


**L5-S1 facet joint arthrosis / synovitis.**

**A tiny , 1.0 x 0.5 cm 'synovial cyst' arising from left facet joint protruding into L5-S1 left lateral recess affecting traversing left S1 nerve root.**

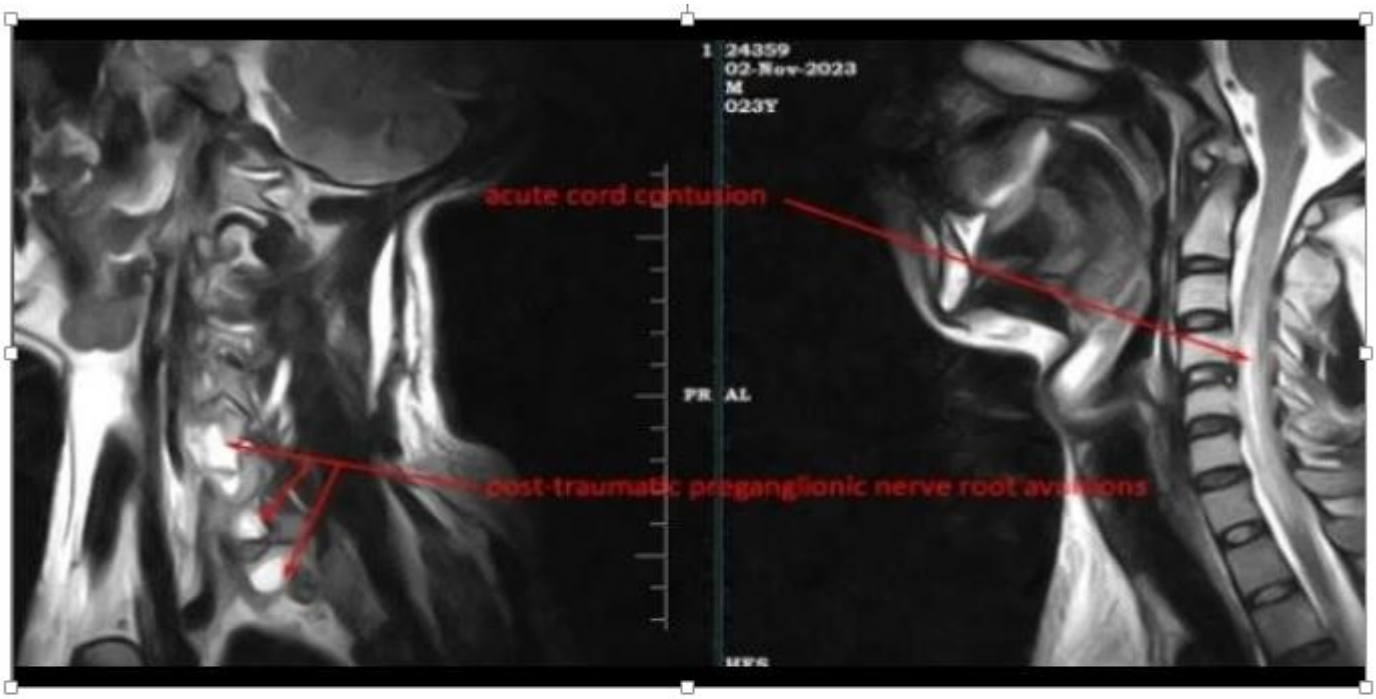



**Findings suggestive of unfused apophysis of C2 – 'os odontoideum'.**

**Focal narrowing of the bony central canal at C1-C2 level, likely related to atlanto-axial joint instability.**

**Marked tapering of the cord caliber at C1-C2 level demonstrating height focal T2 cord signal intensity - *suggestive of 'chronic compressive myelopathy' due to atlanto-axial joint instability ( dystopic os odontoideum).***

**Recommend clinical correlation, follow up.**



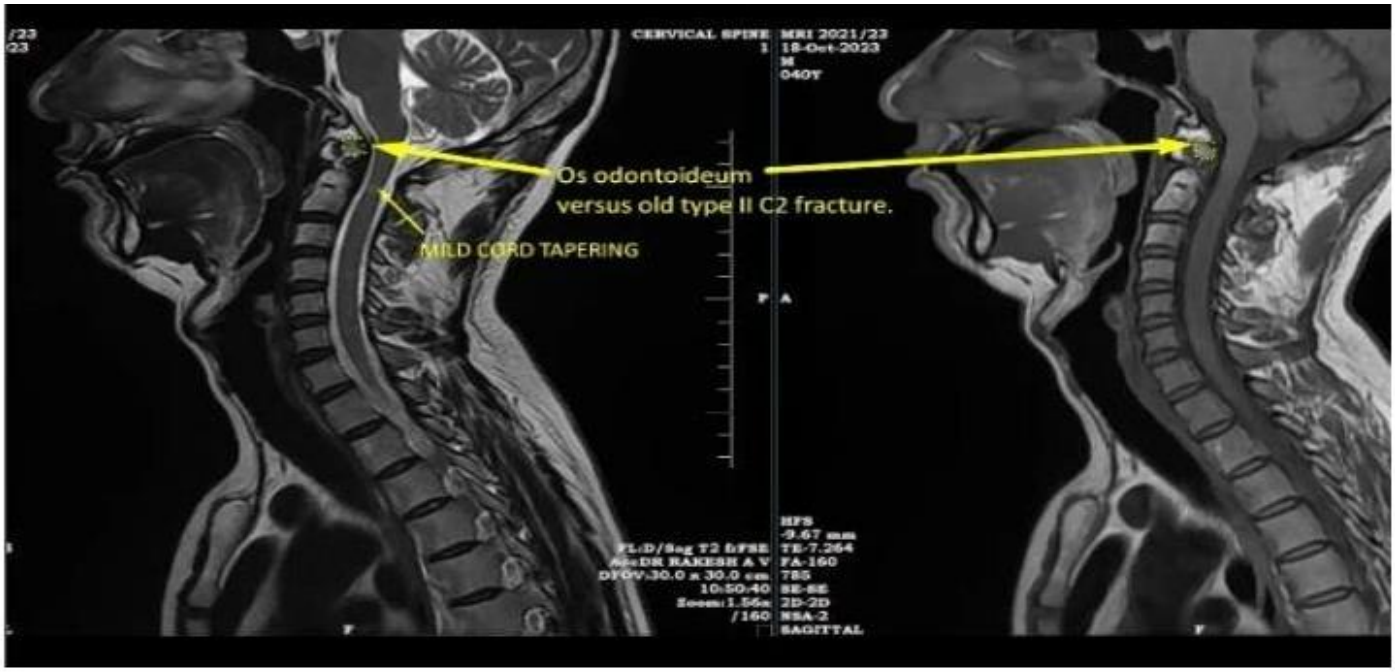

**Mild diffuse cord expansion at C3 to C7 level demonstrating long segment T2 cord hyperintensity ( not well evident on T1 W images) - *suggestive of acute cord contusion in the given clinical settings***

**Significant focal widening of the right C5-C6, C6-C7, C7-T1, T1-T2, T2-T3 neural foramina containing high T2 signal intensities within the foramen with featureless appearance (pseudomeningocele formation) - *suggestive of right C6, C7, C8, D1, D2 post-traumatic preganglionic nerve root avulsions***

**Mild disc bulges at C4-C5, C5-C6, C6-C7 levels slightly indenting thecal sac. No evidence of significant neural foraminal encroachment**

**No evidence of abnormal flow voids.**

**Recommend clinical correlation, total spine screening, MRI brachial plexus , follow up**

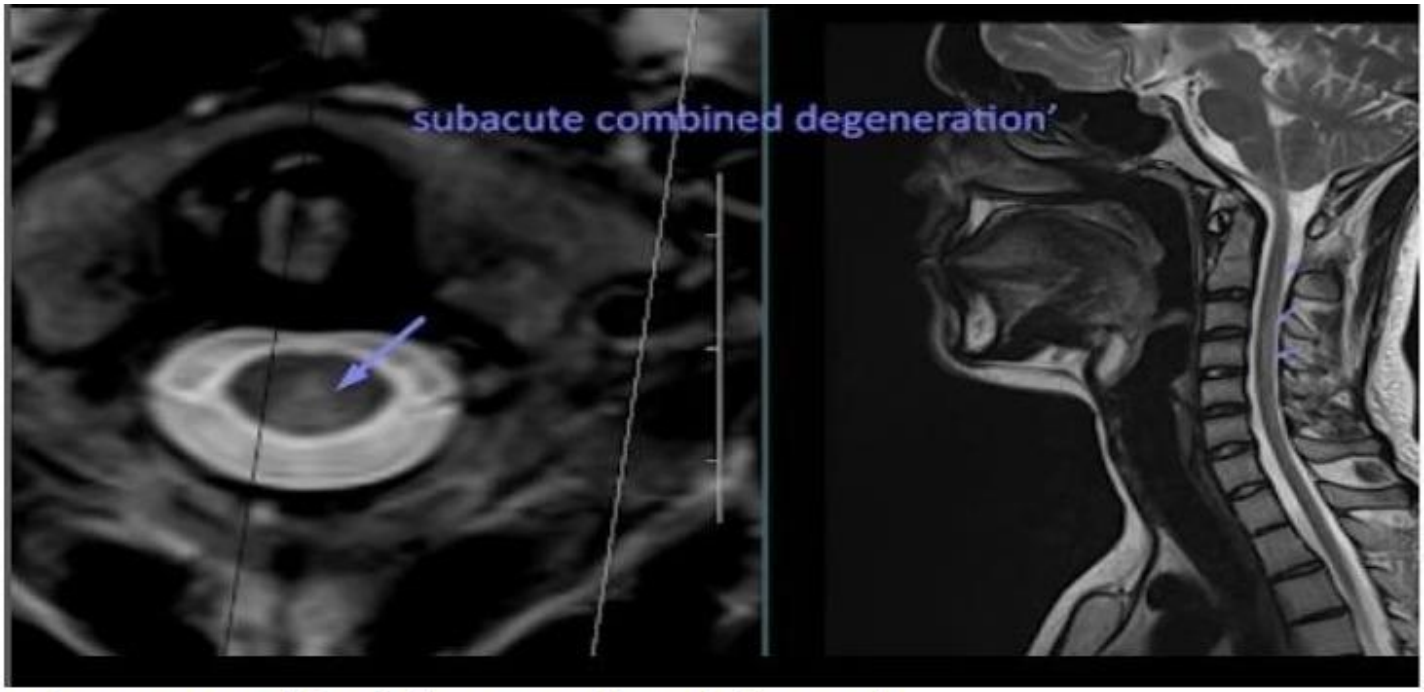



**Evidence of well corticated horizontal defect involving the superior part of odontoid process of C2 with normal marrow signal intensity - *likely suggestive of Os odontoideum ( likely dystopic) versus old type II C2 fracture.***

**Normal atlanto axial joint alignment in this study.**

**Minimal focal tapering of the cord caliber at this level of odontoid defect with subtle small T2 cord hyperintensity and normal CSF space - **suggestive of old compressive myelopathy, either related to atlanto-axial instability or old cord injury*.***

**Recommend clinical correlation, flexion and extension imaging of the cervical cord, follow up**

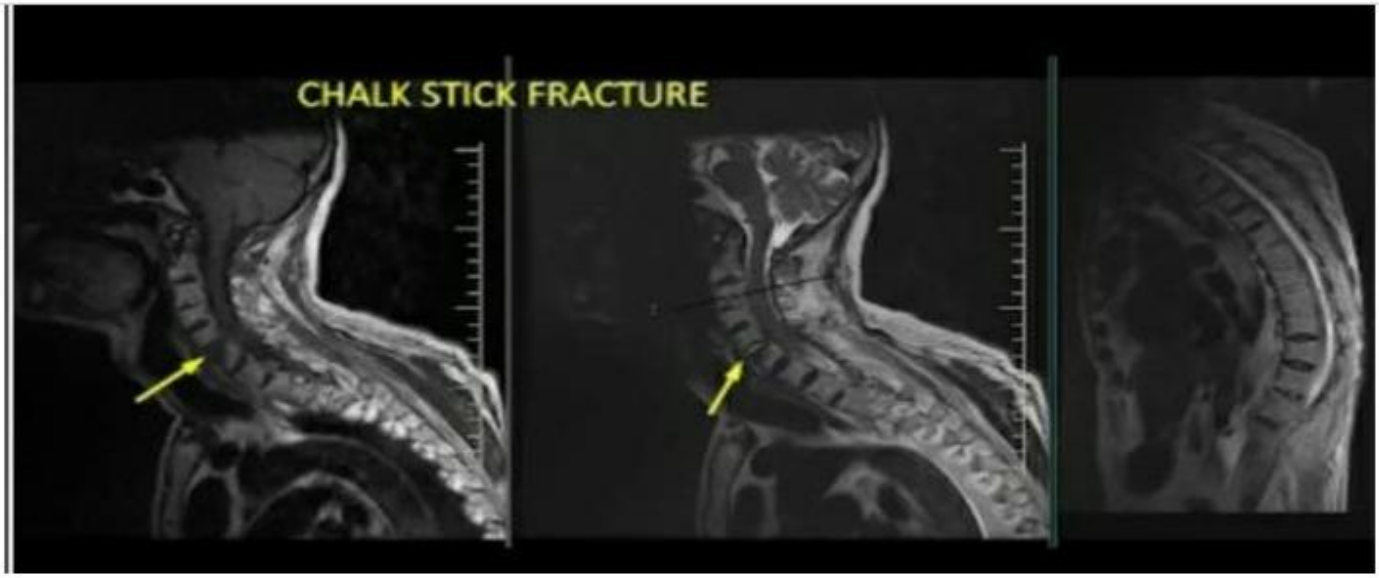



## Subacute combined degeneration of the cord

The cervical cord demonstrates long segment T2 hyperintensity involving the posterior column ( axial sections of the brain demonstrates inverted v shaped posterior cord T2 hyperintensity in the upper cervical cord ) - likely suggestive of 'subacute combined degeneration'

Normal cord caliber is noted. Thoracic cord appears grossly normal. Conus ends at normal level.

No evidence of significant disc bulge or herniation to the extent visualized.



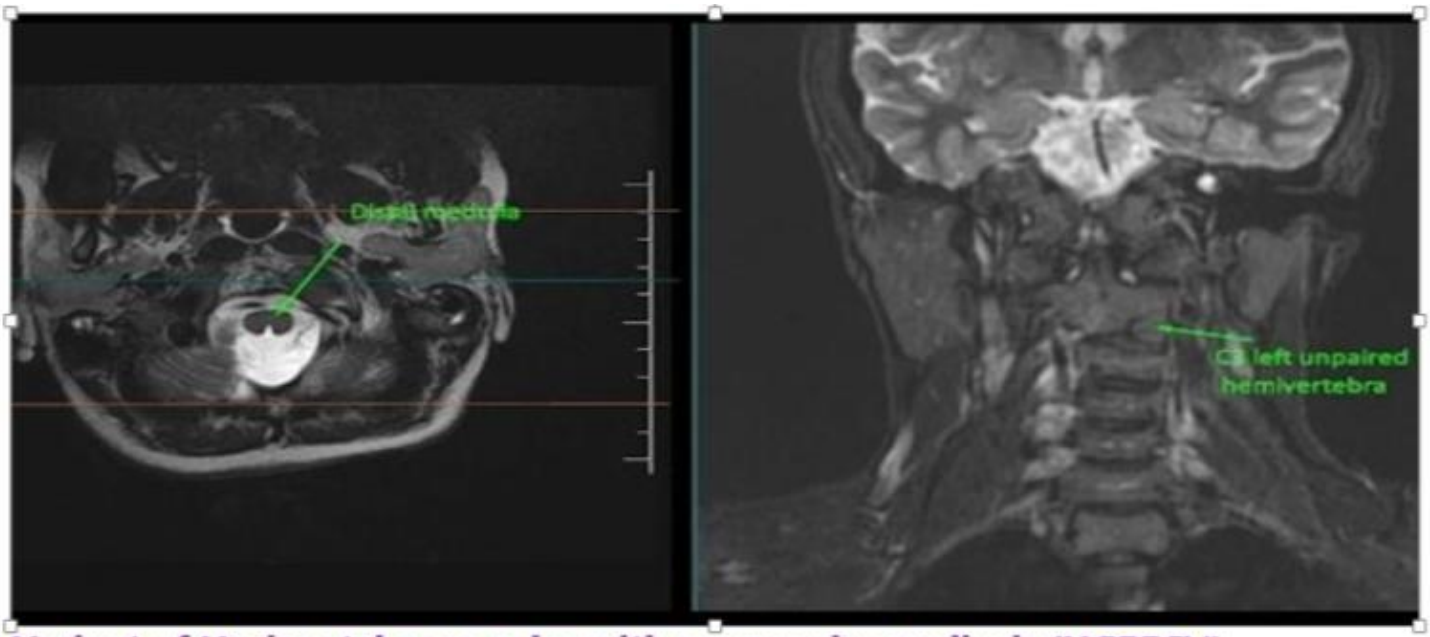

## CHALK STICK FRACTURE

**Relatively narrow bony lower cervical canal with paucity of CSF space.**

**Cervical anterior longitudinal ligament ossification with altered signals at anterosuperior and inferior corners of cervical, thoracic vertebral bodies – suggestive of chronic inflammatory enthesopathy.**

**Widening of anterior part of C5-C6 disc space with small marrow edema at C6 upper endplate and ossified anterior longitudinal ligament and posterior longitudinal ligament – suggestive of i Chalk stick fracture – likely related to underlying ankylosing spondylitis / seronegative arthropathy / diffuse idiopathic skeletal hyperostosis (DISH).**

**Mild disc bulge at C5-C6 level along with bilateral prominent disc osteophytes complexes mild posterior longitudinal ligament thickening / ossification , ligamentum flavum hypertrophy effacing thecal sac causing mild cord compression without obvious abnormal cord signal – 'early compressive myelopathy' cannot be ruled out.**

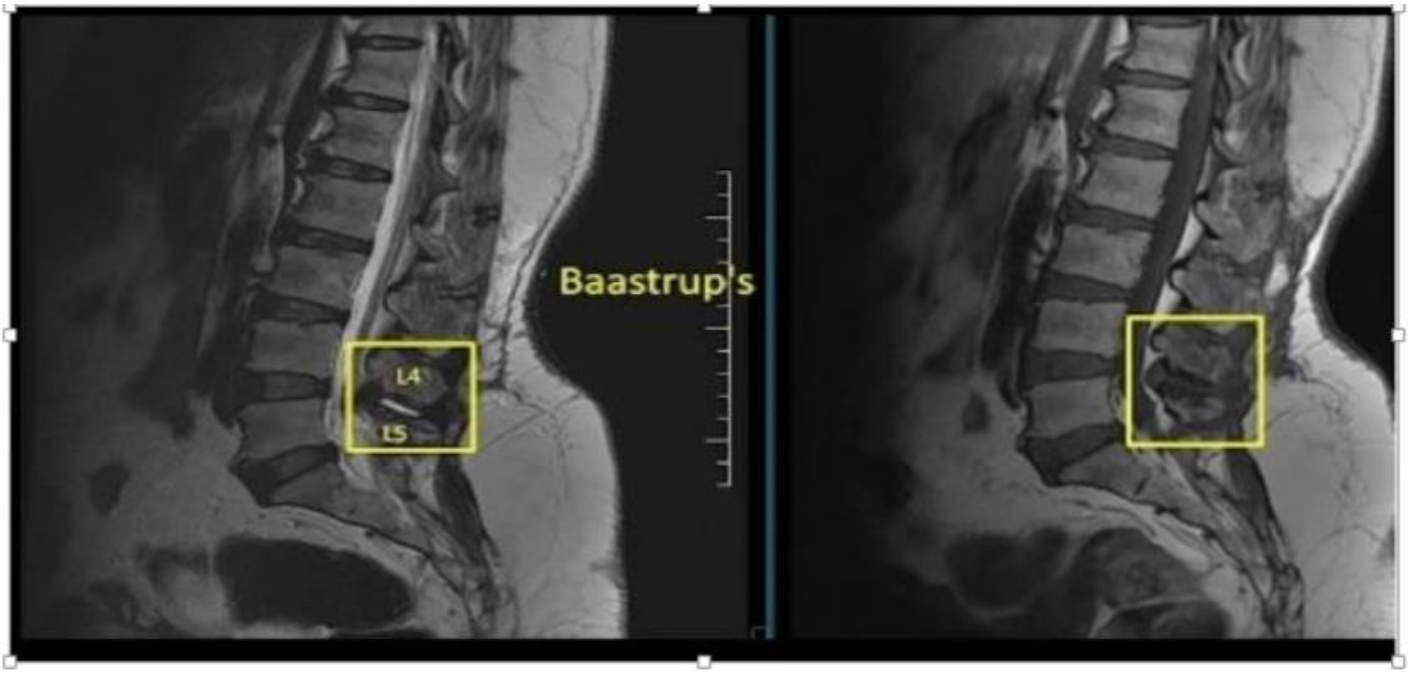



## Variant of Horizontal gaze palsy with progressive scoliosis (HGPPS)#

**Mild cervical scoliosis convex to the left. Vertebral mild segmentation anomaly:**

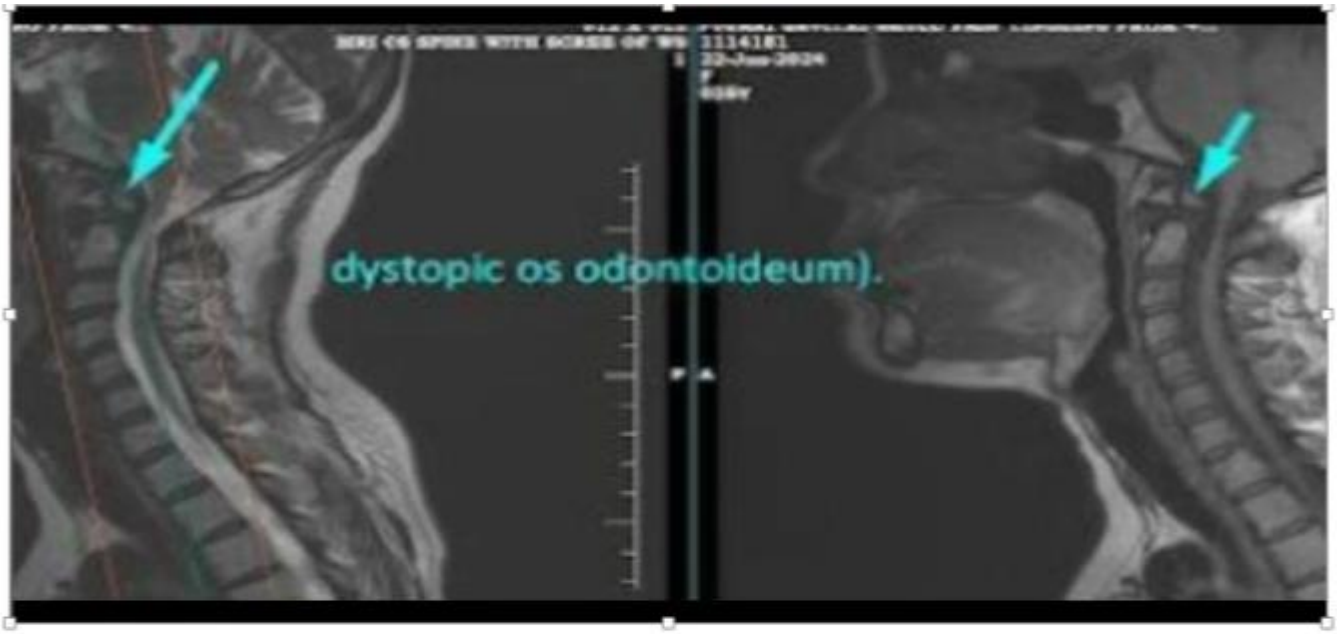
- **Left C3 unpaired hemivertebra with incarceration into the C2 body.**
- **Hypoplastic C2-C3, C3-C4 intervertebral disc spaces.**
- **Butterfly C4 vertebra with normal marrow signals.**

**Evidence of bifid / butterfly shaped distal medulla oblongata and proximal cervical cord at C1 level with normal signal intensities - recommend clinical correlation, further evaluation in vie of mild variant of Horizontal gaze palsy with progressive scoliosis (HGPPS)**




**Spinous processes of L4 and L5 vertebrae are in contact with each other with reactive marrow changes involving margins of spinous processes-** ***suggestive of Baastrup's disease***

**Incidentally noted 6.5 x 6 cm left adnexal pelvic cyst**

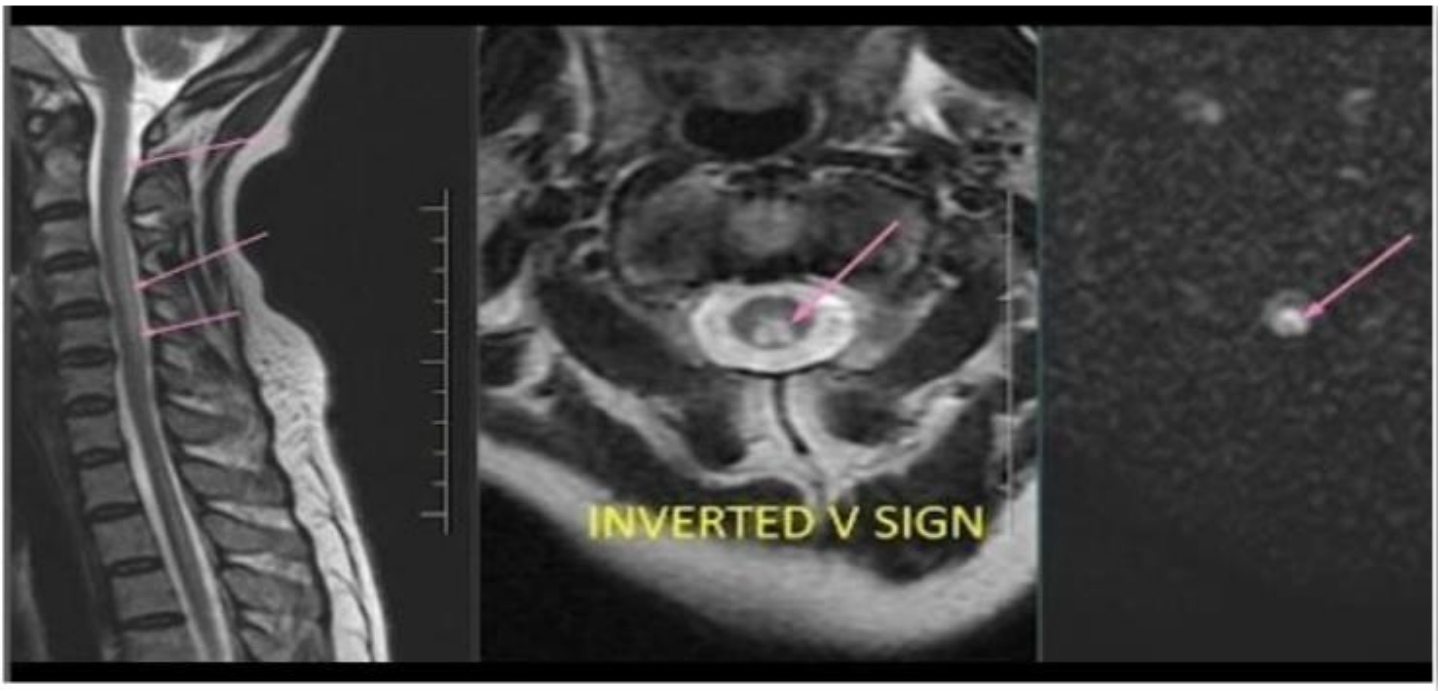



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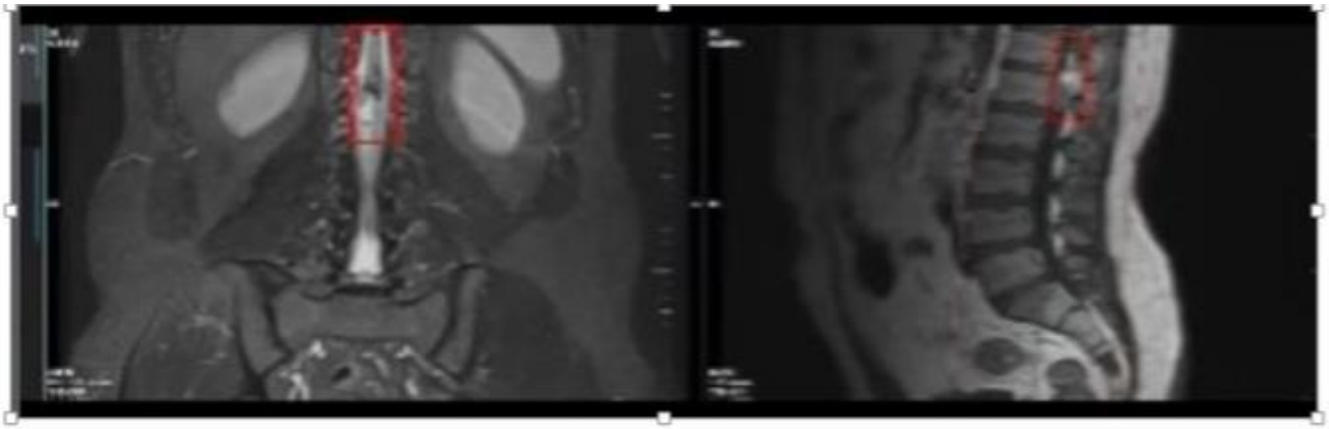
**Recommend clinical correlation, follow up.**




MRI - THORACOLUMBAR SPINE( W & W/O CONTRAST)

**Long segment linearly oriented posterior T2 cord hyperintensity with evidence of inverted V sign on axial sections (*predominantly involving the dorsal column) –*suggestive of subacute combined degeneration of the cord**

**Recommend correlation , *Vitamin B12 levels*, copper levels, follow up.**



**An approximately 5.2 x 1.3 x 1.2 cm intramedullary complex partially cystic mass lesion involving the distal cord, conus medullaris at D12, L1 levels demonstrated mixed signal, predominantly hyperintense on T2 as well as T1Wt sequence with low intensity T2 areas. (evaluation is limited due to lack of IV contrast) – *suggestive of an ependymoma with tumour bleed***

**No evidence of foraminal extension. No evidence of bone scalloping or erosion.**

**Posterior central disc protrusion at L5-S1 level producing moderate central canal narrowing encroaching left lateral recess affecting traversing left S1 nerve roots**

**Posterior right paracentral disc protrusion at L3-L4 level encroaching right lateral recess appear to abut the traversing right L4 nerve root.**

**Recommend IV Contrast study for complete evaluation, HPE correlation, follow up.**



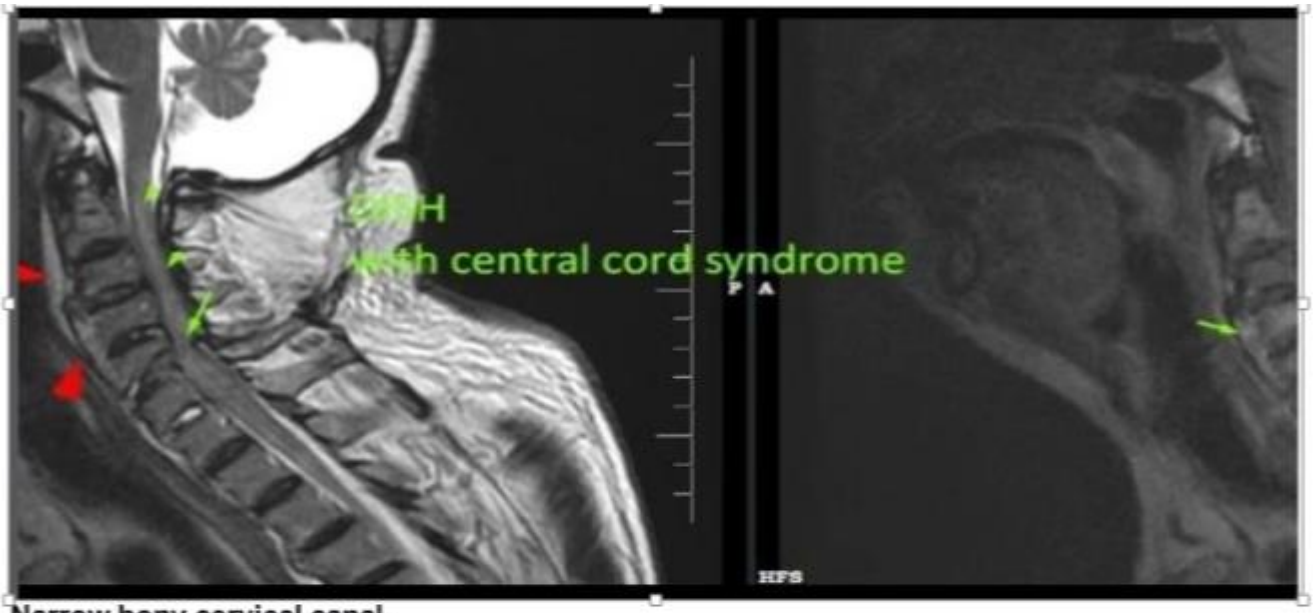

**Narrow bony cervical canal.**

**Extensive anterior longitudinal ligament ossification at C2 to D2 level – likely related to chronic seronegative arthropathy , such as diffuse idiopathic skeletal hyperostosis (DISH).**

**Mild posterior wedging of C5 body demonstrating normal marrow signals**

**Focal ligamentum flavum hypertrophy at C5-C6 level effacing thecal sac , causing mild cord compression**

**Subtle long segment T2 cord hyperintensity at C2 to C6 level – *suggestive of cord edema (central cord syndrome)***
**Recommend clinical correlation, further evaluation, follow up.**



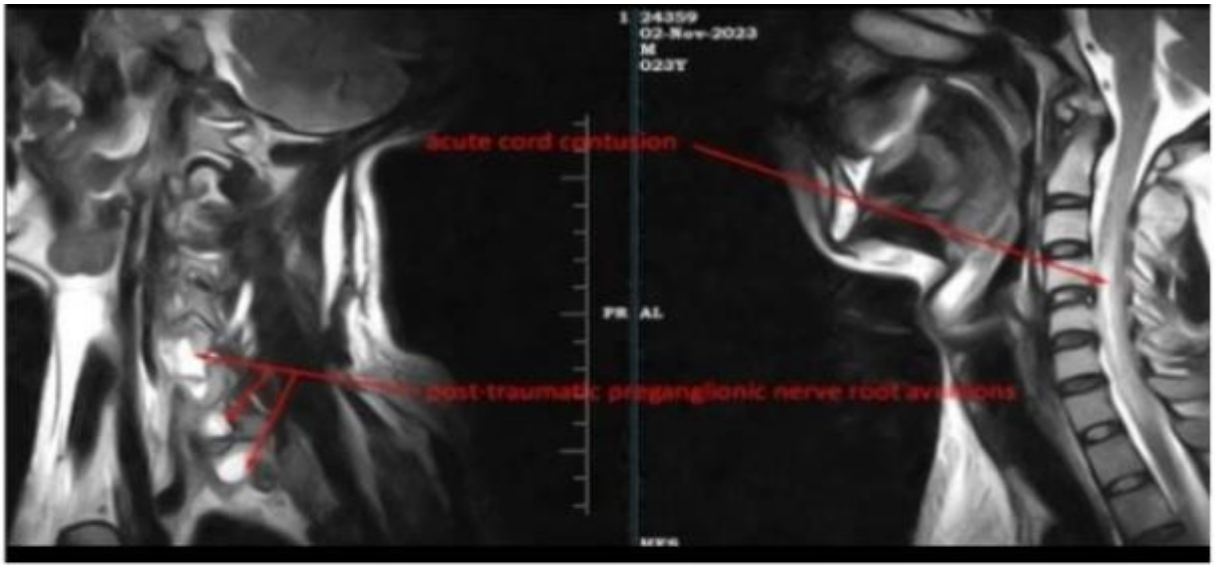

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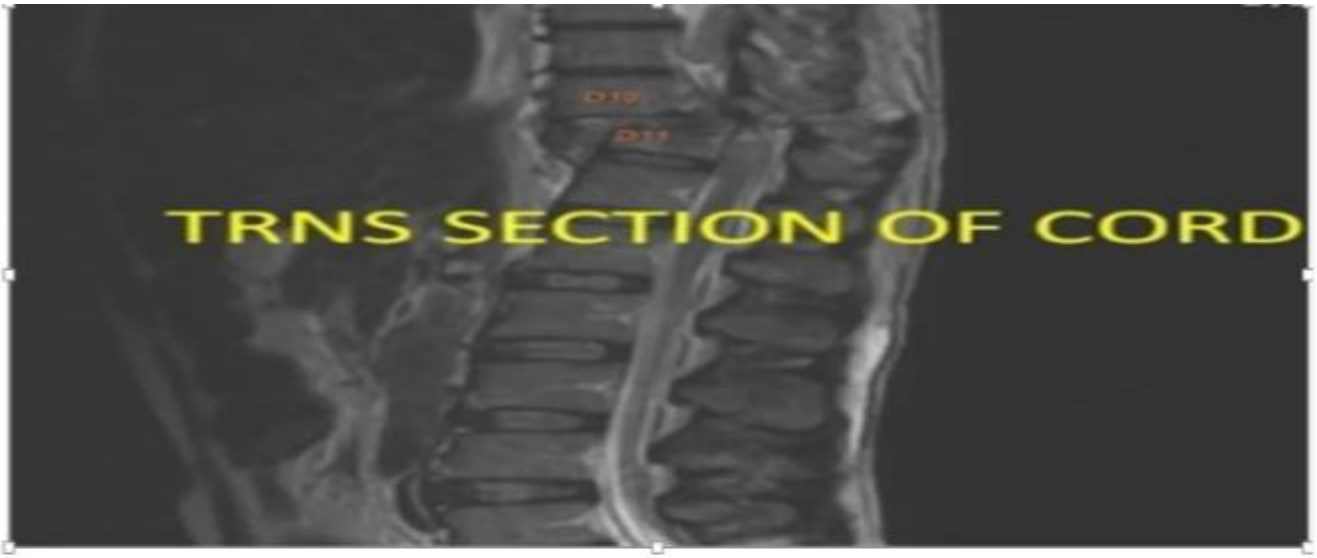

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**MRI – THORACOLUMBARSPINE**

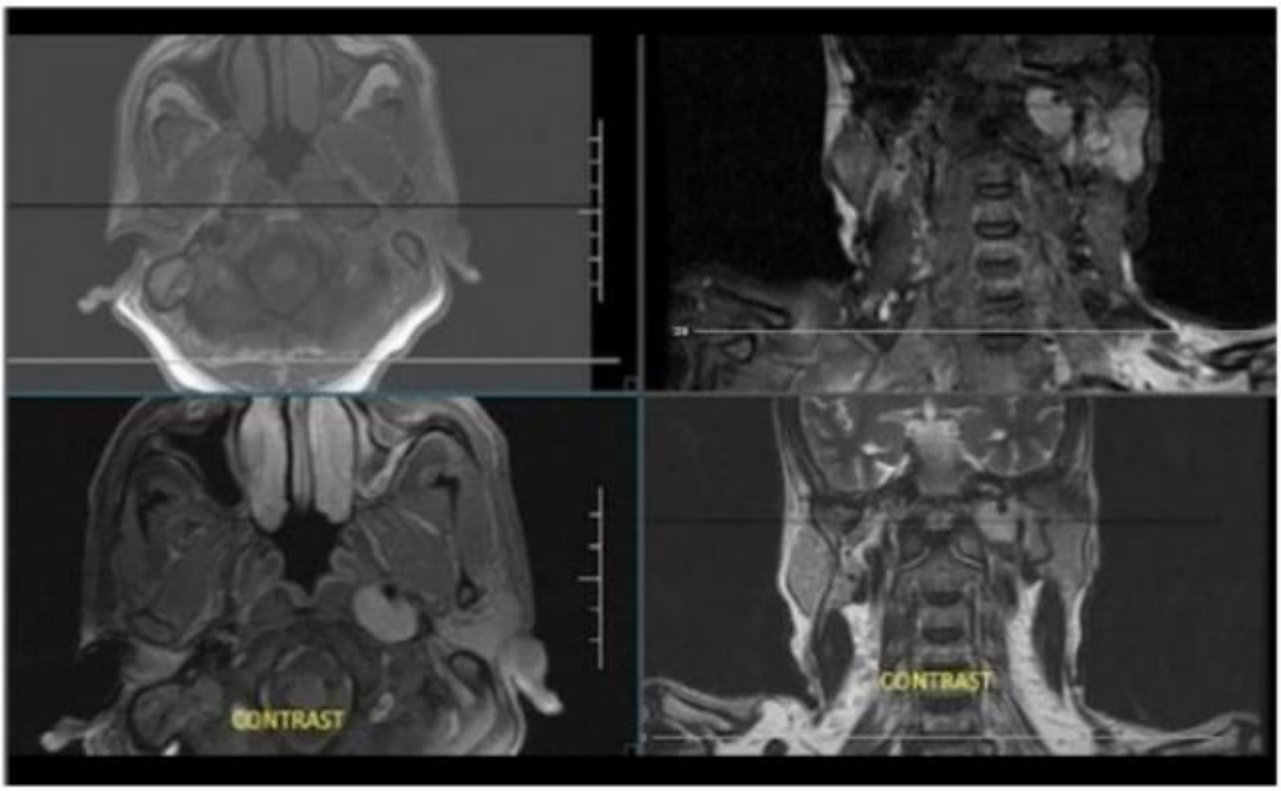
**Post traumatic grade II to III anterolisthesis of D10 over D11 with bilateral facet joint dislocatic and locking**

**Acute post traumatic anterior wedge compression fracture of D11 with upper endplate collaps and 40% reduction in vertebral height at anterior aspect.**

**Slight retropulsion of posterior cortex associated with vertebral listhesis causing severe cord compression resulting into '*complete transection of the cord at D10, D11 level*'.**

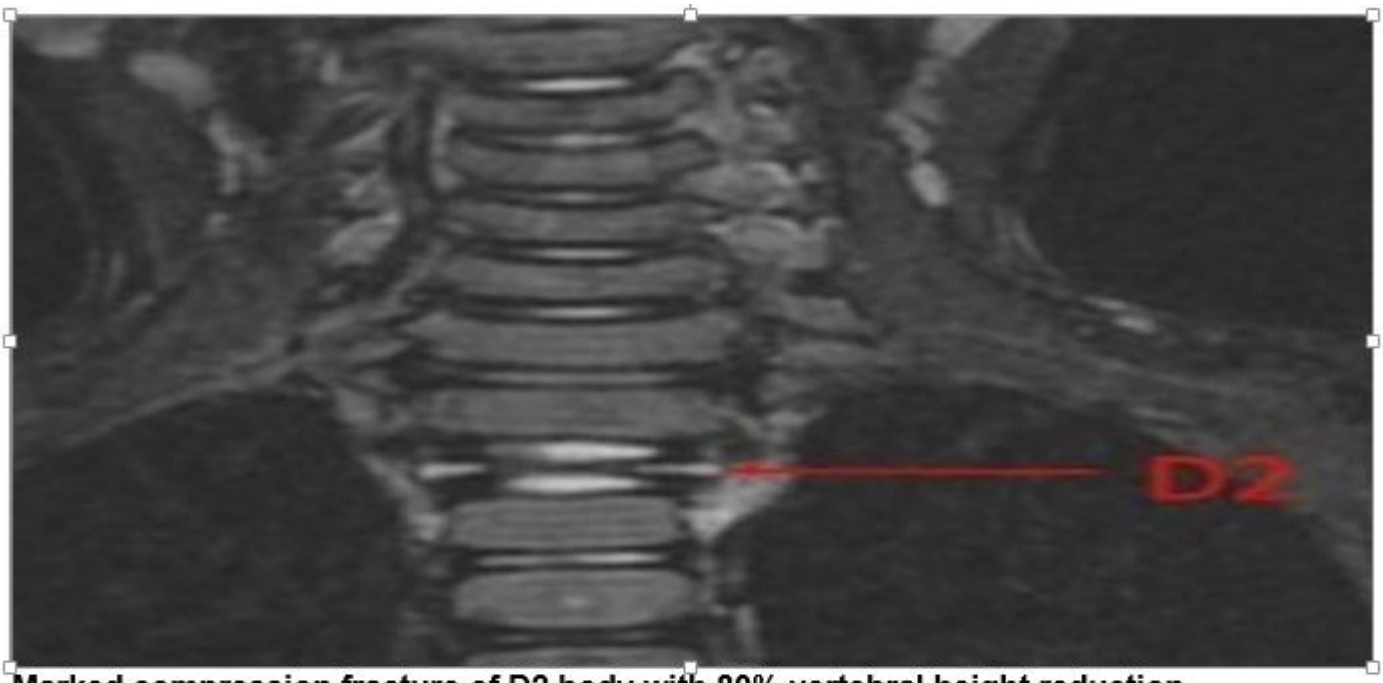
**Long segment cord contusion at D8 to D12 level.**

**Paravertebral fluid collections at lower thoracic and upper lumbar region associated with small bilateral pleural effusions.**




An approximately 2.8x2.2 x 1.3 cm lobulated iso to hyperintense, vividly enhancing mass lesion involving the left lateral retropharyngeal space at C1 level, just lateral to the longus colli muscle encasing the posterior wall of left ICA , preserving the normal flow voids **– represents a neoplasm, likely vagal paraganglioma versus vagal neurogenic tumour**

No evidence of bone erosions. No evidence of obvious spinal communication.
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**Marked compression fracture of D2 body with 80% vertebral height reduction demonstrating slightly altered marrow signal intensities (slightly hyperintense on T2, STIR and hypointense on T1) - *represents Vertebra Plana likely suggestive of Langerhans cell histiocytosis (LCH)***

**Retropulsion of posterior cortex of D2 associated with thin abnormal anterior epidural soft tissue effacing anterior thecal sac, abutting the anterior cord surface.**

**No significant cord compression or abnormal cord signal in this study .**

**Small bilateral paravertebral abnormal soft tissue atD2level.**