Basic , Cheryl
22 Strabane Green RIDGEWOOD 6030
Phone: 93044558

Birthdate:	24/11/1950	**Sex:**	F	**Medicare Number:**	6060 02484 9-
Your Reference:	2024K0004869	**Lab Reference:**	2024K0004869-1		
Laboratory:	westnrad				
Addressee:	Dr Ifunanya Ijeneme	**Referred by:**	Dr Ifunanya Ijeneme		
Name of test:	Lumbar Spine CT				
Requested	22/02/2024	**Collected:**	22/02/2024	**Reported:**	23/02/2024 12:31:00

Western Radiology

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Patient Name: Basic, Cheryl
Patient DOB: 24/11/1950
Date of service: 22/02/2024
WR Patient ID: WR254582

CT LUMBAR SPINE

CLINICAL HISTORY:

Minimal lower back pain. Right straight leg raise reduced. No saddle paraesthesia. Sharp pain shooting down right leg. Sciatica, ? cause.

FINDINGS:

Normal vertebral body alignment without spondylolisthesis. Preserved vertebral body height throughout.

L1/2: Mild reduction of the intervertebral disc height. No disc bulge, canal stenosis or exit foraminal stenosis. Moderate facetal OA.

L2/3: Mild reduction of the intervertebral disc height. No disc bulge, canal stenosis or exit foraminal stenosis. Mild bilateral facetal OA.

L3/4: Preserved intervertebral disc height. No disc bulge or canal stenosis. No exit foraminal stenosis. Moderate bilateral facetal OA.

L4/5: Preserved intervertebral disc height. Mild posterior annular bulge encroaching on the AP canal dimensions stenosing it to approximately 70% of its original. There is mild bilateral exit foraminal stenosis, but this is unlikely to result in exiting nerve impingement. Moderate to severe bilateral facetal OA.

L5/S1: Mild reduction of intervertebral disc height. No disc bulge or canal

stenosis. There is mild left exit foraminal stenosis secondary to posterior osteophytic spurring and abutment of the left exiting L5 nerve cannot be excluded, however, I note that the symptoms are right sided.

There is no sacroiliitis. Moderate degenerative changes of the sacroiliac joints bilaterally are noted.
The partly visualised upper abdominal solid organs are unremarkable on this non-enhanced study.

COMMENT:

Mild exit foraminal stenosis at the right L4 exit foramen. Although on imaging this is not convincingly molding the right L4 exiting nerve, I note that the symptoms. A nerve root sleeve injection with local anaesthetic and steroid may be trialled.
Exit foraminal stenosis at L5 with abutment of the left exiting L5 nerve. I note, however, the symptoms are contralateral.
Multilevel degenerative changes in the facet joints slightly more prominent at L4/5 and L5/S1 levels.

Thank you for your referral.

Yours sincerely,

Dr Miltiadis Vouros
MBCHB MRCS FRCR

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Basic , Cheryl
22 Strabane Green RIDGEWOOD 6030
Phone: 93044558

Birthdate:	24/11/1950	**Sex:**	F	**Medicare Number:**	6060 02484 9-
Your Reference:	2024K0005007	**Lab Reference:**	2024K0005007-1		
Laboratory:	westnrad				
Addressee:	Dr Ifunanya Ijeneme	**Referred by:**	Dr Ifunanya Ijeneme		
Name of test:	Hip Left CT				
Requested	22/02/2024	**Collected:**	23/02/2024	**Reported:**	23/02/2024 16:39:00

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Patient Name: Basic, Cheryl
Patient DOB: 24/11/1950
Date of service: 23/02/2024
WR Patient ID: WR254582

CT BOTH HIPS

CLINICAL HISTORY:

Malalignment of the hip joints, shooting pain right leg.

FINDINGS:

Alignment of the both hip joints are normal. No fracture or dislocation. Early OA both hip joints with slight joint space reduction.

Os acetabulum is noted on right side. Bump at the head-neck junction of the right femur is also noted. These changes predispose to femoroacetabular impingement and labral tears. This can be better assessed with MRI study.

There is mild tendinosis of bilateral gluteal tendons especially on the right side. Tiny calcification in bilateral gluteal medius tendons. Mild to moderate tendinosis of left hamstring tendon with prominent calcification. Mild tendinosis and small calcification of right hamstring tendon.

There are small diverticula from the right and left lateral aspect of the bladder. Faecal loading of the colon is seen. Rest of the visualised pelvic structures are normal.

There is no lytic or sclerotic lesion. No finding to suggest avascular necrosis.

COMMENT:

Possible right femoroacetabular impingement as described. Early OA both hip joints.
Bilateral gluteal and hamstring tendinosis especially on the right side. Is there any tenderness over the greater trochanter? Ultrasound hip can be considered.
Bladder diverticula are noted incidentally.

Thank you for your referral.

Yours sincerely,

Dr Vinod Attarde
MD. FRANZCR.

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