PI SCAN

MRI LUMBAR SPINE

IMPRESSION:

Loss of normal lumbar lordosis which may be seen with spasm.

T12-L1: Disc is desiccated with a circumferential disc bulge of 1.5 mm with a small cranial extension indenting the anterior thecal sac. The canal and neural foramina are patent. The facet joints are not hypertrophied.

L1-L2: Disc is desiccated with a circumferential disc bulge of 1 mm. The canal and neural foramina are patent. The facet joints are not hypertrophied.

L2-L3: Disc is desiccated with a circumferential disc bulge of 1.5 mm with a small cranial extension indenting the anterior thecal sac. The canal and neural foramina are patent. The facet joints are not hypertrophied.

L3-L4: Disc is desiccated with circumferential bulge of 1.5 mm indenting the anterior thecal sac and causing subtle abutment of bilateral traversing L4 nerve roots. Mild disc bulge with mild ligamentum flavum hypertrophy and facet joint arthropathy cause mild narrowing of the spinal canal. Mild narrowing of the lateral recesses and neural foramina.

L4-L5: Disc is desiccated with circumferential bulge of 1.5 mm indenting the anterior thecal sac and causing abutment of bilateral traversing L5 nerve roots. Mild disc bulge with mild ligamentum flavum hypertrophy and facet joint arthropathy cause mild narrowing of the spinal canal. Mild narrowing of the lateral recesses and neural foramina.

L5-S1: There is a circumferential disc bulge of 1.5 mm abutting bilateral traversing S1 nerve roots. The canal and neural foramina are patent. Mild bilateral facet arthropathy.

INDICATION FOR SCAN:

Motor vehicle accident. Back pain.

COMPARISON:

None.

TECHNIQUE:

Using the GE high field 1.5 Tesla HDXT MRI scanner, the following sequences were obtained of the lumbar spine without contrast:

1. Sagittal T1
2. Sagittal T2
3. Sagittal T2 FS
4. Axial T1
5. Axial T2
6. Angled axial T2

FINDINGS:

There is loss of normal lumbar lordosis, which may be seen with spasm. The lumbar vertebral body heights are preserved. The conus medullaris terminates in normal position. The visualized paralumbar soft tissues are unremarkable.

T12-L1: Disc is desiccated with a circumferential disc bulge of 1.5 mm with a small cranial extension indenting the anterior thecal sac. The canal and neural foramina are patent. The facet joints are not hypertrophied.

L1-L2: Disc is desiccated with a circumferential disc bulge of 1 mm. The canal and neural foramina are patent. The facet joints are not hypertrophied.

L2-L3: Disc is desiccated with a circumferential disc bulge of 1.5 mm with a small cranial extension indenting the anterior thecal sac. The canal and neural foramina are patent. The facet joints are not hypertrophied.

L3-L4: Disc is desiccated with circumferential bulge of 1.5 mm indenting the anterior thecal sac and causing subtle abutment of bilateral traversing L4 nerve roots. Mild disc bulge with mild ligamentum flavum hypertrophy and facet joint arthropathy cause mild narrowing of the spinal canal. Mild narrowing of the lateral recesses and neural foramina.

L4-L5: Disc is desiccated with circumferential bulge of 1.5 mm indenting the anterior thecal sac and causing abutment of bilateral traversing L5 nerve roots. Mild disc bulge with mild ligamentum flavum hypertrophy and facet joint arthropathy cause mild narrowing of the spinal canal. Mild narrowing of the lateral recesses and neural foramina.

L5-S1: There is a circumferential disc bulge of 1.5 mm abutting bilateral traversing S1 nerve roots. The canal and neural foramina are patent. Mild bilateral facet arthropathy.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI LUMBAR SPINE

IMPRESSION:

1. Moderate lumbar spondylosis most pronounced at L4-L5 level with an asymmetric disc bulge with predominant right foraminal component of 3.5 mm. The disc bulge causes indentation over the thecal sac abutting bilateral traversing L5 nerve roots. Moderate narrowing of the right lateral recess and neural foramina abutting the exiting L4 nerve root. Mild narrowing of the left lateral recess and neural foramina. Disc bulge along with mild ligamentum flavum hypertrophy cause mild narrowing of the neural foramina. Mild bilateral facet arthropathy.

2. Mild spondylolis at rest of the levels in the lumbar spine. Mild bulges at T12-L1, L1-, L2-L3, L3-L4 and L5-S1 levels. Mild canal narrowing at L3-L4 level. Mild narrowing of both the lateral recesses and neural foramina at L3-L4 level. There is abutment of bilateral traversing L4 and S1 nerve roots.

3. Loss of normal lumbar lordosis which may be seen with spasm.

INDICATION FOR SCAN:

Pain. Motor vehicle accident.

COMPARISON:

None.

TECHNIQUE:

Using the GE high field 1.5 Tesla HDXT MRI scanner, the following sequences were obtained of the lumbar spine without contrast:

1. Sagittal T1
2. Sagittal T2
3. Sagittal T2 FS
4. Axial T1
5. Axial T2
6. Angled axial T2

FINDINGS:

There is loss of normal lumbar lordosis, which may be seen with spasm. The lumbar vertebral body heights are preserved. Multilevel anterior osteophytes. The conus medullaris terminates in normal position. The visualized paralumbar soft tissues are unremarkable.

T12-L1: The disc is desiccated with an annular bulge of 1 mm. The canal and neural foramina are patent. The facet joints are not hypertrophied.

L1-L2: The disc is desiccated with an annular bulge of 1 mm. The canal and neural foramina are patent. The facet joints are not hypertrophied.

L2-L3: The disc is desiccated with an annular bulge of 1 mm. Mild narrowing of both lateral recesses. No narrowing of the neural foramina. Mild ligamentum flavum hypertrophy along with mild disc bulge cause mild canal narrowing. The facet joints are not hypertrophied.

L3-L4: Disc is desiccated with an annular bulge of 1 mm indenting the anterior thecal sac and abutting bilateral traversing L4 nerve roots. Small bilateral foraminal components cause mild narrowing of the lateral recesses and neural foramina. Mild bilateral facet arthropathy and ligamentum flavum hypertrophy. Mild canal narrowing .

L4-L5: Disc is desiccated with an asymmetric disc bulge with predominant right foraminal component of 3.5 mm. The disc bulge causes indentation over the thecal sac abutting bilateral traversing L5 nerve roots. Moderate narrowing of the right lateral recess and neural foramina abutting the exiting L4 nerve root. Mild narrowing of the left lateral recess and neural foramina. Disc bulge along with mild ligamentum flavum hypertrophy cause mild narrowing of the neural foramina. Mild bilateral facet arthropathy.

L5-S1: Disc is desiccated with a circumferential disc bulge of 1.5 mm causing subtle indentation over the thecal sac and abutting bilateral traversing S1 nerve roots. The canal and neural foramina are patent. The facet joints are not hypertrophied.

Subcutaneous edema in the back along the lumbar region.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI CERVICAL SPINE

IMPRESSION:

1. **C3-C4: Disc is desiccated with a 3.0 mm posterior disc osteophyte complex indenting the anterior thecal sac and abutting the spinal cord. Bilateral foraminal components cause mild narrowing of both the neural foramina. Moderate canal narrowing. The facet joints are mildly hypertrophied.**

2. **C4-C5: Disc is desiccated with a 2.5 mm posterior disc osteophyte complex indenting the anterior thecal sac and abutting the spinal cord. Bilateral foraminal components cause mild narrowing of both the neural foramina. Moderate canal narrowing. The facet joints are mildly hypertrophied.**

3. **C5-C6: There is 2 mm of anterolisthesis of C5 on C6. Disc is desiccated with a diffuse disc bulge of 3.0 mm indenting the anterior thecal sac and abutting the spinal cord. Bilateral foraminal components with left dominance causing mild narrowing of both neural foramina abutting the exiting C6 nerve roots. Moderate canal narrowing. The facet joints are not hypertrophied.**

4. **C6-C7: There is disc desiccation present. There is 2 mm of anterolisthesis of C6 on C7. There is no significant disc bulge or protrusion. The canal and neural foramina are patent. The facet joints are not hypertrophied.**

5. **C7-T1: There is disc desiccation present. There is 2 mm of anterolisthesis of C7 on T1. There is no significant disc bulge or protrusion. The canal and neural foramina are patent. The facet joints are not hypertrophied.**

6. **Mild increased signal intensity in the interspinous ligament at C3-C4-C5 vertebral bodies and could suggest posttraumatic strain.**

INDICATION FOR SCAN:

Pain. Motor vehicle accident.

COMPARISON:

None.

TECHNIQUE:

Using the GE high field 1.5 Tesla HDXT MRI scanner, the following sequences were obtained of the cervical spine without contrast:

1. Sagittal T1
2. Sagittal T2
3. Sagittal STIR
4. Oblique sagittal T2
5. Axial T2

FINDINGS:

There is normal lordosis of the cervical spine. The cervical vertebral body heights are preserved. Mild increased signal intensity in the interspinous ligament at C3-C4-C5 vertebral bodies and could suggest posttraumatic strain. The visualized portions of the posterior fossa and cervical cord demonstrate normal morphology and signal intensity.

C2-C3: Disc is desiccated. There is no significant disc bulge or protrusion. The canal and neural foramina are patent. The facet joints are not hypertrophied.

C3-C4: Disc is desiccated with a 3.0 mm posterior disc osteophyte complex indenting the anterior thecal sac and abutting the spinal cord. Bilateral foraminal components cause mild narrowing of both the neural foramina. Moderate canal narrowing. The facet joints are mildly hypertrophied.

C4-C5: Disc is desiccated with a 2.5 mm posterior disc osteophyte complex indenting the anterior thecal sac and abutting the spinal cord. Bilateral foraminal components cause mild narrowing of both the neural foramina. Moderate canal narrowing. The facet joints are mildly hypertrophied.

C5-C6: There is 2 mm of anterolisthesis of C5 on C6. Disc is desiccated with a diffuse disc bulge of 3.0 mm indenting the anterior thecal sac and abutting the spinal cord. Bilateral foraminal components with left dominance causing mild narrowing of both neural foramina abutting the exiting C6 nerve roots. Moderate canal narrowing. The facet joints are not hypertrophied.

C6-C7: There is disc desiccation present. There is 2 mm of anterolisthesis of C6 on C7. There is no significant disc bulge or protrusion. The canal and neural foramina are patent. The facet joints are not hypertrophied.

C7-T1: There is disc desiccation present. There is 2 mm of anterolisthesis of C7 on T1. There is no significant disc bulge or protrusion. The canal and neural foramina are patent. The facet joints are not hypertrophied.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI CERVICAL SPINE

IMPRESSION:

1. There is disc desiccation with moderate reduction in the intervertebral disc height and Modic type II endplate changes at C4-C5 level. Moderate narrowing of the left neural foramina and mild narrowing of the right neural foramina and spinal canal secondary to an asymmetric disc bulge with predominant left foraminal component of 3 mm. There is abutment of bilateral exiting C5 nerve roots. Bilateral uncovertebral joint hypertrophy.

2. There is disc desiccation with moderate reduction in the intervertebral disc height and Modic type II endplate changes at C5-C6 level. Moderate narrowing of both the neural foramina and spinal canal secondary to a circumferential bulge of 2 mm. There is abutment of bilateral exiting C6 nerve roots. Bilateral uncovertebral joint hypertrophy.

3. 1 mm retrolisthesis of C6 over C7 vertebral body. There is disc desiccation with moderate reduction in the intervertebral disc height and Modic type II endplate changes at C6-C7 level. Moderate narrowing of both the neural foramina and spinal canal secondary to a circumferential bulge of 2 mm. There is abutment of bilateral exiting C6 nerve roots. Bilateral uncovertebral joint hypertrophy.

4. There is disc desiccation with a 2 mm posterior central disc protrusion at C2-C3 level. The canal and neural foramina are patent. The facet joints are not hypertrophied.

5. There is disc desiccation with mild reduction in the intervertebral disc height and 1 mm disc bulge at C3-C4 level. The canal and neural foramina are patent. The facet joints are not hypertrophied.

6. Loss of normal cervical lordosis could be secondary to muscular spasm.

INDICATION FOR SCAN:

Motor vehicle accident.

COMPARISON:

None.

TECHNIQUE:

Using the GE high field 3 Tesla HDXT MRI scanner, the following sequences were obtained of the cervical spine without contrast:

1. Sagittal T1
2. Sagittal T2
3. Sagittal STIR
4. Oblique sagittal T2
5. Axial T2

FINDINGS:

There is loss of normal lordosis of the cervical spine. The cervical vertebral body heights are preserved. Multilevel anterior osteophytes. The visualized portions of the posterior fossa and cervical cord demonstrate normal morphology and signal intensity.

C2-C3: There is disc desiccation with a 2 mm posterior central disc protrusion. The canal and neural foramina are patent. The facet joints are not hypertrophied.

C3-C4: There is disc desiccation with mild reduction in the intervertebral disc height and 1 mm disc bulge. The canal and neural foramina are patent. The facet joints are not hypertrophied.

C4-C5: There is disc desiccation with moderate reduction in the intervertebral disc height and Modic type II endplate changes. Moderate narrowing of the left neural foramina and mild narrowing of the right neural foramina and spinal canal secondary to an asymmetric disc bulge with predominant left foraminal component of 3 mm. There is abutment of bilateral exiting C5 nerve roots. Bilateral uncovertebral joint hypertrophy.

C5-C6: There is disc desiccation with moderate reduction in the intervertebral disc height and Modic type II endplate changes. Moderate narrowing of both the neural foramina and spinal canal secondary to a circumferential bulge of 2 mm. There is abutment of bilateral exiting C6 nerve roots. Bilateral uncovertebral joint hypertrophy.

C6-C7: 1 mm retrolisthesis of C6 over C7 vertebral body. There is disc desiccation with moderate reduction in the intervertebral disc height and Modic type II endplate changes. Moderate narrowing of both the neural foramina and spinal canal secondary to a circumferential bulge of 2 mm. There is abutment of bilateral exiting C6 nerve roots. Bilateral uncovertebral joint hypertrophy.

C7-T1: There is no significant disc bulge or protrusion. The canal and neural foramina are patent. The facet joints are not hypertrophied.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI BRAIN

IMPRESSION:

1. No acute intracranial abnormality identified.

2. Mild age-related cerebral atrophy.

EXAM:

MR Brain Without and With IV Contrast

CLINICAL HISTORY:

Vertigo.

TECHNIQUE:

Multiplanar multi-sequence MRI of the brain on 3 Tesla MRI machine.

COMPARISON:

None provided.

FINDINGS:

No abnormal parenchymal signal is present. No abnormal postcontrast enhancement.

No evidence of acute cortical infarction, hemorrhage, mass or mass effect.

The ventricular system, sulci and cisterns appear mildly prominent.

No hydrocephalus.

No abnormal extra-axial fluid collection is present.

The marrow signal within the skull base and calvarium is intact.

The paranasal sinuses and mastoid air cells are clear.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

MRI THORACIC SPINE

IMPRESSION:

1. No significant central canal or neural foraminal stenosis.

2. Mild multilevel degenerative changes with marginal osteophytes and mild bilateral facet arthropathy throughout the thoracic spine.

INDICATION FOR SCAN:

Back pain. History of motor vehicle accident on 07/15/2026.

COMPARISON:

None.

TECHNIQUE:

Using the GE high field 3 Tesla HDXT MRI scanner, the following sequences were obtained of the thoracic spine without and with contrast:

1.Axial T1

2.Axial T2

3.Sagittal T1

4.Sagittal T2

FINDINGS:

Marginal osteophytes are present along multiple thoracic vertebral bodies. The thoracic cord demonstrates normal morphology and signal intensity. The conus medullaris terminates in normal position. The thoracic vertebral body heights are preserved.

C7-T1: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T1-T2: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T2-T3: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T3-T4: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T4-T5: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T5-T6: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T6-T7: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T7-T8: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T8-T9: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T9-T10: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T10-T11: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T11-T12: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

T12-L1: Disc hydration and height are preserved. There is no significant disc bulge or protrusion. No central canal stenosis. No neural foraminal stenosis. Mild bilateral facet arthropathy.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI THORAIC SPINE.

IMPRESSION:

1. Diffuse disc desiccation with mild disc height loss at T11-T12. The disc is degenerated. Right-dominant circumferential disc bulge measuring 3-4 mm with mild bilateral facet arthropathy. No central canal stenosis. Right neural foraminal stenosis. Stable.

2. Diffuse disc desiccation with mild disc height loss at C7-T1. Right-dominant circumferential disc bulge measuring 2-3 mm with mild bilateral facet arthropathy. No central canal stenosis. Mild bilateral neural foraminal stenosis, left greater than right. C7-T1 was not covered on the prior examination; therefore, comparison at this level cannot be performed.

3. Diffuse disc desiccation with mild disc height loss at T9-T10. The disc is degenerated. Diffuse circumferential disc bulge with superimposed right paracentral disc protrusion measuring 2-3 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

4. Diffuse disc desiccation with mild disc height loss at T7-T8. Circumferential disc bulge with superimposed right paracentral disc protrusion measuring 2-3 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

5. Diffuse disc desiccation with mild disc height loss at T10-T11. The disc is degenerated. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

6. Diffuse disc desiccation with mild disc height loss at T12-L1. The disc is degenerated Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

7. Diffuse disc desiccation with mild disc height loss at T1-T2. Modic type 1 degenerative endplate changes. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

8. Diffuse disc desiccation with mild disc height loss at T2-T3. Modic type 1 degenerative endplate changes. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

9. Diffuse disc desiccation with mild disc height loss at T3-T4. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

10. Diffuse disc desiccation with mild disc height loss at T4-T5. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

11. Diffuse disc desiccation with mild disc height loss at T5-T6. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

12. Diffuse disc desiccation with mild disc height loss at T6-T7. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

13. Diffuse disc desiccation with mild disc height loss at T8-T9. Mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

INDICATION FOR SCAN:

Back pain. No prior surgery.

COMPARISON:

MRI thoracic spine dated 08/22/2024.

TECHNIQUE:

Using the GE high field 3 Tesla Verio MRI scanner, the following sequences were obtained of the thoracic spine without and with contrast:

1.Axial T1

2.Axial T2

3.Sagittal T1

4.Sagittal T2

5.Sagittal T2 fat-saturated

FINDINGS:

Normal alignment of the thoracic spine. Thoracic vertebral body heights are preserved. Marginal osteophytes along multiple thoracic vertebrae. T11 vertebral body hemangioma. The thoracic cord maintains normal morphology and signal intensity. Prominent central canal within the lower cervical and upper thoracic spinal cord extending from C7 through T2. The conus medullaris terminates in normal position.

C7-T1: Diffuse disc desiccation with mild disc height loss. Right-dominant circumferential disc bulge measuring 2-3 mm with mild bilateral facet arthropathy. No central canal stenosis. Mild bilateral neural foraminal stenosis, left greater than right. C7-T1 was not covered on the prior examination; therefore, comparison at this level cannot be performed.

T1-T2: Diffuse disc desiccation with mild disc height loss. Modic type 1 degenerative endplate changes. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T2-T3: Diffuse disc desiccation with mild disc height loss. Modic type 1 degenerative endplate changes. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T3-T4: Diffuse disc desiccation with mild disc height loss. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T4-T5: Diffuse disc desiccation with mild disc height loss. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T5-T6: Diffuse disc desiccation with mild disc height loss. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T6-T7: Diffuse disc desiccation with mild disc height loss. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T7-T8: Diffuse disc desiccation with mild disc height loss. Circumferential disc bulge with superimposed right paracentral disc protrusion measuring 2-3 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T8-T9: Diffuse disc desiccation with mild disc height loss. Mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T9-T10: Diffuse disc desiccation with mild disc height loss. The disc is degenerated Diffuse circumferential disc bulge with superimposed right paracentral disc protrusion measuring 2-3 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T10-T11: Diffuse disc desiccation with mild disc height loss. The disc is degenerated. Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

T11-T12: Diffuse disc desiccation with mild disc height loss. The disc is degenerated Right-dominant circumferential disc bulge measuring 3-4 mm with mild bilateral facet arthropathy. No central canal stenosis. Right neural foraminal stenosis. Stable.

T12-L1: Diffuse disc desiccation with mild disc height loss. Disc is degenerated Circumferential disc bulge measuring 1-2 mm with mild bilateral facet arthropathy. No central canal stenosis. No neural foraminal stenosis. Stable.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI SHOULDER LEFT

IMPRESSION:

1. There is a full-thickness, partial width tear of the supraspinatus tendon involving the anterior 30% of the supraspinatus footprint. There is approximately 1.4 cm of retraction. There is no fatty atrophy of the supraspinatus muscle belly.

2. There are mild tendinosis changes of the infraspinatus tendon. The teres minor and subscapularis tendons are unremarkable.

3. There is no evidence of labral pathology or biceps tendon tear.

4. Moderate acromioclavicular joint degenerative changes with capsular hypertrophy and inferior osteophytosis have increased the risk for impingement.

INDICATION FOR SCAN:

Trauma.

COMPARISON:

None

TECHNIQUE:

Using the GE high field 1.5 Tesla HDXT MRI scanner, the following sequences were obtained of the left shoulder:

Coronal T2 fat sat, axial PD fat sat, sagittal T1, sagittal T2 fat sat

FINDINGS:

ROTATOR CUFF:

Noted is a full-thickness, partial width insertional tear involving the anterior 30% of the supraspinatus footprint. There is retraction of about 1.4 cm. There is no fatty atrophy of the supraspinatus muscle belly. There are tendinosis changes of the infraspinatus tendon.

The subscapularis and teres minor tendons and muscles are unremarkable.

BICEPS:

The long head of the biceps tendon is within bicipital groove. There are mild tendinopathy changes of the interarticular segment of the long head of the biceps tendon.

LABRUM:

No discrete linear fluid signal abnormality to suggest labral tear.

JOINTS:

Glenohumeral cartilage remains intact, no measurable defect or subchondral marrow signal abnormality. No joint effusion. There is mild inferior capsular thickening with edema.

Moderate acromioclavicular joint osteoarthrosis changes with capsular hypertrophy and inferior osteophytosis have mildly increased risk for impingement. There are no periarticular soft tissue masses.

BONE MARROW:

The bone marrow signal intensity is normal. The alignment is anatomic. There is no evidence of marrow contusion or fracture.

OTHER:

No mass, fluid collection, or hematoma.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI SHOULDER RIGHT

IMPRESSION:

1. Mild supraspinatus and infraspinatus insertional tendinosis. Partial thickness anterior supraspinatus interstitial footprint tear measuring 0.8 cm AP and 0.4 cm wide involving 25% of the tendon thickness without any retraction. Mild subacromial bursal fluid and edema.

2. Mild subscapularis insertional tendinosis. Mild intra-articular long head of biceps tendinosis.

3. Posterior superior labral tear.

4. Posterior inferior quadrant glenoid-sided intermediate grade chondral thinning and fissuring with subchondral cystic changes and mild edema.

5. Small joint effusion.

INDICATION FOR SCAN:

Right shoulder pain.

COMPARISON:

None.

TECHNIQUE:

Using the GE high field 1.5 Tesla HDXT MRI scanner, the following sequences were obtained of the right shoulder:

Coronal T2 fat sat, axial PD fat sat, sagittal T1, sagittal T2 fat sat

FINDINGS:

ROTATOR CUFF:

Mild supraspinatus and infraspinatus insertional tendinosis. There is partial thickness anterior supraspinatus interstitial footprint tear measuring 0.8 cm AP and 0.4 cm wide involving 25% of the tendon thickness without any retraction. Mild subscapularis insertional tendinosis. Remainder of the rotator cuff remains intact.

Rotator cuff muscles are normal in signal and bulk.

BICEPS:

Biceps long head tendon remains intact. Mild intra-articular long head of biceps tendinosis. No tenosynovitis.

LABRUM:

Posterior superior labral tear.

JOINT:

Posterior inferior quadrant glenoid-sided intermediate grade chondral thinning and fissuring with subchondral cystic changes and mild edema. Small joint effusion.

Acromioclavicular joint is normal.

BONE:

No acute fracture.

OTHER:

Mild subacromial bursal fluid and edema. No bursitis.

No mass, fluid collection, or hematoma.

Partially imaged lung is clear.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI HIP LEFT

IMPRESSION:

1. Mild left peritrochanteric edema with small fluid.

2. Left anterior superior labral fraying.

3. 1 x 1.2 cm posterior uterine wall intramural fibroid, amenable for ultrasound evaluation.

INDICATION:

Left hip pain.

COMPARISON:

None.

TECHNIQUE:

MRI of the left hip was obtained using the GE high field 1.5 Tesla HDXT MRI scanner. The following sequences were obtained:

Sagittal PD fat sat, axial T1, axial PD fat sat, axial STIR, coronal STIR, coronal PD fat sat and coronal T1

FINDINGS:

BONE:

No marrow signal abnormality. No acute fracture. No bone lesion.

JOINTS:

No measurable cartilage defect. No subchondral marrow signal abnormality.

No significant joint effusion.

Sacroiliac joints are maintained.

LABRUM:

Left anterior superior labral fraying.

TENDONS:

The tendons including the hamstring, gluteal, iliopsoas, and rectus femoris tendons remain intact. The ischiofemoral space is maintained without quadratus femoris edema.

MUSCLES AND SOFT TISSUES:

Muscles are normal in signal and bulk. No intramuscular edema or significant fatty atrophy.

No mass, fluid collection, or hematoma. No bursitis. Mild left peritrochanteric edema with small fluid.

Sciatic nerve is normal in caliber and signal.

OTHER:

1 x 1.2 cm posterior uterine wall intramural fibroid, amenable for ultrasound evaluation. Partially imaged abdomen and pelvis is not well evaluated, otherwise grossly unremarkable.

Partially imaged lower lumbar spine is not well evaluated, grossly unremarkable.

Contralateral hip is incompletely imaged, grossly unremarkable.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI HIP LEFT

IMPRESSION:

1. Left anterior superior labral tear. Small left hip joint fluid.

2. Visualized vertebrae, pelvic bones, and femora demonstrate diffuse mottled appearance, likely osteoporotic.

INDICATION:

Left hip pain.

COMPARISON:

None.

TECHNIQUE:

MRI of the left hip was obtained using the GE high field 1.5 Tesla HDXT MRI scanner. The following sequences were obtained:

Sagittal PD fat sat, axial T1, axial PD fat sat, axial STIR, coronal STIR, coronal PD fat sat and coronal T1

FINDINGS:

BONE:

Visualized vertebrae, pelvic bones, and femora demonstrate diffuse mottled appearance, likely osteoporotic. No other marrow signal abnormality. No acute fracture. No bone lesion.

JOINTS:

No measurable cartilage defect. No subchondral marrow signal abnormality.

Small left hip joint fluid.

Small likely degenerative subchondral cystic changes in the sacral aspect of the left sacroiliac joint. Sacroiliac joints are otherwise maintained.

LABRUM:

Left anterior superior labral tear.

TENDONS:

The tendons including the hamstring, gluteal, iliopsoas, and rectus femoris tendons remain intact. The ischiofemoral space is maintained without quadratus femoris edema.

MUSCLES AND SOFT TISSUES:

Muscles are normal in signal and bulk. No intramuscular edema or significant fatty atrophy.

No mass, fluid collection, or hematoma. No bursitis. No peritrochanteric edema.

Sciatic nerve is normal in caliber and signal.

OTHER:

Partially imaged abdomen and pelvis is not well evaluated, grossly unremarkable.

Partially imaged lower lumbar spine is not well evaluated, grossly unremarkable.

Contralateral hip is incompletely imaged and demonstrates tiny degenerative cystic changes in the anterior lateral acetabulum but otherwise grossly unremarkable.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI KNEE LEFT

IMPRESSION:

1. Moderate joint effusion. Small leaking Baker's cyst. Mild prepatellar subcutaneous edema.

2. Mild anterior cruciate ligament mucoid degeneration.

3. Complex posterior horn body junction and body medial meniscus tear with moderate attenuation of the body segment, 0.4 cm extrusion of the body segment in the medial gutter and small flap displaced undersurface of the body segment.

4. Diffuse high-grade medial femorotibial weight-bearing chondral loss involving almost entire articular surface, with small tibial-sided subchondral cystic changes and small medial femorotibial marginal osteophytes. Diffuse intermediate to high-grade medial trochlear chondral thinning.

INDICATION FOR SCAN:

Left knee pain.

COMPARISON:

None

TECHNIQUE:

Using the GE high field 1.5 Tesla HDXT MRI scanner, the following sequences were obtained of the left knee:

1. Coronal T1
2. Coronal PD FS
3. Axial PD FS
4. Sagittal PD
5. Sagittal PD FS

FINDINGS:

BONE:

No marrow signal abnormality. No acute fracture. No bone lesion.

LIGAMENTS:

Anterior cruciate ligament: Mild anterior cruciate ligament mucoid degeneration.

Medial collateral ligament: The medial collateral ligament remains intact.

Posterior cruciate ligament: The posterior cruciate ligament remains intact.

Lateral supporting ligaments and tendons: Fibular collateral ligament remains intact. The iliotibial band and biceps femoris remain intact.

Patellofemoral supporting structures: The medial and lateral patellofemoral ligament/retinaculum remain intact.

EXTENSOR MECHANISM:

Patellar tendon: The patellar tendon remains intact, no tendinopathy or tendon tear.

Quadriceps tendon: The quadriceps tendon remains intact.

CARTILAGE:

Diffuse high-grade medial femorotibial weight-bearing chondral loss involving almost entire articular surface, with small tibial-sided subchondral cystic changes and small medial femorotibial marginal osteophytes. Diffuse intermediate to high-grade medial trochlear chondral thinning.

Mild joint effusion.

MENISCUS:

Medial meniscus: Complex posterior horn body junction and body medial meniscus tear with moderate attenuation of the body segment, 0.4 cm extrusion of the body segment in the medial gutter and small flap displaced under surface of the body segment.

Lateral meniscus: The lateral meniscus remains intact.

OTHER:

Small leaking Baker's cyst. Mild prepatellar subcutaneous edema.

No mass, fluid collection, or hematoma.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI KNEE RIGHT

IMPRESSION:

1. Complex posterior horn and body medial meniscus tear with marked attenuation of the posterior horn and body segment.

2. Diffuse high-grade medial femoral tibial weight-bearing condyle loss involving almost the entire articular surface, with tibial-sided subchondral cystic changes and small marginal osteophytes.

3. A 1.1 x 1.7 x 0.5 cm (AP by transverse by craniocaudal) multiloculated ganglion cyst seen anterior to the anterior horn lateral meniscus root attachment.

4. Moderate joint effusion. Small leaking Baker's cyst.

5. Diffuse intermediate to high-grade medial and central trochlear chondral thinning and fissuring and small patellofemoral marginal osteophytes. Mild prepatellar subcutaneous edema.

INDICATION FOR SCAN:

Right knee pain.

COMPARISON:

None.

TECHNIQUE:

Using the GE high field 1.5 Tesla HDXT MRI scanner, the following sequences were obtained of the right knee:

1. Coronal T1
2. Coronal PD FS
3. Axial PD FS
4. Sagittal PD
5. Sagittal PD FS

FINDINGS:

BONE:

No marrow signal abnormality. No acute fracture. No bone lesion.

LIGAMENTS:

Anterior cruciate ligament: Anterior cruciate ligament remains intact.

Medial collateral ligament: The medial collateral ligament remains intact.

Posterior cruciate ligament: The posterior cruciate ligament remains intact.

Lateral supporting ligaments and tendons: Fibular collateral ligament remains intact. The iliotibial band and biceps femoris remain intact.

Patellofemoral supporting structures: The medial and lateral patellofemoral ligament/retinaculum remain intact.

EXTENSOR MECHANISM:

Patellar tendon: The patellar tendon remains intact, no tendinopathy or tendon tear.

Quadriceps tendon: The quadriceps tendon remains intact.

CARTILAGE:

Diffuse high-grade medial femoral tibial weight-bearing condyle loss involving almost the entire articular surface, with tibial-sided subchondral cystic changes and small marginal osteophytes. Diffuse intermediate to high-grade medial and central trochlear chondral thinning and fissuring and small patellofemoral marginal osteophytes.

Moderate joint effusion.

MENISCUS:

Medial meniscus: Complex posterior horn and body medial meniscus tear with marked attenuation of the posterior horn and body segment.

Lateral meniscus: The lateral meniscus remains intact. A 1.1 x 1.7 x 0.5 cm (AP by transverse by craniocaudal) multiloculated ganglion cyst seen anterior to the anterior horn lateral meniscus root attachment.

OTHER:

Small leaking Baker's cyst. Mild prepatellar subcutaneous edema.

No mass, fluid collection, or hematoma.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI FOOT RIGHT

IMPRESSION:

1. Small first to third metatarsophalangeal joint fluid.

2. Mild first metatarsophalangeal joint osteoarthritis.

3. Small flexor hallucis longus tendon sheath fluid at the level of great toe proximal phalanx.

4. Mild marrow edema involving the medial hallux sesamoid, likely stress related.

INDICATION:

Right foot pain.

COMPARISON:

None.

TECHNIQUE:

MRI of the right foot was obtained using the GE high field 1.5 Tesla HDXT MRI scanner. The following sequences were obtained:

Sagittal T1, Sagittal STIR, Coronal proton density fat saturated, Coronal T1, Axial proton density fat saturated, Axial T2 and Axial T1.

FINDINGS:

BONE:

No marrow signal abnormality. No acute fracture. No bone lesion. Mild marrow edema involving the medial hallux sesamoid.

JOINTS:

Small first to third metatarsophalangeal joint fluid. Mild first metatarsophalangeal joint osteoarthritis.

LIGAMENTS:

The ligaments including the Lisfranc ligament are normal in signal and morphology, intact.

The plantar plates are intact.

The hallux sesamoid tendinoligamentous complex remains intact.

TENDONS:

Small flexor hallucis longus tendon sheath fluid at the level of great toe proximal phalanx. The tendons remain intact, no tendinopathy or tendon tear. No other tenosynovitis.

MUSCLES AND SOFT TISSUES:

Muscles are normal in signal and bulk. No intramuscular edema or significant fatty atrophy.

No mass, fluid collection, or hematoma.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI FOOT LEFT

IMPRESSION:

1. Mild first metatarsophalangeal joint osteoarthritis.

2. Mild dorsal midfoot subcutaneous edema.

3. Small first to fourth metatarsophalangeal joint fluid.

INDICATION:

Left foot pain.

COMPARISON:

None.

TECHNIQUE:

MRI of the left foot was obtained using the GE high field 1.5 Tesla HDXT MRI scanner. The following sequences were obtained:

Sagittal T1, Sagittal STIR, Coronal proton density fat saturated, Coronal T1, Axial proton density fat saturated, Axial T2 and Axial T1.

FINDINGS:

BONE:

No marrow signal abnormality. No acute fracture. No bone lesion.

JOINTS:

Mild first metatarsophalangeal joint osteoarthritis. The joint spaces are otherwise maintained. Small first to fourth metatarsophalangeal joint fluid.

LIGAMENTS:

The ligaments including the Lisfranc ligament are normal in signal and morphology, intact.

The plantar plates are intact.

The hallux sesamoid tendinoligamentous complex remains intact.

TENDONS:

The tendons remain intact, no tendinopathy or tendon tear. No tenosynovitis.

MUSCLES AND SOFT TISSUES:

Muscles are normal in signal and bulk. No intramuscular edema or significant fatty atrophy.

No mass, fluid collection, or hematoma. Mild dorsal midfoot subcutaneous edema.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI FINGER RIGHT

IMPRESSION:

1. Low-grade radial collateral ligament sprain at the 4th digit proximal interphalangeal joint.

2. Small joint effusions at the 2nd through 4th metacarpophalangeal joints.

3. No fracture, avascular necrosis, or tendon injury.

EXAMINATION:

NONCONTRAST MRI OF THE RIGHT HAND WITHOUT CONTRAST.

CLINICAL HISTORY:

Right 4th digit injury after slip and fall in the last week of May. Patient presents with 4th digit pain and swelling, especially at the proximal phalanx and proximal interphalangeal joint level.

COMPARISON:

None.

TECHNIQUE:

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

FINDINGS:

There is normal bone marrow signal without evidence for fracture or avascular necrosis. The osseous alignment is within normal limits.

There is a small amount of fluid within the 2nd through 4th metacarpophalangeal joints.

There is a low-grade radial collateral ligament sprain at the proximal interphalangeal joint of the 4th digit, characterized by mild periligamentous edema and slight thickening of the ligament without full-thickness discontinuity.

The extensor and flexor tendons demonstrate normal signal and morphology. There is no tenosynovitis.

The visualized musculature demonstrates appropriate bulk and signal attenuation.

No subcutaneous or superficial myofascial contusion edema.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

MRI HAND RIGHT

IMPRESSION:

1. Moderate first carpometacarpal joint osteoarthritis with marginal osteophytes and small joint fluid.

2. Small radiocarpal joint fluid. Small distal radioulnar joint fluid. Small second to fourth metacarpophalangeal joint fluid.

3. Small 0.3 cm cyst seen at the level of A3 pulley, along the fourth finger proximal phalanx, concerning for peripulley cyst.

INDICATION:

Right hand pain.

COMPARISON:

None.

TECHNIQUE:

MRI of the right hand was obtained using the GE high field 1.5 Tesla HDXT MRI scanner. The following sequences were obtained:

Sagittal PD fat sat, Sagittal T1, Axial T1, Axial STIR, Coronal STIR, Coronal T2 gradient echo, Coronal PD fat sat and Coronal T1.

FINDINGS:

BONE:

No marrow signal abnormality. No acute fracture. No bone lesion.

JOINTS:

Moderate first carpometacarpal joint osteoarthritis with marginal osteophytes and small joint fluid. Small radiocarpal joint fluid. Small distal radioulnar joint fluid. Small second to fourth metacarpophalangeal joint fluid.

LIGAMENTS:

The ligaments remain normal in signal morphology, no ligamentous tear.

The volar plates remain intact.

TENDONS:

The flexor tendons remain intact. No tendinopathy or tendon tear. No tenosynovitis.

The flexor pulleys remain grossly intact. Small 0.3 cm cyst seen at the level of A3 pulley, along the fourth finger proximal phalanx, concerning for peripulley cyst.

The extensor tendons remain intact. No tendinopathy or tendon tear. No tenosynovitis.

MUSCLES AND SOFT TISSUES:

Muscles are normal in signal and bulk. No intramuscular edema or significant fatty atrophy.

No mass, fluid collection, or hematoma.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

MRI ANKLE RIGHT

IMPRESSION:

1. Remodeled moderately attenuated anterior talofibular ligament, consistent with moderate to high-grade partial-thickness tear of the anterior talofibular ligament.

2. Mild tibiotalar joint effusion. Mild subtalar joint fluid. Mild sinus tarsi edema.

3. Mild tibialis posterior insertional tendinosis with small tendon sheath fluid.

INDICATION:

Chronic lateral right ankle pain.

COMPARISON:

None.

TECHNIQUE:

MRI of the right ankle was obtained using the GE high field 1.5 Tesla HDXT MRI scanner. The following sequences were obtained:

1. Sagittal T1
2. Sagittal STIR
3. Axial PD fat sat
4. Axial T2
5. Coronal PD fat sat
6. Coronal T2
7. Coronal 1
8. Axial T1

FINDINGS:

BONE:

No marrow signal abnormality. No acute fracture. No bone lesion.

JOINTS:

The joint spaces are maintained. Mild tibiotalar joint effusion. Mild subtalar joint fluid.

LIGAMENTS:

Remodeled moderately attenuated anterior talofibular ligament, consistent with moderate to high-grade partial-thickness tear of the anterior talofibular ligament. There is small amount of fluid in the lateral gutter.

The posterior talofibular remain intact. The inferior transverse and intermalleolar ligaments remain intact.

The anterior and posterior tibiofibular ligaments remain intact.

The deltoid ligament complex remains intact. The spring ligament complex remain intact.

The mid tarsal ligaments remain intact.

Partially characterized Lisfranc ligament remains grossly intact.

TENDONS:

The tibialis posterior, flexor digitorum longus, and flexor hallucis longus remain intact. No tenosynovitis. Tarsal tunnel is normal without space occupying lesion. Mild tibialis posterior insertional tendinosis with small tendon sheath fluid.

The peroneus longus and brevis remain intact. No tenosynovitis.

The Achilles tendon is normal in signal and morphology, no tendinopathy, tendon tear, or inflammatory change.

The tibialis anterior, extensor hallucis, and extensor digitorum tendons remain intact.

PLANTAR FASCIA:

Normal in signal and morphology.

OTHER:

Mild sinus tarsi edema.

No mass, fluid collection, or hematoma.

Muscles are normal in signal and bulk. No intramuscular edema or significant fatty atrophy.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

PI X-rays

XR RIBS LEFT

IMPRESSION:

1. No displaced rib fracture. No pneumothorax.

INDICATION FOR SCAN:

Fall.

COMPARISON:

None.

TECHNIQUE:

AP and oblique views of the left ribs were obtained (3 views).

FINDINGS:

The lungs are clear, with no consolidation, pleural effusion, or pneumothorax.

The cardiomediastinal silhouette is unremarkable.

No displaced rib fracture.

10 mm calcified density in the left humeral head suggests an enchondroma.

Small focus of calcification in the left neck.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR WRIST LEFT

IMPRESSION:

1. No fracture or dislocation.

2. Osteopenia with mild degenerative changes.

INDICATION FOR SCAN:

Fall.

COMPARISON:

None.

TECHNIQUE:

XR Wrist left AP, lateral, and oblique views.

FINDINGS:

No acute fracture or dislocation.

Decreased bone mineralization. Mild generalized reduction in the joint spaces. No significant joint osteophyte formation. No erosion or chondrocalcinosis.

No discrete osseous lesion.

No radiopaque foreign body.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR HAND LEFT

IMPRESSION:

1. No evidence of acute fracture or dislocation.

2. Osteopenia with mild to moderate generalized degenerative changes in the left hand, predominantly involving the distal interphalangeal joint of the little finger.

INDICATION FOR SCAN:

Fall.

COMPARISON:

None.

TECHNIQUE:

AP, oblique, and lateral views of the left hand (3 views).

FINDINGS:

No acute fracture or dislocation.

Osteopenia.

Mild generalized reduction in the joint spaces, predominantly in the interphalangeal joints. Moderate to severe degenerative changes in the distal interphalangeal joint of the little finger.

No erosion or chondrocalcinosis.

No discrete osseous lesion.

No radiopaque foreign body.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR ANKLE LEFT

IMPRESSION:

1. Mild degenerative changes.

2. No acute fracture or subluxation.

INDICATION FOR SCAN:

Arthritis.

COMPARISON:

None.

TECHNIQUE:

XR ankle left AP, oblique, and lateral views were obtained (3 views).

FINDINGS:

No acute fracture or dislocation.

Tibiotalar alignment is within normal limits.

Mild reduction in the joint space.

No joint effusion.

No discrete osseous lesion. Posterior calcaneal enthesophyte.

No radiopaque foreign body.

Soft tissues are within normal limits.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR LUMBAR SPINE AP-LAT

IMPRESSION:

1. No acute fracture or subluxation.

2. Moderate lumbar spondylosis. Moderate reduction in T12-L1, L1-L2, L4-L5, and L5-S1 intervertebral disc heights. Degenerative endplate sclerosis. Mild reduction in L2-L3 and L3-L4 intervertebral disc heights.

3. An inhomogeneous medium-sized focus of calcification is identified in the pelvis, perhaps related to a calcified leiomyoma.

INDICATION FOR SCAN:

Status post motor vehicle accident.

COMPARISON:

None.

TECHNIQUE:

AP, lateral, and coned-down views were obtained (3 views).

FINDINGS:

There is loss of normal lumbar lordosis, which may be seen with spasm. Mild dextroscoliosis.

Multilevel anterior and lateral osteophytes.

There is no focal cortical discontinuity or vertebral body height loss to suggest acute fracture.

The lumbar vertebral body heights are preserved. There is moderate reduction in T12-L1, L1-L2, L4-L5, and L5-S1 intervertebral disc heights. Degenerative endplate sclerosis. Mild reduction in L2-L3 and L3-L4 intervertebral disc heights.

The facet joints are intact with multilevel facet arthropathy.

The sacroiliac joints are anatomic.

An inhomogeneous medium-sized focus of calcification is identified in the pelvis, perhaps related to a calcified leiomyoma.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR KNEE RIGHT

IMPRESSION:

1. Mild degenerative changes of the right knee joint with mild medial tibiofemoral joint space narrowing and marginal osteophytes.

2. No evidence of acute fracture or dislocation.

INDICATION FOR SCAN:

Nontraumatic right knee pain.

COMPARISON:

None.

TECHNIQUE:

XR knee right AP, oblique, and lateral views.

FINDINGS:

No acute fracture or dislocation.

Mild narrowing of the medial tibiofemoral joint space with marginal osteophytes.

Small superior and inferior patellar osteophytes are noted.

Small superior patellar enthesophyte is identified.

No knee joint effusion or intra-articular body.

No focal bone lesion.

No radiopaque foreign body.

No acute soft tissue abnormality.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR THORACIC SPINE 2-3 VIEW

IMPRESSION:

1. No acute fracture or subluxation.

2. Loss of normal thoracic kyphosis could be secondary to muscular spasm. Mild thoracic spondylosis.

INDICATION FOR SCAN:

Motor vehicle accident.

COMPARISON:

None.

TECHNIQUE:

AP and lateral views of the thoracic spine (2 views).

FINDINGS:

Suboptimal visualization of the cervicothoracic junction.

Mild loss of normal thoracic kyphosis.

Vertebral body heights are maintained. Mild generalized reduction in the intervertebral disc height.

Multilevel anterior osteophytes.

No focal cortical discontinuity or vertebral body height loss to suggest acute fracture.

The partially imaged lung is clear.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR CERVICAL SPINE AP-LAT & FLEX-EXT

IMPRESSION:

1. Mild dynamic anterolisthesis of C3 over C4 measuring 2 mm on flexion view, which reduces on neutral and extension views, suggesting mild segmental instability.

2. Loss of normal cervical lordosis, which could be secondary to muscular spasm.

3. Mild degenerative disc disease of the lower cervical spine with small anterior osteophytes and mild reduction in C6-C7 intervertebral disc height.

INDICATION FOR SCAN:

Motor vehicle accident with neck pain.

COMPARISON:

None.

TECHNIQUE:

XR cervical spine AP, lateral, flexion, extension and open mouth views.

FINDINGS:

There is loss of normal cervical lordosis.

Small anterior marginal osteophytes are identified in the lower cervical spine.

Mild reduction in the C6-C7 intervertebral disc height is noted.

No anterolisthesis or retrolisthesis is identified on neutral and extension views.

On flexion view, there is 2 mm anterolisthesis of C3 over C4, which reduces on neutral and extension views.

No acute fracture is identified on the provided radiographs.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR ELBOW LEFT 2-3 VIEW

IMPRESSION:

1. Mild degenerative changes of the left elbow joint with mild joint space narrowing.

2. Osteopenia with mild soft tissue swelling around the elbow.

3. No acute fracture or dislocation. No elbow joint effusion.

INDICATION FOR SCAN:

Slip and fall with left elbow pain.

COMPARISON:

None.

TECHNIQUE:

AP, oblique, and lateral views of the left elbow (3 views). Examination is slightly suboptimal as the patient was unable to fully cooperate with positioning.

FINDINGS:

No acute fracture or dislocation. Small degenerative osteophytes in the olecranon process medially.

Decreased bone mineralization.

Mild narrowing of the elbow joint space.

No elbow joint effusion.

Mild soft tissue swelling around the elbow.

No radiopaque foreign body.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR ABDOMEN 2-3 VIEW

IMPRESSION:

1. Prominent air-filled bowel loops in the left upper and mid abdomen. There is relatively decreased bowel gas distally in the rectosigmoid and descending colon. Presence of partial/intermittent or early small bowel obstruction cannot be excluded. Further evaluation with CT of abdomen and pelvis with oral contrast is recommended, if clinically indicated or if the patient's symptoms progress.

2. Moderate fecal loading of the large bowel.

3. S-shaped thoracolumbar scoliosis with multilevel spondylosis and mild degenerative changes of both hip joints.

INDICATION FOR SCAN:

Sudden onset of left lower quadrant abdominal pain.

COMPARISON:

None.

TECHNIQUE:

Standing and supine radiographs of the abdomen (4 views).

FINDINGS:

Prominent air-filled bowel loops are identified in the left upper and mid abdomen. There is relative decreased bowel gas pattern distally. This may represent early or partial/intermittent obstruction. Clinical correlation and further evaluation with CT of the abdomen and pelvis are recommended.

Mild to moderate fecal loading of the large bowel.

S-shaped scoliosis of the lower thoracic and lumbar spine.

Multilevel thoracolumbar spondylosis.

Mild degenerative changes of both hip joints.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.

XR CHEST 2 VIEW

IMPRESSION:

1. Stable mild prominence of bilateral bronchovascular markings, possibly secondary to chronic bronchitis or mild pulmonary vascular congestion.

2. Stable bilateral upper lobe calcified granulomas.

3. Mild degenerative disc disease of the thoracic spine.

INDICATION FOR SCAN:

Preoperative chest radiograph.

COMPARISON:

Prior chest radiograph dated 08/30/2024.

TECHNIQUE:

XR Chest 2 view.

FINDINGS:

Stable mild prominence of bilateral bronchovascular markings, possibly secondary to chronic bronchitis or mild pulmonary vascular congestion.

Stable 2 mm calcified granuloma in the left upper lobe. Stable 5 mm calcified granuloma in the right upper lung zone.

No focal consolidation, pleural effusion, or pneumothorax.

Cardiomediastinal silhouette is within normal limits.

No acute displaced fracture.

Mild degenerative disc disease of the thoracic spine.

Disclaimer: This document was generated using a voice recognition system, which may produce sporadic inaccurate transcription or nonsensical phrases.

Thank you for referring this patient.