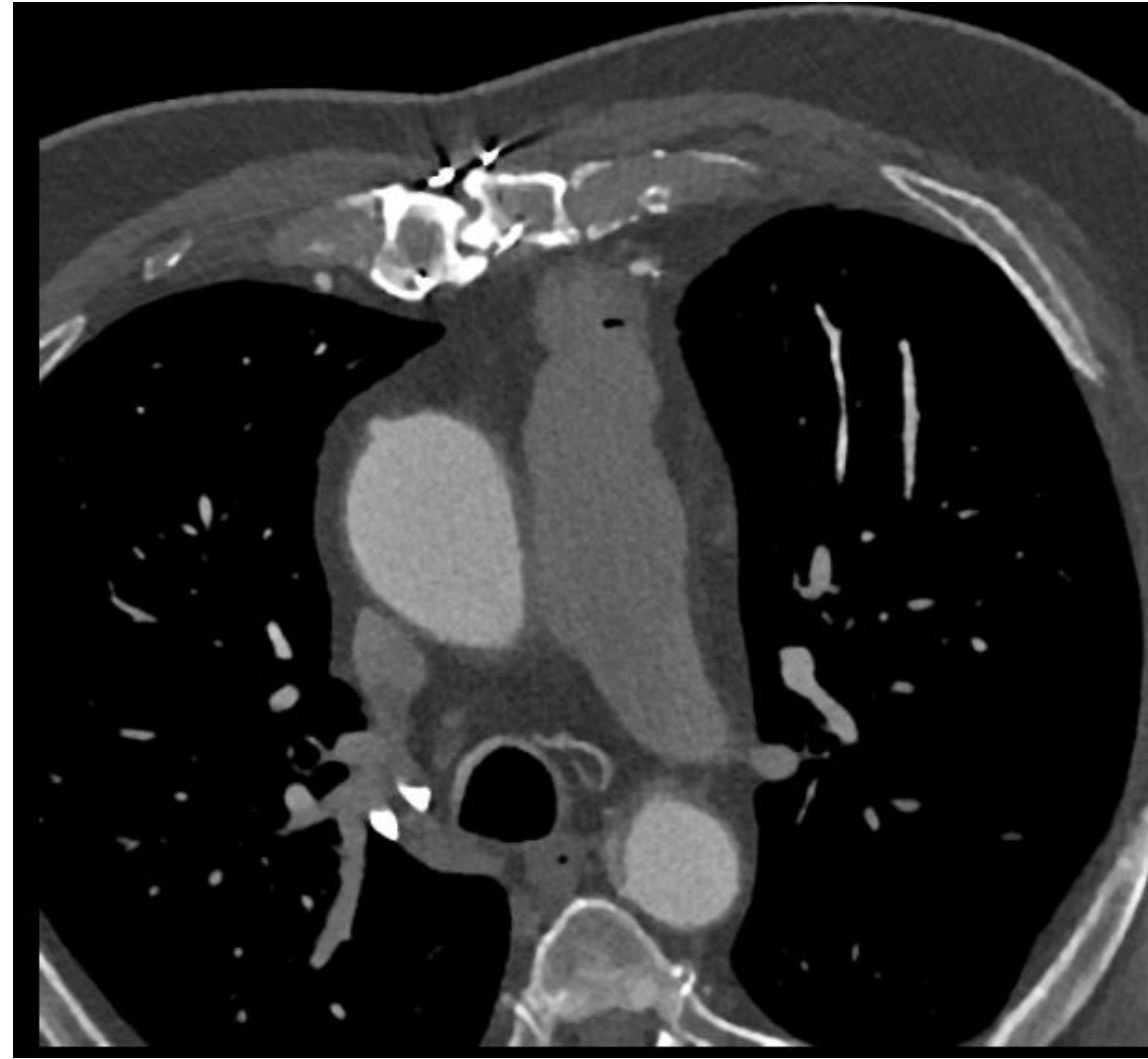
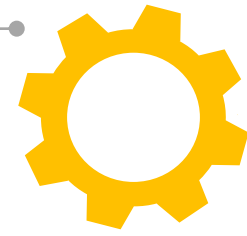
SOFT TISSUE & BONES

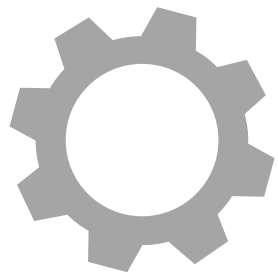


SOFT TISSUE & BONES

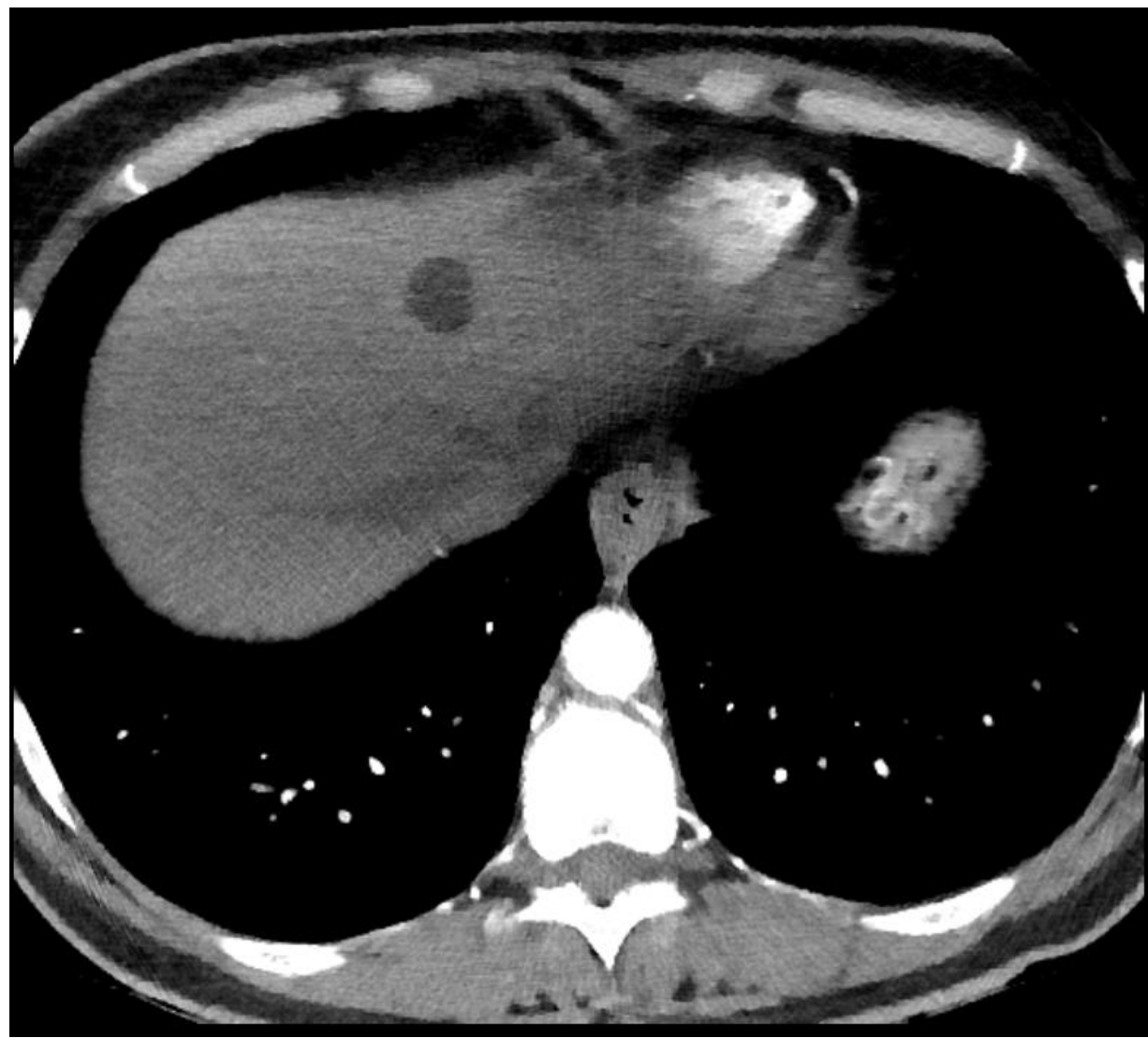


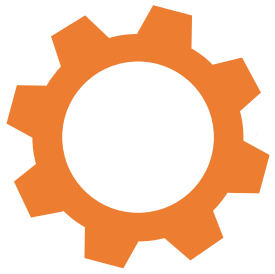
SOFT TISSUE & BONES



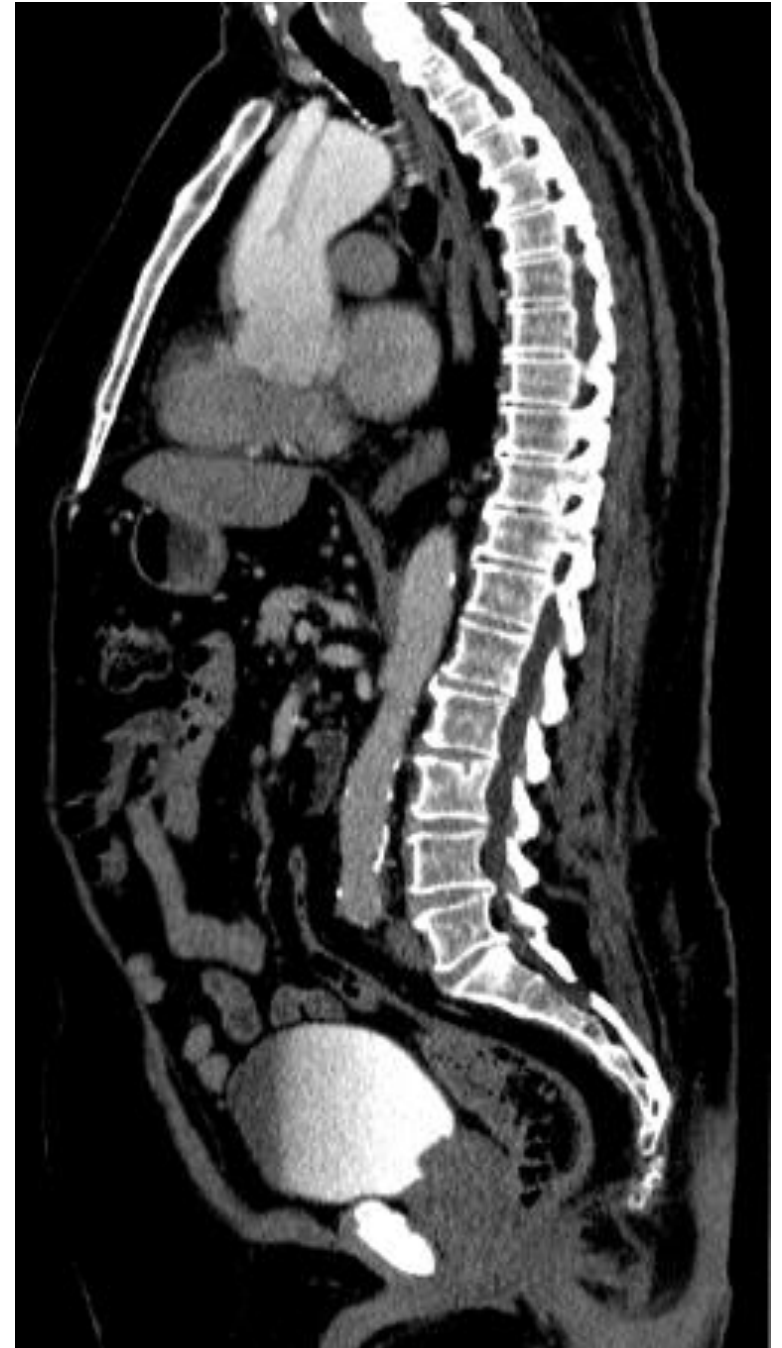


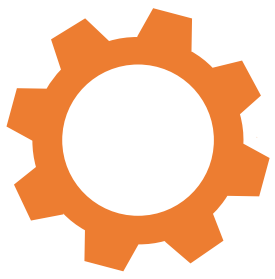
ABDOMEN





MISCELLANEOUS

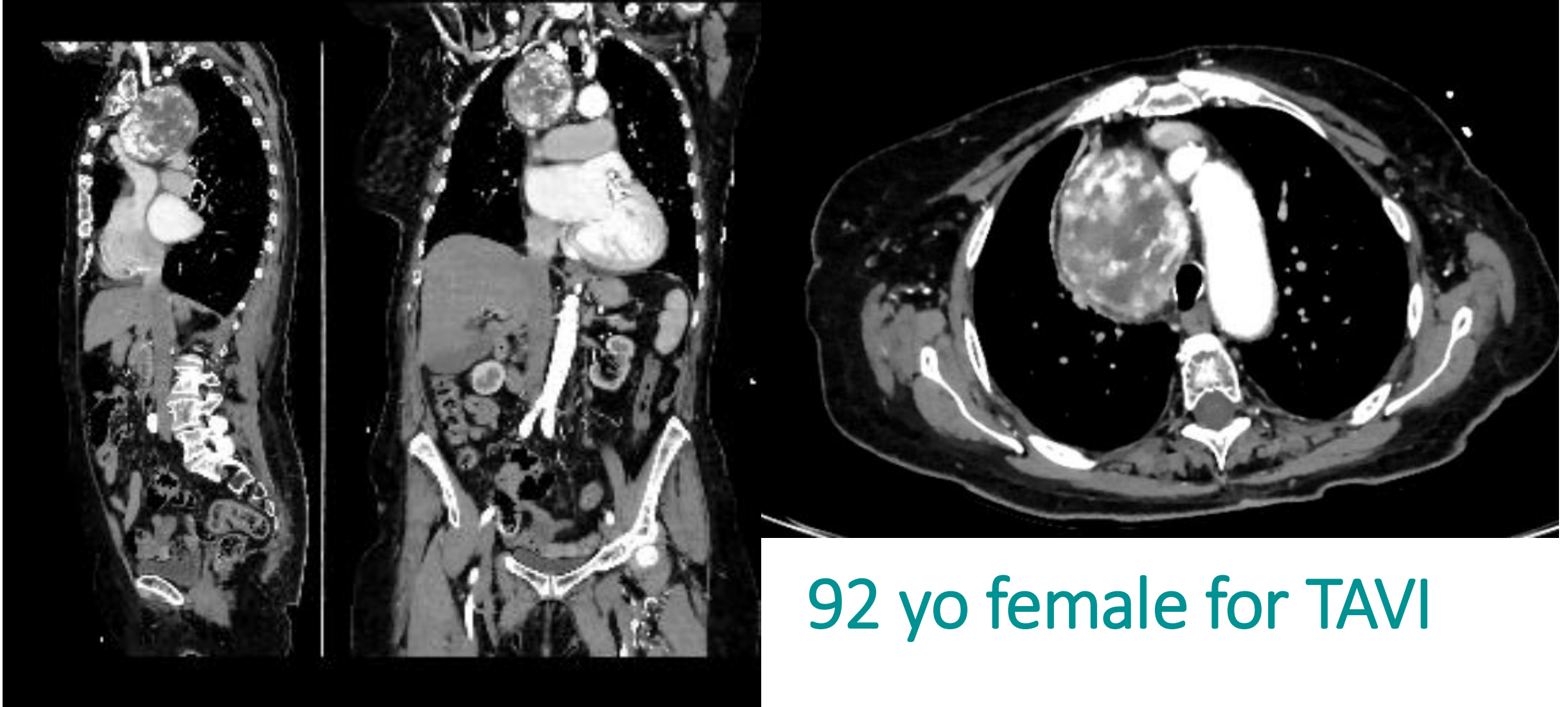




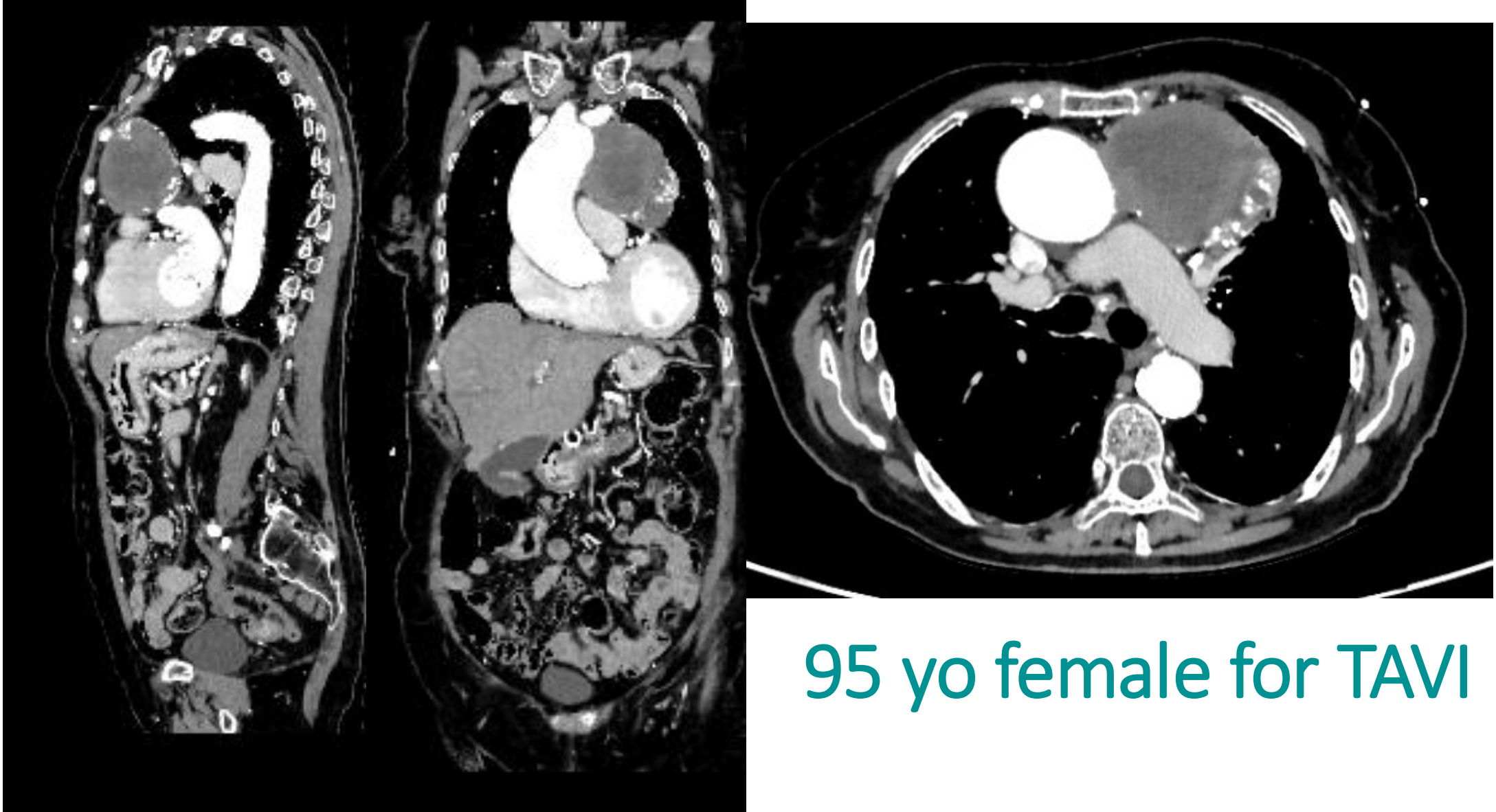
MISCELLANEOUS



TAVI Cases

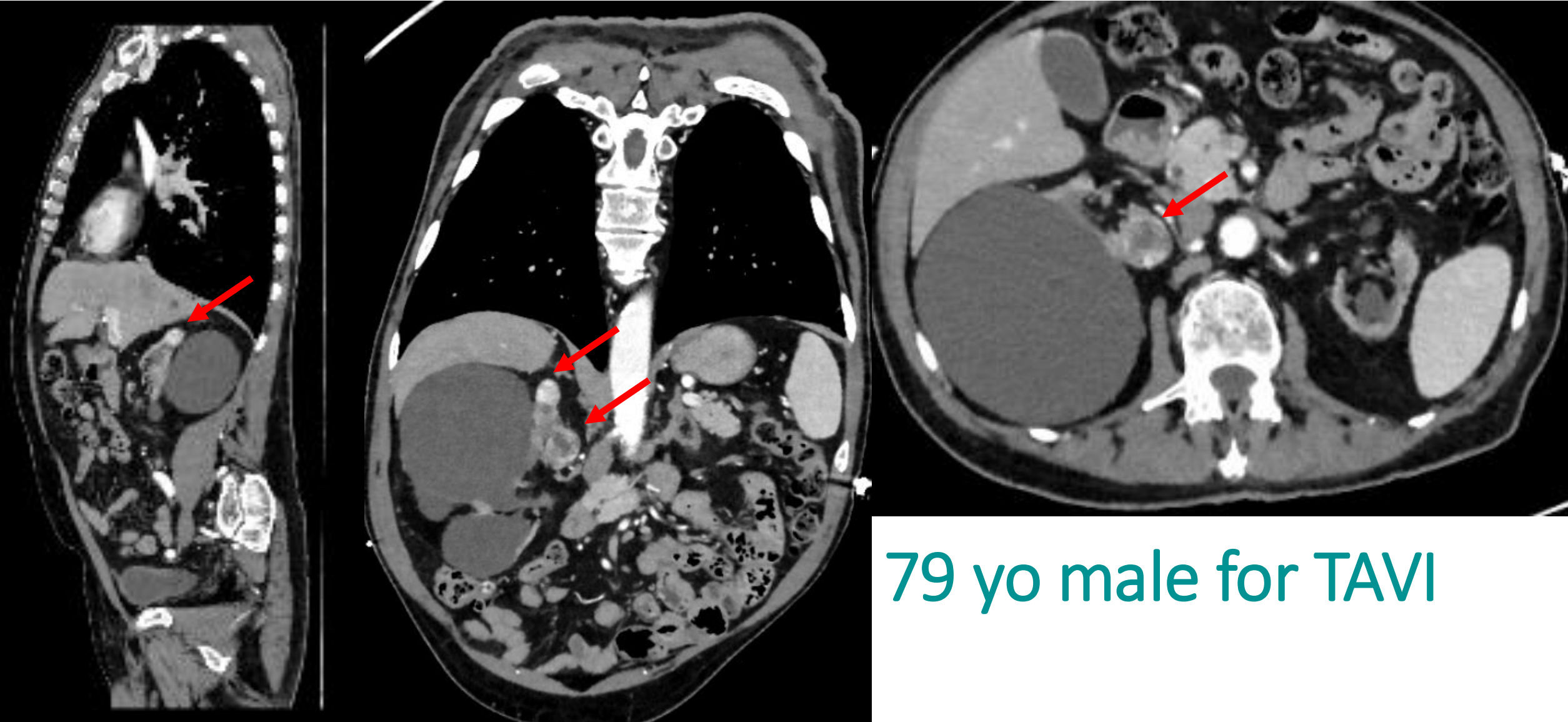


TAVI Cases



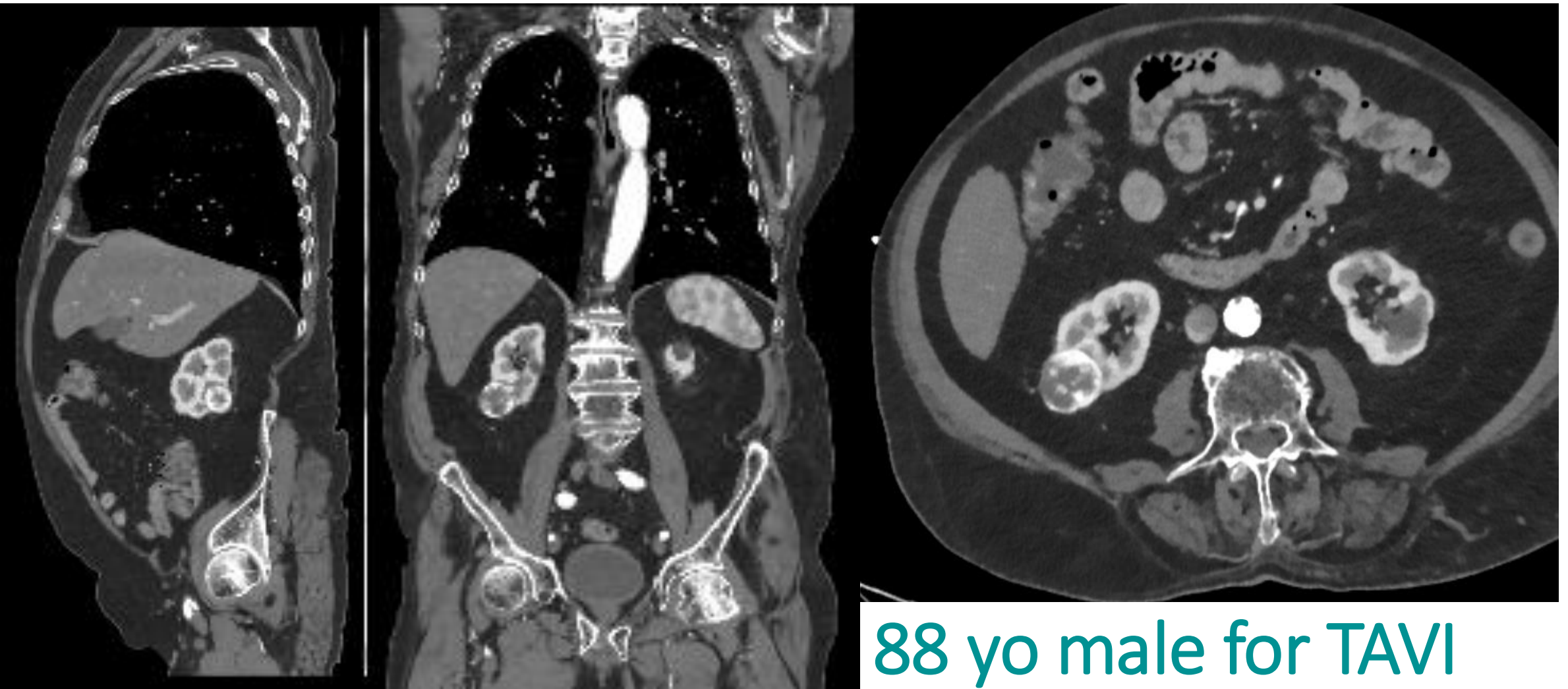
95 yo female for TAVI

TAVI Cases

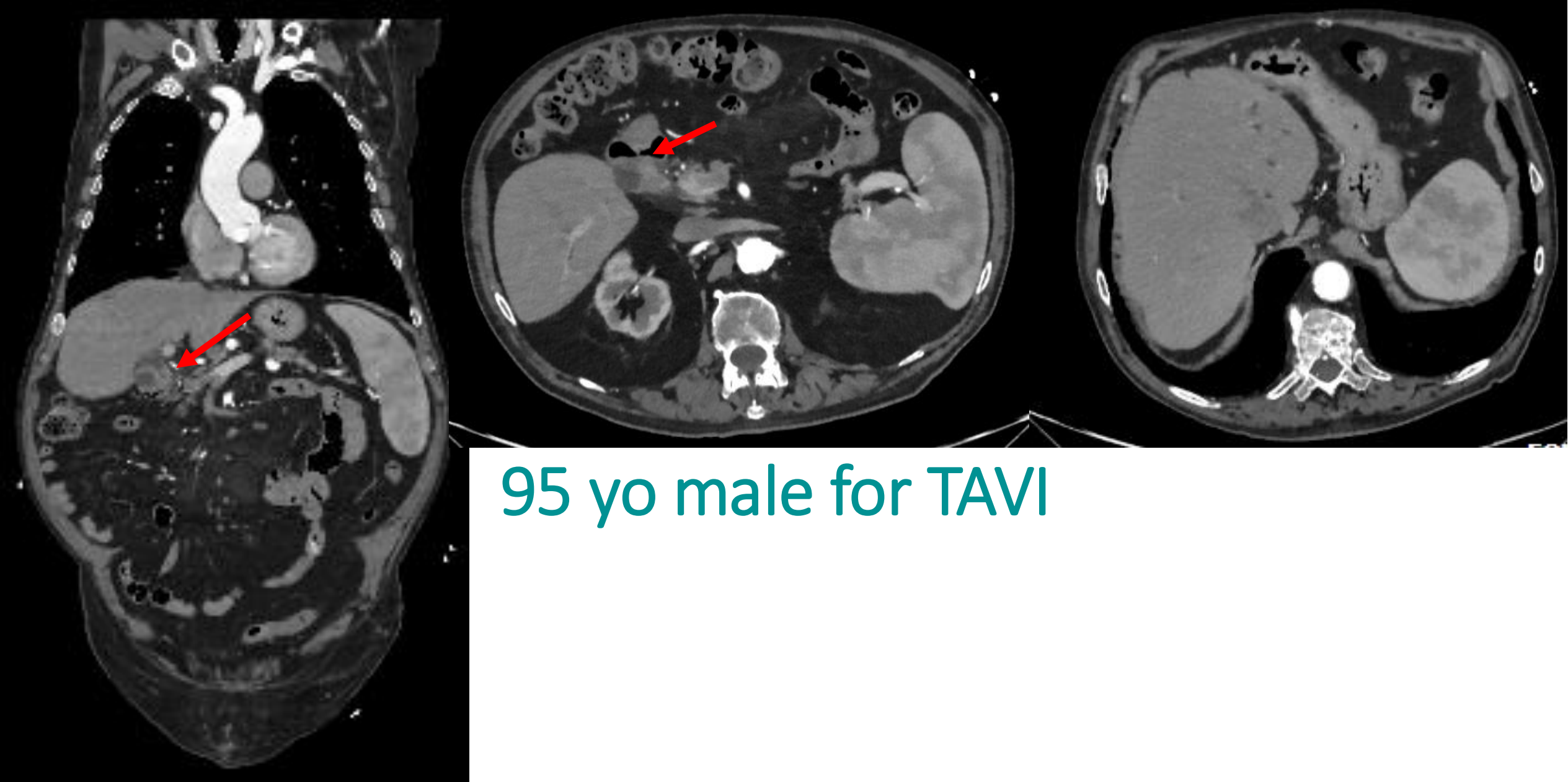


79 yo male for TAVI

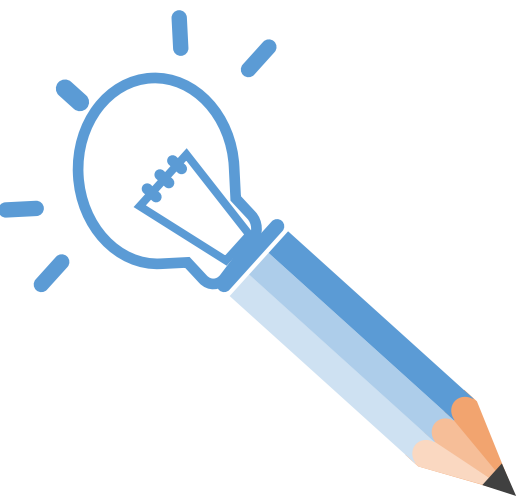
TAVI Cases



TAVI Cases



95 yo male for TAVI



TAKE HOME MESSAGES

- Τα εξωκαρδιακά ευρήματα στην CTCA δεν είναι σπάνια και πρέπει να διαχωρίζονται τα κλινικά σημαντικά που χρήζουν περαιτέρω κλινική αξιολόγηση από τις do not touch lesions
- Είναι πιο συχνά στην TAVI- μεγαλύτερο πεδίο σάρωσης
- Η ηλικία σχετίζεται με υψηλότερο ποσοστό εξωκαρδιακών ευρημάτων
- Επί “αρνητικών” CTCA, η συμπτωματολογία μπορεί να αποδοθεί σε κάποιο εξωκαρδιακό εύρημα π.χ διαφραγματοκήλη
- Εγρήγορση των κλινικών ιατρών και ορθή επικοινωνία με τους ακτινολόγους



ΣΑΣ ΕΥΧΑΡΙΣΤΩ