

MRI Reports — Multimodal / Longitudinal Set (4 studies)

Dates de-identified; study timing shown as intervals. Current MRI episode = clustered cervical / sacroiliac / lumbar studies; the cervical MRI with contrast was obtained ~4 years earlier.

REPORT 1 OF 4

MRI Cervical Spine without contrast

Age/Sex: 39y F

Timepoint: Current MRI episode · service date not stated on the provided document

CPT code: 72141 — MRI NECK SPINE W/O DYE

History: Upper extremity radiculopathy.

Technique: Multiplanar MRI of the cervical spine without gadolinium.

Findings

There are no prior studies for comparison.

The visualized posterior fossa and paravertebral soft tissue structures are normal.

There are no cervical cord signal abnormalities.

There is no fracture or spondylolisthesis of the cervical spine.

C4-C5: There is a posterior disc osteophyte complex resulting in mild central stenosis.

C5-C6: There is left uncovertebral joint hypertrophy resulting in mild left neuroforaminal stenosis.

C6-C7: There is a posterior disc osteophyte complex resulting in minimal central stenosis.

Impression

Mild spondylotic degenerative changes of the lower cervical spine.

MRI Lumbar Spine without contrast

Sex: Female

Date of service: Current MRI episode · ≈2 weeks after the sacroiliac-joint MRI

Exam: MRI LUMBAR SP W/O CONTRAST

CPT code: 72148 — MRI LUMBAR SPINE W/O DYE

History: Low back pain.

Technique: Multiplanar MRI of the lumbar spine without gadolinium.

Findings

There are no prior studies for comparison.

The visualized paravertebral and retroperitoneal soft tissue structures are unremarkable.

There is no fracture or spondylolisthesis of the lumbar spine. There are no vertebral body signal abnormalities.

The distal cord terminates at T12-L1. There are no signal abnormalities within the distal cord or conus.

L5-S1: There is disc desiccation with a minimal broad-based disc bulge resulting in minimal bilateral neuroforaminal stenosis.

Impression

Mild spondylotic degenerative changes at L5-S1.

MRI Pelvis / Sacroiliac Joints without contrast

Sex: Female

Date of service: Current MRI episode · earliest of the current set

Exam: MRI PELVIS W/O CONTRAST

CPT code: 72195 — MRI PELVIS W/O DYE

History: Bilateral sacroiliitis.

Technique: MRI of the sacrum and sacroiliac joints was performed without contrast.

Comparison: None available.

Findings

There is mild marrow edema like signal on both sides of both sacroiliac joints. No bone erosions. No sacroiliac joint effusion. Marrow signal elsewhere is normal. No fracture or suspicious bone lesion. There is a broad-based shallow central disc protrusion at L5-S1 with an associated annular fissure. The visualized muscles are unremarkable.

Impression

- Mild marrow edema like signal on both sides of both sacroiliac joints. No erosions or joint effusion. Findings could be degenerative in etiology with mild sacroiliitis not excluded.
- Shallow broad-based central disc protrusion at L5-S1 with an associated annular fissure.

MRI Cervical Spine without and with IV contrast

Source: Incoming / outside radiology result

Timepoint: ~4 years before the current MRI episode

Exam: MRI CERVICAL SPINE WITHOUT AND WITH IV CONTRAST

Resulting system: RADIANT

History: Numbness or tingling, paresthesia (Ped 0-18y) Numbness.

Comparison: MRI brain, ~2 weeks earlier (same prior timepoint).

Technique: Pre and post infusion multiplanar multisequence through the cervical spine. Post infusion images were obtained following intravenous injection of 20 ml of ProHance.

Findings

Normal cervical lordosis. The vertebral bodies are normal in height and alignment. The intervertebral disc spaces are maintained. The craniocervical junction and C1-C2 articulation are normal.

No abnormal signal or enhancement involving the cervical cord.

At **C4-C5**, small central disc protrusion with mild spinal canal stenosis. At **C6-C7**, small central disc protrusion with minimal spinal canal stenosis and left foraminal stenosis. Mild left foraminal stenosis at **C5-C6** secondary to uncovertebral arthropathy. No critical neural foraminal or spinal canal stenosis at any level.

Unremarkable prevertebral and paraspinal soft tissues.

Impression

Mild degenerative changes in the cervical spine as above. No high-grade spinal or foraminal stenosis at any level. No cord signal abnormality or abnormal enhancement.