Patient Name :	**Gender** : Female
Age : 50 Y	**Date** : Nov 27, 2024
Referring Doctor :	**Patient ID** :

REPORT OF MRI ABDOMEN AND PELVIS

PROCEDURE: Multiplanar MRI of abdomen and pelvis was performed with T1WI, T2WI, DWI and fat suppressed imaging.

FINDINGS:

LOWER PLEURAL SPACE: There is no pleural effusion.

PERITONEUM: There is no free fluid in peritoneal cavity.

LIVER: Liver is normal in size with normal contour and smooth surface. It shows normal signal pattern. No evidence of any focal parenchymal lesion.

Intrahepatic biliary radicles are not dilated. Structures at porta are within normal limits.

GALL BLADDER: Gall bladder is physiologically distended and shows smooth wall. No evidence of any filling defect. No evidence of any mass lesion in gall bladder fossa. Pericholecystic fat planes are normal.

BILE DUCTS: Right hepatic duct, left hepatic duct, common hepatic duct and common bile duct appears normal. No evidence of any filling defect noted.

PANCREAS: Pancreas is normal in shape, size and contour. It shows normal signal intensity. No evidence of any focal lesion. Pancreatic fat planes and vascular structures are normal. No evidence of any pancreatic calcification.

SPLEEN: Spleen is normal in size with normal contour. It shows normal signal pattern. No evidence of any focal lesion noted. Structure at splenic hilum are within normal limits.

ADRENALS: All the three limbs of adrenal glands are well outlined. There is no focal thickening in any of its limb.

KIDNEYS: Bilateral kidneys are normal in shape, size, outline and position. They show normal signal pattern. No evidence of any hydronephrosis. Perirenal fat planes are within normal limits. **Tiny simple renal cortical cyst noted at mid pole of left kidney.**

URINARY BLADDER: Urinary bladder is distended without any focal wall abnormality. No evidence of any papillary growth or intravesical abnormality. Perivesical fat planes are normal.

UTERUS AND ADNEXA: Lower uterine segment and cervix of uterus appear distended. It is filled by a large polypoidal inhomogeneous soft tissue measuring about 7.1 x 4.8 cm. Internal multiple linear an irregular T2 hyperintense cystic areas noted. This soft tissue is attached to posterior wall of body of uterus via a T2 hypointense stalk-like structure measuring about 8.8 mm in maximum thickness.

Rest of uterus appears normal in size and echotexture. Endometrial cavity at fundus and proximal body appears normal.

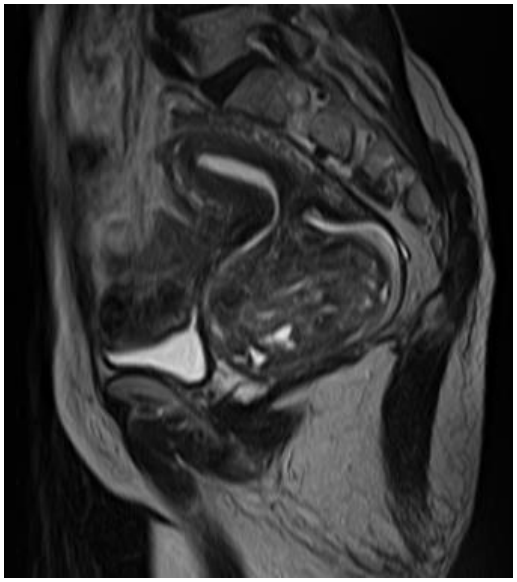
Bilateral adnexa appear normal. No evidence of any solid & cystic lesion on either side. **Approx 2.6 x 2.1 cm sized follicular cyst noted in left ovary.**

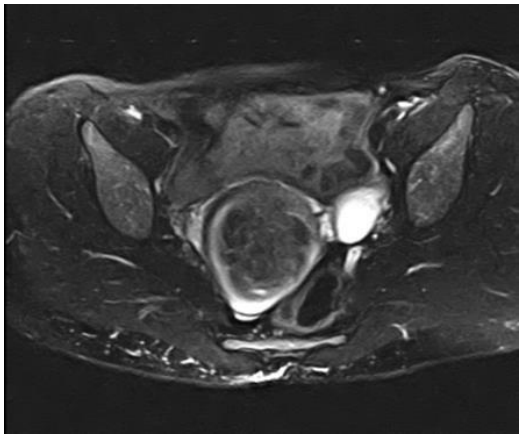
RETROPERITONEUM: No evidence of any retroperitoneal lymphadenopathy or mass lesion. Retroperitoneal fat planes appear normal.

MISC: Gut loops reveal no significant abnormality.

IMPRESSION:

- **Findings are suggestive of a large endometrial polyp / adenomyoma arising from posterior uterine wall and prolapsed within cervical canal.**
- **Left ovarian follicular cyst.**





Dr. (Radiologist Name)
MBBS,MD Radiodiagnosis

Patient Name :	**Gender** : Female
Age : 50 Y	**Date** : Nov 27, 2024
Referring Doctor :	**Patient ID** :

MRI SCAN OF THE PELVIS

CLINICAL HISTORY

H/O LOWER ABDOMEN PAIN SINCE 01 MONTH NO ANY OTHER AND PREVIOUS HISTORY C/O DIFFICULTY TO PASS URINE SINCE 01 WEEK. NO ANY OPERATE HISTORY.

PROTOCOL

MRI of pelvis was performed in multiplanar and multiecho sequences.

FINDINGS

Urinary bladder is normal in size and signal intensity. No focal mass lesion.

Uterus is normal in size and signal intensity. **Uterus measures 8.8 x 4.5 x 4.0 cm.**

The myometrium shows normal signal changes.

The endometrium appears normal **and measures 7.0 mm.**

The junctional line between the endometrium and myometrium is normal appearing hypointense on T2 Wt images.

Few small nabothian cysts seen in cervix, largest measuring 8 mm.

A thick wall abscess, showing variable restricted diffusion in the walls is seen in the pouch of Douglas, roughly measuring 7.0 cm (WD) x 6.0 cm (CC) x 4.0 cm (AP). The collection is seen extending towards both the adnexa and left paracolic gutter with extensive pelvic fat stranding and reactive subcentrimetric lymphadenitis.

The right ovary is mildly bulky and measures 4 x 3.4 cm. and shows T2W hyperintense unilocular simple cyst of 1.4 x 1.2 cm.

The left ovary is normal and measures 2.6 x 1.8 cm.

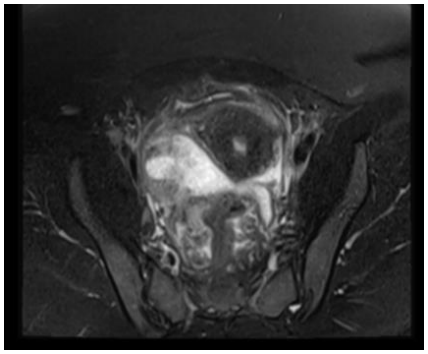
Mild wall thickneing of sigmoid colon noted with inflammatory changes in sigmoid mesocolon. Fat stranding is seen in peri rectal fat plane.

IMPRESSION

Thick-walled collection in POD extending to both adnexa and left paracolic gutter with extensive pelvic inflammatory changes / fat stranding. The findings favour pelvic abcess.

RECOMMENDATION

Suggested clinical correlation.



Dr (Radiologist Name,
Digital Sign)

MBBS DMRD DNB

Patient Name	:	**Gender**	: Male
Age	: 46 Y	**Date**	: Nov 25, 2024
Referring Doctor	:	**Patient ID**	:

MRI SCAN OF THE PELVIS

CLINICAL HISTORY

PREVIOUS REPORT AND FILM ATTACHED. K/C/O CA RECTUL SINCE 15 DAYS NOT TAKEN ANY CHEMO AND RADIATION NO DONE ANY OPERATION C/O BLOOD IN STOOL SINCE 08 DAYS NO ANY OTHER HISTORY

PROTOCOL

MRI of pelvis was performed in multiplanar and multiecho sequences.

FINDINGS

Approximately 4 cm size long segment of rectosigmoid junction shows heterogeneous asymmetrical irregular wall thickening, wall thickness 11-12 mm, approximately 10.5 cm from anal verge. There is resultant severe luminal narrowing. It shows patchy diffusion restriction.

Linear strands noted to extend in mesorectum on either side (by 7 mm-maximum dimension) s/o extramural extension into mesoectum suggestive of T3b stage.

Few varying size perilesional lymph nodes noted(more than 3), largest measures 1.8 cm in size- s/o N2 stage

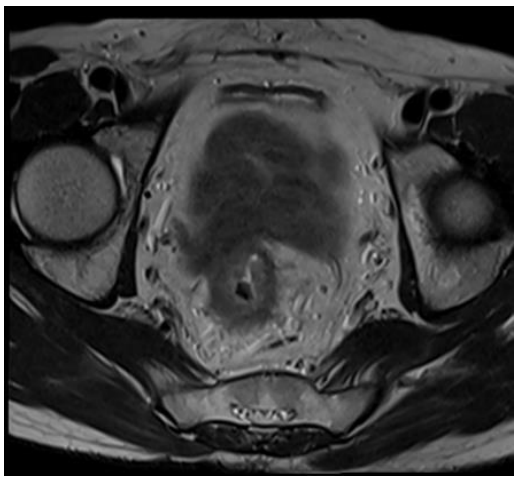
Urinary bladder is minimally distended No focal mass lesion/ calculi.
Wall thickness is normal.
Prostate is normal in size and signal intensity. No mass lesion seen.
Seminal vesicles appear normal.
Pelvic bones and joints are normal.
No free fluid in the pelvis.

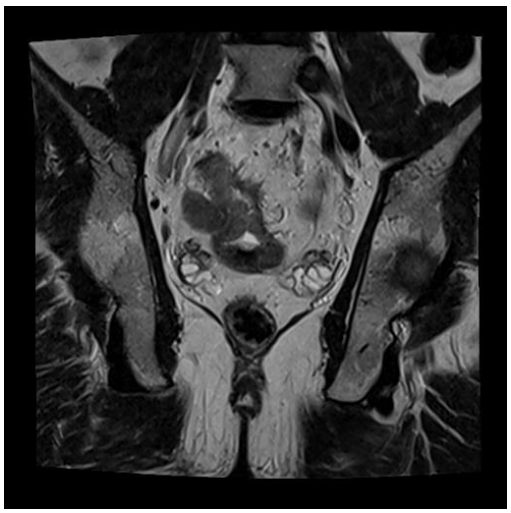
IMPRESSION

- ***Rectosigmoid mass as described above- T3b N2 stage.***

RECOMMENDATION

Suggested clinical correlation.





Dr (Radiologist Name,
Digital Sign)
MD,DNB,FRCR,EDiR,DICRI

Patient Name	:	**Gender**	: Female
Age	: 54 Y	**Date**	: Nov 24, 2024
Referring Doctor	:	**Patient ID**	:

MRI SCAN OF THE PELVIS

CLINICAL HISTORY

LOWER ABDOMEN MODRATE PAIN AND WEIGHT LOSS . URINE BURNING .ITCHING .WIGHT WATER DISCHARGE FOR 1 MONTH .HYSTERCTOMY FOR 3 MONTH AGO .BACK PAIN .

PROTOCOL

MRI of pelvis was performed in multiplanar and multiecho sequences.

FINDINGS

A large approx. 7.5 x 6.2 x 7.6 cm irregular ulcero-proliferative lobulated soft tissue mass lesion showing restricted diffusion with corresponding low ADC is seen involving the cervix, upper half of vagina causing its distension, lower part of uterus. The lesion is extending into the bilateral parametrial region, involving the posterior wall urinary bladder with intraluminal components.

Posteriorly, the lesion is related to rectum with focal loss of intervening fat planes.

Extending surrounding fat stranding noted in the parametrial region.

Few surrounding subcm to cm size discrete lymphnodes are seen.

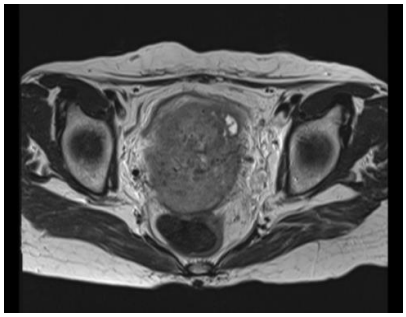
Rest of the uterus (fundus and part of body) appears atrophic with distended endometrial cavity.
Both ovaries are normal in size and signal intensity.
No free fluid is seen.

IMPRESSION

Above imaging findings are most likely suggestive of Malignant etiology, likely Ca cervix with involvement of upper part of vagina, lower part of uterus, parametrium and urinary bladder (FIGO Stage IVA).

RECOMMENDATION

Suggest histopathology correlation and further evaluation with PET CT.



Dr (Radiologist Name, Digital Sign)

MD Radiology

Patient Name :	**Gender** : Female
Age : 20 Y	**Date** : Nov 20, 2024
Referring Doctor :	**Patient ID** :

MRI SCAN OF THE PELVIS

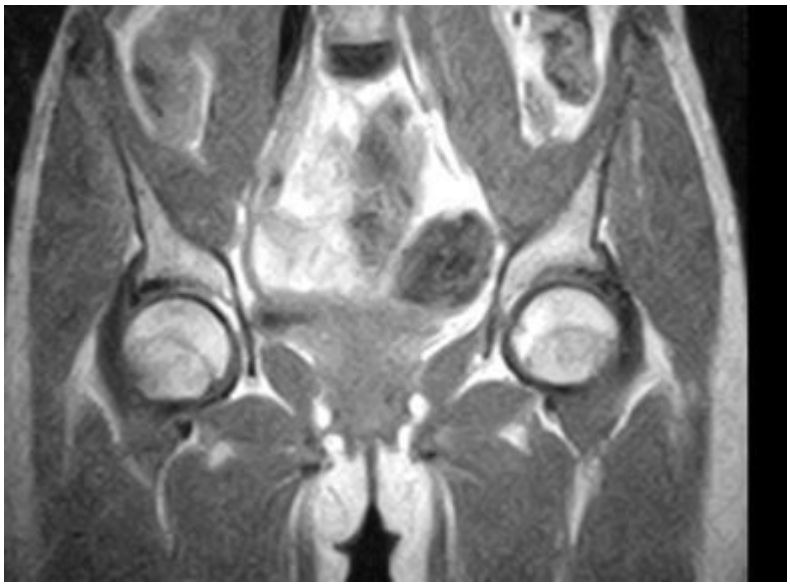
CLINICAL HISTORY
Sirf 2 time period aya hai, 8 month se period nahi aya hai

PROTOCOL
MRI of pelvis was performed in multiplanar and multiecho sequences.

FINDINGS
Small-sized uterus, measuring 3.5 x 2.6 x 1.4 cm. The endometrial line is barely visualized along the uterine body and endocervical canal.
Uterine body to cervix ratio measures 0.8.
Bilateral ovaries not visualised. However bilateral adnexa appears normal.
Urinary bladder is normal in size and signal intensity. No focal mass lesion.
No evidence of pelvic lymphadenopathy.
Minimal fluid intensity collection noted in pouch of Douglas.

IMPRESSION
- Features suggestive of uterine hypoplasia with ? coexistence of gonadal dysgenesis.

RECOMMENDATION
Suggested clinical correlation and karyotyping for further evaluation.



Dr (Radiologist Name,
Digital Sign)

MBBS,MD,DNB Radiodiagnosis

Patient Name	:	**Gender**	: Male
Age	: 9 Y	**Date**	: Nov 06, 2024
Referring Doctor	:	**Patient ID**	:

MRI FISTULOGRAM

CLINICAL HISTORY

pulse discharge 2/3 months and pain

PROTOCOL

Multiplanar and multi-echo MRI of the pelvis for fistula was performed without administration of intravenous contrast.

FINDINGS

External opening:

It is in gluteal cleft on left side, placed antero-omedially, width of opening 2.8 mm. Shows focal puckering and scarring.

Main Tract:

It is linear with trans-sphincteric course in left gluteal region reaching anterior to base of perineum and inflammatory changes in adjacent fat. Maximum width measures 4.5 mm.

Internal Opening:

It is placed just above external anal orifice and opening between 12- 1 'O clock position on left side.

Side Tracts:

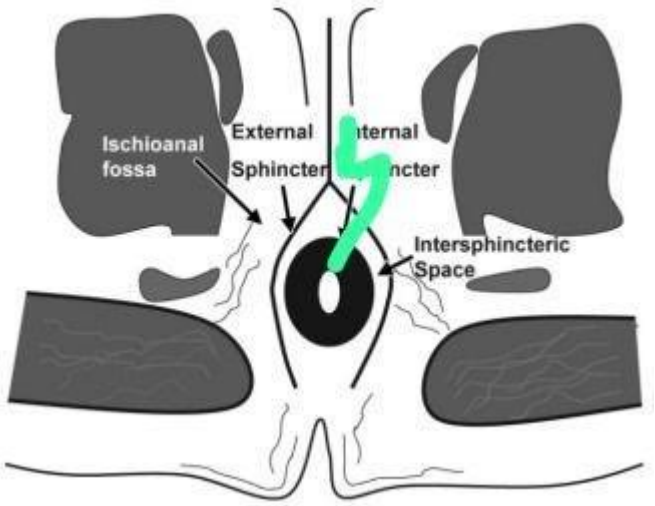
No e/o side tracts or abscess noted.

Sphincters:

External sphincter and internal sphincter are intact.

Miscellaneous:

- The Levator Ani and the Pelvic musculature appear normal
- Urinary bladder is well distended.
- Visualized pelvic viscera appear normal.
- There is no evidence of significant pelvic lymphadenopathy or free fluid.
- **Few mildly enlarged left sided inguinal lymph nodes noted.**



IMPRESSION

Grade III- Trans-sphincteric fistula as described.

St James's University Hospital MR Imaging Classification of Perianal Fistulas

(Modified from Spencer et al)

Grade	Description
0	Normal appearance.
1	Simple linear intersphincteric fistula.
2	Intersphincteric fistula with intersphincteric abscess or secondary fistulous track
3	Trans-sphincteric fistula.
4	Trans-sphincteric fistula with abscess or secondary track within the ischioanal or ischiorectal fossa.
5	Supralevator and translevator disease.

RECOMMENDATION:

Suggested clinical correlation and follow-up.

Dr (Radiologist Name, Digital Sign)

MD,DNB,FRCR,EDiR,DICRI

Patient Name	:	**Gender**	: Male
Age	: 39 Y	**Date**	: Nov 01, 2024
Referring Doctor	:	**Patient ID**	:

MRI FISTULOGRAM

CLINICAL HISTORY

PUS DISCHARGE AT ANAL REGION SINCE 1 MONTH

PROTOCOL

Multiplanar and multi-echo MRI of the pelvis for fistula was performed without administration of intravenous contrast.

FINDINGS

Internal Opening:

It is placed just above external anal orifice and opening at 6 'O clock position.

Side Tracts:

No evidence of side tracts seen on either side.

Abscess:

A localised T2Wt hyperintense oblong intersphincteric abscess is noted measuring 21 x 11 x 12 mm.

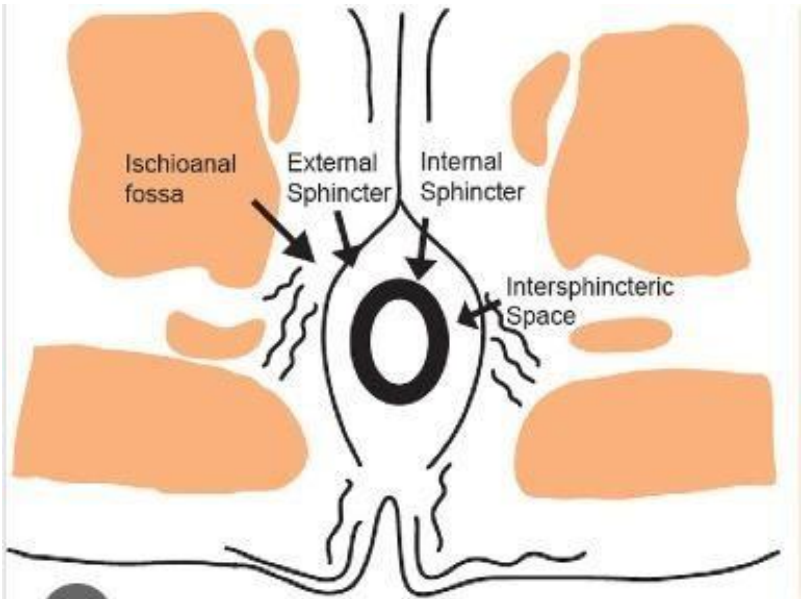
This collection is seen communicating with anal canal through the internal anal sphincter at 6 o'clock.

Sphincters:

External sphincter is intact.

Miscellaneous:

- The Levator Ani and the Pelvic musculature appear normal
- Urinary bladder is well distended.
- Visualized pelvic viscera appear normal.
- There is no evidence of pelvic lymphadenopathy or free fluid.



IMPRESSION

Grade – 2 – Intersphincteric fistula with intersphincteric abscess

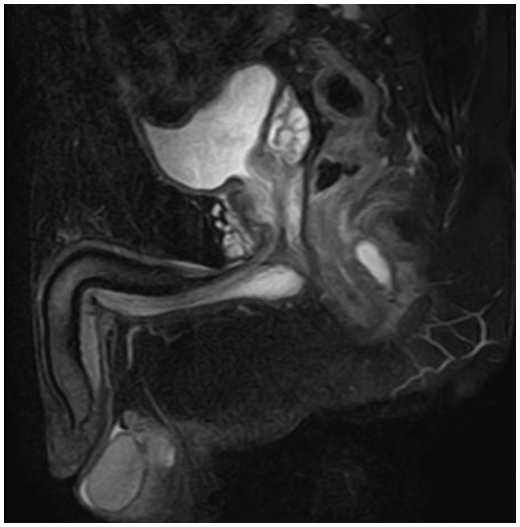
St James's University Hospital MR Imaging Classification of Perianal Fistulas

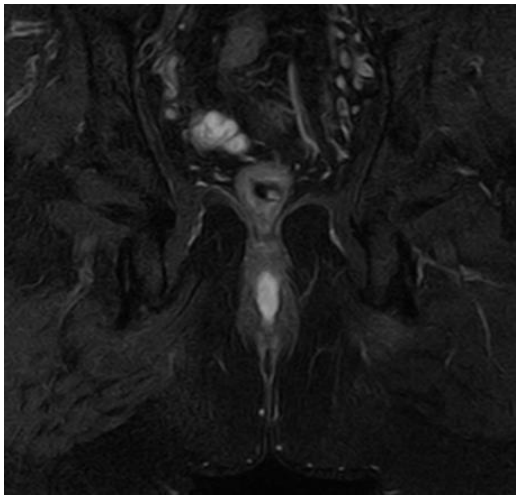
(Modified from Spencer et al)

Grade	Description
0	Normal appearance.
1	Simple linear intersphincteric fistula.
2	**Intersphincteric fistula with intersphincteric abscess or secondary fistulous track**
3	Trans-sphincteric fistula.
4	Trans-sphincteric fistula with abscess or secondary track within the ischioanal or ischiorectal fossa.
5	Supralevator and translevator disease.

RECOMMENDATION

Suggested clinical correlation and follow-up.





Dr (Radiologist Name, Digital Sign)

MBBS, MD
RADIOLOGY

Patient Name	:	**Gender**	: Male
Age	: 48 Y	**Date**	: Oct 31, 2024
Referring Doctor	:	**Patient ID**	:

MRI FISTULOGRAM WITH CONTRAST

CLINICAL HISTORY

RECURRENT SWELLING AT LEFT ANAL REGION PREV OPERTATED FOR FISTULA PREV MR DONE REPORT ATTACHED

PROTOCOL

Multiplanar and multi-echo MRI of the pelvis for fistula was performed without administration of intravenous contrast.

FINDINGS

External opening:

It is in gluteal cleft on left side, slightly posteriorly placed at 3-4 o clock. Shows focal puckering and scarring.

Main Tract:

It is reverse 'C' shaped. It is traversing through left ischioanal fossa, with inflammatory change in adjacent fat. Length ~ 1.8cm, and width ~ 1mm.

Internal Opening:

It is placed just above external anal orifice and opening at 6 'O clock position.

Side Tracts:

No evidence of side tracts seen on either side.

Abscess:

A large peripheral enhancing collection of size ~ 2.9x3.8x6.6cm (APxTRxCC) is seen in left ischio-anal fossa. It is communicating with the anal canal via a short thin fistulous tract as described.

Sphincters:

External sphincter and internal sphincter are intact.

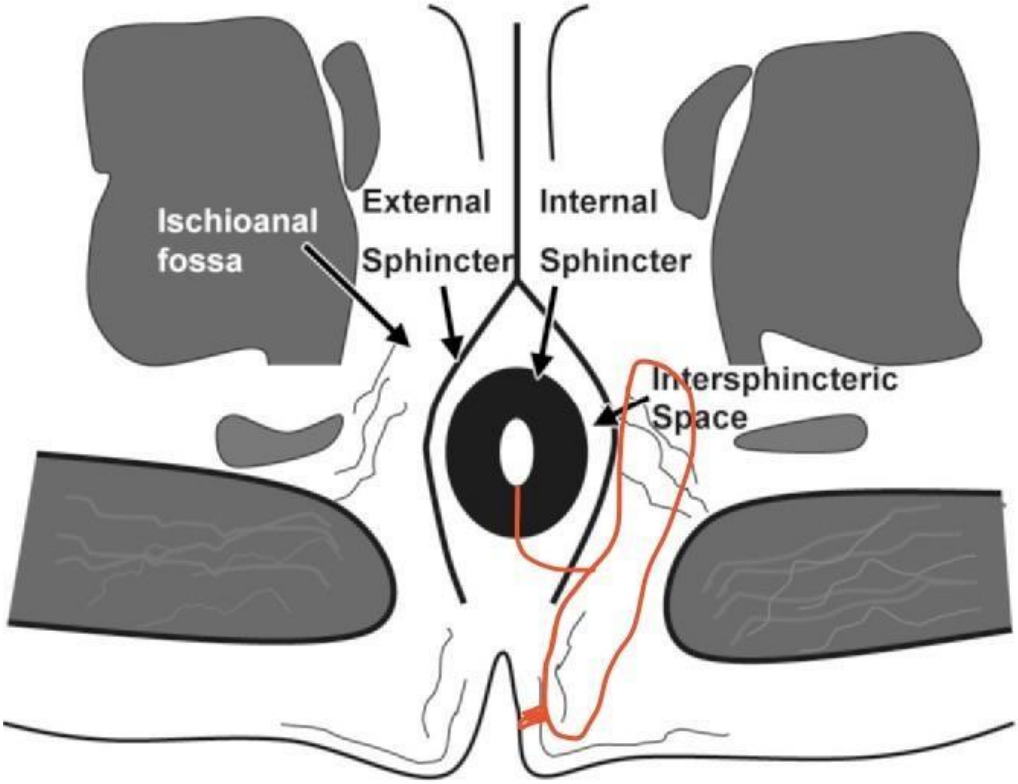
Miscellaneous:

- **Fat stranding in left perianal and gluteal region.**
- The Levator Ani and the Pelvic musculature appear normal
- Urinary bladder is well distended.
- Visualized pelvic viscera appear normal.
- There is no evidence of pelvic lymphadenopathy or free fluid.

IMPRESSION

Grade – IV – Left ischio-anal abscess with trans-sphincteric fistula.

St James's University Hospital MR Imaging Classification of Perianal Fistulas

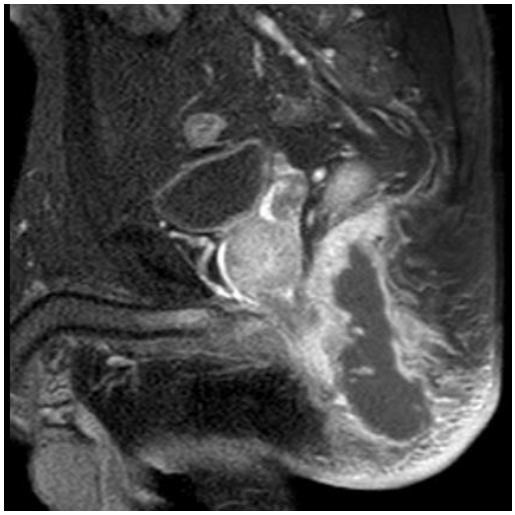


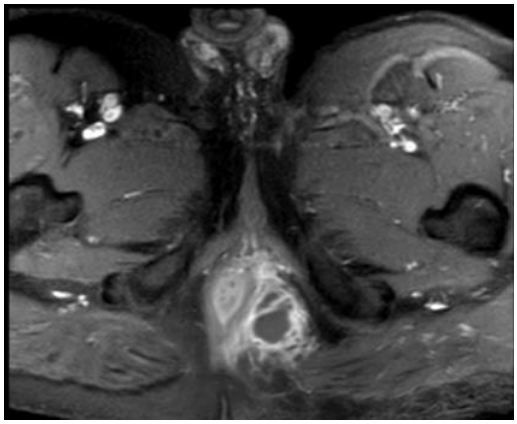
(Modified from Spencer et al)

Grade	Description
0	Normal appearance.
1	Simple linear intersphincteric fistula.
2	Intersphincteric fistula with intersphincteric abscess or secondary fistulous track
3	Trans-sphincteric fistula.
4	Trans-sphincteric fistula with abscess or secondary track within the ischioanal or ischiorectal fossa.
5	Supralevator and translevator disease.

RECOMMENDATION

Suggested clinical correlation and follow-up.





Dr (Radiologist Name, Digital Sign)

MD Radiodiagnosis

Patient Name	:	**Gender**	: Male
Age	: 28 Y	**Date**	: Nov 27, 2024
Referring Doctor	:	**Patient ID**	:

MR CHOLANGIOPANCREATOGRAPHY (MRCP)

CLINICAL HISTORY

UPPER ABDOMEN PAIN SINCE YESTERDAY . CT CUT TAKEN . PLZ CHECK.

PROTOCOL

Multiplanar spin echo pulse sequences obtained. Exam is performed without IV contrast. MRCP images obtained.

FINDINGS

Lung bases: **Bilateral small basal pleural effusions noted.** No consolidation.

Liver:**Enlarged measures 20.1 cm.** No mass. No evidence of intrahepatic ductal dilation. **Mild periportal T2 hyperintensity noted s/o periportal edema.**

Gallbladder and bile ducts: Unremarkable. No stones identified in the extrahepatic biliary ducts. No ductal dilation.
Pancreas:

- **Pancreas is diffusely bulky and altered in attenuation with interstitial edema, measures 3.6 cm in head region, 3.9 cm in body and 3.0 cm in tail region.**
- **Ill defined peripancreatic fluid collection predominantly in anterior pararenal space is noted. Fluid is noted to extend into bilateral paracolic gutters.**
- **Extensive surrounding peripancreatic and retroperitoneal fat stranding is noted.**
- **Surrounding subcentimetric size peripancreatic lymph nodes are noted.**
- **Mild to moderate ascites is noted.**
- No ductal dilation. No mass. No calcification.

Spleen: Unremarkable. No splenomegaly.
Adrenals: Unremarkable. No mass.
Kidneys and ureters: Unremarkable. No hydronephrosis. No solid mass.
Stomach and bowel: Unremarkable. No evidence of obstruction.
Soft tissues: Unremarkable. No evidence of mass, hematoma or abscess.
Bones: No evidence of acute fracture or dislocation.
Vasculature: Unremarkable. No abdominal aortic aneurysm.

IMPRESSION

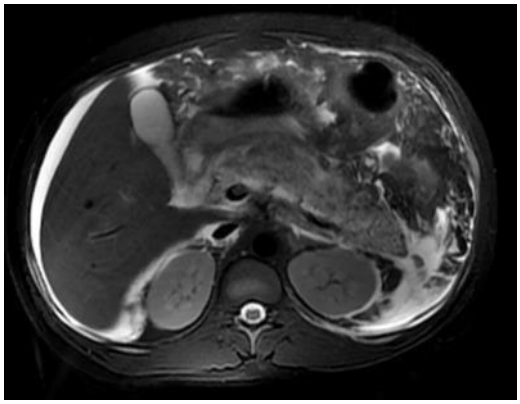
Changes of acute interstitial pancreatitis as described.

Bilateral small basal pleural effusions and mild to moderate ascites.

Hepatomegaly.

RECOMMENDATION

Suggested clinical correlation.



Dr (Radiologist Name, Digital Sign)
MD,DNB,FRCR,EDiR,DICRI

Patient Name :	**Gender** : Male
Age : 53 Y	**Date** : Nov 27, 2024
Referring Doctor :	**Patient ID** :

MR CHOLANGIOPANCREATOGRAPHY (MRCP)

CLINICAL HISTORY
H/o Nausea general Weekness Chronic alcoholic No other History

PROTOCOL
Multiplanar spin echo pulse sequences obtained. Exam is performed without IV contrast. MRCP images obtained.

FINDINGS
Lung bases: No consolidation.
Liver: Unremarkable. No mass. No evidence of intrahepatic ductal dilation.
Gallbladder and bile ducts: Unremarkable. No stones identified in the extrahepatic biliary ducts. No ductal dilation.
Pancreas: Unremarkable. No ductal dilation. No mass.

Spleen: Moderate splenomegaly is noted measuring 15.8 cm in long axis.

Adrenals: Unremarkable. No mass.
Kidneys and ureters: Unremarkable. No hydronephrosis. No solid mass.
Stomach and bowel: Unremarkable. No evidence of obstruction.
Intraperitoneal space: No significant fluid collection.
Soft tissues: Unremarkable. No evidence of mass, hematoma or abscess.
Bones: No evidence of acute fracture or dislocation.
Vasculature: Unremarkable. No abdominal aortic aneurysm.
Lymph nodes: Unremarkable. No enlarged lymph nodes.

MEASUREMENTS :

Right hepatic duct - 6.1 mm
Left hepatic duct - 5 mm
Common hepatic duct - 6.4 mm
Proximal common bile duct - 6.5 mm
Mid common bile duct - 5.5 mm
Distal common bile duct - 4.8 mm

IMPRESSION
Moderate splenomegaly.

RECOMMENDATION
Suggested clinical correlation.

Dr (Radiologist Name, Digital Sign)

Patient Name :	**Gender** : Female
Age : 0 Y	**Date** :
Referring Doctor :	**Patient ID** :

MR CHOLANGIOPANCREATOGRAPHY (MRCP)

CLINICAL HISTORY
GB STONE

PROTOCOL
Multiplanar spin echo pulse sequences obtained. Exam is performed without IV contrast. MRCP images obtained.

FINDINGS:

Gallbladder is not visualised distinctly - ? operated.

CBD and CHD and mildly prominent measuring about 6.0 mm in diameter. Distal smooth tapering noted. No evidence of any internal filling defect or calculus noted. No evidence of any wall thickening. No evidence of dilatation of IHBR.

Lung bases: No consolidation.
Liver: Unremarkable. No mass. No evidence of intrahepatic ductal dilation.
Pancreas: Unremarkable. No ductal dilation. No mass.
Spleen: Unremarkable. No splenomegaly.
Adrenals: Unremarkable. No mass.
Kidneys and ureters: Unremarkable. No hydronephrosis. No solid mass.
Stomach and bowel: Unremarkable. No evidence of obstruction.
Intraperitoneal space: No significant fluid collection.
Soft tissues: Unremarkable. No evidence of mass, hematoma or abscess.
Bones: No evidence of acute fracture or dislocation.
Vasculature: Unremarkable. No abdominal aortic aneurysm.
Lymph nodes: Unremarkable. No enlarged lymph nodes.

IMPRESSION

- **Gallbladder is not visualised distinctly - ? operated.**
- **CBD and CHD and mildly prominent measuring about 6.0 mm in diameter. Distal smooth tapering noted. No evidence of any internal filling defect or calculus noted. No evidence of any wall thickening. No evidence of dilatation of IHBR. Findings are concerning for post-cholecystectomy status.**

Dr.Jainex Patel

Patient Name	:	**Gender**	: Female
Age	: 58 Y	**Date**	: Nov 22, 2024
Referring Doctor	:	**Patient ID**	:

MR CHOLANGIOPANCREATOGRAPHY (MRCP)

CLINICAL HISTORY

RT HYPOCHONDRIAC PAIN 1 YR PREVIOUS MRCP DONE OUTSIDE ON 29-01-2024 NO SURGERY DONE

PROTOCOL

Multiplanar spin echo pulse sequences obtained. Exam is performed without IV contrast. MRCP images obtained.

FINDINGS

Lung bases: No consolidation.

Liver: **Enlarged in size (15.0 cm) with fatty changes and keeping with steatosis. A small T2W hyper intense focus is seen in segment VIII of liver.** No evidence of intrahepatic ductal dilation.

Gallbladder and bile ducts: Unremarkable. No stones identified in the extrahepatic biliary ducts. No ductal dilation. **CBD measures 5.5 mm.**

Pancreas: **Pancreas appears atrophic with dilated main pancreatic duct and lateral side branches (less than 3 in number) . The main pancreatic duct measures 6.8 mm .Mild peri pancreatic inflammatory fat stranding and free fluid noted.**

A lobulated soft tissue lesion measuring 1.8 x 1.6 cm is seen in region of pancreatic uncinate process. The lesion shows an intermediate signal on T1W and T2W images. No restricted diffusion seen.

Spleen: **Enlarged in size (12.0 cm).**

Adrenals: Unremarkable. No mass.
Kidneys and ureters: Unremarkable. No hydronephrosis. No solid mass.
Stomach and bowel: Unremarkable. No evidence of obstruction.
Intraperitoneal space: No significant fluid collection.
Soft tissues: Unremarkable. No evidence of mass, hematoma or abscess.
Bones: No evidence of acute fracture or dislocation.
Vasculature: Unremarkable. No abdominal aortic aneurysm.

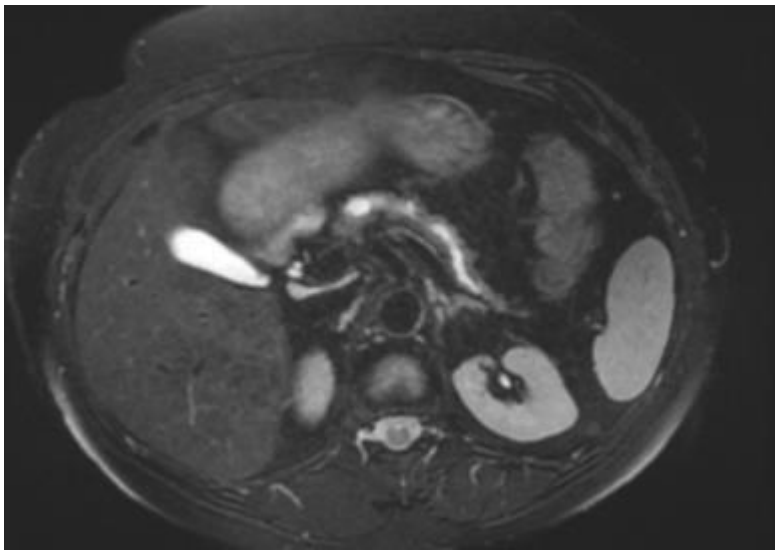
Lymph nodes: **Few subcentimetric para pancreatic and upper para aortic enlarged lymph nodes.**

IMPRESSION

- **Hepatomegaly with features of steatosis.**
- **Mild splenomegaly**
- **Chronic pancreatitis.**
- **No biliary outflow obstruction seen.**
- **A Lobulated solid lesion in the pancreatic uncinate process without local mass effect or fat stranding. The minor duct is seen traversing the lesion- Could be part of mass forming pancreatitis. However further evaluation is suggested with PET CT / Endoscopic USG to rule out underlying neoplastic aetiology.**

RECOMMENDATION

Suggested clinical correlation.



Dr (Radiologist Name, Digital Sign)

MBBS MD
Radiodiagnosis

Patient Name	:	**Gender**	: Female
Age	: 38 Y	**Date**	: Nov 26, 2024
Referring Doctor	:	**Patient ID**	:

MRI SCAN OF THE RIGHT SHOULDER

CLINICAL HISTORY

RT shoulder pain. RT U/ L radiating pain

PROTOCOL

Multiplanar multisequence MR images of the right shoulder was obtained without the administration of intravenous contrast.

FINDINGS

Rotator Cuff and Biceps Tendon

PD FAT SAT hyperintensity involving footprint of supraspinatus tendon with partial tear of fibers involving both articular and bursal side of critical zone of supraspinatus tendon with surrounding peritendinous free fluid and edema. teres minor, and subscapularis tendons are normal in appearance. **Inflammation and edema noted in the rotator interval of right shoulder.** Normal muscle volume and symmetry are preserved. The extra-articular and intra-articular components of the long head of the biceps tendon are unremarkable.

Labrum

The glenoid labrum is normal in appearance. The bicipital-labral complex is unremarkable.

Gleno-Humeral Joint

Minimal amount of free fluid in subscapular bursaarticular cartilage is preserved.

Acromio-Clavicular Joint

A type II acromion is present.**Mild degenerative changes involving acromio-clavicular joint.** Superior and inferior acromioclavicular ligaments are normal and show no tear or frank separation of the acromioclavicular joint. The coracoclavicular ligament complex is normal in appearance.

Gleno-Humeral Ligaments

The anterior and posterior bands of the inferior glenohumeral ligament are normal in appearance. The axillary pouch of the inferior glenohumeral ligament is unremarkable. The middle glenohumeral ligament is normal. The superior glenohumeral ligament is show no abnormality.

Other

The remaining musculotendinous and ligamentous structures of the shoulder are unremarkable.

Osseous Structures-

few tiny subcentimeter bony cysts at the greater & lesser tuberosity of the humeral head.

Miscellaneous Findings

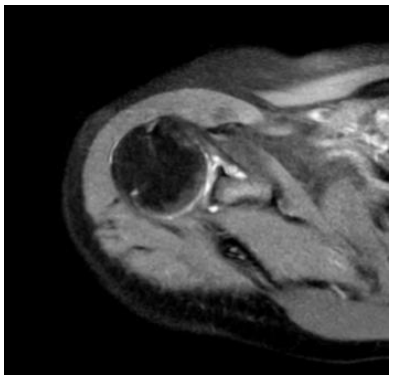
The remaining soft tissues are unremarkable.

IMPRESSION:-

- **PD FAT SAT hyperintensity involving footprint of supraspinatus tendon with partial tear of fibers involving both articular and bursal side of critical zone of supraspinatus tendon with surrounding peritendinous free fluid and edema.**
- **Minimal amount of free fluid in subscapular bursa.**
- **Mild degenerative changes involving acromio-clavicular joint.**
- **Edema / inflammation within the rotator interval.**

RECOMMENDATION

Suggested clinical correlation.



Dr (Radiologist Name, Digital Sign)

MD Radiodiagnosis

Patient Name :	**Gender** : Female
Age : 66 Y	**Date** : Nov 27, 2024
Referring Doctor :	**Patient ID** :

MRI SCAN OF THE RIGHT SHOULDER

CLINICAL HISTORY

FALL 3 MONTHS BACK SINCE THEN PAIN IS THERE

PROTOCOL

Multiplanar multisequence MR images of the right shoulder was obtained without the administration of intravenous contrast.

FINDINGS

Rotator Cuff and Biceps Tendon

There is fluid signal intensity noted at foot print region of supraspinatus tendon insertion along posterior fibres with retraction consistent with partial thickness tear. Medial to lateral dimension of tear measures approximately 6 mm.

The critical zone is bulky and shows PD/SPIR hyperintensity with mild irregularity s/o tendinosis.

Fatty atrophy of supraspinatus muscle is noted.

Infraspinatus, teres minor, and subscapularis tendons are normal in appearance. Normal muscle volume and symmetry are preserved. The extra-articular and intra-articular components of the long head of the biceps tendon are unremarkable.

Moderate joint effusion with fluid extending along the subacromial-subdeltoid and subcoracoid bursa. Multiple small hypointensities noted within the fluid giving rice bodies appereance. Few septations noted within as well.

Labrum

The glenoid labrum is normal in appearance. The bicipital-labral complex is unremarkable.

Gleno-Humeral Joint

The glenohumeral joint is normal in appearance. The articular cartilage is preserved.

Acromio-Clavicular Joint

A type II acromion is present. **Grade I arthropathy noted with mild inferior spurring of acromian process and capsular hypertrophy. No obvious impingement noted.** Superior and inferior acromioclavicular ligaments are normal and show no tear or frank separation of the acromioclavicular joint. The coracoclavicular ligament complex is normal in appearance. No fracture, stress reaction, or osseous lesion is seen. No acromioclavicular joint effusion seen.

Gleno-Humeral Ligaments

The anterior and posterior bands of the inferior glenohumeral ligament are normal in appearance. The axillary pouch of the inferior glenohumeral ligament is unremarkable. The middle glenohumeral ligament is normal.

Other

The remaining musculotendinous and ligamentous structures of the shoulder are unremarkable.

Osseous Structures

Mild PD/SPIR hyperintensity is noted in humeral head in greater tuberosity consistent with bone marrow edema. Suspicious depressed fracture noted along posterosuperior aspect . However CT correlation is suggested.

Miscellaneous Findings

The remaining soft tissues are unremarkable.

IMPRESSION

-Findings are suggestive of rotator cuff tear- involving supraspinatus with tendinopathy as described.

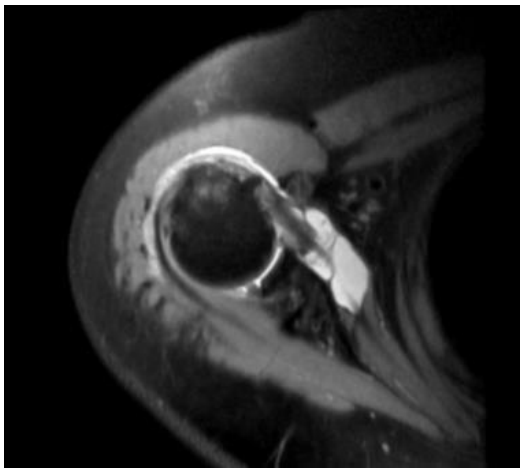
-Grade I arthopathy of Acromioclavicular joint.

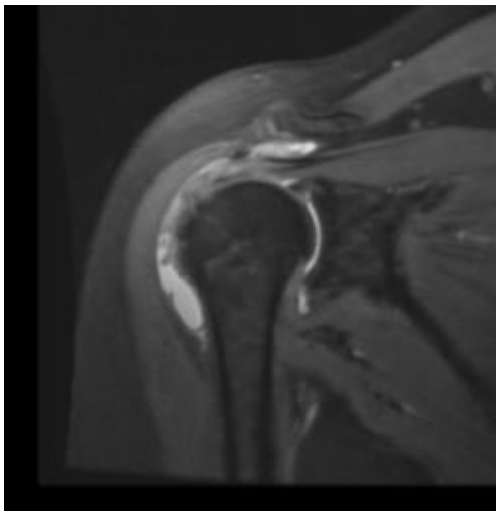
-Moderate joint effusion with fluid extending along the subacromial-subdeltoid and subcoracoid bursa. Multiple small hypointensities noted within the fluid giving rice bodies appereance. Few septations noted within as well. ?chronic collection

-Mild PD/SPIR hyperintensity in humeral head in greater tuberosity consistent with bone marrow edema. Suspicious depressed fracture noted along posterosuperior aspect. However CT correlation is suggested.

RECOMMENDATION

Suggested clinical correlation.





Dr (Radiologist Name, Digital Sign)
MD,DNB,FRCR,EDiR,DICRI

Patient Name	:	**Gender**	: Male
Age	: 42 Y	**Date**	: Nov 26, 2024
Referring Doctor	:	**Patient ID**	:

MRI SCAN OF THE RIGHT SHOULDER

CLINICAL HISTORY

H/O MULTIPLE EPISODES OF RT SHOULDER JOINT DISLOCATE SINCE 10 YEARS NO ANY TRAUMA AND FALL HISTORY NOT DONE ANY PREVIOUS CT & MRI SCAN. NO ANY OPERATE HISTORY.

PROTOCOL

Multiplanar multisequence MR images of the right shoulder was obtained without the administration of intravenous contrast.

FINDINGS

Rotator Cuff and Biceps Tendon

Minimal edematous changes along the bursal aspect of the supraspinatus tendon.

Muscle belly of supraspinatus appears normal in shape and signal. Infraspinatus, teres minor, and subscapularis tendons are normal in appearance. The rotator Interval is unremarkable. Normal muscle volume and symmetry are preserved. The extra-articular and intra-articular components of the long head of the biceps tendon are unremarkable. Minimal fluid is noted along the biceps tendon in bicipital groove without obvious tear. No abnormal fluid collection or effusion seen.

Labrum

Abnormal avulsion fracture noted involving antero-inferior aspect of the glenoid bone with extension into the glenoid labrum with adjacent intrasubstance hyperintensity suggestive of Bankart's lesion. The bicipital-labral complex is unremarkable.

Gleno-Humeral Joint

There is seen minimal flattening with cartilage thinning along the posterolateral aspect of the head of humerus without obvious wedge shaped Hill-Sachs defect at present scan. The articular cartilage is preserved.

Acromio-Clavicular Joint

Type III downward sloping acromion process is noted causing narrowing of the acromiohumeral space. Superior and inferior acromioclavicular ligaments are normal and show no tear or frank separation of the acromioclavicular joint. The coracoclavicular ligament complex is normal in appearance. No fracture, stress reaction, or osseous lesion is seen. Soft tissue surrounding the joint are normal. No acromioclavicular joint effusion seen.

Gleno-Humeral Ligaments

The anterior and posterior bands of the inferior glenohumeral ligament are normal in appearance. The axillary pouch of the inferior glenohumeral ligament is unremarkable. The middle glenohumeral ligament is normal. The superior glenohumeral ligament is show no abnormality.

Other

Minimal fluid is noted within subacromial and subcoracoid Bursa. The remaining musculotendinous and ligamentous structures of the shoulder are unremarkable.

Osseous Structures

No worrisome marrow lesions are present.

Miscellaneous Findings

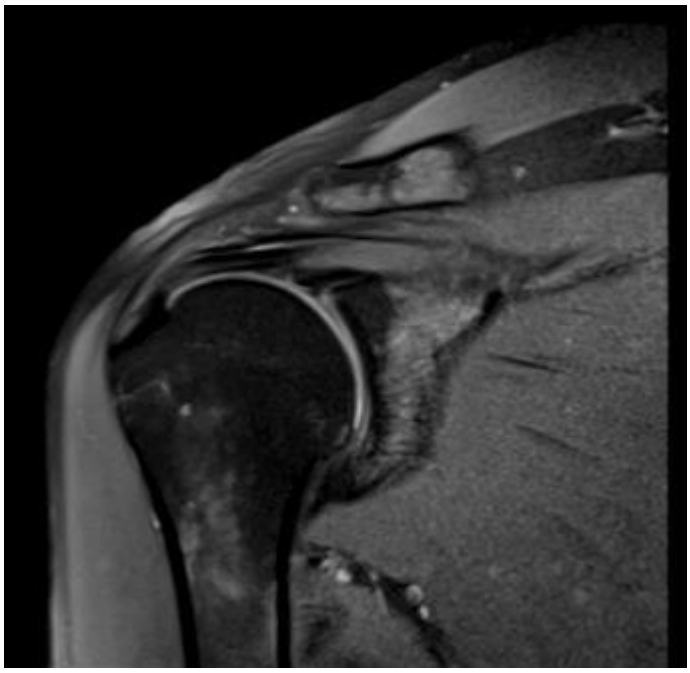
The remaining soft tissues are unremarkable.

IMPRESSION

- **Minimal flattening with cartilage thinning along the posterolateral aspect of the head of humerus.**
- **Type III downward sloping acromion process causing narrowing of the acromiohumeral space with minimal edematous changes along the bursal aspect of the supraspinatus tendon, suggestive of type II impingement syndrome.**
- **Minimal fluid within subacromial and subcoracoid Bursa.**
- **Abnormal avulsion fracture involving antero-inferior aspect of the glenoid bone with extension into the glenoid labrum with adjacent intrasubstance hyperintensity suggestive of Bankart's lesion.**

RECOMMENDATION

Suggested clinical correlation.



Dr (Radiologist Name, Digital Sign)

MBBS,MD
Radiodiagnosis

MRI SCAN OF THE LEFT KNEE

CLINICAL HISTORY

H/O KNEE JOINT PAIN

PROTOCOL

Multiplanar multisequence MR images of the left knee were obtained without the administration of intravenous contrast.

FINDINGS

Cruciate ligament:

Mild diffuse anterior cruciate ligament sprain noted with interstitial fraying and hyperintensity with subtle low grade partial interstitial tear along its inferior fibers.

Posterior cruciate ligaments are normal in size and signal intensity.

Menisci

Medial meniscus and **lateral meniscus** appears normal in bulk and signal intensity. No evidence of tear. The transverse and menisco-femoral ligaments are normal.

Collateral ligaments

The **lateral collateral ligament and medial collateral ligaments** are intact and show normal signal intensity.

Joint capsule

Patellofemoral ligaments are normal. Medial and Lateral patellar retinaculum are normal. Surrounding soft tissue show no abnormality. **Mild knee joint effusion noted.**

Bones and articular cartilage

Alignment of tibia, femur as well maintained. The patella is normally positioned within the femoral groove. Tibial and femoral condyles and visible bones appear normal in signal intensity. The femoral, patellar and tibial articular cartilage appear normal. No fracture, stress reaction, or osseous lesion is seen.

Muscles, tendons and postero-lateral complex

No hyaline cartilaginous disease in patellofemoral, medial and lateral compartments. The distal quadriceps and patellar tendons are intact. The biceps femoris tendon and ilio-tibial tract are normal. The quadriceps and patellar tendons are normal. The popliteal vessels are normal. Hoffa's fat pad is normal. The muscles surrounding the knee joint are normal. No evidence of obvious loose bodies.

IMPRESSION

- **Mild diffuse anterior cruciate ligament sprain with interstitial fraying and hyperintensity with subtle low grade partial interstitial tear along its inferior fibers.**
- **Mild knee joint effusion.**

Dr (Radiologist Name, Digital Sign)

MBBS,MD Radiodiagnosis

Patient Name :	**Gender** : Male
Age : 70 Y	**Date** : Nov 28, 2024
Referring Doctor :	**Patient ID** :

MRI SCAN OF THE RIGHT KNEE

CLINICAL HISTORY

JERK 2 MONTH BACK , PAIN & MOVEMENT DIFFICULTY

PROTOCOL

Multiplanar multisequence MR images of the right knee were obtained without the administration of intravenous contrast.

FINDINGS:

Cruciate ligament

Non-visualisation of ACL fibers with significant inflammation noted within the knee joint capsule with anterior tibial translation of 1.3 cms.

Buckling of PCL fibers noted.

Menisci

PD FAT SAT hyperintensity involving posterior horn of medial meniscus reaching up to the articular surface. Lateral meniscus appears normal in bulk and signal intensity. The transverse and menisco-femoral ligaments are normal.

Collateral ligaments

The **lateral collateral ligament and medial collateral ligaments** are intact and show normal signal intensity.

Joint capsule

Patellofemoral ligaments are normal. Medial and Lateral patellar retinaculum are normal. **Minimal amount of effusion noted within the knee joint space. Baker's**

cyst of size measuring 4.3 x 5 x 4 cm in popliteal fossa communicating with the knee joint cavity

Bones and articular cartilage

- **Marginal osteophytes with joint space narrowing involving knee joint**
- **Grade III chondromalacia patella changes noted**
- **Minimal amount of inflammation noted in the knee joint capsule and Hoffa's fat pad.**

Muscles, tendons and postero-lateral complex

No hyaline cartilaginous disease in patellofemoral, medial and lateral compartments. The distal quadriceps and patellar tendons are intact. The biceps femoris tendon and ilio-tibial tract are normal. The quadriceps and patellar tendons are normal. The popliteal vessels are normal.The muscles surrounding the knee joint are normal. No evidence of obvious loose bodies.

IMPRESSION:----

- **Complete tear of ACL noted with significant inflammation noted within the knee joint capsule along with anterior tibial translation**
- **Complex tear involving posterior horn of medial meniscus**
- **Baker's cyst in popliteal fossa communicating with the knee joint cavity**
- **Mild degenerative osteoarthritis changes involving knee joint**
- **Grade III chondromalacia patella changes**
- **Minimal amount of inflammation noted within the knee joint capsule and Hoffa's fat pad**
- **Minimal knee joint effusion.**

RECOMMENDATION

Suggested clinical correlation.

Dr (Radiologist Name, Digital Sign)

MD Radiodiagnosis

Patient Name :	**Gender** : Female
Age : 24 Y	**Date** : Nov 27, 2024
Referring Doctor :	**Patient ID** :

MRI SCAN OF THE RIGHT KNEE JOINT

CLINICAL HISTORY

Old H/o RTA 4 year back Trauma on RT knee Now h/o RT knee pain and Swelling Difficulty while walking since 8 days No other History

PROTOCOL

Multiplanar multisequence MR images of the right knee were obtained without the administration of intravenous contrast.

FINDINGS

Cruciate ligament

Mild intrasubstance hyperintensity noted involving the anterior cruciate ligament, predominantly involving posterolateral bundle fibers without obvious tear suggesting interstitial edema.

Mild hypertrophy with interstitial edema noted involving proximal 1/3rd femoral aspect of the posterior cruciate ligament.

Menisci

Medial meniscus and **lateral meniscus** appears normal in bulk and signal intensity. No evidence of tear. The transverse and menisco-femoral ligaments are normal.

Collateral ligaments

The **lateral collateral ligament** and **medial collateral ligaments** are intact and show normal signal intensity.

Joint capsule

There is evidence of diffuse soft tissue edema changes involving the lateral compartment and anterior compartment of the knee joint, predominantly involving prepatellar soft tissue with associated approx 27 x 5 mm sized localized collection within. Suggesting possible bursitis likely.

Minimal joint effusion noted involving tibio-femoral and patello-femoral aspects of the knee joint.

Patellofemoral ligaments are normal. Medial and Lateral patellar retinaculum are normal.

Bones and articular cartilage

Alignment of tibia, femur as well maintained. The patella is normally positioned within the femoral groove. Tibial and femoral condyles and visible bones appear normal in signal intensity. The femoral, patellar and tibial articular cartilage appear normal. No fracture, stress reaction, or osseous lesion is seen.

Muscles, tendons and postero-lateral complex

There is seen multiple hypointense foci with associated metallic artifacts in prepatellar soft tissue region. Possibility of ? foreign bodies likely in view of prior history of trauma.

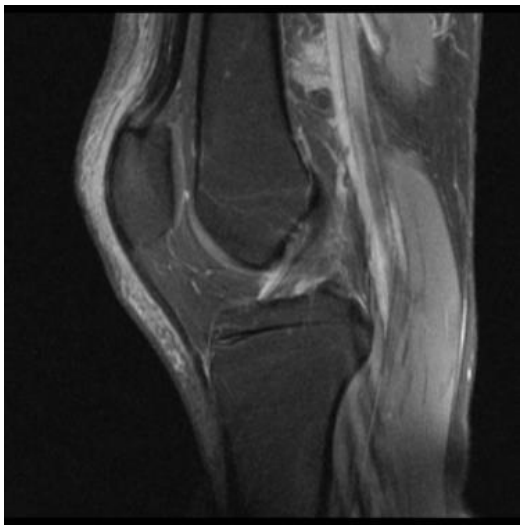
No hyaline cartilaginous disease in patellofemoral, medial and lateral compartments. The distal quadriceps and patellar tendons are intact. The biceps femoris tendon and ilio-tibial tract are normal. The quadriceps and patellar tendons are normal. The popliteal vessels are normal. Hoffa's fat pad is normal. The muscles surrounding the knee joint are normal. No evidence of obvious loose bodies.

IMPRESSION

- **Diffuse soft tissue edema changes involving the lateral and anterior compartments of the knee joint, predominantly involving prepatellar soft tissue with associated localized collection suggesting possible bursitis.**
- **Multiple hypointense foci with associated metallic artifacts in prepatellar soft tissue region, likely foreign bodies due to prior trauma.**
- **Minimal joint effusion involving tibio-femoral and patello-femoral aspects of the knee joint.**
- **Mild intrasubstance hyperintensity involving the anterior cruciate ligament, predominantly involving posterolateral bundle fibers suggesting interstitial edema.**
- **Mild hypertrophy with interstitial edema involving proximal 1/3rd femoral aspect of the posterior cruciate ligament.**

RECOMMENDATION

Suggested clinical correlation.



Dr (Radiologist Name, Digital Sign)

MBBS,MD Radiodiagnosis

Patient Name	:	**Gender**	: Female
Age	: 60 Y	**Date**	: Nov 28, 2024
Referring Doctor	:	**Patient ID**	:

MRI SCAN OF THE CERVICAL SPINE

CLINICAL HISTORY

H/O NECK PAIN U/L BOTH SIDE PAIN X 1 MONTH

PROTOCOL

Multiplanar and multi-echo MRI of the cervical spine was performed without administration of intravenous contrast.

FINDINGS

Anterior marginal osteophytes and IV disc desiccation changes at multiple levels in visualized cervical spine suggestive of degenerative changes

Mild scoliosis of cervical spine noted with convexity towards right side

C2-C3 block vertebra noted with reduced C2-C3 intervening disc space height

Dens of C2 vertebra appears mildly retroflexed

Reduced height of C4, C5, C6 and C7 vertebral bodies with adjacent intervening IV disc space height. No osseous destruction noted.

Disc Spaces:

C2-C3: There is no evidence of disc disease or protrusion, central canal stenosis, or neural foraminal narrowing.

C3-C4: There is no evidence of disc disease or protrusion, central canal stenosis, or neural foraminal narrowing.

Disc osteophyte complex is noted at C4-C5, C5-C6, C6-C7 and C7-T1 levels causing canal stenosis with anterior cord compression on bilateral exiting nerve root compression

Disc Spaces	AP canal diameter (mm)	Status
C2 - C3	11.4	Patent
C3 - C4	11.2	Patent
C4 - C5	**6.9**	**STENOSIS**
C5 - C6	**6.3**	**STENOSIS**
C6 - C7	**5.5**	**STENOSIS**

C7 - T1	**7.6**	**STENOSIS**

Cervical spinal cord shows normal MR morphology and signal characteristics.
Posterior osseous structures and soft tissue structures are normal.
Craniovertebral junction is normal. The cervico-medullary junction appears unremarkable.
No pre / paraspinal soft tissue abnormality seen.

IMPRESSION:

Mild scoliosis of cervical spine noted with convexity towards right side

C2-C3 block vertebra noted with reduced intervening C2-C3 disc space height.

Cervical spondylosis with degenerative disc disease changes causing

- **Canal stenosis with anterior cord compression & bilateral exiting nerve root compression at C4-C5, C5-C6, C6-C7 and C7-T1 levels.**

RECOMMENDATION

Suggested clinical correlation.

Dr (Radiologist Name, Digital Sign)
MD Radiodiagnosis

Patient Name	:	**Gender**	: Female
Age	: 54 Y	**Date**	: Nov 28, 2024
Referring Doctor	:	**Patient ID**	:

MRI SCAN OF THE CERVICAL SPINE

CLINICAL HISTORY

H/O- NECK PAIN , RT UL TINGLING AND NUMBNESS, SINCE LAST 2 MONTHS

PROTOCOL

Multiplanar and multi-echo MRI of the cervical spine was performed without administration of intravenous contrast.

FINDINGS

Straightening of the cervical spine with loss of cervical lordosis is noted.

Marginal osteophytes formation is seen involving all cervical vertebrae.

The vertebrae appear normal in height, signal intensity and show normal alignment. No osseous destruction noted.

Disc Spaces:

Disc desiccation noted involving all cervical intervertebral discs.

C2-C3: There is no evidence of disc disease or protrusion, central canal stenosis, or neural foraminal narrowing.

C3-C4: Disc osteophyte complex with mild posterior disc bulge causing indentation over ventral dural theca with mild narrowing of bilateral intervertebral foramen and compression over bilateral exiting nerve roots.

C4-C5: Disc osteophyte complex with mild posterior disc bulge causing indentation over ventral dural theca with mild narrowing of bilateral intervertebral foramen and compression over bilateral exiting nerve roots.

C5-C6: Disc osteophyte complex with broad-based posterior disc protrusion causing indentation over ventral dural theca with mild to moderate narrowing of bilateral intervertebral foramen and compression over bilateral exiting nerve roots.

C6-C7: Disc osteophyte complex with broad-based posterior disc protrusion causing indentation over ventral dural theca with mild to moderate narrowing of bilateral intervertebral foramen and compression over bilateral exiting nerve roots.

C7-T1: There is no evidence of disc disease or protrusion, central canal stenosis, or neural foraminal narrowing.

Disc Spaces	AP canal diameter (mm)	Status
C2 - C3	14.9	Patent
C3 - C4	11.7	Mild narrowing
C4 - C5	9.7	Mild narrowing
C5 - C6	13.2	Mild narrowing
C6 - C7	7.6	Moderate narrowing
C7 - T1	13	Patent

Cervical spinal cord shows normal MR morphology and signal characteristics.
Posterior osseous structures and soft tissue structures are normal.
Craniovertebral junction is normal. The cervico-medullary junction appears unremarkable.
No pre / paraspinal soft tissue abnormality seen.

IMPRESSION

- **Straightening of the cervical spine with loss of cervical lordosis.**
- **Disc desiccation involving all cervical intervertebral discs.**
- **C3-C4 and C4-C5 levels show Disc osteophyte complex with mild posterior disc bulge causing indentation over ventral dural theca with mild narrowing of bilateral intervertebral foramen and compression over bilateral exiting nerve roots.**
- **C5-C6 and C6-C7 levels show Disc osteophyte complex with broad-based posterior disc protrusion causing indentation over ventral dural theca with mild to moderate narrowing of bilateral intervertebral foramen and compression over bilateral exiting nerve roots.**

RECOMMENDATION

Suggested clinical correlation.

Dr (Radiologist Name, Digital Sign)

MBBS,MD Radiodiagnosis

Patient Name :	**Gender : Female**
Age : 51 Y	**Date : Nov 27, 2024**
Referring Doctor :	**Patient ID**

MRI SCAN OF THE LUMBO-SACRAL (LS) SPINE
CLINICAL HISTORY
H/O LOWER BACK AND LT LOWER LIMB WITH LT KNEE JOINT PAIN SINCE 03 MONTHS NO ANY OTHER AND PREVIOUS HISTORY NO ANY TRAUMA HISTORY.
PROTOCOL
Multiplanar and multi-echo MRI of the lumbosacral spine was performed without administration of intravenous contrast.
FINDINGS
Partial sacralization of L5 vertebra is noted.
Marginal osteophytes formation are seen involving all lumbar vertebrae.
Disc desiccation noted involving all lumbar intervertebral discs.
The study shows normal curvature and alignment of the Lumbo-Sacral spine.
The vertebrae appear normal in height, signal intensity and show normal alignment. No osseous destruction noted.
The signal from the marrow of the visualized vertebrae is normal.
The visualized spinal cord shows normal MR morphology and signal characteristics.
Disc Spaces:
L1-L2: There is no evidence of disc disease or protrusion, central canal stenosis, or neural foraminal narrowing.
L2-L3: There is no evidence of disc disease or protrusion, central canal stenosis, or neural foraminal narrowing.
L3-L4: There is no evidence of disc disease or protrusion, central canal stenosis, or neural foraminal narrowing.
L4-L5: Mild diffuse posterior disc bulge causing indentation over ventral dural theca and abutment over bilateral exiting nerve roots.
L5-S1: There is no evidence of disc disease or protrusion, central canal stenosis, or neural foraminal narrowing.

DISC SPACES	AP CANAL DIAMETER (mm)	STATUS
L1 - L2	19 mm	PATENT
L2 - L3	20 mm	PATENT
L3 - L4	18.7 mm	PATENT
L4 - L5	16.9 mm	PATENT
L5 - S1	10.4 mm	PATENT

The facet joints appear normal. The bony spinal canal appears normal in dimensions.
Posterior osseous structures and soft tissue structures are normal.
No pre / paraspinal soft tissue collection is seen.
Abnormal subarticular no sclerosis with underlying patchy marrow edema noted along bilateral sacro-iliac joints. Suggest possibility of acute on chronic sacroiliitis likely.
IMPRESSION
Partial sacralization of L5 vertebra.
Marginal osteophytes formation involving all lumbar vertebrae.
Disc desiccation involving all lumbar intervertebral discs.
Mild diffuse posterior disc bulge at L4-L5 causing indentation over ventral dural theca and abutment over bilateral exiting nerve roots.
Abnormal subarticular no sclerosis with underlying patchy marrow edema along bilateral sacro-iliac joints suggesting possibility of acute on chronic sacroiliitis.
RECOMMENDATION
Suggested clinical correlation.

Dr (Radiologist Name, Digital Sign)

MBBS,MD Radiodiagnosis

Patient Name	:	**Gender**	: Female
Age	: 42 Y	**Date**	: Nov 27, 2024
Referring Doctor	:	**Patient ID**	:

MRI SCAN OF THE LUMBO-SACRAL (LS) SPINE WITH WHOLE SPINE SCREENING

CLINICAL HISTORY

C/ O LT SIDE WHOLE BODY PAIN FROM MANY YEAR , NO TRAUMA

PROTOCOL

Multiplanar and multi-echo MRI of the lumbosacral spine was performed without administration of intravenous contrast.

FINDINGS

The normal curvature of the lumbar spine is maintained.

Degenerative anterior marginal osteophytes noted at all lumbar levels.

Diffuse mild disc dessication noted at multiple intervertebral disc levels with loss of normal hyperintense T2 signal of IVD discs.

Vertebrae: No fracture or dislocation identified. Spinal alignment is within normal limits. Vertebral body heights are preserved. No evidence of tumor. No abscess or osteomyelitis.
Spinal cord: Unremarkable. No spinal cord edema, laceration or hematoma. No epidural hematoma identified.
Soft tissues: Unremarkable. No evidence of mass, hematoma or abscess.
DISCS/SPINAL CANAL/NEURAL FORAMINA:
L1-L2: No posterior disc herniation. No neuroforaminal stenosis. No spinal canal stenosis.
L2-L3: No posterior disc herniation. No neuroforaminal stenosis. No spinal canal stenosis.
L3-L4: No posterior disc herniation. No neuroforaminal stenosis. No spinal canal stenosis.

L4-L5: **Diffuse mild disc dessication noted. Diffuse posterocentral disc bulge causing mild ventral thecal sac indentation.** No neuroforaminal stenosis. No spinal canal stenosis.

L5-S1: **Diffuse mild disc dessication noted. Diffuse posterocentral disc bulge causing mild ventral thecal sac indentation.** No neuroforaminal stenosis. No spinal canal stenosis.

DISC SPACES	AP CANAL DIAMETER (mm)	STATUS
L1 - L2	17.4	PATENT
L2 - L3	18.7	PATENT
L3 - L4	14.3	PATENT
L4 - L5	12.1	PATENT
L5 - S1	10.4	PATENT

The facet joints appear normal. The bony spinal canal appears normal in dimensions.
Posterior osseous structures and soft tissue structures are normal.
No pre / paraspinal soft tissue collection is seen.

MRI SCREENING OF THE CERVICO DORSAL SPINE

FINDINGS

CERVICAL SPINE:

- **Straightening of the normal curvature of the cervical spine noted.**
- **Posterior disc osteophyte complex noted at C5-6 and C6-7 IVD level causing mild spinal canal compromise with indentation on ventral thecal sac.**
- The normal vertebral alignment is maintained.
- The vertebrae show normal marrow signal with no focal lesions.
- The other cervical intervertebral discs appear normal. No significant bulge noted.
- The cervical cord, CVJ and the cervico-medullary junctions are normal.
- Pre and para vertebral soft tissues are normal.

DORSAL SPINE:

- Normal curvature and vertebral alignment is maintained.
- **Degenerative anterior marginal osteophytes noted at multiple levels.**
- **Ligamentum flavum hypertrophy noted at multiple levels causing mild indentation on dorsal thecal sac.**
- **Type II modic endplate changes noted in dorsal vertebrae.**
- **Posterior disc bulges noted at multiple levels causing mild indentation on ventral thecal sac.**
- The dorsal cord appears normal.
- Pre and para vertebral soft tissues are normal.

IMPRESSION-

-Spondylo-degenerative changes noted in lumbar spine as described.

-Whole spine screening reveals spondylo-degenerative changes in cervico-dorsal spine.

RECOMMENDATION

Suggested clinical correlation.

Dr (Radiologist Name, Digital Sign)MD,DNB,FRCR,EDiR,DICRI

Patient Name :	**Gender** : Male
Age : 64 Y	**Date** : Nov 25, 2024
Referring Doctor :	**Patient ID** :

MRI SCAN OF THE BRAIN

CLINICAL HISTORY

YESTERDAY MRI REPORT ATTACHED. H/O TRAUMA BACK SIDE 4 DAYS AGO & SINCE THEN BACK PAIN , BOTH LL PAIN TINGLING MORE THAN RT SIDE & RT LL WEAKNESS , UNABLE TO WALK

PROTOCOL

Magnetic resonance images of the head/brain without intravenous contrast in multiple planes.

FINDINGS

INFRATENTORIAL REGION

Brain stem is normal.
Cerebello-pontine angle cisterns are normal.
7^{th} and 8^{th} nerve complexes are normal.
Cranio-vertebral and cervico-medullary junctions are normal.

SUPRATENTORIAL REGION:

sulcal spaces, cisterns and ventricular system appears prominent

Multiple foci of T2 and FLAIR hyperintensities in the subcortical and periventricular white matter of bilateral cerebral parenchyma

FLAIR hyperintensity showing restricted diffusion on DWI images involving parasagittal left fronto-parietal lobe suggestive of acute infarct

Chronic infarcts involving bilateral lentiform region and bilateral cerebellar hemisphere

Chronic lacunar infarcts noted in the deep subcortical white matter of right frontal lobe

No focal mass lesion.
No midline shift.
Sella, pituitary and parasellar regions are normal.
Myelination is normal.

T2 and FLAIR hyperintensities involving bilateral ethmoidal and maxillary sinuses suggestive of sinusitis.

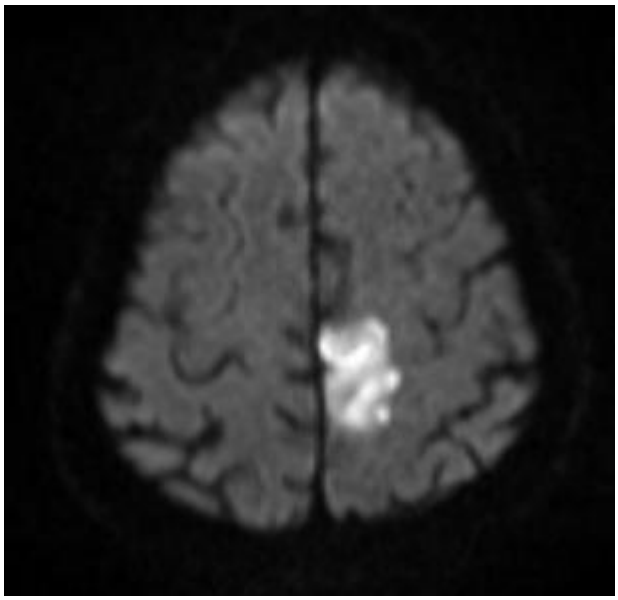
FLAIR hyperintense fluid attenuation involving bilateral mastoid air cells suggestive of mastoiditis

IMPRESSION: ----

- **Mild age related cerebral atrophy with small vessel ischemic changes.**
- **Acute infarct involving parasagittal aspect of left frontal parietal lobe with no evidence of any significant brain herniations or hemorrhagic transformation.**
- **Chronic lacunar infarct in deep subcortical white matter of right frontal lobe**
- **Chronic infarcts involving bilateral lentiform region and bilateral cerebellar hemispheres**
- **Bilateral ethmoidal and maxillary sinusitis**
- **Bilateral mastoiditis.**

RECOMMENDATION

Suggested clinical correlation.



Dr (Radiologist Name, Digital Sign)

MD Radiodiagnosis

Patient Name :	**Gender** : Female
Age : 81 Y	**Date** : Nov 25, 2024
Referring Doctor :	**Patient ID** :

MRI SCAN OF THE BRAIN

CLINICAL HISTORY

H/O U/L L/L RT SIDE WEAKNESS X 2 DAY

PROTOCOL

Magnetic resonance images of the head/brain without intravenous contrast in multiple planes.

FINDINGS

INFRATENTORIAL REGION:

Cerebellar hemispheres are normal.
Brain stem is normal.
Cerebello-pontine angle cisterns are normal.
7^{th} and 8^{th} nerve complexes are normal.
Cranio-vertebral and cervico-medullary junctions are normal.

SUPRATENTORIAL REGION:

sulcal spaces, cisterns and ventricular system appears prominent

Multiple foci of T2 and FLAIR hyperintensities in the subcortical and periventricular white matter of bilateral cerebral parenchyma

Area of FLAIR hyperintensity showing restricted diffusion on DWI images in left precentral gyrus and left frontal lobe cortex suggestive of acute infarct

Chronic lacunar infarcts in bilateral capsuloganglionic region and bilateral thalami

No focal mass lesion.
No midline shift.
Sella, pituitary and parasellar regions are normal.
Thalami are normal.
Myelination is normal.

T2 and FLAIR hyperintensities involving bilateral ethmoidal and maxillary sinuses suggestive of sinusitis

IMPRESSION:

Diffuse age related cerebral atrophy with small vessel ischemic changes

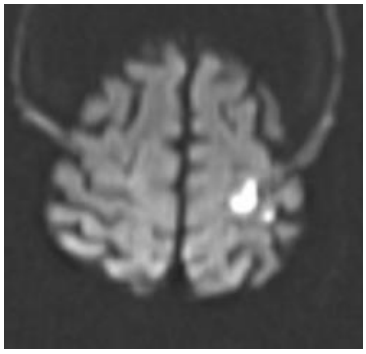
Acute infarct involving left precentral gyrus and left frontal lobe cortex. No evidence of any mass effect or hemorrhagic transformation

Chronic lacunar infarcts in bilateral capsuloganglionic region and bilateral thalami

Bilateral ethmoidal and maxillary sinusitis

RECOMMENDATION

Suggested clinical correlation.



Dr (Radiologist Name, Digital Sign)

MD Radiodiagnosis

Patient Name :	**Gender** : Male
Age : 74 Y	**Date** : Nov 27, 2024
Referring Doctor :	**Patient ID** :

MRI BRAIN WITH ANGIOGRAPHY

CLINICAL HISTORY

MRI BRAIN WITH ANGIOGRAM

PROTOCOL

Axial T1, T2 Wt and FLAIR sequences. Coronal T2 and Sagittal T1 Wt sequences.
3D Time of Flight MR Angiography through Circle of Willis

FINDINGS

INFRATENTORIAL REGION:

Cerebellar hemispheres are normal.
Fourth ventricle is normal.
Brain stem is normal.
Cerebello-pontine angle cisterns are normal.
7^{th} and 8^{th} nerve complexes are normal.
Cranio-vertebral and cervico-medullary junctions are normal.

SUPRATENTORIAL REGION:

Mild discrete and confluent chronic small vessel ischaemic changes noted in bilateral fronto-parietal periventricular and deep white matter.

Multiple tiny chronic lacunar infarcts with gliosis noted in bilateral thalamus, bilateral ganglio-capsular regions and bilateral centrum semiovale.

Multiple tiny petechial haemorrhage is noted in bilateral thalamus, bilateral ganglio-capsular regions, bilateral centrum semiovale and bilateral parietotemporal lobes, concerning for changes of hypertensive microangiopathy.

Mild diffuse cerebral and cerebellar cortical atrophy noted.

No focal mass lesion. No midline shift.
No evidence of intracerebral/subdural bleed/ infarct.
Brain parenchyma shows normal gray/white matter differentiation.
Sella, pituitary and parasellar regions are normal.
Basal ganglia and thalami are normal.
Myelination is normal.

3-D Time of Flight MR Angiography through Circle of Willis:

Mild narrowing within supraclinoid segment of bilateral intracranial internal carotid arteries.

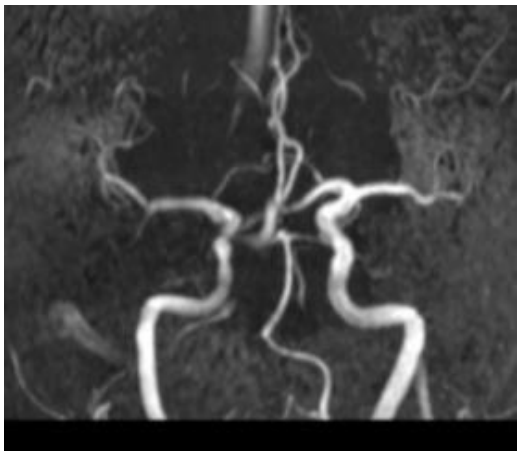
The petrous and cavernous portions of internal carotid arteries are normal in course and calibre. No evidence of narrowing.
Anterior, middle and posterior cerebral arteries are normal in course and calibre.

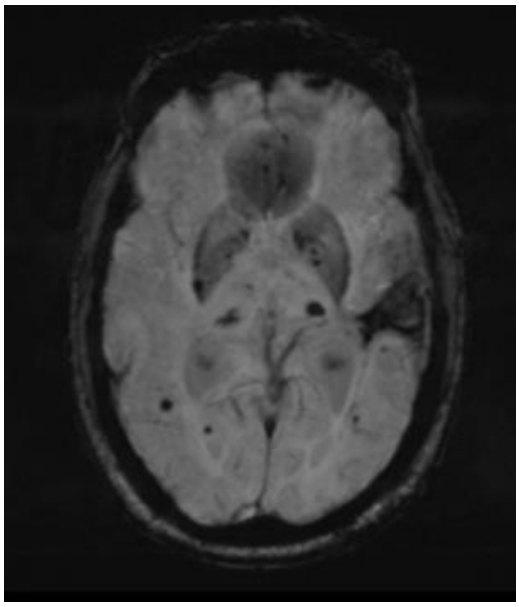
Right vertebral artery is hypoplastic. Basilar artery is diffusely narrowed in calibre, concerning for hypoplastic status. Foetal origin of bilateral posterior cerebral arteries is noted.

No evidence of aneurysm/ arterio-venous malformation.

IMPRESSION

- **Mild discrete and confluent chronic small vessel ischaemic changes in bilateral fronto-parietal periventricular and deep white matter.**
- **Multiple tiny chronic lacunar infarcts with gliosis in bilateral thalamus, bilateral ganglio-capsular regions and bilateral centrum semiovale.**
- **Multiple tiny petechial haemorrhage in bilateral thalamus, bilateral ganglio-capsular regions, bilateral centrum semiovale and bilateral parietotemporal lobes, concerning for changes of hypertensive microangiopathy.**
- **Mild diffuse cerebral and cerebellar cortical atrophy noted.**
- **Mild narrowing within supraclinoid segment of bilateral intracranial internal carotid arteries.**
- **Hypoplastic posterior circulation with predominance of anterior circulation.**





Dr (Radiologist Name, Digital Sign)
MBBS,MD Radiodiagnosis