X-rays

EXAM:
CR Right Knee, 3 Views

CLINICAL HISTORY:
Laceration.

COMPARISON:
None provided.

FINDINGS:
BONES:
No acute fracture or aggressive-appearing osseous lesion.

JOINTS:
Early changes of osteoarthritis with mild joint space reduction in the medial tibiofemoral compartment and mild tibial spiking. A fabella is noted. No joint effusion is appreciated.

SOFT TISSUES:
A focal skin defect in the prepatellar region with surrounding soft tissue swelling. No definite radiodense foreign body is identified.

IMPRESSION:
1. No acute osseous pathology is evident.

2. Focal skin defect in the prepatellar region with surrounding soft tissue swelling. No definite radiodense foreign body is identified.

EXAM:
CR Left Forearm, 2 Views

CLINICAL HISTORY:
Trauma/Injury.

COMPARISON:
None provided.

FINDINGS:
BONES AND JOINTS:
Acute comminuted, minimally displaced fractures of the distal radius with subtle intra-articular extension along the posterior radiocarpal and distal radioulnar articulations and mild dorsal tilt of the distal radial fracture fragment. Acute minimally displaced fracture of the ulnar styloid process. Subtle subluxation at the distal radioulnar articulation.

SOFT TISSUES:
Mild diffuse soft tissue swelling around the wrist and distal forearm.

IMPRESSION:
1. Acute comminuted, minimally displaced fractures of the distal radius with subtle intra-articular extension along the posterior radiocarpal and distal radioulnar articulations and mild dorsal tilt of the distal radial fracture fragment. Acute minimally displaced fracture of the ulnar styloid process with subtle subluxation at the distal radioulnar articulation.

2. Mild diffuse soft tissue swelling around the wrist and distal forearm.

EXAM:
CR Chest, 1 View

CLINICAL HISTORY:
Chest pain.

COMPARISON:
09/04/2026.

FINDINGS:
LUNGS:
Patchy infiltrates versus atelectasis at the right lung base with elevation of the right hemidiaphragm. Possible free air pockets versus a cystic area beneath the right hemidiaphragm.

PLEURAL SPACES:
No pleural effusion or pneumothorax.

MEDIASTINUM:
Cardiac size and mediastinal contours are within normal limits.

BONES:
No acute osseous abnormality.

IMPRESSION:
1. Patchy infiltrates versus atelectasis at the right lung base with elevation of the right hemidiaphragm. Possible free air pockets versus a cystic area beneath the right hemidiaphragm, a new finding. Clinical correlation and further evaluation with CT of the chest are recommended.

EXAM:
CR Lumbar Spine, 3 Views

CLINICAL HISTORY:
Right leg weakness.

COMPARISON:
None provided.

FINDINGS:
BONES:
Straightening of the lumbar spine may reflect paraspinal muscle spasm. Alignment is otherwise within normal limits. Intervertebral disc prostheses and posterior instrumented fusion at L3-L5. No evidence of hardware failure or loosening. Severe disc disease at L2-L3. Minimal grade 1 retrolisthesis of L2 relative to L3. Mild disc disease at the remaining lumbar levels. Vertebral body heights are maintained, with no displaced fracture.

SOFT TISSUES:
Prominent air-filled loops of small bowel in the left abdomen may reflect ileus or partial bowel obstruction. If clinically warranted, dedicated abdominal radiographs are recommended.

IMPRESSION:
1. Prior L3-L5 fusion without evidence of hardware failure.

2. Severe disc disease at L2-L3 with minimal grade 1 retrolisthesis.

3. Possible ileus or partial small bowel obstruction.

EXAM:
CR Left Hand, 3 Views

CLINICAL HISTORY:
Pain, no trauma.

COMPARISON:
August 7, 2026.

FINDINGS:
BONES:
No acute fracture or aggressive-appearing osseous lesion.

JOINTS:
Joint space narrowing, large periarticular erosions, and osteophytes. Dorsal subluxation of the ulna relative to the carpus. Findings are suggestive of advanced inflammatory arthropathy, possibly rheumatoid arthritis. Clinical correlation is advised. No displaced fracture is appreciated.

SOFT TISSUES:
Unremarkable.

IMPRESSION:
1. Advanced inflammatory arthropathy with joint space narrowing, large periarticular erosions, osteophytes, and dorsal ulnar subluxation, suggestive of rheumatoid arthritis.

EXAM:
CR Right Knee, 3 Views

CLINICAL HISTORY:
Pain.

COMPARISON:
None provided.

FINDINGS:
BONES:
No acute fracture or aggressive-appearing osseous lesion.

JOINTS:
Mild to moderate osteoarthritic changes of the knee, characterized by mild tricompartmental joint space narrowing and osteophytosis along the tibiofemoral margins and patellar poles. Mild soft tissue edema surrounding the knee joint with a mild infrapatellar joint effusion.

IMPRESSION:
1. No acute osseous pathology is evident.

2. Mild to moderate osteoarthritic changes of the knee, characterized by mild tricompartmental joint space narrowing and osteophytosis along the tibiofemoral margins and patellar poles, with mild surrounding soft tissue edema and a mild infrapatellar joint effusion.

EXAM:
CR Left Hand, 4 Views

CLINICAL HISTORY:
Pain, no injuries.

COMPARISON:
None provided.

FINDINGS:
BONES:
No acute fracture or aggressive-appearing osseous lesion. Subchondral cysts along the radiocarpal and ulnocarpal joint margins, with joint space narrowing and mild irregularity of the articular margins, consistent with degenerative osteoarthritic changes.

JOINTS:
No evidence of dislocation.

SOFT TISSUES:
The soft tissues appear within normal limits. No radiopaque foreign body is identified.

IMPRESSION:
1. No acute pathology. No acute fracture or dislocation.

2. Degenerative osteoarthritic changes involving the radiocarpal and ulnocarpal joints, characterized by subchondral cysts, joint space narrowing, and mild articular margin irregularity.

EXAM:
CR Left Ankle, 3 Views

CLINICAL HISTORY:
Ankle pain and swelling.

COMPARISON:
03/27/2026.

FINDINGS:
BONES:
Tibiotalar joint space narrowing with large subchondral cysts in the distal fibula and lateral talar dome. Osteoarthritic changes are noted in the midfoot and hindfoot joints. No displaced fracture. Possible posterior calcaneal enthesophyte at the Achilles tendon insertion. Prominent plantar calcaneal spur and subtle heterotopic ossification within the plantar fascia, which may reflect chronic fasciitis.

JOINTS:
The remaining joint spaces appear within normal limits. No dislocation or radiographic evidence of joint effusion.

SOFT TISSUES:
Soft tissue swelling/fullness around the lateral ankle. Small superficial calcific densities along the lateral soft tissues are likely dystrophic or soft tissue calcifications.

IMPRESSION:
1. No acute osseous injury.

2. Tibiotalar joint space narrowing with large subchondral cysts in the distal fibula and lateral talar dome, along with osteoarthritic changes in the midfoot and hindfoot joints. Interval progression.

3. Soft tissue swelling around the lateral ankle region, with interval progression.

4. Stable additional findings as described above.

EXAM:
CR Pelvis and Right Hip, 3 Views

CLINICAL HISTORY:
Pain.

COMPARISON:
August 18, 2026.

FINDINGS:
BONES:
No acute fracture or aggressive-appearing osseous lesion.

JOINTS:
No dislocation. The joint spaces are maintained.

SOFT TISSUES:
Colonic stool burden with multiple calcific-density opacities in the pelvis, possibly representing fecoliths, suggesting constipation.

IMPRESSION:
1. No acute osseous abnormality.

2. Colonic stool burden with multiple calcific-density opacities in the pelvis, possibly representing fecoliths, suggesting constipation.

3. No significant interval change, apart from an interval increase in constipation.

EXAM:
CR Chest, 1 View

CLINICAL HISTORY:
Difficulty breathing.

COMPARISON:
CR Chest, 10/07/2026 at 18:10 EDT.

FINDINGS:
LUNGS:
Stable bilateral perihilar and bibasilar airspace disease. Interval development of left lower lung zone atelectasis.

PLEURAL SPACES:
No pneumothorax. Stable small bilateral pleural effusions.

MEDIASTINUM:
Cardiac size and mediastinal contours are within normal limits.

BONES:
No acute osseous abnormality.

IMPRESSION:
1. Stable bilateral perihilar and bibasilar airspace disease, with interval development of left lower lung zone atelectasis.

2. Stable small bilateral pleural effusions.

CT SCAN

EXAM:

CT Chest Without IV contrast.

CLINICAL HISTORY:

Persistent cough.

TECHNIQUE:

Axial computed tomography images of the chest were obtained without intravenous contrast with multiplanar reformatted images.

COMPARISON:

CT chest without contrast dated September 26, 2025.

FINDINGS:

LUNGS:

Patchy ground-glass airspace opacities are present in both lungs, predominantly involving the upper lobes, with several areas in a subpleural distribution.

Compared with the prior study, there is a mild interval increase in the ground-glass opacities, particularly in the left upper lobe.

Mild bibasilar atelectatic changes.

No focal pulmonary mass.

PLEURAL SPACES:

No pleural effusion or pneumothorax.

HEART:

No cardiomegaly. No significant pericardial effusion.

LYMPH NODES:

No pathologically enlarged mediastinal lymph nodes.

UPPER ABDOMEN:

Mild diffuse hepatic steatosis.

BONES:

Small sclerotic focus in the L1 vertebral body measuring approximately 1.0 cm, likely benign in appearance.

No acute osseous abnormality.

IMPRESSION:

1. Patchy bilateral ground-glass airspace opacities, predominantly in the upper lobes and partly subpleural in distribution, likely infectious/inflammatory in etiology.

2. Mild interval increase in the ground-glass opacities, particularly in the left upper lobe, compared with September 26, 2025.

EXAM:

CT abdomen and pelvis with intravenous contrast.

CLINICAL HISTORY:

Abdominal pain, status post gastrectomy.

TECHNIQUE:

Axial computed tomography images of the abdomen and pelvis were acquired with intravenous contrast. Multiplanar reformatted images were generated and reviewed.

CONTRAST:

Intravenous contrast was administered.

COMPARISON:

CT abdomen and pelvis dated August 5, 2026.

FINDINGS:

LUNG BASES:

Bibasilar atelectasis. No pleural effusion.

LIVER:

Hepatomegaly with craniocaudal extent of 21 cm. No focal hepatic lesion. No intrahepatic biliary dilatation.

GALLBLADDER AND BILE DUCTS:

Sludge in the gallbladder. No radiopaque gallstones. No biliary ductal dilatation.

PANCREAS:

Unremarkable.

SPLEEN:

The spleen is normal in size and attenuation.

ADRENAL GLANDS:

Bilateral adrenal glands are unremarkable.

KIDNEYS, URETERS, AND BLADDER:

The kidneys are normal in size and attenuation. No hydronephrosis or hydroureter. No urinary calculi. Partially distended urinary bladder.

STOMACH AND BOWEL:

Status post gastrectomy. Severe gastric mucosal hypertrophy predominantly involving the gastric body. Mildly dilated proximal jejunal loops measuring 3.2 cm, concerning for enteritis or ileus. Scattered colonic diverticulosis without CT evidence of diverticulitis or bowel obstruction.

APPENDIX:

No CT imaging features of acute appendicitis.

PERITONEUM:

No free fluid. No free air.

LYMPH NODES:

No lymphadenopathy.

REPRODUCTIVE:

Pelvic reproductive organs are unremarkable.

VASCULATURE:

Mild atherosclerotic wall calcifications in the aorta and its branches. No abdominal aortic aneurysm.

BONES:

Moderate to severe degenerative changes in the spine. No aggressive osseous lesion.

ABDOMINAL WALL:

2.0 x 3.6 cm right lower quadrant anterior abdominal wall subcutaneous collection with mild fat stranding and skin thickening, concerning for an evolving abscess. Small fat-containing umbilical hernia and small hiatus hernia.

IMPRESSION:

1. Right lower quadrant anterior abdominal wall subcutaneous collection (2.0 x 3.6 cm) with mild fat stranding and skin thickening, concerning for an evolving abscess. Interval change.

2. Mildly dilated proximal jejunal loops concerning for enteritis or ileus. Interval change.

3. Stable severe gastric mucosal hypertrophy predominantly involving the gastric body in the setting of gastrectomy, concerning for hypertrophic gastritis/Menetrier Disease.

4. Stable hepatomegaly.

EXAM:

CTA Head and Neck with Intravenous Contrast.

CLINICAL HISTORY:

Suspected stroke

TECHNIQUE:

Axial CTA images of the head and neck were performed with intravenous contrast in the arterial phase.

Coronal and sagittal reformatted images were generated and reviewed. 3-D reformatted images generated on an independent workstation were also reviewed. NASCET criteria were used in assessment of stenosis.

CONTRAST:

Contrast was injected without incident.

COMPARISON:

None provided.

FINDINGS:

VASCULATURE:

NECK:

COMMON CAROTID ARTERIES

Eccentric calcifications in both the carotid bulbs causing mild narrowing of up to 20%.

No dissection or occlusion.

EXTERNAL CAROTID ARTERIES

Patent.

INTERNAL CAROTID ARTERIES

Eccentric calcifications in the cavernous portions of both internal carotid arteries, causing mild narrowing of up to 30%. No dissection or occlusion.

VERTEBRAL ARTERIES

Eccentric patchy calcifications in the V4 segment of both vertebral arteries, causing severe narrowing in the left vertebral artery of up to 80% and moderate narrowing of up to 50% in the right vertebral artery.

No dissection.

HEAD:

ANTERIOR CEREBRAL ARTERIES

No significant stenosis. No occlusion. No aneurysm.

MIDDLE CEREBRAL ARTERIES

No significant stenosis. No occlusion. No aneurysm.

POSTERIOR CEREBRAL ARTERIES

No significant stenosis. No occlusion. No aneurysm.

BASILAR ARTERY

No significant stenosis. No occlusion. No aneurysm.

OTHER:

SOFT TISSUES

No acute finding.

BONES

No acute osseous abnormality.

IMPRESSION:

1. Eccentric patchy calcifications in the V4 segment of both vertebral arteries, causing severe narrowing in the left vertebral artery of up to 80% and moderate narrowing of up to 50% in the right vertebral artery.

2. Eccentric calcifications in the cavernous portions of both internal carotid arteries, causing mild narrowing of up to 30%.

3. Eccentric calcifications in both the carotid bulbs, causing mild narrowing of up to 20%.

EXAM:

CT Chest with Intravenous Contrast.

CT Abdomen and Pelvis with Intravenous Contrast

CLINICAL HISTORY:

Stage 4 cancer

TECHNIQUE:

Axial computed tomography images of the chest, abdomen, and pelvis with intravenous contrast.

COMPARISON:

CT ABDOMEN PELVIS W IV CONTRAST ONLY dated 04/30

CT ANGIOGRAM CHEST W WO CONTRAST 07/01

FINDINGS:

CHEST:

Lungs and Pleura:

Diffuse centrilobular emphysematous changes in both lungs. Mild bibasilar dependent atelectatic changes. No focal air-space consolidation, pleural effusion, or pneumothorax.

Heart and Mediastinum:

Cardiomegaly. Left chest wall pacemaker with leads projecting over the right atrium/right ventricle. No significant pericardial effusion.

Vasculature:

No acute abnormality of the visualized thoracic aorta. Atherosclerotic calcifications are noted.

Lymph Nodes:

No pathologically enlarged mediastinal or hilar lymph nodes identified.

Chest Wall/Osseous Structures:

No acute osseous abnormality. Multilevel degenerative changes of the visualized spine.

ABDOMEN AND PELVIS:

Liver:

Multiple hypodense hepatic lesions are again identified, the largest measuring approximately 1.7 cm, without significant interval change. Multiple calcified hepatic granulomas are again noted.

Gallbladder and Biliary System:

Cholelithiasis without CT evidence of acute cholecystitis. No biliary ductal dilatation.

Pancreas:

Mildly prominent main pancreatic duct. Stable.

Spleen:

Unremarkable.

Adrenal Glands:

Stable 0.7 cm left adrenal nodule.

Kidneys/Ureters/Bladder:

Multiple bilateral renal non-enhancing hypodensities, the largest measuring approximately 3.4 cm in the right lower pole, favored to represent renal cysts. No hydronephrosis, hydroureter, or urinary calculi.

Stomach and Bowel:

Persistent suspicious irregular wall thickening involving the antral-pyloric region, extending over approximately 5.8 cm, concerning for underlying neoplasm.

Large hiatal hernia with herniation of the gastric fundus, cardia, and proximal body into the thorax. No bowel obstruction.

Appendix:

Appendix is not separately visualized. No focal pericecal inflammatory changes.

Peritoneum/Omentum:

Multiple nodular omental deposits are again seen, largest measuring approximately 1.5 cm, without significant interval change. No ascites or pneumoperitoneum.

Lymph Nodes:

A few enlarged right inguinal lymph nodes are again noted, the largest measuring approximately 1.3 cm, without significant interval change.

Pelvic Organs:

Status post hysterectomy.

Vasculature:

IVC filter remains in situ. Atherosclerotic calcification of the abdominal aorta and its major branches. No abdominal aortic aneurysm.

Bones:

Multilevel degenerative changes of the visualized spine. No aggressive osseous lesion or acute osseous abnormality.

Soft Tissues:

Multiple pelvic phleboliths.

IMPRESSION:

1. No acute pathology identified in the chest abdomen and pelvis.

2. No significant interval change in the suspicious antral pyloric wall thickening, concerning for underlying gastric malignancy.

3. Multiple omental nodular deposits, compatible with peritoneal/omental metastatic deposits, are grossly unchanged.

4. Stable multiple hepatic hypodensities and calcified hepatic granulomas.

5. Cholelithiasis without CT evidence of acute cholecystitis.

6. Stable bilateral renal cysts and small left adrenal nodule.

7. Stable large hiatal hernia.

EXAM:

CT Angiography of the Left Lower Extremity with Intravenous Contrast.

CLINICAL HISTORY:

Peripheral arterial disease.

COMPARISON:

None provided.

TECHNIQUE:

CT angiography of the left lower extremity was performed following intravenous administration of iodinated contrast. Multiplanar reformatted and maximum intensity projection images were generated and reviewed. Evaluation is technically limited by metallic streak artifacts from the knee prosthesis.

FINDINGS:

LEFT COMMON ILIAC ARTERY:

The left common iliac artery is patent.

LEFT EXTERNAL ILIAC ARTERY:

The left external iliac artery is patent.

LEFT COMMON FEMORAL ARTERY:

The left common femoral artery is patent.

LEFT SUPERFICIAL FEMORAL ARTERY:

Patchy atherosclerotic calcifications are identified along the superficial femoral artery, more pronounced in its distal segment, causing mild luminal narrowing of up to 30%.

LEFT POPLITEAL ARTERY:

Eccentric atherosclerotic calcifications are identified in the proximal popliteal artery, causing mild luminal narrowing of up to 25%. Evaluation of the popliteal artery at the level of the knee joint is technically limited by metallic streak artifacts from the knee prosthesis.

LEFT TIBIOPERONEAL TRUNK:

Multiple foci of atherosclerotic calcification are identified, causing multifocal varying degrees of luminal narrowing.

LEFT ANTERIOR TIBIAL ARTERY:

Multiple calcified atherosclerotic plaques are identified along the anterior tibial artery, resulting in multifocal luminal stenosis.

LEFT PERONEAL ARTERY:

Multiple foci of atherosclerotic calcification are identified along the peroneal artery, causing multifocal varying degrees of luminal narrowing.

The maximum degree of stenosis involving the tibioperoneal trunk, anterior tibial artery, and peroneal artery is approximately 80%.

LEFT POSTERIOR TIBIAL ARTERY:

The left posterior tibial artery is patent.

SOFT TISSUES:

Diffuse subcutaneous edema is identified throughout the left lower extremity.

BONES AND JOINTS:

Postsurgical changes of knee arthroplasty are noted, with associated metallic streak artifacts limiting evaluation of the adjacent vascular structures.

IMPRESSION:

1. Multifocal atherosclerotic disease involving the arteries of the left lower extremity, most pronounced in the infrapopliteal arteries.

2. Multiple calcified atherosclerotic plaques involving the tibioperoneal trunk, anterior tibial artery, and peroneal artery, causing multifocal varying degrees of stenosis, with maximum luminal narrowing of up to 80%.

3. Atherosclerotic calcifications involving the distal superficial femoral artery, causing mild luminal narrowing of up to 30%.

4. Eccentric calcified plaques in the proximal popliteal artery, causing mild luminal narrowing of up to 25%.

5. Diffuse subcutaneous edema involving the left lower extremity.

6. Evaluation of the popliteal artery and adjacent vascular structures at the level of the knee joint is limited by metallic streak artifacts from the knee prosthesis.

EXAM:

CT Abdomen and Pelvis with Intravenous Contrast.

CLINICAL HISTORY:

Suspected bowel obstruction.

COMPARISON:

Prior CT abdomen and pelvis dated 09/20/2026.

TECHNIQUE:

Axial computed tomography images of the abdomen and pelvis were acquired following intravenous contrast administration. Multiplanar reformatted images were generated and reviewed.

FINDINGS:

LUNG BASES:

Subsegmental atelectatic changes are identified in both lung bases.

LIVER:

No focal abnormality identified.

GALLBLADDER AND BILE DUCTS:

No acute abnormality identified.

PANCREAS:

Stable mild fatty infiltration of the pancreas.

SPLEEN:

No focal abnormality identified.

ADRENAL GLANDS:

No abnormality identified.

KIDNEYS, URETERS, AND BLADDER:

Stable hypodense cortical cysts are identified in the lower pole of the right kidney, the largest measuring approximately 1.8 cm.

STOMACH AND BOWEL:

Moderate colonic stool burden is redemonstrated. Multiple colonic diverticula are identified without surrounding inflammatory changes to suggest acute diverticulitis. No evidence of bowel obstruction.

PERITONEUM AND ABDOMINAL WALL:

Mild interval increase in the size of the fat-containing umbilical hernia, now measuring approximately 2.8 × 2.0 cm.

VASCULATURE:

Patchy atherosclerotic calcifications are identified in the abdominal aorta and its major branches.

LYMPH NODES:

No lymphadenopathy identified.

BONES AND SPINE:

Mild dextroscoliosis of the lumbar spine is noted. Stable multilevel degenerative spondylotic changes are identified throughout the lumbar spine. Stable chronic compression deformities of the thoracolumbar vertebral bodies are redemonstrated.

MEDICAL DEVICES:

Stable spinal stimulator device with the battery pack located in the right posterior abdominal wall. The stimulator leads extend into the thoracic spinal canal, with their tips beyond the field of view.

IMPRESSION:

1. No evidence of bowel obstruction.

2. Moderate colonic stool burden. Colonic diverticulosis without evidence of acute diverticulitis.

3. Mild interval increase in the size of the fat-containing umbilical hernia, now measuring 2.8 × 2.0 cm.

4. Stable other chronic findings as described.

EXAM:

CT Abdomen and Pelvis with Intravenous Contrast.

CLINICAL HISTORY:

Abdominal pain and fever. Abdominal radiographs demonstrated air-fluid levels. Rule out small bowel obstruction.

COMPARISON:

Prior CT abdomen and pelvis (date not provided).

TECHNIQUE:

Axial computed tomography images of the abdomen and pelvis were acquired following intravenous contrast administration. Multiplanar reformatted images were generated and reviewed.

FINDINGS:

LUNG BASES:

An incompletely imaged right infrahilar mass lesion is identified. There has been interval development of multiple pulmonary nodules in the right middle lobe, which may represent an infectious/inflammatory or neoplastic process. Further evaluation with a dedicated CT scan of the chest is recommended.

LIVER:

Stable chronic liver parenchymal disease with postoperative changes involving the right hepatic lobe.

GALLBLADDER AND BILE DUCTS:

Status post cholecystectomy.

PANCREAS:

No abnormality described.

SPLEEN:

No abnormality described.

ADRENAL GLANDS:

No abnormality described.

KIDNEYS, URETERS, AND BLADDER:

Stable nonobstructing calculi measuring 2 mm and 4 mm are identified in the lower pole of the left kidney. Stable mild calyectasis involving the lower pole of the left kidney.

STOMACH:

Edematous thickening of the gastric wall is identified in the setting of an undistended stomach. This may be related to underdistention or gastritis.

SMALL BOWEL:

No abnormal dilatation of the small bowel loops to suggest obstruction. The previously demonstrated small bowel feces sign is no longer visualized.

LARGE BOWEL:

Moderate fecal retention is redemonstrated throughout the large bowel. No evidence of bowel obstruction.

MESENTERY:

Mild diffuse mesenteric inflammatory changes are redemonstrated, similar to the prior examination.

PERITONEUM:

No additional abnormality described.

PELVIC ORGANS:

Status post hysterectomy.

BONES:

Diffuse decreased bone mineralization, consistent with osteopenia. Multilevel degenerative spondylotic changes of the thoracolumbar spine. Interval development of mild compression of the superior endplate of the L2 vertebral body by up to 15% with vacuum phenomenon in the L1-L2 intervertebral disc.

SOFT TISSUES:

No additional abnormality described.

IMPRESSION:

1. Edematous wall thickening of the undistended stomach, which may be related to underdistention or gastritis. Clinical correlation is recommended.

2. No evidence of bowel obstruction. Previously demonstrated small bowel feces sign is no longer visualized.

3. Redemonstrated moderate fecal retention in the large bowel.

4. Stable mild diffuse mesenteric inflammatory changes.

5. Stable chronic liver parenchymal disease with postoperative changes in the right hepatic lobe.

6. Stable nonobstructing left renal calculi measuring 2 mm and 4 mm, with stable mild left lower pole calyectasis.

7. Incompletely imaged right infrahilar mass lesion with interval development of multiple pulmonary nodules in the right middle lobe. Findings may represent an infectious/inflammatory or neoplastic process. Further evaluation with a dedicated contrast-enhanced CT scan of the chest is recommended.

8. Osteopenia and multilevel thoracolumbar spondylosis. Interval development of mild compression of the superior endplate of the L2 vertebral body by up to 15%, with vacuum phenomenon in the L1-L2 intervertebral disc.

EXAM:

CT Lumbar Spine Without IV Contrast

CLINICAL HISTORY:

Lumbar back pain. Chronic worse than baseline.

TECHNIQUE:

Spiral axial CT images through the lumbar spine were acquired, reconstructed in axial and sagittal projections, and imaged using soft tissue and bone algorithms. Reformatted/MPR images were performed. A CT scan is done according to ALARA (As Low as Reasonably Achievable).

CONTRAST:

None.

COMPARISON:

None provided.

FINDINGS:

No acute fracture.

Normal lordotic curvature.

Normal vertebral body and disc heights.

Normal bone density.

The surrounding soft tissues are unremarkable.

Individual spinal levels are described as follows:

T12-L1: No disc bulge or herniation. No neural foraminal, lateral recess, or spinal canal stenosis.

L1-L2: No disc bulge or herniation. No neural foraminal, lateral recess,s or spinal canal stenosis.

L2-L3: Degenerative reduction in disc space with vacuum phenomena. Circumferential 3 mm disc bulge.ge No neural foraminal, lateral recess, or spinal canal stenosis.

L3-L4: No disc bulge with a circumferential 3 mm disc bulge. No neural foraminal, lateral recess, or spinal canal stenosis.

L4-L5: Degenerative reduction in disc space with vacuum phenomena. Mild retrolisthesis of L4 over L5 (4 mm). Circumferential 4 mm disc bulge with moderate bilateral facet arthropathy and ligamentum flavum hypertrophy. Moderate narrowing of the left neural foramina and mild narrowing of the right neural foramina. No spinal canal stenosis.

L5-S1:Pars isthmic defect. on the leftside. Mild bilateral facet arthropathy, left more than right. Moderate narrowing of the left neural foramina. No significant lateral recess or spinal canal stenosis.

Degenerative changes in the bilateral sacroiliac joint.

IMPRESSION:

1. No evidence of acute fracture. Normal vertebral body height. Minimal retrolisthesis of L4 over L5.

2. Mild reduction in disc space at the L2-L3 and L4-L5 levels with vacuum phenomena. Mild disc bulges at L2-L3, L3-L4, L4-L5, and L5-S1 levels, most prominent at the L4-L5 level. Multilevel degenerative facet arthropathy and moderate degenerative changes at the L4-L5 level as described above. Pars isthmic defect, on the left side at L5-S1 LEVEL, without evidence of anterolisthesis.

EXAM:

CT Lumbar Spine Without IV Contrast.

CLINICAL HISTORY:

LBP, flank pain

TECHNIQUE:

Axial computed tomography images of the lumbar spine without intravenous contrast. Sagittal and coronal reformatted images were generated.

COMPARISON:

June 11, 2026.

FINDINGS:

ALIGNMENT:

Bony alignment is anatomic.

DISCS/DEGENERATIVE CHANGES:

T12-L1 through L2-L3: The disc height is maintained. No significant disc bulge, central canal, or neural foraminal stenosis. Mild bilateral facet hypertrophy, without significant interval change.

L3-4: The disc height is maintained. No significant disc bulge, central canal, or neural foraminal stenosis. Bilateral facet hypertrophy.

L4-5 and L5-S1: The disc height is mildly reduced. Disc vacuum phenomenon at the L5-S1 level. Mild disc bulge with facet arthropathy and ligamentum flavum hypertrophy causing mild central canal stenosis and mild to moderate bilateral neural foraminal stenosis, worse on the right than the left. There is a possibility of mild compression of the exiting right L4 and L5 nerve roots.

BONES:

No acute fracture or aggressive-appearing osseous lesion. Sacro-iliac joints are intact and demonstrate degenerative changes without significant interval change.

Tiny 1-2 mm nonobstructive left renal calculi.

The other findings are grossly stable since prior examination.

SOFT TISSUES:

Mild subcutaneous soft tissue edema in the lumbosacral region.

IMPRESSION:

1. No acute lumbar spine abnormality.

2. Lumbar spondylosis, predominantly at L4-L5 and L5-S1 levels, with possibility of mild compression of the exiting right L4 and L5 nerve roots, without significant interval change.

Other findings as described above.

No significant interval change.

If there are persistent clinical symptoms or additional clinical concerns, consider MRI.

EXAM:

CT Lumbar Spine Without IV Contrast.

CLINICAL HISTORY:

Patient presents with back pain without known trauma.

TECHNIQUE:

Axial computed tomography images of the lumbar spine without intravenous contrast. Sagittal and coronal reformatted images were generated.

COMPARISON:

07/07/2024

FINDINGS:

ALIGNMENT:

Bony alignment is anatomic.

DISCS/DEGENERATIVE CHANGES:

Multilevel moderate spondylosis. Mild diffuse disc bulge at L4-L5 and L5-S1 levels causing indentation on the anterior thecal sac. Multilevel moderate facet arthropathy, most pronounced at L3-L4.

Tiny 3 mm sclerotic focus in the left L3 vertebra, probable bone island.

SOFT TISSUES:

The paraspinal soft tissues are unremarkable.

BONES:

No acute fracture or aggressive-appearing osseous lesion. Moderate bilateral sacroiliac joint osteoarthritis.

IMPRESSION:

1. No acute lumbar spine abnormality. Tiny 3 mm sclerotic focus in the left L3 vertebra, probable bone island.

2. Multilevel moderate lumbar spondylosis with multilevel moderate facet arthropathy, most pronounced at L3-L4.

3. Mild diffuse disc bulges at L4-L5 and L5-S1 causing mild indentation on the anterior thecal sac.

4. Moderate bilateral sacroiliac joint osteoarthritis.

5. No significant interval change.

Recommend MRI lumbar spine without contrast for further evaluation of disc disease, neural element involvement, and persistent symptoms.

EXAM:

CTA Chest with Intravenous Contrast for PE evaluation

CLINICAL HISTORY:

Elevated d dimer, shortness of breath.

TECHNIQUE:

Axial CTA images of the chest with intravenous contrast using a pulmonary embolism protocol. Multiplanar reconstructed images were created and reviewed.

CONTRAST:

IV contrast

COMPARISON:

10/28

FINDINGS:

PULMONARY ARTERIES:

No evidence of central or segmental pulmonary embolism is seen.

AORTA:

There is no evidence for aneurysm or dissection of the thoracic aorta.

LUNGS:

Emphysematous bulla in the medial basal segment of the right lower lobe measuring approximately 5.1 x 2.9 cm.

Otherwise, the lungs appear clear.

PLEURAL SPACES:

No pleural effusion seen. No pneumothorax evident.

HEART:

Heart size is within normal limits. No significant pericardial effusion.

LYMPH NODES:

No lymphadenopathy is evident.

BONES:

No focal osseous abnormality or acute fracture.

UPPER ABDOMEN:

Images of the upper abdomen are unremarkable.

IMPRESSION:

1. No pulmonary embolism.

EXAM:

CTA Head and Neck with and without Intravenous Contrast.

CLINICAL HISTORY:

Subarachnoid hemorrhage seen on recent CT head.

TECHNIQUE:

Axial CTA images of the head and neck performed with and without intravenous contrast in the arterial phase.

Coronal and sagittal reformatted images were generated and reviewed. 3-D reformatted images generated on an independent workstation were also reviewed. NASCET criteria were used in assessment of stenosis.

CONTRAST:

Contrast injected without incident.

COMPARISON:

CT head 10/13/2026.

FINDINGS:

VASCULATURE:

NECK:

COMMON CAROTID ARTERIES

No significant stenosis. No dissection or occlusion.

EXTERNAL CAROTID ARTERIES

Patent.

INTERNAL CAROTID ARTERIES

No stenosis by NASCET criteria. No dissection or occlusion.

VERTEBRAL ARTERIES

No significant stenosis. No dissection or occlusion.

HEAD:

Intracranial internal carotid arteries:

Atherosclerosis. No flow-limiting stenosis, occlusion or aneurysm.

ANTERIOR CEREBRAL ARTERIES A1 A2

Right A1 segment is congenitally absent. The left A1 segment bifurcates into the right and left A2 segments. No significant stenosis. No occlusion. No aneurysm.

MIDDLE CEREBRAL ARTERIES M1 M2

No significant stenosis. No occlusion. No aneurysm.

POSTERIOR CEREBRAL ARTERIES P1 P2

Fetal contribution of the right PCA. No significant stenosis. No occlusion. No aneurysm.

BASILAR ARTERY

No significant stenosis. No occlusion. No aneurysm.

OTHER:

SOFT TISSUES

No acute finding.

BONES

Severe multilevel degenerative changes of the spine.

IMPRESSION:

1. Patent neck and intracranial vasculature without stenosis, dissection, occlusion, or aneurysm. No findings to explain patient's subarachnoid hemorrhage.

2. Intracranial atherosclerosis without flow-limiting stenosis.

3. Congenital variant with absent right A1 segment and fetal origin of right posterior cerebral artery.

4. Severe multilevel degenerative changes of the cervical spine.

EXAM:

Non-contrast CT examination of the Brain

CLINICAL HISTORY:

Mental status change.

TECHNIQUE:

Thin collimated axial CT images of the brain were obtained with sagittal and coronal reformatted images also submitted. CT scan done according to ALARA (As Low as Reasonably Achievable).

CONTRAST USED:

None.

COMPARISON:

None provided.

FINDINGS:

Diffuse cerebral volume loss is evident by dilated lateral ventricles, prominent cisterns and sulcal spaces. Disproportionate dilatation of the bilateral lateral and third ventricles in comparison to the cerebral atrophy. Imaging findings concerning for normal pressure hydrocephalus. Recommend clinical correlation.

No acute cortical infarction, hemorrhage, mass or mass effect. subarachnoid hemorrhage noted in the left frontoparietal region

Chronic lacunar infarcts in the bilateral basal ganglia and right thalamus. Confluent hypodensities in the white matter of the bilateral cerebral hemispheres, likely moderate chronic small vessel ischemic changes.

The posterior fossa is unremarkable.

The skull base and calvarium are intact.

Chronic right maxillary and right anterior ethmoid sinusitis. The included portions of the mastoid air cells are clear.

IMPRESSION:

1. Acute subarachnoid hemorrhage in the left frontoparietal region.

EXAM:

CTA Chest with Intravenous Contrast for PE evaluation

CLINICAL HISTORY:

Pulmonary embolism (PE) suspected, positive D-dimer

TECHNIQUE:

Axial CTA images of the chest with intravenous contrast using a pulmonary embolism protocol. Multiplanar reconstructed images were created and reviewed.

CONTRAST:

None was administered without incident.

COMPARISON:

None provided.

TECHNIQUE:

Contrast CT of chest performed utilizing multiple contiguous axial sections. Coronal and sagittal reformations performed.

FINDINGS:

LUNGS:

Irregular streaky linear density, fibrosis, or atelectasis seen involving the right middle lobe and anterior portion right lower lobe. No pleural effusion, pneumothorax, or dense pulmonary consolidation. No bronchiectasis noted. No suspicious appearing pulmonary nodules noted. Unremarkable appearance of the central airways.

MEDIASTINUM:

No pathologically enlarged lymph nodes noted. No mediastinal hematoma noted.

HEART AND VASCULAR:

No pericardial effusion noted. No abnormal intraluminal filling defects or emboli seen within the main, right, left, segmental, and visualized subsegmental pulmonary arteries. No aortic intimal flap identified.

NECK:

No discrete or focal thyroid nodule identified.

UPPER ABDOMEN:

No significant abnormality noted.

MUSCULOSKELETAL:

Multilevel cervical and thoracic spondylosis noted. No aggressive osseous lesion noted.

On axial image 27 series 13, asymmetric 2.3 x 2.7 cm spiculated soft tissue opacity seen involving medial right breast. Punctate calcification seen along periphery of this spiculated appearing opacity. Right breast skin thickening noted.

IMPRESSION:

1. No definite pulmonary emboli identified.

2. Asymmetric 2.3 x 2.7 cm spiculated soft tissue opacity in the medial right breast. Finding may be due to scar. Breast malignancy difficult to exclude. Skin thickening right breast may be due to prior treatment or radiation. Correlation with prior mammography and surgical history may be helpful.

3. Irregular streaky linear densities involving the anterior aspect right lower lobe and right middle lobe may be due to fibrosis, scarring, or postradiation changes.

EXAM:

CT Chest with Intravenous Contrast.

CT Abdomen and Pelvis with Intravenous Contrast

CLINICAL HISTORY:

Patient presents with x-ray findings of pleural effusion and generalized abdominal pain.

TECHNIQUE:

Axial computed tomography images of the chest, abdomen, and pelvis with intravenous contrast.

CONTRAST:

Intravenous contrast was administered.

COMPARISON:

None provided.

FINDINGS:

CHEST:

LUNGS:

Large right pleural effusion with compressive collapse of the underlying right lung with sparing of the right lung apex. Multiple patchy heterogeneous ground-glass opacities are scattered throughout the left upper lobe. Subtle ground-glass opacities in the visualized right upper lobe.

PLEURAL SPACES:

Large right pleural effusion. No pneumothorax evident.

HEART:

No cardiomegaly. No significant pericardial effusion.

LYMPH NODES:

No lymphadenopathy is evident.

BREASTS:

The right breast is mildly enlarged compared to the left, with thickening of the overlying skin.

ABDOMEN AND PELVIS:

LIVER:

The liver is enlarged, measuring 18 cm, with mild heterogeneous attenuation of the parenchyma. Questionable hypodense foci in the right lobe adjacent to the gallbladder fossa, indeterminate.

GALLBLADDER AND BILE DUCTS:

The gallbladder appears within normal limits. No radioopaque gallstones are seen. No biliary ductal dilatation is evident.

PANCREAS:

Unremarkable.

SPLEEN:

Borderline splenomegaly measuring 12.9 cm.

ADRENAL GLANDS:

Unremarkable.

KIDNEYS, URETERS, AND BLADDER:

Unremarkable. No hydronephrosis or nephrolithiasis. No ureteral or bladder calculi.

STOMACH AND BOWEL:

Mild fecal loading of the colon. Unremarkable appearance of the stomach and bowel otherwise. No evidence of bowel obstruction. No evidence suggesting enteritis or colitis. Dilated and tortuous IMV.

APPENDIX:

No evidence of acute appendicitis on CT examination.

PERITONEUM:

Small ascites. No free air.

REPRODUCTIVE:

The uterus is pulled up with an elongated cervix and adhesions between the uterus and the anterior abdominal wall.

LYMPH NODES:

No lymphadenopathy is evident.

VASCULATURE:

No evidence of abdominal aortic aneurysm.

BONES:

Mild degenerative thoracolumbar spondylosis. No acute osseous abnormality otherwise.

IMPRESSION:

1. Large right pleural effusion with near complete compressive collapse of the right lung with relative sparing of the right lung apex.

2. Patchy bilateral ground-glass pulmonary opacities, more prominent in the left upper lobe, likely infective/inflammatory in etiology.

3. Mild asymmetric enlargement of the right breast with overlying skin thickening. Dedicated breast evaluation is recommended.

4. Hepatomegaly with heterogeneous hepatic attenuation. Recommend correlation with liver function tests to evaluate for parenchymal liver disease.

5. Questionable hypodense foci in the right hepatic lobe adjacent to the gallbladder fossa, indeterminate on the present study. MRI of the abdomen, with and without contrast, may be considered for further characterization if clinically warranted.

6. Small ascites.

7. Postoperative/post-inflammatory pelvic adhesions with pulled-up uterus and elongated cervix.

8. Mild fecal loading of the colon. Dilated and tortuous IMV.

EXAM:

CT Abdomen and Pelvis Without IV contrast

CLINICAL HISTORY:

HYPOGLYCEMIA, Renal failure

TECHNIQUE:

Axial computed tomography images of the abdomen and pelvis without intravenous contrast.

CONTRAST:

No IV contrast.

COMPARISON:

None provided.

FINDINGS:

LUNG BASES / LOWER THORAX:

Bandlike densities are present at the lung bases, consistent with subsegmental atelectasis or chronic scarring. No pleural effusions. Mild multivessel coronary artery calcifications are noted.

LIVER:

Unremarkable.

GALLBLADDER AND BILE DUCTS:

Surgical clips in the gallbladder fossa compatible with prior cholecystectomy. No intrahepatic or extrahepatic biliary ductal dilatation.

PANCREAS:

Unremarkable. No calcifications or mass.

SPLEEN:

Unremarkable.

ADRENAL GLANDS:

Unremarkable.

KIDNEYS, URETERS, AND BLADDER:

The kidneys appear within normal limits. There is no hydronephrosis, hydroureter, or urinary calculi seen. A Foley catheter balloon is present within the urinary bladder lumen.

STOMACH AND BOWEL:

Unremarkable appearance of the stomach and bowel. No evidence of bowel obstruction. No evidence suggesting enteritis or colitis.

APPENDIX:

No evidence of acute appendicitis on CT examination.

PERITONEUM / ABDOMINAL WALL:

Small sliding-type ventral hernia without bowel incarceration or strangulation. No free fluid. No free air.

LYMPH NODES:

No lymphadenopathy is evident.

REPRODUCTIVE:

The uterus is atrophic, consistent with patient age.

VASCULATURE:

Moderate atherosclerotic calcification of the abdominal aorta and its branch vessels. No evidence of abdominal aortic aneurysm.

BONES:

Multilevel degenerative changes of the lumbar spine. No aggressive appearing osseous lesion or acute fracture.

IMPRESSION:

1. No acute intra-abdominal or pelvic abnormality.

2. Small sliding-type ventral hernia without obstruction.

EXAM:

CT abdomen and pelvis without intravenous contrast.

CLINICAL HISTORY:

Abdominal pain.

TECHNIQUE:

Axial computed tomography images of the abdomen and pelvis were acquired without intravenous contrast. Multiplanar reformatted images were generated and reviewed.

CONTRAST:

None.

COMPARISON:

None provided.

FINDINGS:

LUNG BASES:

Trace bilateral pleural effusion. Bibasilar atelectasis. Small pericardial effusion with maximum thickness 1.3 cm.

LIVER:

Hepatomegaly, craniocaudal extent 16.4 cm. Remaining liver unremarkable on limited non-contrast evaluation.

GALLBLADDER AND BILE DUCTS:

The gallbladder is within normal limits. No radiopaque gallstones. No biliary ductal dilatation.

PANCREAS:

Moderate pancreatic atrophy.

SPLEEN:

Unremarkable.

ADRENAL GLANDS:

Unremarkable.

KIDNEYS, URETERS, AND BLADDER:

1.3 x 1.5 cm exophytic right upper pole hyperdense renal lesion or cyst. 1.3 x 1.3 cm right midpole fat attenuation renal lesion. Punctate 2 mm left lower pole non-obstructing renal calculus. Mild non-specific bilateral perinephric edema. The ureters and bladder are unremarkable.

STOMACH AND BOWEL:

Unremarkable appearance of the stomach and bowel. No bowel obstruction. No enteritis or colitis.

APPENDIX:

No imaging features of acute appendicitis.

PERITONEUM:

No free fluid. No free air.

LYMPH NODES:

No lymphadenopathy.

REPRODUCTIVE:

Dystrophic calcifications in the prostate.

VASCULATURE:

Atherosclerotic wall calcifications in the aorta and its branches. No abdominal aortic aneurysm. Atherosclerotic wall calcifications in coronary arteries. Multiple phleboliths in the pelvis.

BONES:

Chronic T12 edge compression deformity with 50% vertebral body height loss without significant retropulsion. Moderate degenerative changes in the spine. Mild degenerative changes in the right hip joint. No aggressive osseous lesion. No acute osseous pathology.

SOFT TISSUES:

Incidental lipoma in the right iliopsoas muscle, measuring 1.6 x 2.5 x 7 cm. A tiny uncomplicated fat-containing umbilical hernia.

IMPRESSION:

1. No acute intra-abdominal or pelvic pathology.

2. 2 mm non-obstructing left lower pole renal calculus.

3. 1.3 x 1.5 cm hyperdense upper pole renal lesion or cyst. Recommend contrast CT or MRI renal mass protocol for further characterization.

4. 1.3 x 1.3 cm right midpole fat-attenuating renal lesion, likely representing an angiomyolipoma.

5. Trace bilateral pleural effusion and small pericardial effusion.

EXAM:

CT Head Without Intravenous Contrast

CLINICAL HISTORY:

Fall.

TECHNIQUE:

Axial computed tomography images of the head were obtained without intravenous contrast, with multiplanar reformatted images reviewed.

COMPARISON:

None available.

FINDINGS:

BRAIN:

No acute intracranial hemorrhage, mass effect, or midline shift. No extra-axial collection. No definite computed tomography evidence of acute territorial infarction. Generalized cerebral volume loss with chronic microvascular ischemic changes. Prominent calcification of the anterior falx.

Ill-defined hypodensity is noted in the left cerebellar hemisphere, indeterminate in age and potentially representing an age-indeterminate infarct. No associated hemorrhage or significant mass effect.

VENTRICLES:

No hydrocephalus.

ORBITS:

Unremarkable.

SINUSES AND MASTOIDS:

Paranasal sinuses and mastoid air cells are clear.

BONES:

No acute calvarial fracture.

SOFT TISSUES:

No significant abnormality identified.

IMPRESSION:

1. Ill-defined hypodensity in the left cerebellar hemisphere, indeterminate in age and potentially representing an age-indeterminate infarct. If there is clinical concern for acute ischemia, magnetic resonance imaging of the brain with diffusion-weighted imaging is recommended.

EXAM:

CT Abdomen and Pelvis With Intravenous Contrast

INDICATION:

Acute, nonlocalized abdominal pain. Hepatomegaly.

COMPARISON:

None provided.

TECHNIQUE:

Axial CT images of the abdomen and pelvis were obtained following intravenous contrast administration. Multiplanar reformatted images were generated and reviewed.

FINDINGS:

LIVER:

Moderate hepatomegaly is noted, with the liver measuring 24.5 cm in craniocaudal dimension. Diffuse fatty infiltration of the hepatic parenchyma is identified.

A few scattered homogeneously enhancing lesions are identified in both hepatic lobes, the largest measuring 9 mm in the right hepatic lobe.

An additional heterogeneously enhancing lesion with predominant peripheral enhancement is identified in the right hepatic lobe, measuring approximately 3.4 × 2.8 cm. This lesion is indeterminate on the current examination and requires further characterization with dedicated multiphasic contrast-enhanced MRI of the liver.

GALLBLADDER AND BILE DUCTS:

The gallbladder is distended with subtle pericholecystic fluid.

PANCREAS:

Mild diffuse pancreatic parenchymal atrophy is noted with multiple tiny intraparenchymal calcifications, suggestive of chronic calcific pancreatitis.

The main pancreatic duct is mildly prominent.

Mild peripancreatic fat stranding is identified adjacent to the pancreatic tail, with a small amount of peripancreatic fluid, raising concern for superimposed mild acute pancreatitis.

SPLEEN:

Mild splenomegaly is noted, with the spleen measuring 14.5 cm.

The splenic vein is prominent, measuring approximately 10 mm in diameter.

ADRENAL GLANDS:

No abnormality described.

KIDNEYS AND URETERS:

No abnormality described.

STOMACH AND BOWEL:

Mild diffuse gastric wall thickening is identified, possibly related to gastritis.

Mild fecal loading is identified throughout the large bowel.

PERITONEAL CAVITY:

Mild free fluid is identified in the pelvis.

URINARY BLADDER:

No abnormality described.

REPRODUCTIVE ORGANS:

Small peripherally arranged follicles are suspected in both ovaries. Correlation with pelvic ultrasound may be considered if clinically indicated.

VASCULATURE:

The splenic vein is mildly prominent, measuring 10 mm in diameter.

IMPRESSION:

1. Moderate hepatomegaly (24.5 cm) with diffuse hepatic steatosis. Multiple enhancing hepatic lesions, including a 3.4 × 2.8 cm heterogeneously enhancing lesion with predominant peripheral enhancement in the right hepatic lobe. Recommend dedicated multiphasic contrast-enhanced MRI of the liver for further characterization.

2. Mild peripancreatic fat stranding and fluid adjacent to the pancreatic tail, concerning for mild acute pancreatitis. Background pancreatic atrophy, parenchymal calcifications, and mild pancreatic duct prominence suggest chronic pancreatitis. Recommend correlation with serum lipase levels.

3. Distended gallbladder with subtle pericholecystic fluid.

4. Mild splenomegaly (14.5 cm) with prominence of the splenic vein.

5. Mild gastric wall thickening suggestive of gastritis.

6. Trace pelvic free fluid and suspected peripherally arranged bilateral ovarian follicles.

EXAM:

CT of the right lower extremity without intravenous contrast.

CLINICAL HISTORY:

Fell more than 24 hours ago and complains of pain just distal to the right hip.

TECHNIQUE:

Axial computed tomography images of the right lower extremity were acquired without intravenous contrast. Multiplanar reformatted images were generated and reviewed.

CONTRAST:

None.

COMPARISON:

Radiograph of femur dated October 11, 2026.

FINDINGS:

BONES:

Acute non-displaced subcapital femoral neck fracture without articular surface extension, step-off, or gap. No destructive osseous lesion.

JOINTS:

Small femoroacetabular lipohemarthrosis. No dislocation. Mild femoroacetabular osteoarthritis. Degenerative changes in the right sacroiliac joint. Degenerative changes in the lower lumbar spine.

SOFT TISSUES:

Fat-, bowel-, and appendix-containing right inguinal hernia. Mild subcutaneous edema in the lateral proximal thigh and in the right gluteal subcutaneous fat. Atherosclerotic vascular calcifications.

IMPRESSION:

1. Acute non-displaced subcapital femoral neck fracture without articular surface extension, step-off, or gap.

2. Small femoroacetabular lipohemarthrosis.

EXAM:

CT Chest Without IV contrast.

CLINICAL HISTORY:

Pneumonia, effusion or abscess suspected, xray done.

TECHNIQUE:

Axial computed tomography images of the chest without intravenous contrast.

COMPARISON:

CT chest 09/20/2024.

FINDINGS:

LUNGS:

Biapical interlobular septal thickening. Bibasilar compressive subsegmental atelectasis versus consolidation, with similar findings in the lingula. Proximal central airways are patent. There is circumferential thickening of the distal bronchioles especially of the left lower lobe.

PLEURAL SPACES:

No evidence of pneumothorax. Small left and small-to-moderate right pleural effusion.

HEART:

No cardiomegaly. Small pericardial effusion. Multivessel coronary artery calcifications. Calcifications of the thoracic aorta without aneurysm. Right subclavian vein stent.

LYMPH NODES:

No lymphadenopathy is evident.

UPPER ABDOMEN:

Spleen is somewhat lobulated. Kidneys are small and atrophic.

BONES:

Degenerative changes of the spine. Old left lateral rib fractures.

SOFT TISSUES:

Gynecomastia. Mild anasarca.

IMPRESSION:

1. Bibasilar consolidation versus atelectasis and lingular opacities, with distal bronchiolar thickening especially left lower lobe, concerning for pneumonia or bronchiolitis.

2. Biapical interlobular septal thickening.

3. Small pericardial effusion.

4. Multivessel coronary artery calcifications and thoracic aortic calcifications without aneurysm.

5. Other incidental or chronic findings as discussed above which can be further worked up if clinically indicated.

EXAM:

CT right hip without intravenous contrast.

CLINICAL HISTORY:

Hip fracture.

TECHNIQUE:

Axial computed tomography images of the hip were acquired without intravenous contrast. Multiplanar reformatted images were generated and reviewed.

CONTRAST:

None.

COMPARISON:

Radiograph on October 18, 2026.

FINDINGS:

BONES:

Status post hip arthroplasty. Acute non-displaced fracture of the intertrochanteric region of the femur extending into the proximal shaft. Acute non-displaced acetabular fossa fracture. Degenerative changes in the lower lumbar spine.

JOINTS:

Posterior-superior dislocation of the femoral head prosthesis in relation to the acetabulum.

SOFT TISSUES:

Moderate soft tissue edema around the hip and proximal thigh. Small subcutaneous and soft tissue emphysema in the proximal thigh. 4 x 2.6 cm subcutaneous hyperdense collection in the proximal lateral thigh. 1.5 x 1.9 cm hyperdensity in the right lateral pelvic wall adjacent to the aforementioned acetabular fracture. Small fat- and bowel-containing right inguinal hernia. Atherosclerotic vascular calcifications. Colonic diverticulosis. Multiple surgical clips/metallic sutures along the anterior aspect of the hip and proximal thigh.

IMPRESSION:

1. Posterior-superior dislocation of the femoral head prosthesis.

2. Acute non-displaced intertrochanteric femur fracture extending into the proximal shaft.

3. Acute non-displaced acetabular fossa fracture. 1.5 x 1.9 cm hyperdensity in the right lateral pelvic wall adjacent to the acetabular fracture, uncertain etiology, may represent a small hematoma or cement leakage.

4. 4 x 2.6 cm subcutaneous hyperdense collection in the proximal lateral thigh consistent with hematoma.

5. Moderate soft tissue edema around the hip and proximal thigh with small subcutaneous and soft tissue emphysema.

EXAM:

CTA Abdomen and Pelvis with Intravenous Contrast.

CLINICAL HISTORY:

Assess for underlying pathology

TECHNIQUE:

Axial CTA images of the abdomen and pelvis with intravenous contrast in the arterial phase with coronal and sagittal reformatted images generated and reviewed. 3-D reformatted images generated on an independent workstation and also reviewed.

CONTRAST:

Was injected intravenously without incident.

COMPARISON:

None provided.

FINDINGS:

VASCULATURE

Aorta:

No acute finding. No abdominal aortic aneurysm. No dissection.

Celiac trunk:

No acute finding. No occlusion or significant stenosis.

Superior mesenteric artery:

No acute finding. No occlusion or significant stenosis

Inferior mesenteric artery:

No acute finding. No occlusion or significant stenosis.

Renal arteries:

No acute finding. No occlusion or significant stenosis.

Iliac arteries:

No acute finding. No occlusion or significant stenosis.

Lower thorax:

No basilar airspace consolidation.

ABDOMEN:

Liver:

Unremarkable. No mass.

Gallbladder and bile ducts:

No calcified stone. No ductal dilation.

Pancreas:

Unremarkable. No ductal dilation.

Spleen:

Unremarkable.

Adrenals:

No mass.

Kidneys and ureters:

Atrophic bilateral kidneys

Stomach and bowel:

Moderate stool burden in the colon

Small right inguinal hernia containing a loop of large bowel. No CT evidence of strangulation.

Appendix:

The appendix is within normal limits.

PELVIS:

Bladder:

Unremarkable.

Reproductive:

Unremarkable as visualized.

Peritoneum:

No free fluid. No free air.

Lymph nodes:

No lymphadenopathy is evident.

Bones:

There is a separation of the acetabular head prosthesis from the right hip.

MISCELLANEOUS:

Mild soft tissue anasarca

Multilevel degenerative disc disease with disc height loss. Multilevel Modic type changes.

IMPRESSION:

1. There is a separation of the acetabular head prosthesis from the right hip. Overall the prosthetic right femoral head and acetabular cup are superiorly displaced.

2. Mild soft tissue anasarca.

3.Moderate stool burden in the colon.

4. Small right inguinal hernia containing a loop of large bowel. No CT evidence of strangulation.

EXAM:

CTA examination of the chest for PE evaluation.

CLINICAL HISTORY:

Pulmonary embolism suspected. Positive D-dimer.

TECHNIQUE:

Thin-slice, collimated axial CTA images of the chest with intravenous contrast were obtained, with sagittal and coronal reformatted images also submitted. A CT scan was performed according to ALARA (As Low as Reasonably Achievable).

COMPARISON:

CTA examination of the chest 03/15 8:38 EDT.

FINDINGS:

Interval moderate right pleural effusion which has increased as compared to prior CT scan. Stable mild left pleural effusion.

Redemonstrated is nodular pleural thickening on both sides, more pronounced on the left side.

There is re-demonstration of near-complete collapse of the left lower lobe with partial sparing of the superior segment. There is marginal improvement in aeration in the basal segments. Redemonstration of subsegmental atelectasis in the lingular segment of the left upper lobe and medial and lateral segments of the right middle lobe with marginal improvement in aeration. A large right hilar perihilar mass showing mild interval reduction in size, causing invasion of the surrounding right hilar structures, including the pulmonary artery/vein, right main bronchus, and carina, with extension towards the left main bronchus and further extension through matted lymph nodes along the paratracheal locations. Subpleural atelectasis in the posterior basal and lateral basal segments of the right lower lobe.

Multiple stable nodules in the bilateral lungs, the largest measuring 1.6 cm in the left upper lobe.

Interseptal thickening with ground-glass attenuation in the bilateral lungs.

There is moderate stable narrowing of the left pulmonary artery by enlarged mediastinal lymph nodes and hilar lymph nodes. The maximum caliber of the left pulmonary artery measures approximately 1.2 cm.

Redemonstrated severe narrowing of the segmental left upper lobar pulmonary artery.

The Chemoport is identified with its tip in the SVC.

Multiple enlarged right supraclavicular and right axillary lymph nodes. Enlarged mediastinal and hilar lymph nodes, the largest measuring approximately 2.7 cm in the right inferior hilar region.

An enhancing, partially imaged soft tissue lytic lesion is seen involving the anterolateral aspect of the left eighth rib, measuring approximately 4.5 cm.

Redemonstrated lytic lesions are seen involving the T3, T6, T10, and T12 vertebrae.

Sections through the upper abdomen reveal peripherally enhancing lesions in the visualized liver concerning for metastasis. Recommend CT abdomen for further evaluation.

IMPRESSION:

1. No pulmonary arterial thromboembolism. Redemonstarted severe narrowing of the proximal left upper lobar segmental pulmonary arteries by the enlarged mediastinal and hilar lymph nodes.

2. Marginal interval reduction in the size of the right hilar perihilar mass with extensions into the surrounding hilar and mediastinal structures as described.

3. Extensive stable nodular pleural thickening on the left side suggests pleural metastasis.

4. Stable multiple pulmonary nodules in the bilateral lung fields are concerning for pulmonary metastasis.

5. Interstitial septal thickening with ground-glass densities in both lungs, more pronounced on the left side, concerning for lymphangitic carcinomatosis. Stable.

6. Enlarged mediastinal, hilar, right supraclavicular, and right axillary lymph nodes. Marginal interval reduction in the size of the largest lymph node in the right infrahilar region.

7. Stable lytic lesion with soft tissue component in the anterolateral aspect of the left 8th rib. Lytic lesions in the T3, T6, T10, and T12 vertebrae.

8. As compared to the prior CT, there is an interval increase in the right pleural effusion.

9. Sections through the upper abdomen reveal peripherally enhancing lesions in the visualized liver concerning for metastasis. Recommend CT abdomen for further evaluation.

EXAM:

CT Chest Without IV contrast.

CLINICAL HISTORY:

Pneumonia, unresolved.

TECHNIQUE:

Axial computed tomography images of the chest without intravenous contrast.

COMPARISON:

Chest radiograph from today, CT chest from 08/29/2025.

FINDINGS:

LUNGS:

Consolidation versus subsegmental atelectasis of the right lower lobe. Subsegmental atelectasis of the right middle lobe. Left lung is clear.

PLEURAL SPACES:

No pneumothorax evident. Moderate size increased density right pleural effusion may suggest exudative process such as empyema, though evaluation is limited without IV contrast.

HEART:

No cardiomegaly. No significant pericardial effusion. Coronary artery calcifications. Right IJ central line with the tip in the right atrium.

LYMPH NODES:

No lymphadenopathy is evident.

UPPER ABDOMEN:

The upper abdominal solid organs are unremarkable.

BONES:

Chronic healed proximal right humeral fracture. More pronounced thoracic kyphosis. Mild anterior wedge deformities of numerous midthoracic vertebrae.

IMPRESSION:

1. Right lower lobe consolidation versus subsegmental atelectasis, concerning for pneumonia in the appropriate clinical setting.

2. Moderate right pleural effusion with increased density suggesting possible empyema, though evaluation limited without IV contrast.

3. Right middle lobe subsegmental atelectasis.

4. Right internal jugular central line tip in right atrium, which is slightly deep and could be retracted for more optimal positioning in the SVC.

5. Coronary artery calcifications.

6. Chronic healed proximal right humeral fracture.

7. Other incidental or chronic findings as discussed above which can be further worked up if clinically indicated.

MRI SCAN

EXAMINATION:

NONCONTRAST MRI OF THE RIGHT SHOULDER.

CLINICAL HISTORY:

Right shoulder pain.

COMPARISON:

None.

TECHNIQUE:

Multiplanar, multisequence MR images of the right shoulder are submitted.

FINDINGS:

There is type I acromion without subacromial spur. The coracoclavicular ligament is intact. Mild acromioclavicular joint osteoarthritis is present with marginal osteophytes indenting the bursal aspect of the supraspinatus tendon. There is mild subacromial bursal edema.

The supraspinatus tendon demonstrates mild insertional tendinosis with a partial-thickness 2.3 cm AP footprint and critical zone tear involving approximately 50% of tendon thickness. Mild supraspinatus muscle atrophy is present. The infraspinatus tendon shows mild insertional tendinosis. The subscapularis tendon demonstrates moderate insertional tendinosis. The teres minor tendon is intact. The musculature of the rotator cuff otherwise demonstrates normal bulk and signal.

The long head of the biceps tendon demonstrates moderate intra-articular tendinosis. There is posterior superior labral tear with biceps-labral junction fraying.

There is mild to moderate inferior capsular thickening and rotator interval scarring with edema, concerning for adhesive capsulitis. Mild joint effusion is present with fluid extending into the subcoracoid bursa and bicipital groove.

There is normal bone marrow signal within the shoulder girdle without fracture, avascular necrosis, or osteomyelitis.

The glenohumeral joint is otherwise intact.

The soft tissues are normal.

IMPRESSION:

1. Mild supraspinatus insertional tendinosis with partial-thickness (2.3 cm AP, 50% thickness) footprint and critical zone tear. Mild supraspinatus muscle atrophy. Mild subacromial bursal edema.

2. Mild acromioclavicular joint osteoarthritis with marginal osteophytes indenting the bursal surface of the supraspinatus tendon.

3. Mild infraspinatus and moderate subscapularis insertional tendinosis. Moderate intra-articular long head of biceps tendinosis.

4. Posterior superior labral tear with biceps-labral junction fraying.

5. Mild to moderate inferior capsular thickening and scarring with edema, concerning for adhesive capsulitis. Mild joint effusion with extension into the subcoracoid bursa and bicipital groove.

EXAMINATION:

NONCONTRAST MRI OF THE LEFT HIP.

HISTORY:

Left hip and groin pain status post right total hip arthroplasty.

COMPARISON:

None.

TECHNIQUE:

Multiplanar, multisequence MR images of the pelvis and left hip are submitted.

FINDINGS:

There is advanced left hip joint osteoarthritis demonstrating diffuse high-grade femoroacetabular chondral loss, femoral-sided subchondral cystic changes, mild to moderate joint effusion, protrusio acetabuli, and a degenerative labral tear.

The sacroiliac joints are preserved.

The musculature of the pelvis, including the piriformis muscles, appear within normal limits. The iliopsoas tendon appears intact. The hamstring origin at the ischial tuberosity is normal.

There is no iliopsoas or greater trochanteric bursitis.

Visualized aspect of the left sciatic nerve appears within normal limits.

There is no evidence of fracture, avascular necrosis, or osteomyelitis.

Urinary bladder is normal.

IMPRESSION:

1. Advanced left hip osteoarthritis with diffuse high-grade chondral loss, femoral-sided subchondral cysts, mild-to-moderate effusion, protrusio acetabuli, and degenerative labral tearing. No displaced labral tear or acute osseous abnormality.

EXAMINATION:

NONCONTRAST MRI OF THE LEFT KNEE.

CLINICAL HISTORY:

PAIN.

COMPARISON:

None.

TECHNIQUE:

Multiplanar, multisequence MR images of the left knee were obtained.

FINDINGS:

Ligaments:

Anterior cruciate: Moderate mucoid degeneration with small degenerative cystic changes at its tibial attachment.

Posterior cruciate: Intact

Lateral collateral: Intact

Medial collateral: Intact

Tendons:

Quadriceps: Intact

Patellar: Intact

Iliotibial band: Intact

Popliteus: Intact

Retinacula: The medial and lateral patellar retinacula are intact.

Bones: No acute fracture or aggressive appearing osseous lesion. Bone marrow signal intensity is within normal limits except for small subchondral cystic changes in the medial femoral condyle and patella.

Soft tissues: The visualized muscles demonstrate normal girth and signal intensity.

Fluid: Mild joint effusion.

Cartilage:

Diffuse high-grade medial femorotibial weight-bearing chondral loss involving almost the entire articular surface.

Diffuse high-grade medial and central patellar chondral loss with subchondral cystic changes.

Diffuse intermediate to high-grade medial and central trochlear chondral thinning and fissuring.

Menisci:

Full-thickness posterior horn medial meniscus root tear with 0.2 cm extrusion of the body segment in the medial gutter. The remainder of the medial meniscus and the entire lateral meniscus are intact.

IMPRESSION:

1. Full-thickness posterior horn medial meniscus root tear with 0.2 cm body extrusion.

2. Diffuse high-grade chondral loss involving the medial femorotibial compartment, patella, and trochlea with associated subchondral cystic changes and marginal osteophytes.

3. Moderate ACL mucoid degeneration with small tibial attachment cysts.

4. Mild joint effusion.

EXAMINATION:

NONCONTRAST MRI OF THE LEFT FOOT.

CLINICAL HISTORY:

Status post partial great toe, complete 2nd, 3rd, and 4th toe amputations. Rule out osteomyelitis.

COMPARISON:

None.

TECHNIQUE:

Multiplanar, multisequence MR images of the left foot were obtained.

FINDINGS:

There is moderate subcutaneous edema and overlying cutaneous irregularity at the level of the amputations corresponding to the second through fourth metatarsal residual shafts. There is moderate marrow edema involving the second and third metatarsal shafts as well as the fifth metatarsal head. Periosteal effusion is present at the amputated ends of the second and third metatarsal shafts. There is an ill-defined periosteal collection measuring 0.7 × 0.6 × 0.6 cm (AP by transverse by craniocaudal) along the lateral aspect of the third metatarsal amputated end.

Moderate diffuse edema is seen throughout the plantar intrinsic foot muscles as well as the dorsal forefoot and midfoot subcutaneous tissues.

The remaining visualized bone marrow signal is otherwise normal without fracture or avascular necrosis. Joint spaces are preserved.

Visualized extensor and flexor tendons are normal in course and morphology without evidence of tenosynovitis.

Plantar musculature is normal in bulk aside from the diffuse edema described above. Soft tissues are otherwise within normal limits.

IMPRESSION:

1. Moderate marrow edema involving the second and third metatarsal shafts and fifth metatarsal head with associated periosteal effusion at the amputated ends. Ill-defined 0.7 cm periosteal collection along the lateral aspect of the third metatarsal stump. Findings are concerning for osteomyelitis in the appropriate clinical setting.

2. Moderate diffuse plantar intrinsic muscle edema and moderate dorsal forefoot/midfoot subcutaneous edema with cutaneous irregularity at the amputation sites.

3. No fracture or avascular necrosis.

EXAMINATION:

NONCONTRAST MRI EXAMINATION OF THE SACRUM.

CLINICAL HISTORY: Suspected sacral osteomyelitis.

COMPARISON: None.

TECHNIQUE: Multiplanar, multisequence MR images of the sacrum are submitted.

FINDINGS:

The urinary bladder is empty with Foley's bulb in situ.

There is moderate to marked edema involving the right gluteus maximus, medius, and minimus muscles, with associated myofascial edema. Mild to moderate edema is also seen within the right quadriceps, adductor, and iliopsoas muscles. There is overlying diffuse moderate subcutaneous edema in the proximal right thigh, extending into the perianal region. Mild to moderate diffuse edema is present within the left adductor, iliopsoas, and quadratus muscles. Moderate marrow edema involving right ischial tuberosity and extending into the inferior pubic ramus.

No discrete drainable fluid collection is identified. The sacroiliac joints appear within normal limits. Limited views of the pelvis are otherwise unremarkable.

IMPRESSION:

1. Moderate marrow edema involving right ischial tuberosity and extending into the inferior pubic ramus, concerning for osteomyelitis.

2. Moderate to marked right gluteal and proximal thigh myofascial and subcutaneous edema with extension into the perianal region.

3. Mild to moderate contralateral (left) adductor, iliopsoas, and quadratus muscle edema. Imaging features are concerning for myositis.

EXAMINATION:

NONCONTRAST MRI OF THE LEFT ELBOW.

CLINICAL HISTORY:

Left elbow pain.

COMPARISON:

None.

TECHNIQUE:

Multiplanar, multisequence MR images of the left elbow were obtained.

FINDINGS:

There is no bone marrow signal abnormality seen to suggest a fracture, avascular necrosis, or osteomyelitis.

The lateral humeral condyle and olecranon process of the ulna are normal. The radiohumeral and humeroulnar articulations are normal.

Ligaments: On this noncontrast examination, the ulnar collateral, lateral ulnar collateral, annular, and radial collateral ligaments appear normal.

Tendons: The origin of the common flexor tendon from the medial humeral epicondyle is normal. The distal biceps, brachialis, and triceps tendons are intact. There is mild tendinosis of the common extensor tendon origin at the lateral humeral epicondyle with a partial-thickness 0.4 cm interstitial tear involving approximately 25% of the tendon thickness.

There is a small physiologic amount of fluid within the radiocapitellar and ulnotrochlear compartments of the elbow joint. There is no synovitis. The soft tissues are normal. Visualized muscles demonstrate appropriate bulk and signal.

IMPRESSION:

1. Mild common extensor origin tendinosis with a partial-thickness interstitial tear involving approximately 25% of the tendon thickness (0.4 cm).

2. Small joint fluid in the radiocapitellar and ulnotrochlear compartments.

FINDINGS:

Moderate marrow edema involving the base and proximal shaft of the 5th metatarsal with moderate adjacent soft tissue edema. A sinus tract extending laterally from the base of the 5th metatarsal measuring 0.6 cm in thickness and 1.5 cm in length, with an external opening on the lateral aspect. Moderate plantar intrinsic foot muscle edema. Mild dorsal hindfoot, perimalleolar, and distal leg subcutaneous edema. Mild tibiotalar joint effusion. Mild subtalar joint effusion. Mild sinus tarsi edema.

Mild marrow edema seen in the base of the 4th metatarsal. Mild patchy marrow edema involving the medial and intermediate cuneiforms, posterior aspect of the lateral cuneiform, and navicular bone.

The intra-articular surfaces are within normal limits.

Within the tarsal tunnel, the posterior tibial tendon, flexor hallucis longus tendon, and the flexor digitorum longus tendon are normal. Evaluation of the peroneal tendons demonstrates no evidence of peroneal tendon tear or abnormality. There is no evidence of dislocation of the peroneal tendons.

The talar dome is intact without evidence of fracture. The tibia-talar cartilage is intact. The peroneal brevis and longus tendons show no abnormality. The Achilles tendon demonstrates no evidence of Achilles tendon tear. The extensor digitorum longus, anterior tibial tendon, and extensor hallucis longus tendons are normal in appearance.

Evaluation of the ligaments demonstrates the anterior talo-fibular ligament (ATFL) is not torn and is normal in appearance. The lateral ligamentous complex and syndesmosis ligaments show no gross abnormality. The medial complex ligaments, including the deltoid ligament and spring ligament, are visualized and are unremarkable.

IMPRESSION:

1. Osteomyelitis of the base and proximal shaft of the 5th metatarsal with associated sinus tract and overlying soft tissue infection.

2. Reactive bone marrow edema involving the base of the 4th metatarsal, medial and intermediate cuneiforms, posterior lateral cuneiform, and navicular.

3. Moderate plantar intrinsic foot muscle edema and mild dorsal hindfoot/perimalleolar/distal leg subcutaneous edema.

4. Mild tibiotalar and subtalar joint effusions with mild sinus tarsi edema.

EXAMINATION:

NONCONTRAST MRI OF THE RIGHT SHOULDER.

CLINICAL HISTORY:

Insert clinical history.

COMPARISON:

None.

TECHNIQUE:

Multiplanar, multisequence MR images of the right shoulder are submitted.

FINDINGS:

There is a type I acromion without subacromial spur. The coracoclavicular ligament is intact. There is mild acromioclavicular joint osteoarthritis. No periosseous synovial thickening. There is mild subacromial bursal fluid/edema. The peritendinous soft tissues are otherwise normal.

There is a full-thickness delaminating supraspinatus footprint tear measuring 2.4 cm in the AP dimension. There is retraction of the bursal fibers by 1.6 cm to the mid-humeral level and retraction of the articular-sided fibers by 2.7 cm to the level of the glenohumeral joint. Moderate insertional infraspinatus tendinosis is present. The supraspinatus muscle demonstrates moderate atrophy with mild fatty infiltration.

There is a full-thickness subscapularis footprint tear measuring 1.8 cm longitudinally with 3.9 cm medial retraction to the level of the glenohumeral joint. The superior subscapularis muscle demonstrates moderate atrophy with mild fatty infiltration. The inferior subscapularis fibers remain intact.

The long head of the biceps tendon is completely torn at the biceps-labral junction. No healthy intra- or extra-articular long head biceps tendon remnant is identified. There is a posterior superior labral tear.

There is mild glenohumeral joint effusion with fluid extending into the subcoracoid bursa.

The teres minor tendon is intact. The musculature of the rotator cuff otherwise demonstrates normal signal.

There is normal bone marrow signal within the shoulder girdle without fracture, avascular necrosis, or osteomyelitis.

The acromioclavicular joint is otherwise unremarkable. The glenohumeral joint articular cartilage is intact.

The soft tissues are normal.

IMPRESSION:

1. Full-thickness delaminating tear of the supraspinatus footprint measuring 2.4 cm AP with differential retraction (bursal fibers 1.6 cm, articular fibers 2.7 cm). Moderate supraspinatus muscle atrophy with mild fatty infiltration.

2. Full-thickness subscapularis footprint tear measuring 1.8 cm longitudinally with 3.9 cm retraction. Moderate superior subscapularis muscle atrophy with mild fatty infiltration.

3. Complete tear of the long head of the biceps tendon at the biceps-labral junction with absence of a healthy intra- or extra-articular tendon remnant.

4. Posterior superior labral tear.

5. Moderate insertional infraspinatus tendinosis with mild infraspinatus muscle atrophy.

6. Mild subacromial bursitis and mild acromioclavicular joint osteoarthritis.

7. Mild glenohumeral joint effusion extending into the subcoracoid bursa.

EXAMINATION:

MRI Left Hip

TECHNIQUE:

Multiplanar multisequence MRI of the right hip was performed.

CLINICAL HISTORY:

Patient presents for evaluation of right hip pain.

COMPARISON:

None provided.

FINDINGS:

Evaluation of bone marrow signal demonstrates diffuse high-grade right femoroacetabular chondral loss with marked femoral head resorption, flattening, and osseous remodeling. Mild marrow edema involves the femoral head and neck. Deepening of the right acetabulum is present. Moderate right hip joint effusion with synovial debris and thickening is seen. Degenerative anterior superior labral tear is present. Lateral acetabular and femoral head-neck junction marginal osteophytes are noted. Mild degenerative marrow edema involves the right acetabulum. Degenerative changes are seen in the lower lumbar intervertebral disc levels. Mild bilateral iliopsoas bursal edema is present, right more than left. Moderate gluteus medius muscle edema is present. Mild gluteus minimus muscle edema is present. The bilateral sacral neural foramen show no gross abnormality. The surrounding musculature, including the flexors, extensors, and hamstring muscles and tendinous attachments surrounding the hip, are grossly unremarkable.

IMPRESSION:

1. Diffuse high-grade right femoroacetabular chondral loss with marked femoral head resorption, flattening, and osseous remodeling.

2. Mild marrow edema involves the right femoral head and neck with mild degenerative marrow edema in the right acetabulum. Lateral acetabular and femoral head-neck junction marginal osteophytes. Degenerative anterior superior labral tear.

3. Moderate right hip joint effusion with synovial debris and thickening.

4. Moderate right gluteus medius muscle edema with mild gluteus minimus muscle edema.

5. Mild bilateral iliopsoas bursal edema, right greater than left.

6. Degenerative changes in the lower lumbar intervertebral disc levels.

EXAMINATION:

NONCONTRAST MR EXAMINATION OF THE RIGHT WRIST

CLINICAL HISTORY:

Digital radius fracture evaluation.

COMPARISON:

None.

TECHNIQUE:

Multiplanar, multisequence MR images of the right wrist are submitted.

FINDINGS:

There is a fragmented distal radius fracture. The fracture line extends to the distal radial articular surface without overt gap or depression. Patchy marrow edema is present involving the distal radius, distal ulna, and carpal bones. Clinical correlation for complex regional pain syndrome is requested.

A degenerative cystic lesion is seen along the volar aspect of the scaphoid, measuring 0.6 cm. There is mild intercarpal joint effusion and mild periarticular soft tissue edema. An undisplaced ulnar styloid process fracture is also present.

There is a very small radioscaphoid joint effusion.

There is normal bone marrow signal without evidence of osteomyelitis or avascular necrosis.

Flexor group tendons demonstrate normal course and morphology. Visualized ligaments are normal.

Contents of the carpal tunnel appear within normal limits. Median nerve to the extent seen shows normal caliber and signal intensity.

Joint spaces are preserved. No obvious TFCC tear.

Visualized musculature demonstrates normal bulk and signal.

IMPRESSION:

1. Fragmented distal radius fracture extending to the articular surface without significant gap or depression. Undisplaced ulnar styloid fracture.

2. Patchy marrow edema throughout the distal radius, distal ulna, and carpal bones – clinical correlation for complex regional pain syndrome is recommended.

0.6 cm degenerative cyst along the volar scaphoid.

3. Mild intercarpal joint effusion and mild periarticular soft tissue edema.