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Customer Complaint Policy

POLICY STATEMENT

Inverness Leisure aims to provide its customers, partners and suppliers (our stakeholders) with an excellent customer service. The Organisation will listen to the needs of our stakeholders and provide opportunities for feedback.

1. INTRODUCTION

Inverness Leisure wishes to put customer needs at the very heart of the way we develop and enhance our services. Customer feedback is part of our ongoing consultation process which we will use to learn and continuously improve our service.

We will promote the use of customer feedback via our comments system, customer surveys, mystery shoppers, social media, website and face-to-face interaction. Customer feedback will be analysed and viewed as an opportunity to assist in continuous improvement of our service.

The Inverness Leisure Mission Statement & Customer Promise document will underpin our service delivery in line with the values, aims and objectives of the company.

We will ensure that all our associates are trained and therefore competent in the delivery of excellent customer service and are fully aware of the relevant company policies and procedures. Associates will be encouraged to respond positively, be problem solvers and successfully resolve any issues as quickly as possible, and to refer on those which are more complex or remain unresolved.

2. REFERENCE DOCUMENTS

INTERNAL

Inverness Leisure Mission Statement & Customer Promise Customer Comment Response Procedure FAA - 1075 Customer Comments Database (CFS)

EXTERNAL

SPSO Guidance on a Model Complaints Handling Procedure

Data Protection Act 1998 Personal Safety at Work H&S 2.29

3. WHAT IS A COMPLAINT?

An expression of dissatisfaction by one or more people about the standard of service provided by Inverness Leisure.

Safety Training Needs Assessment Form

Instructions: Peace review each question and either check "YES" or "NO". If a question is checked "YES" you will be required to complete the training topic before initial assignment of job task. Peace discuss with your supervisor and have him/her sign the form. Pleace review the EH&S website for registration information.

Safety Training Needs Assessment	Department:
Employee Name (Print):	Employee (Signature):

Supervisor Name:		Supervisor (Signature):	Date:	
Read and answer each question. If answer is Answer yes, see middle column for training, right column for traguency of training.		Taining	RequiredOptional, Prequency	
Do you receive a paycheck from UNC Charlotle (regardless if you are a student worker or fullipart time employee()?	⊡Yes ⊡No	Departmental Safety Checklist & New Employee Orientation (NEC) • Supervisor safety hazard and safe operating procedure discussion. • Accident Prevention, Investigation and Reporting • Back Safety and Injury Prevention • Building Emergency Evacuation Plan • Fire Safety and Prevention • Sigs, Trips, Falls	REQUIRED TRAINING: Initial REGISTRATION: Atland New Employee Orientation (NEO) sponsored by Human Resources Department or complete Skilport online modules Duration: 2-4 hours	
lo you operate scissor lifts, man lifts or ther aerial elevating platforms?	⊡Yes ⊡No	Aerial Lift Training	REQUIRED TRAINING: Periodic REGISTRATION: EH&S. Duration: 2-4 hours	
Are you an employee of the University?	⊡Yes ⊡No	Accident Reporting and Investigation	REQUIRED TRAINING: Periodic REGISTRATION: NEO or Shilport Duration: 1 hours	
lo you work for maintenance, custodial, ir facility operations <u>AND</u> disturb esbestos?	⊡Yes ⊡No	Asbestos Awareness	REQUIRED TRAINING: Annual REGISTRATION: EH&S Duration: 1 hours	
Does your work require you to lift heavy objects or repeatedly move or carry terns throughout the day?	our work require you to lift heavy or repeatedly move or carry troughout the day?		REQUIRED TRAINING: Pariodic REGISTRATION: NEO or Skilport Duration: 1 hours	



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Massage Therapy Services' Consent Form

THIS FORM MUST BE COMPLETED & SIGNED BEFORE RECEIVING A MASSAGE

which areas would you like to focus on during this massage? Do you have any of the following conditions? If yes, please explain below as clearly as possible. Stress Allereies Contacture disease Diabetes Wear contact lenses Back pairs
Do you have any of the following conditions? If yes, please explain below as clearly as possible. Stress Allereins Contacious disease Diabetes Wear contact lenses Back pain
Stress Allergies Contagious disease Diabetes Wear contact lenges Back pain
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Pregnant Cancer Cardiac/circulatory problems Arthritis Sensitive to touch or press
Frequent headaches Osteoporosis Epilepsy or seizures Bruise easily Joint swelling
Varicose veins Depression
Numbness or stabbing pains? Explain below.
High blood pressure. If yes, are you taking medication for this? Explain below.
Surgery in the past five years? Explain below.
Accident or suffered any injuries in the past 2 years? Broken bones, etc. Explain below.
Other medical conditions not listed. Explain below.
Comments:

which body areas will be worked on, the reasons why I should have treatment, the alternatives to having treatment, what may happen if I do not have treatment.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strakes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental liness, and that nothing

said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, Laffern that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any elicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. Labo understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Patient Signature:	Date
THERAPIST'S SINGTURE:	Date

	-		<u></u>	
	Fasting	Normal values		Observation
Complete Blood Count (CBC)	Fasting	not essential		
RBC (Erythrocytes)	No	M-4.5-6.4 F-4.0-5.4	Mil. / c. mm	If less: anemia
Haemoglobin	No	M-14-18 F-12-16,4	Gm / 100 ml	
PCV (RBC)	No	M-42-52 F-37-47	%	
MCV (Mean corpacells volume)	No	78-94	Fl. Cu	Type of anemia
MCH	No	27-32		
MCHC	No	32-38	Gms/dl %	
WBV (Lescocytes)	No	4000-	Per c.	If less-susceptibility to
				If very high in Lacs- Leukemia
Differential WBC count	No	alexander de	.96	
Neutrophils	11 - 11 - 1 2	60-75		If more-acute infection
Lymphocytes	8 8	20-30		If more-chronic infection
Monocytes		2-8		If more-T.B. Typhoid, urinary infection
Esoinophils	()	1-6		If more-allergy, cough, cold, asthma, and worms,
Basophils	8 8	0-1		Led poisoning, Leukemia
Abnormal cells	Q 8		2	
Platelets	No	150000-	Cu. Mm	If less-bleeding disorder, dengue,
Peripheral smear	No			A CONTRACTOR OF THE OWNER OWNE
Morphology of:			0.0000	
RBC	No	Normochromic /Hypochromic / Anisocytosis		
Observation	2 2	Normal / Anaemia /size of RBC differs		te of RBC differs
WBC	No			
Blood Parasites	No		3	MP, Filaria
Reticulocytes	No	0.5-1.57 0.2-2.2		If more-anemia
Color Index	No	0.85-1.15	S	
In bacterial infection with feve Pneumonia, appendicitis, urina infection = WBC may be norm	r, WBC o ry infect	count goes up ion 12000-2	E.g. Ton 25000 WB	ullitis, sinusitis, bronchitis, IC, In Typhoid & viral

Coronary bypass graft fate and patient outcome: angiographic follow-up of 5,065 grafts related to survival and reoperation in 1,388 patients during 25 years. Patients were advised to exhale slowly if they could not maintain breath-holding throughout the examination. Although bypass graft occlusion was not routinely confirmed on catheter angiography, the rates of graft failure are concordant with the published literature [8]. Automated bolus timing was performed using a threshold value of 150 H and a region of interest was placed over the ascending aorta. In an effort to evaluate the internal mammary arteries, the CABG CTA protocol extends more cephalic than a typical cardiac CTA examination. Nearly every coronary bypass patient has known ischemic heart disease. None of the internal mammary artery grafts occluded. Hypertension. [3] examined patients who underwent a cardiac EBCT examination for calcium scoring or coronary angiography. Nevertheless, cardiac CTA has shown greater than 90% sensitivity and specificity for detection of graft occlusion using invasive angiography as a standard of reference [11-14]. In summary, cardiac CTA performed after CABG surgery is valuable to determine graft patency and also frequently detects clinically occult and potentially life-threatening abnormalities. AJR. A pitch of 0.2-0.3 was used with a scanner rotation time of 0.42 second. I Thorac Imaging, Therefore, the discovery of complicating conditions, such as intracardiac thrombi, myocardial perfusion deficits, and ventricular aneurysms, from significant coronary artery disease is not surprising. Five patients had two noncardiac findings (1.9%). A finding was judged potentially significant if a therapeutic intervention or radiologic follow-up was deemed advisable on the basis of the cardiac CTA. The patency of each graft was assessed. [PubMed] [Google Scholar]10. 7) were saphenous vein grafts. 1996;28:616-626. The second adrenal mass remained indeterminate on follow-up abdominal CT. [1] reported that 7.8% of patients undergoing coronary calcium scoring required additional workup for noncardiac disease. It has been proposed that subacute premature saphenous vein graft failures (i.e., the additional grafts that occluded after the early postoperative period) are due to neointimal hyperplasia, which predominately affects venous but not arterial grafts [9, 10]. This study has important clinical ramifications. Pulmonary hypertension was designated if the main pulmonary artery diameter was greater than 3.1 cm. The scanning protocol included collimation of 0.75 mm × 16 with section thickness of 1 mm. All images were reconstructed with a small field of view centered on the heart. In the immediate postoperative period, 259 patients (mean age, 63.7 years; age range, 37-89 years; 73.4% men, 26.6% women) underwent a routine contrast-enhanced cardiac CTA examination. 2006;27:976-980. For each patient, retrospective ECG-gated images were obtained through the entire chest during a single breath-hold beginning at the inferior margin of the heart and extending to the top of the lung apices (Fig. The purpose of our study was to retrospectively assess the prevalence of unsuspected disease identified on cardiac CTA examinations after CABG and to determine their potential clinical significance.CTA was performed postoperatively in 259 patients (mean, 5.2 days), and 40 patients underwent a follow-up CT scan (mean, 12.7 months). Common and expected postsurgical findings (e.g., small pleural or pericardial effusions, pneumomediastinum, mild pulmonary edema, etc.) were not included. Iodinated contrast material (120-150 mL) was injected through an 18- to 20-gauge angiocatheter into an antecubital vein at 3-4 mL/s. Four patients (10.0%) had at least one graft occlusion.Cardiac CTA after CABG revealed a high prevalence of unsuspected cardiac and noncardiac findings with potential clinical significance. The grafts were graded as occluded or nonoccluded. In each patient, a phase obtained at 75% of the R-R interval was reconstructed and used for primary analysis. [PubMed] [Google Scholar]13. Three patients had two cardiac findings (1.2%). The most common cardiac findings were a moderate or large pericardial effusion (Fig. Noncardiac was classified as pulmonary, mediastinal, pleural, or involving the upper abdomen. 1995;26:38-43. Several issues may account for this discrepancy. Wider field of view images (x, y direction) were not reconstructed from the raw data.Each examination was interpreted at the time of scanning by a thoracic radiologist. 2005;184(American Roentgen Ray Society 105th Annual Meeting Abstract Book suppl):3. Motwani JG, Topol EJ. Initial experience with 64-slice cardiac CT: non-invasive visualization of coronary artery bypass grafts. 2 and 8), intracardiac thrombi (Figs. For accurate image acquisition, sinus rhythm was required, with a mean heart rate less than 100 beats per minute. Average scanning time was 30-40 seconds. [PubMed] [Google Scholar]2. [5] and Onuma et al. The prevalence of graft disease and incidental findings (cardiac and noncardiac) was established. Because our patient population recently had undergone major cardiovascular surgery and have known ischemic heart disease, we cannot generalize these findings for outpatients or patients with suspected coronary artery disease. One consideration is that the patient cohort in our study is presumably a higher risk group than the majority of patients who undergo cardiac CTA as outpatients. Therefore, determining if a therapeutic intervention or specialty consult was ultimately performed or planned on the basis of the imaging interpretation alone was sometimes difficult. Pache G, Saueressig U, Frydrychowicz A, et al. Bias was introduced because of the retrospective design of the study. Most studies, including this one, define "significant" or "potentially significant" if imaging follow-up or a therapeutic intervention was advised. Moore RK, Sampson C, MacDonald S, Moynahan C, Groves D, Chester MR. Am Heart J. These findings included a new left subclavian artery thrombus, pulmonary edema, apical left ventricular perfusion defect, moderate pericardial effusion, new central venous obstruction, and moderate-sized pleural effusion. 2005;150:775-781. In a later study, Schragin et al. In addition, previous incidental MDCT cardiac CTA studies have focused on patients were treated conservatively. With respect to bypass graft assessment, one or more bypass grafts were occluded in 17 patients (6.6%) in the immediate period. One patients (and in four patients (6.6%) in the immediate period. One patients (6.6%) in the immediate period and in four patients (10.0%) in the late postoperative day 5.2 (range, 1-38). Cardiac CT angiography (CTA) examinations are typically acquired with a small field of view focused on the heart, but portions of the lungs, pleura, chest wall, mediastinum, thoracic skeleton, and upper abdomen are often included as part of the examination. [PubMed] [Google Scholar]9. Bypass graft occlusions were analyzed separately. In the immediate postoperative period, 51 patients (19.7%) had at least one unsuspected, potentially significant finding. The remaining 26 patients (10.0%) were lost to follow-up or did not have further intervention to our best knowledge. An institutional review board exemption was granted for this study, and the study was performed in compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations.CT angiography was acquired using a 16-MDCT scanner (MX8000 IDT, Philips Medical Systems). We retrospectively evaluated the frequency of unsuspected cardiac and noncardiac disease in patients who underwent cardiac CTA for routine assessment of coronary artery bypass graft (CABG) patency. Patients who receive CABG at the University of Maryland Medical Center often undergo cardiac CTA to assess for graft patency as part of their routine postoperative care. Dobrin PB. Clin Radiol. Circulation. Several studies have assessed the frequency of incidental findings in the context of various types of cardiac-focused CT examinations [1-7]. A modest body of literature has been published concerning incidental findings on unenhanced EBCT scans obtained for coronary calcium scoring (1-3). This may explain the lower rate of abnormalities with potential clinical impact detected in the EBCT studies. The prevalence of incidental findings was found to be higher with the use of IV contrast. Axial CT image shows anterior ventricular pseudoaneurysm (white arrow) and large hemopericardium (open arrow). Patel S, Woodrow A, Bogot N, et al. However, limited information exists regarding the prevalence of clinically significant incidental unsuspected findings in patients undergoing CTA [3-7]. In the later postoperative period, seven patients (17.5%) had a potentially significant unsuspected finding. A moderate or large pericardial effusion was denoted by fluid completely encircling the heart. Graft abnormalities were analyzed separately. Hunold P, Schmermund A, Seibel RM, Gronemeyer DH, Erbel R. Nearly all graft failures involved saphenous vein grafts and none occurred with internal mammary grafts. A fourth patient is scheduled for CT follow-up. Onuma Y, Tanube K, Hatori M, et al. Patients who underwent scanning for nonroutine cardiopulmonary disease were excluded. 2006;48:402-406. These studies differ from the current study in that they were performed with relatively thick sections (3 mm) and without the use of IV contrast material, precluding evaluation of cardiovascular and mediastinal structures. 3 and 4) (six patients, 2.3%), and substantial paracardiac or mediastinal hemorrhage (six patients, 2.3%). Cardiac disease was documented if the abnormality was paracardiac, pericardial, or within the heart itself. Bypass graft patency is a common indication for cardiac CTA, particularly among patients with recurrent symptoms after CABG. [4] showed that 4.8% of patients undergoing cardiac finding. 6). Haller S, Kaiser C, Buser P, Bongartz G, Bremerich J. Fitzgibbon GM, Kafka

HP, Leach AJ, Keon WJ, Hooper GD, Burton JR. Coronary artery bypass graft imaging using ECG-gated multislice CT: comparison with the spectrum of these abnormalities. Keywords: bypass, cardiac imaging, CT coronary arteriography, lung diseases ECG-gated cardiac CT, initially with electron beam CT (EBCT) and more recently with MDCT, is increasingly being used to evaluate the coronary arteries and to provide an assessment of noncoronary arteries and to provide an assessment of noncoronary arteries and 34 patients (13.1%) had a noncardiac finding including pulmonary embolism, lung cancer, or pneumonia. Including the superior thorax with a longer z-axis area of coverage allows additional abnormalities to be detected (Fig. One mass was diagnosed as a lipid-rich adrenal adenoma. 2002;106:532-537. 5) (five patients, 1.9%) were most frequent (Table 1) (five patients, 1.9%) were most frequent (Table 2) (five patients, 1.9%) (five patients, 1.9%) were most frequent (Table 2) (five patients, 1.9%) (five patients, 1.9\%) (five p 1).45-year-old man who underwent cardiac CT angiography 6 days after coronary bypass grafting surgery. [6], the rate of significant noncardiac findings requiring further investigation or treatment on contrast enhanced cardiac CTA examinations was 16% in both studies. When radial grafts were used, spasm was defined as a patent graft with diffuse narrowing. This highlights the need to evaluate extracoronary cardiac structures as well as the noncardiac anatomy on every cardiac extracoronary extracoronar patients was based on the combination of the CT interpretations and the low hemoglobin levels. Schragin JG, Weissfeld JL, Edmundowicz D, Strollo D, Fuhrman CR. A small pericardial fluid did not completely encircle the heart. Non-cardiac findings in coronary imaging with multi-detector computed tomography. In addition, long-term clinical and imaging follow-up were not available in many patients with a significant finding. [PubMed] [Google Scholar]14. 2004;110(suppl 3):523. The prevalence of each finding was calculated. Non-coronary findings on 16-row multidetector CT coronary find 500 mAs. The typical field of view was 250 mm with a matrix of 512 × 512. J Am Coll Cardiol. 2001;22:1748-1758. Spasm was a frequent finding with radial artery grafts, although none of these grafts were occluded. 1Department of Diagnostic Radiology, University of Maryland School of Medicine, 22 S Greene St., Baltimore, MD 21201Find articles University of Maryland School of Medicine, 22 S Greene St., Baltimore, MD 21201Find articles by Charles S. Aortocoronary saphenous vein graft disease: pathogenesis, predisposition, and prevention. [PubMed] [Google Scholar]3. [2] found 4.2% of patients required CT follow-up and 20.5% of examinations had at least one noncardiac finding, including one patient where the incidental finding was the cause of death. 1). A native coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent coronary artery aneurysm was defined as a lumen diameter at least 1.5 times the size (> 6 mm) of a normal adjacent cor cardiomegaly, emphysema, etc.) based on information in the electronic medical record (history and physical, operative note, discharge summary, echocardiogram, clinic notes, previous radiology studies, etc.) were noted, but not included in the final analysis. Surgical techniques included both off-pump (178 patients, 68.7%) and on-pump (69 patients, 26.6%) cardiac bypass and minimally invasive (six patients, 2.3%) or hybrid coronary bypass grafting (six patients, 2.3%). Patient had good recovery after surgery. 73-year-old man who underwent routine cardiac CT angiography 7 days after surgery. Although a wider field of view may be reconstructed from the raw data to assess for additional thoracic findings, these images are not typically used to evaluate the coronary arteries and bypass grafts. A substantial rate of incidental findings necessitating therapeutic intervention or further radiologic evaluation has been found in patients undergoing coronary artery calcium scoring examinations without IV contrast with EBCT [1-3]. Shafique I, Shapiro EP, Stafford S, Bush DE. Two thoracic radiologists assessed each examination in consensus. [PubMed] [Google Scholar]5. 5), pneumonia, cardiac pseudoaneurysms (Figs. Coronary artery imaging with contrast-enhanced MDCT: extracardiac findings. This was evident from our investigation because we found a number of treatable conditions that were not clinically suspected at the time. All of the occluded grafts (Fig. One mitigating factor that may have paradoxically lowered the prevalence of certain abnormalities is that common postoperative abnormalities such as atelectasis and effusions obscured significant abnormalities. Another consideration is that the definition of what constitutes a clinically significant finding varies among different studies. Intraoperative transesophageal echocardiogram showed no intracardiac thrombus (not shown). Significant and Unexpected Immediate Postoperative FindingsaPatientsPercentImaging Follow-UpTreatment Incidental noncardiac findings Pulmonary nodule93.5Four patients (antibiotics) Large mucous plug62.3One bronchoscopy Pulmonary embolism51.9Three patients (anticoagulation) Aortic ulcer or aneurysm31.2Three patients (follow-up chest CT) Adrenal mass20.8Two patients (follow-up addominal CT) Moderate pleural effusion20.8One patient (follow-up chest CT) Sternal dehiscence10.4Reoperation Mediastinitis10.4One patient (follow-up chest CT) Sternal dehiscence10.4Reoperation Mediastinitis10.4 Incidental cardiac findings Moderate-to-large pericardial drain); one patient (reoperation); two patients (blood transfusion) Large mediastinal hematoma62.3One patient (reoperation); two patients (blood transfusion) Large mediastinal hematoma62.3One patient (reoperation); two patients (blood transfusion) Large mediastinal hematoma62.3One patient (reoperation); two patients (blood transfusion) Large mediastinal hematoma62.3One patient (reoperation); two patients (blood transfusion) Large mediastinal hematoma62.3One patient (reoperation); two patients (blood transfusion) Large mediastinal hematoma62.3One patient (reoperation); two patients (blood transfusion) Large mediastinal hematoma62.3One patient (reoperation); two patients (blood transfusion) Large mediastinal hematoma62.3One patient (reoperation); two patients (blood transfusion) Large mediastinal hematoma62.3One patient (blood transfusion) Large mediastinal hema (anticoagulation) Left ventricular perfusion deficit31.2 Left ventricular pseudoaneurysm20.8One patient (reoperation) Left atrial thrombus20.8One patient (anticoagulation) Right ventricular aneurysm10.4 Apical left ventricular aneurysm10.4 Apical left ventricular perfusion, pectus excavatum10.4 Statement (reoperation) Left atrial thrombus20.8One patient (reoperation) Left ventricular aneurysm10.4 Statement (reoperation) Le patients (5.8%) had a documented clinical intervention and 12 patients (4.6%) had a radiologic follow-up. 2004;44:1224-1229. Relevant cardiac and noncardiac findings were described in the final report and reviewed the electronic medical record of each patient to determine the clinical relevance of noncardiac findings in those studies is similar to this evaluation. Previous incidental studies have focused on outpatients or individuals with suspected coronary artery disease [1-7]. Cardiac CTA was acquired using a 16-MDCT scanner with ECG-gating and bolus timing with a small field of view centered on the heart. We presume the remaining patients with mucous plugging received pulmonary toilet, but clinical documentation. Of the 40 patients who underwent a routine follow-up cardiac CTA in the late postoperative period (mean, 12.7) months), seven patients (17.5%) had an incidental and unsuspected findings and graft abnormalities were reviewed independently by two radiologists (the primary author and a second thoracic radiologist) to substantiate their presence and a final decision was based on consensus. Significant findings were divided into cardiac and noncardiac disease. Comprehensive assessment of patients after coronary bypass grafting by 16 detector row CT. In addition, we studied with EBCT were outpatients. 2006;187:105-110. Other phases were reconstructed in some patients but were not used for this analysis. Thus, we chose the term "potentially significant." Other published studies of incidental findings on cardiac CT also have incomplete or nonexistent follow-up, possibly for the same reasons. Although our overall patients studied in the later postoperative period was low (n = 40), and incidental findings included in the first study were not duplicated in the second. Non-invasive visualization of coronary bypass grafting using 16 detector row CT. Prevalence of significant noncardiac findings on electron-beam computed tomography coronary bypass grafting using 16 detector row CT. Prevalence of significant noncardiac findings on electron-beam computed tomography coronary bypass grafting using 16 detector row CT. old asymptomatic man who underwent cardiac CT angiography 3 days after coronary bypass grafting surgery. A, Axial CT image shows left ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar reformatted image in vertical long axis projection confirms inferior ventricular pseudoaneurysm (arrow). B, Oblique multiplanar p angiography. Our study of a rather large cohort of patients suggests a frequency of unsuspected and potentially significant findings of approximately 20% in patients had both a clinical intervention and a radiologic follow-up. Among noncardiac abnormalities, pulmonary nodule (nine patients, 3.5%), pneumonia (six patients, 2.3%), tracheal or lobar mucous plugging (six patients, 2.3%), and pulmonary embolism (Fig. Of the two adrenal masses, both patients, 2.3%), tracheal or lobar mucous plugging (six patients, 2.3%), tracheal or lobar mucous plugging (six patients, 2.3%), and pulmonary embolism (Fig. Of the two adrenal masses, both patients, 2.3%), tracheal or lobar mucous plugging (six patients, 2.3%), tracheal or lobar mucous p finding. Salm LP, Jukema JW, Schuijf JD, et al. [Google Scholar]6. Malignant disease was detected in three patients. The primary data were also reconstructed using curved planar reconstructions along the long axis of the bypass grafts. The patient has not undergone additional workup or therapy. A third abstract also showed a high prevalence (44%) of significant or potentially significant noncoronary disease [7]. Treatable disease included pulmonary embolism (Fig. (abstr) Circulation. We determined therapeutic intervention on the basis of clinical information in the electronic medical record, which usually includes the operative note, echocardiogram, cardiac catherization, discharge summary, and radiology reports. However, this system does not include every follow-up surgical, cardiology or primary care clinic note. One of the patients who had large mucous plug underwent bronchoscopy for aspiration of the plug. A data sheet was generated that included the patient's age, sex, postoperative day, status of the bypass grafts, and cardiac findings. Axial CT images at 75% of the R-R interval and curved planar postprocessed images were predominantly used for image interpretation. Hunold et al. However, the rate of incidental cardiac findings in this study was much higher. The rate of incidental findings with MDCT may be higher because thinner reconstructions are used and IV contrast material is administered. A finding was defined as potentially significant if a therapeutic intervention was required or if further radiologic evaluation was defined as potentially significant if a therapeutic intervention was required or if further radiologic evaluation was defined as potentially significant if a therapeutic intervention was required or if further radiologic evaluation was defined as potentially significant if a therapeutic intervention was required or if further radiologic evaluation was defined as potentially significant if a therapeutic intervention was required or if further radiologic evaluation was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention was defined as potentially significant if a therapeutic intervention left atrial appendage (arrow). In addition, cardiac CTA examinations performed after major cardiovascular surgery have the potential to detect treatable cardiac and noncardiac disease, they determined that 9.3% of patients required further radiologic investigation, and specific therapy was initiated in 22 patients (1.2%). Repeat findings on the immediate and late postoperative examinations were defined according to following guidelines. Further interventions included repeat cardiac surgery (three patients, 1.2%). hospital readmission (one patient, 0.4%), insertion of a pericardial drainage catheter (one patient, 0.4%), blood transfusion (two patients, 1.2%). Of the nine patient, 0.4%), blood transfusion (two patients, 0.4%), blood transfusion (two patients, 1.2%). pulmonary nodules that were found, one patient underwent pulmonary consultation, PET, and lung biopsy with a histologic diagnosis of lung carcinoma (Fig. WhiteAuthor information DisclaimerCardiac CT angiography (CTA) is commonly performed after coronary artery bypass grafting surgery (CABG) to assess graft patency, but the images also include parts of the lungs, abdomen, and mediastinum. All physicians interpreting cardiac CTA should be cognizant of both cardiac and noncardiac findings commonly present in patients after CABG surgery.1. Horton KM, Post WS, Blumenthal RS, Fishman EK. However, to maintain as much clinical relevance as possible in a postoperative setting, we excluded known disease typically found on preoperative pulmonary function testing or echocardiography (i.e., emphysema or cardiomegaly), abnormalities of minimal significance (i.e., goiter and hiatal hernia), and expected postoperative conditions (i.e., pulmonary edema). We chose to analyze bypass grafts separately because their assessment was the indication for the CTA, and thus a graft occlusion could not truly be called incidental. Finally, our diagnosis of graft occlusion was not confirmed on coronary angiography. The electronic medical record was reviewed. after CABG surgery between October 2002 and March 2006. [Google Scholar]8. Additional images retrospectively reconstructed at 10 phases of the cardiac cycle were also available if needed. Also, the raw data were not reconstructed at 10 phases of the cardiac cycle were also available if needed. Also, the raw data were not reconstructed to create a wider field of view (x, y direction) possibly allowing more incidental findings to be discovered. To our knowledge, no information currently exists on the rate of incidental findings in patients with known ischemic heart disease or following cardiac surgery. 2005;60:990-998. The reviewed all images on soft-tissue, mediastinal, lung, and bone windows. In two recent abstracts by Shafique et al. [PubMed] [Google Scholar]7. [PubMed] [Google Scholar]7. [PubMed] [Google Scholar]12. Noncoronary findings on multidetector CT coronary angiography. At least one failed graft occurred in 6.6% of patients in the immediate postoperative period, indicating a significant attrition rate. [PubMed] [Google Scholar]11. Horton et al. Of the original group, a subset of 40 patients underwent a routine follow-up cardiac CTA an average of 12.7 months) after CABG as part of a research protocol for bypass graft was occluded in 17 patients (6.6%) in the immediate postoperative period. Among these, three patients (7.5%) had a cardiac finding and four patients (10%) had a noncardiac finding. 2) (eight patients, 3.1%), intracardiac thrombus (Figs. To our knowledge, this is the first study examining the rate of incidental findings on cardiac CTA examinations performed primarily on postoperative patients or those with known ischemic heart disease. LA = left atrium, LV = left ventricle. This study has several important limitations. Prevalence and clinical significance of accidental findings in electron beam tomographic scans for coronary artery calcification. A recently published study by Haller et al. Schlosser T. Konorza T. Hunold P, Kuhl H, Schmermund A, Barkhausen J. [PubMed] [Google Scholar]4. Non-cardiac findings on coronary electron beam computed tomography scanning. Mechanical factors associated with the development of intimal and medial thickening in vein grafts subjected to arterial pressure: a model of arteries exposed to hypertension. Beta blockade was typically provided as part of routine postoperative care. 1998;97:916-931. In addition, large mediastinal or paracardiac hemorrhage was included in the cardiac category, another condition that occasionally occurs after coronary bypass. The results of this investigation suggest that the rate of incidental disease detected on cardiac CTA examinations after major cardiovascular surgery in the inpatient or critical care setting is higher than in cardiac CTA examinations typically performed in the outpatients (19.7%) were found to have at least one potentially significant finding requiring therapeutic intervention or further radiologic evaluation. As a result, the rate of incidental cardiac disease was higher (9.3%).

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