

<b>Patient Name</b>	WRIGHT-GITTINS, SHANNON ARINA	<b>Accession</b>	22210092Q2
<b>Patient D.O.B.</b>	25/10/1978	<b>Description</b>	MRI - SPINE (C.A)
<b>Patient ID</b>	QXR1126309	<b>Study Date/Time</b>	30/10/2024 13:31
<b>Referring Physician</b>	CRAIG, DONALD	<b>Modality</b>	MR

**EXAMINATION:**

MRI BRAIN; MRI WHOLE SPINE

**Clinical History:**

Progressive tremors, worsening vision, broad-based/shuffling gait. Question MS or demyelinating lesion.? Stroke. Background of VP shunt.

**Technique:**

Brain: Axial T2, DWI, ADC, SWI; 3D T1 MPRAGE, 3D FLAIR, 3 D time-of-flight MRA.

Spine: Sagittal T2; axial T2.

**Comparison:**

Multiple previous MR examinations most recently MR brain 9 February 2024 dating back to MR 6 April 2022 and CT head 23 June 2021 and 1 October 2020.

**Findings:**

**Brain:**

Right transfrontal VP shunt in situ with the tip in the posterior body of the right lateral ventricle which is slit like. There is a further remnant shunt tubing within the temporal horn and atria of the right lateral ventricle.

There is enlargement of the left occipital and temporal horns with decompressed anterior left lateral ventricle and decompressed 3rd and 4th ventricle with no evidence of hydrocephalus.

There is marked white matter volume loss within the right occipital and temporal lobes with parenchymal defect along the inferior and anterior aspect of the left temporal horn in keeping with encephalomalacia/previous insult. There is further white matter volume loss and T2/FLAIR hyperintensity within the right occipital and temporal lobes but less than marked than the contralateral side. Gliosis along the previous shunt tract within the right parietal lobe is noted. There is T2/FLAIR hyperintensity within the periventricular white matter adjacent to the body and anterior horn of the lateral ventricles which is stable when compared with imaging dating back to 2022. There is volume loss of the left thalamus noted as well as marked thinning of the posterior corpus callosum which is also stable.

Normal appearances of the posterior fossa and craniocervical junction. No abnormality on diffusion-weighted or susceptibility weighted imaging.

Normal appearances of the major intracranial arteries are demonstrated. There is a short-segment duplication of the right A1 segment of the anterior cerebral artery which is a normal variant of no significance.

**Spine:**

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The spinal cord is of normal signal intensity throughout. The conus tapers normally to terminate T11 vertebral level. Mild degenerative changes of the cervical spine. No central canal stenosis. There is fusion of the anterior intervertebral joint at T5/6. Normal appearance of the visualised paravertebral soft tissues. A renal cyst is demonstrated on the right.

**CONCLUSION:**

Appropriately positioned VP shunt with no evidence of hydrocephalus or shunt dysfunction. Stable intracranial appearances when compared with imaging dating back to MR 6 April 2022 and CT 1 October 2020 with no progressive changes evident.

There is marked white matter volume loss as well as encephalomalacia within bilateral occipital and temporal lobes, more marked on the left which is resulting in ex vacuo dilatation of the posterior left lateral ventricle and temporal horn. The T2/FLAIR hyperintense periventricular white matter signal change also likely represents gliosis related to a remote insult. Secondary changes of thinning of the posterior corpus callosum and left thalamic volume loss are also demonstrated and stable.

No acute infarct or features of demyelination are demonstrated.

Normal appearances of the spinal cord.

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