Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Incidental findings of solitary pulmonary nodules on computed tomographic pulmonary angiography: a hidden workload

Computed tomographic pulmonary angiograms (CTPAs) are increasingly used as the primary radiological investigation in suspected pulmonary emboli.[1] Pulmonary nodules measuring 1–2 mm can now be detected on CT scanning. A small number of these turn out to be malignant and guidelines for follow-up have been suggested.[2] The follow-up of these patients often requires further CT scans and places demands on chest physicians and radiologists.

We aimed to investigate the frequency of incidental solitary pulmonary nodules (SPNs) on CT pulmonary angiograms carried out for suspected pulmonary emboli. Using current guidelines we sought to estimate the impact of these findings in terms of additional CT scans.

The reports of CT pulmonary angiograms carried out over 60 consecutive days in a UK district general hospital were examined retrospectively. In total, 132 CT pulmonary angiograms were performed during this period. Pulmonary emboli were found in 20 studies (15.2%). SPNs were found in 10 studies (7.6%). Six patients had SPNs measuring less than 4 mm. A suggested minimum follow-up for these patients is a repeat CT scan after 12 months, assuming they have a significant smoking history. Four patients had SPNs measuring greater than 8 mm. A further three CT scans over a 24-month period are suggested for these patients, in addition to consideration of positron emission tomography (PET) scans or tissue biopsies. In total, an additional 18 CT scans would be required for this cohort, equivalent to 14% of the original number of CT scans requested. The majority of CT pulmonary angiograms performed were negative for pulmonary emboli. However, additional co-pathologies were identified which potentially generated significant extra CT scan requirements and subsequent follow-up. This may have important resource implications that may not have been envisaged at the time of change to CTPAs from isotope lung scanning for the diagnosis of pulmonary emboli.

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References

1 British Thoracic Society guidelines for the management of suspected acute pulmonary embolism. *Thorax* 2003;58:470–83.
2 MacMahon H, Austin JH, Gamsu G *et al.* Guidelines for management of small pulmonary nodules detected on CT scans: a statement from the Fleischner Society. *Radiology* 2005;237:395–400.