647372 (Acc No)- Patient Name: Roberto Puglisi - DOB: 19-08-1972 Sex: Male
ADELAIDE MRI at TORRENSVILLE 8440 7740 - PAYNEHAM 8440 7700 - GOODWOOD 8440 7710 - ELIZABETH 8440 7720 - WOODVILLE 8440 7730 - PARA HILLS WEST 8440 7750

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CT LUMBAR SPINE

KEY FINDINGS
At L4/5, there is a focal central posterior disc protrusion.
At L4/5 an annular fissure may be present in the context of a localised disc protrusion.
At L4/5 there is minor lateral recess impingement of the right and left L5 nerve root.
At L5/S1, there is a moderate broad based posterior disc bulge.
At L5/S1, perineural fat is effaced in the exit foramen on the right and left; there is appreciable exiting right and left L5 nerve root impingement.
There is a pars defect on the right and left at L5
There is anterior spondylolisthesis at L5/S1 estimated at 8.9 mm. The L5 vertebra measures 34.4 mm. There is ~26% spondylolisthesis at L5/S1.
There is a marked reduction in L5 foraminal vertical dimension related to the pars defect on the right and left.

IMPRESSION AND RECOMMENDATIONS
The appearances are typical of spondylolisthesis associated with a deficiency of the pars interarticularis at L5.
There is a Grade 2 out of 4 anterior spondylolisthesis of L5 on S1.
There is marked deformity of the right and left L5 exit foramen secondary to spondylolisthesis at the same level.
A trial of anaesthetic injection around the pars defects at L5 would confirm or exclude mechanical strain at the pars defects as a cause of the clinical symptoms.

COMMENT
An annular fissure at L4/5 is typically associated with non-localised posterior pain at L4.
A pars defect at L5 may be associated with poorly localised midline lumbar pain.

HISTORY
SYSTEM SPECIFIC HISTORY

There was no history of surgery, according to the patient.
The patient presented with MVA on October 11 1985.
The pain distribution was marked up by the patient and confirmed by the reporting practitioner.
The patient rated their pain symptom as 3 out of 10 at the time of the imaging examination.
CLINICAL EXAMINATION, SUSPICION & RULE OUT
The the patient reported MVA.

FINDINGS IN DETAIL
FINDINGS BY LUMBAR SPINE LEVEL
L1 AND L1/2
There is no significant posterior disc protrusion at L1/2.
L2 AND L2/3
There is no significant posterior disc protrusion at L2/3.
L3 AND L3/4
There is no significant posterior disc protrusion at L3/4.
L4 AND L4/5
At L4/5, there is a focal central posterior disc protrusion.
At L4/5 an annular fissure may be present in the context of a localised disc protrusion.
At L4/5 there is minor lateral recess impingement of the right and left L5 nerve root.
L5 AND L5/S1
At L5/S1, there is evidence of discal gas formation, marked disc space narrowing and focal marginal osteophyte formation, all markers of long-standing disc degeneration.
At L5/S1, there is a moderate broad based posterior disc bulge.
At L5/S1 there is an "uncovered disc" associated with significant anterolisthesis of L5 on S1.
At L5/S1, perineural fat is effaced in the exit foramen on the right and left; there is appreciable exiting right and left L5 nerve root impingement.
There is a pars defect on the right and left at L5.
There is anterior spondylolisthesis at L5/S1 estimated at 8.9 mm. The L5 vertebra measures 34.4 mm. There is ~26% spondylolisthesis at L5/S1.
There is a marked reduction in L5 foraminal vertical dimension related to the pars defect on the right and left.
A trial of anaesthetic and steroid guided injection around the right and left pars interarticularis at L5 may provide significant clinical relief.

Thank you for referring this patient,
Dr J Kew, Dr R Davies

647374 (Acc No)- Patient Name: Roberto Puglisi - DOB: 19-08-1972 Sex: Male
ADELAIDE MRI at TORRENSVILLE 8440 7740 - PAYNEHAM 8440 7700 - GOODWOOD 8440 7710 - ELIZABETH 8440 7720 - WOODVILLE 8440 7730 - PARA HILLS WEST 8440 7750

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MRI CERVICAL SPINE

KEY FINDINGS
There is a focal left lateral posterior disc bulge and osteophyte complex at the C4/5 level.
There is focal impingement on the lateral recess neural structures on the left at the C4/5 level.
There is a prominent focal right and left lateral posterior disc protrusion and osteophyte complex at the C5/6 level.
The C5/6 disc protrusion is noted to extend laterally to the right lateral exit foramen.
There is focal impingement on the lateral recess neural structures on the right and left at the C5/6 level.
At C5/6 there is reduced foraminal perineural fat with moderate impingement on the exiting right C6 nerve root.
There is a minor right lateral posterior disc osteophyte complex at the C6/7 level.
There is focal impingement on the lateral recess neural structures on the right at the C6/7 level.

IMPRESSION AND RECOMMENDATIONS
A trial of right C6 peri-neural steroid injection under CT control may be clinically indicated via the C5/6 facet joint if symptoms warrant non-surgical intervention.

COMMENT
The patient will seek their referrer's advice on the options for further medical and/or image guided intervention management.
Treatment goals indicating a successful treatment outcome include:- improved mobility; significantly reduced reported pain levels and/or an improved sense of wellbeing.
Symptoms from lateral recess impingement at C5/6 typically include pain or other sensory symptoms in a C6 dermatomal distribution
The C5 dermatome characteristically includes the lower neck and lateral shoulder.
The C6 dermatome characteristically includes the lateral upper arm and/or forearm.

HISTORY

GENERAL HISTORY

The history of MVA in October 2024 noted.

There was no history of surgery, according to the patient.

The history of aching is noted.

The patient gave no history of anticoagulant administration.

The patient reported no intervention in the symptomatic region.

The patient reported right and left neck symptoms (C3 or C4 dermatome).

The patient reported right and left shoulder symptoms (C4 or C5 dermatome).

The patient reported right wrist and thumb pain (C6 dermatome).

The patient reported right middle finger pain (C7 dermatome).

The patient described left and right lumbar pain (L5 dermatome).

The patient rated their symptom as 10 out of 10 at the time of the imaging examination.

CLINICAL EXAMINATION, SUSPICION & RULE OUT

? radicular cause.

TECHNIQUE

Imaging was obtained with a 1.5 T Philips Achieva dStream MRI with Release 5.7 software.

Sagittal T2 TSE, T1 TSE, Axial T2 TSE (C3-C7); Coronal R & L Oblique T2 TSE

A time-out was observed to confirm the correct patient, procedure, and site.

An MRI safety check was completed and checked.

FINDINGS IN DETAIL

FINDINGS BY CERVICAL SPINE LEVEL

C1 AND C1/2

There is minor age typical degenerative change at the C1 arch/C2 dens joint space.

C2 AND C2/3

There is no significant posterior disc protrusion at C2/3.

C3 AND C3/4

There is no significant posterior disc protrusion at C3/4.

C4 AND C4/5

There is a focal left lateral posterior disc bulge and osteophyte complex at the C4/5 level.

There is focal impingement on the lateral recess neural structures on the left at the C4/5 level.

C5 AND C5/6

There is a moderate reduction in disc height at C5/6.

There is antero-marginal osteophytic lipping of the opposing end plates at C5/6 in keeping with spondylo-degenerative change.

There is a prominent focal right and left lateral posterior disc protrusion and osteophyte complex at the C5/6 level.
The C5/6 disc protrusion is noted to extend laterally to the right lateral exit foramen.
There is focal impingement on the lateral recess neural structures on the right and left at the C5/6 level.
At C5/6 there is reduced foraminal perineural fat with moderate impingement on the exiting right C6 nerve root.
C6 AND C6/7
There is a minor right lateral posterior disc osteophyte complex at the C6/7 level.
There is focal impingement on the lateral recess neural structures on the right at the C6/7 level.
C7 AND C7/T1
There is no significant posterior disc protrusion at C7/T1.
OTHER FINDINGS
The signal intensity of the cervical spinal cord is within normal limits.
There is loss of the usual lower mid cervical lordosis.

Thank you for referring this patient,
Dr J Kew, Dr R Davies
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647371 (Acc No)- Patient Name: Roberto Puglisi - DOB: 19-08-1972 Sex: Male
ADELAIDE MRI at TORRENSVILLE 8440 7740 - PAYNEHAM 8440 7700 - GOODWOOD 8440 7710 - ELIZABETH 8440 7720 - WOODVILLE 8440 7730 - PARA HILLS WEST 8440 7750

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RIGHT HAND XRAY

KEY FINDINGS
There is no linear lucency or sclerosis to suggest a recent or healing bony fracture.
The right scaphoid cortices and trabeculae are intact.
There is minor joint space narrowing of the 1st carpometacarpal joint on the right.

IMPRESSION AND RECOMMENDATIONS
No recent or healing bony injury is identified on the right.

COMMENT
An ultrasound study could be performed to assess the soft tissues.

HISTORY
SYSTEM SPECIFIC HISTORY
The history of pain is noted.

TECHNIQUE
AP, oblique and lateral radiographs of the right hand were obtained.
A time-out was observed to confirm the correct patient, procedure, and site; verbal consent was obtained.

FINDINGS IN DETAIL
FINDINGS SUMMARY
There is no linear lucency or sclerosis to suggest a recent or healing bony fracture.
ALIGNMENT
Bony alignment of the visualised bony structures of the right hand and wrist is anatomical.
The right scaphoid cortices and trabeculae are intact.
There is no widening of the scapho-lunate joint space to suggest post-traumatic instability.
The visualised skeleton exhibits expected bone density for age.

DEGENERATIVE FINDINGS

There is minor joint space narrowing of the 1st carpometacarpal joint on the right.

Thank you for referring this patient,

Dr Roger Davies
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647373 (Acc No)- Patient Name: Roberto Puglisi - DOB: 19-08-1972 Sex: Male
ADELAIDE MRI at TORRENSVILLE 8440 7740 - PAYNEHAM 8440 7700 - GOODWOOD 8440 7710 - ELIZABETH 8440 7720 - WOODVILLE 8440 7730 - PARA HILLS WEST 8440 7750

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RIGHT SHOULDER ULTRASOUND

KEY FINDINGS

There is marked thickening and a small amount of fluid within the subacromial bursa in keeping with subacute bursitis.
On examination, lateral abduction is unimpeded and normal on internal rotation on the right.
The supraspinatus tendon appears slightly heterogeneous in keeping with minimal tendinosis.
There are degenerative changes typical for age in relation to the acromio-clavicular joint (ACJ).

IMPRESSION AND RECOMMENDATIONS

There are features consistent with subacute subacromial bursitis.
There is slight heterogeneity suggesting minor supraspinatus tendinosis.

COMMENT

MRI of the cervical spine has been performed as requested and reported separately.

HISTORY

SYSTEM SPECIFIC HISTORY

The history of persisting right shoulder pain after MVA for investigation.
Neck pain radiating to the shoulder is noted.

GENERAL HISTORY

The history of MVA on the October 11 2024.

TECHNIQUE

A time-out was observed to confirm the correct patient, procedure, and site; verbal and written consent was obtained.
The ultrasound study was targeted to the area of concern.

FINDINGS IN DETAIL

EFFUSION AND SOFT TISSUE FINDINGS

There is marked thickening and a small amount of fluid within the subacromial bursa in keeping with subacute bursitis.

On examination, lateral abduction is unimpeded and normal on internal rotation on the right.

TENDON FINDINGS

The proximal biceps tendon is intact; the tendon exhibits normal echogenicity.

The subscapularis tendon echogenicity and contours appear within normal limits.

The supraspinatus tendon appears slightly heterogeneous in keeping with minimal tendinosis.

The infraspinatus, and teres tendon echogenicity and contours appear within normal limits.

SHOULDER JOINT STRUCTURES

The posterior labrum appears within normal limits for age.

The coracoacromial ligament appears intact and normal.

There are degenerative changes typical for age in relation to the acromio-clavicular joint (ACJ).

LEFT SHOULDER ULTRASOUND

KEY FINDINGS

There is moderate thickening and a small amount of fluid within the subacromial bursa in keeping with subacute bursitis.

On examination, lateral abduction is unimpeded and normal on internal rotation on the left.

The supraspinatus tendon appears slightly heterogeneous in keeping with minimal tendinosis.

There are degenerative changes typical for age in relation to the acromio-clavicular joint (ACJ).

IMPRESSION AND RECOMMENDATIONS

There are features consistent with subacute subacromial bursitis.

There is slight heterogeneity suggesting minor supraspinatus tendinosis.

COMMENT

MRI of the cervical spine has been performed as requested and reported separately.

HISTORY

SYSTEM SPECIFIC HISTORY

The history of persisting left shoulder pain after MVA for investigation.

Neck pain radiating to the shoulder is noted.

GENERAL HISTORY

The history of MVA on the October 11 2024.

TECHNIQUE

A time-out was observed to confirm the correct patient, procedure, and site; verbal and written consent was obtained.

The ultrasound study was targeted to the area of concern.

FINDINGS IN DETAIL

EFFUSION AND SOFT TISSUE FINDINGS

There is moderate thickening and a small amount of fluid within the subacromial bursa in keeping with subacute bursitis.

On examination, lateral abduction is unimpeded and normal on internal rotation on the left.

TENDON FINDINGS

The proximal biceps tendon is intact; the tendon exhibits normal echogenicity.

The subscapularis tendon echogenicity and contours appear within normal limits.

The supraspinatus tendon appears slighily heterogeneous in keeping with minimal tendinosis.

The infraspinatus, and teres tendon echogenicity and contours appear within normal limits.

SHOULDER JOINT STRUCTURES

The posterior labrum appears within normal limits for age.

The coracoacromial ligament appears intact and normal.

There are degenerative changes typical for age in relation to the acromio-clavicular joint (ACJ).

Thank you for referring this patient,

Dr Roger Davies
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