

Structured Radiographic Report

Multi-region axial & peripheral radiographic series · READY+ (Gold Standard depth)

Patient	De-identified	Study date	2025-xx-xx
Demographics	Male, 86 years old	Modality	XR

DECLARED / EXAMINED REGIONS AND PROJECTIONS

- Cervical spine: AP, lateral, right oblique, left oblique
- Thoracic spine: AP, lateral
- Lumbar spine: AP, lateral, right oblique, left oblique, lumbosacral spot lateral
- Sacroiliac joints: AP, right oblique, left oblique
- Right hand/wrist: PA, oblique, lateral
- Left hand/wrist: PA, oblique, lateral

IMAGE QUALITY / COVERAGE

Adequate for clinical interpretation of the submitted regions. Cervicothoracic junction is mildly limited by shoulder overlap. Hips are only partially included and are not fully assessable on this exam.

FINDINGS

AXIAL SKELETON

Cervical spine

There is marked multilevel cervical spondylosis with loss of normal cervical lordosis / mild reversal. Disc degeneration is present from the mid to lower cervical spine, greatest at approximately C4-C5, C5-C6, and C6-C7, where narrowing is moderate to severe. There is multilevel endplate sclerosis and bulky anterior endplate osteophyte / ossification formation, non-marginal in morphology, extending across several contiguous levels. Anterior bridging or near-bridging ossification is present at multiple cervical levels. Multilevel uncovertebral and facet hypertrophic arthropathy is marked, with bilateral multilevel osseous foraminal narrowing, moderate to severe, greatest in the lower cervical spine. No definite thin marginal syndesmophytes are identified. No definite erosive atlantoaxial inflammatory change is seen on the submitted views. No acute fracture is evident radiographically.

Thoracic spine

Thoracic vertebral body heights are maintained. Mild multilevel thoracic disc degeneration and spondylosis are present. In the lower thoracic / thoracolumbar region there is bulky anterior-right/lateral predominant flowing ossification rather than thin marginal syndesmophytes. Definite long-segment ankylosing-spondylitis-type thoracic bamboo-spine morphology is not seen on these views.

Lumbar spine

There is mild levoconvex lumbar curvature. Advanced multilevel lumbar spondylosis is present. Severe degenerative disc disease is seen at the thoracolumbar/upper lumbar junction, centered approximately at T12-L1/L1-L2, with marked disc space loss, prominent endplate sclerosis, and vacuum phenomenon. Additional multilevel degenerative

disc disease is present through the lumbar spine, including moderate to severe narrowing at L4-L5 and moderate narrowing at L5-S1, with lesser but definite multilevel narrowing above. Lower lumbar facet arthropathy is marked bilaterally.

Superimposed on this is extensive bulky flowing anterolateral ossification across multiple contiguous thoracolumbar and lumbar levels, non-marginal in morphology, with bridging / near-bridging ossification across several segments. This pattern is much broader and more exuberant than inflammatory marginal syndesmophytes and is characteristic of DISH-pattern ossification. The overall axial lumbar burden is therefore mixed, with very severe degenerative spondylosis plus marked DISH-type enthesopathic flowing ossification. No erosive endplate destruction is seen. No acute compression deformity is identified on the provided views. No definite high-grade listhesis is visible radiographically.

Sacroiliac joints

Both SI joints remain patent. Mild bilateral subchondral sclerosis and mild articular irregularity are present, compatible with mild degenerative change. No definite erosions are seen. No pseudo-widening is seen. No ankylosis is present. No convincing radiographic inflammatory sacroiliitis is identified on the submitted views.

PERIPHERAL JOINTS

Right hand / wrist

Severe first CMC osteoarthritis is present with marked joint-space loss, sclerosis, osteophytes, remodeling, and degenerative subluxation. Additional degenerative change is present at the scaphotrapezial region. There is multifocal interphalangeal arthropathy in a DIP/PIP-predominant distribution. Multiple joints show central erosive/remodeling change with gull-wing / central collapse morphology, including advanced involvement of the second DIP, third PIP, third DIP, and fourth PIP, with additional involvement of the fourth DIP, fifth PIP, and fifth DIP. Associated osteophytes and subchondral sclerosis are present. Mild degenerative change is present at the first MCP and mild degenerative change at the second and third MCP joints. No convincing marginal erosions are identified in the MCP row or wrist. No carpal collapse is seen.

Left hand / wrist

Severe first CMC osteoarthritis is present with marked joint-space loss, sclerosis, osteophytes, and remodeling. Mild degenerative change is present at the scaphotrapezial region. Multifocal DIP/PIP-predominant arthropathy is present, with central erosive/remodeling change at several joints, including advanced involvement of the second DIP, fourth PIP, and fourth DIP, with additional degenerative/erosive OA change at the second PIP, third DIP, fifth PIP, and fifth DIP. Mild degenerative change is present at the first MCP and mild degenerative change at the second and third MCP joints. No convincing MCP/carpal marginal erosive inflammatory pattern is identified. No carpal collapse is seen.

PARTIALLY VISUALIZED ADDITIONAL STRUCTURES

Partial hip visualization shows bilateral hip osteoarthropathy, greater on the right, incompletely assessed on this exam. Vascular calcifications are present. Prior median sternotomy and left chest pacemaker are incidentally noted.

COMPARISON

No directly comparable prior region-matched radiographs are available in this chat for validated longitudinal comparison. This study is treated as the current baseline within the available dataset.

IMPRESSION

1. Marked mixed axial structural disease, dominated by:
 - very severe multilevel degenerative spondylosis / degenerative disc disease in the cervical and lumbar spine, and
 - prominent DISH-pattern bulky flowing non-marginal bridging ossification across multiple contiguous thoracolumbar/lumbar levels, with additional bulky anterior cervical ossification.
2. No convincing radiographic ankylosing spondylitis pattern on this exam: no definite thin marginal syndesmophytes, no definite bamboo-spine morphology of ankylosing-spondylitis type, and no definite radiographic erosive sacroiliitis or SI ankylosis.
3. Mild bilateral degenerative sacroiliac change only.
4. Bilateral hands show advanced osteoarthritis, including severe bilateral first CMC osteoarthritis and multifocal erosive osteoarthritis of the DIP/PIP joints with central erosive remodeling.
5. No convincing rheumatoid-pattern MCP/carpal marginal erosive arthropathy identified radiographically.
6. Partial hip visualization suggests bilateral hip osteoarthritis, greater on the right.

EMR SUMMARY

Radiographs show a strongly non-inflammatory structural pattern overall, with marked DISH-type flowing enthesopathic ossification superimposed on advanced multilevel degenerative cervical and lumbar spondylosis/DDD, especially severe at the thoracolumbar junction and in the lower lumbar spine. SI joints remain patent without definite erosive sacroiliitis or ankylosis, arguing against radiographic axial spondyloarthritis on this set. Hand radiographs show severe bilateral thumb-base OA plus multifocal erosive osteoarthritis of the DIP/PIP joints with central erosive remodeling, without a convincing RA-type MCP/carpal erosive pattern. In the context of the provided clinical history, these radiographs support predominantly degenerative + DISH-pattern disease burden, not a clearly demonstrated active inflammatory axial arthropathy on plain films.

Limit note: plain radiographs do not exclude a subtle non-radiographic inflammatory component, but this exam does not provide convincing structural support for ankylosing spondylitis.