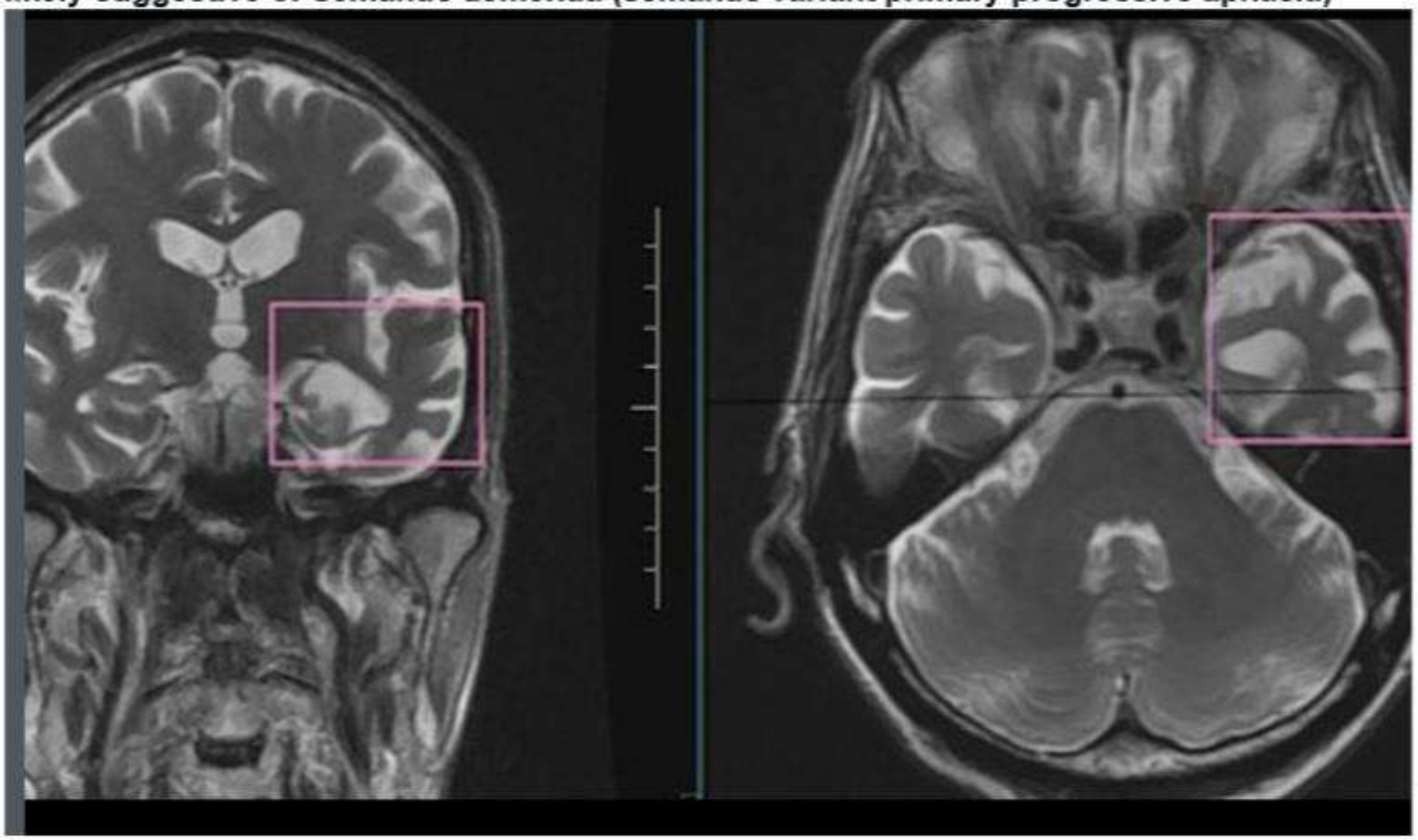
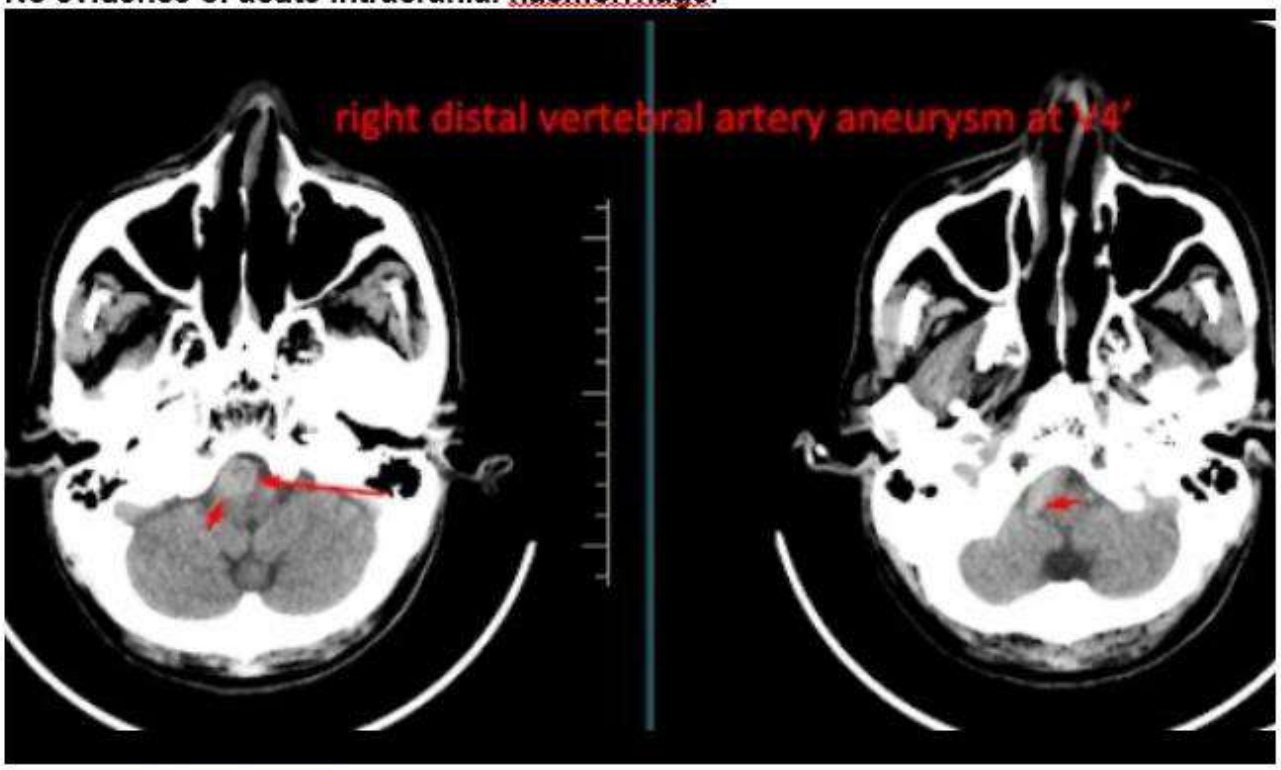
Semantic dementia (semantic variant primary progressive aphasia)

Focal asymmetric temporal atrophy (left>right) with exvacuuo dilatation of left temporal horn - likely suggestive of Semantic dementia (semantic variant primary progressive aphasia)



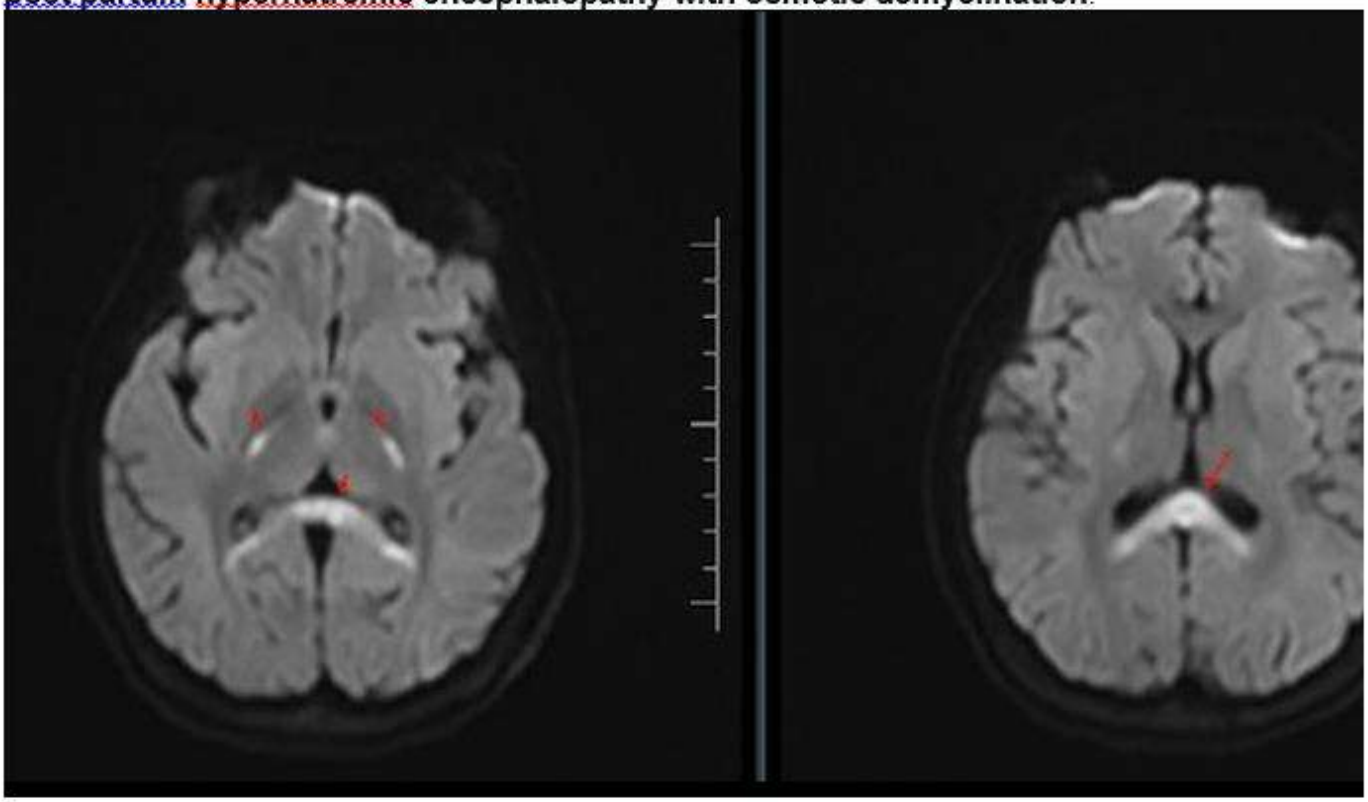
An approximately 1.8 x 1.4 cm extra-axial hyperdense lesion in the right anterolateral perimedullary cistern indenting the medulla, appears in continuation with right vertebral artery at V4 (55 HU) - suggestive of 'right distal vertebral artery aneurysm at V4'

No evidence of acute intracranial haemorrhage.



post partum hypernatremic encephalopathy with osmotic demyelination.

Multifocal symmetric FLAIR hyperintensities with restricted diffusion on DWI involving the splenium of corpus callosum, posterior limbs of bilateral internal capsules–likely suggestive of post partum hypernatremic encephalopathy with osmotic demyelination.



Large lobulated isodense, homogeneously enhancing mass lesions involving bilateral superior parietal, peritrigonal white matter infiltrating the adjoining part of splenium of corpus callosum with subependymal extension, protruding into the body of left lateral ventricle and demonstrated marked perilesional vasogenic edema as described above –*represents neoplasm, likely CNS lymphoma*

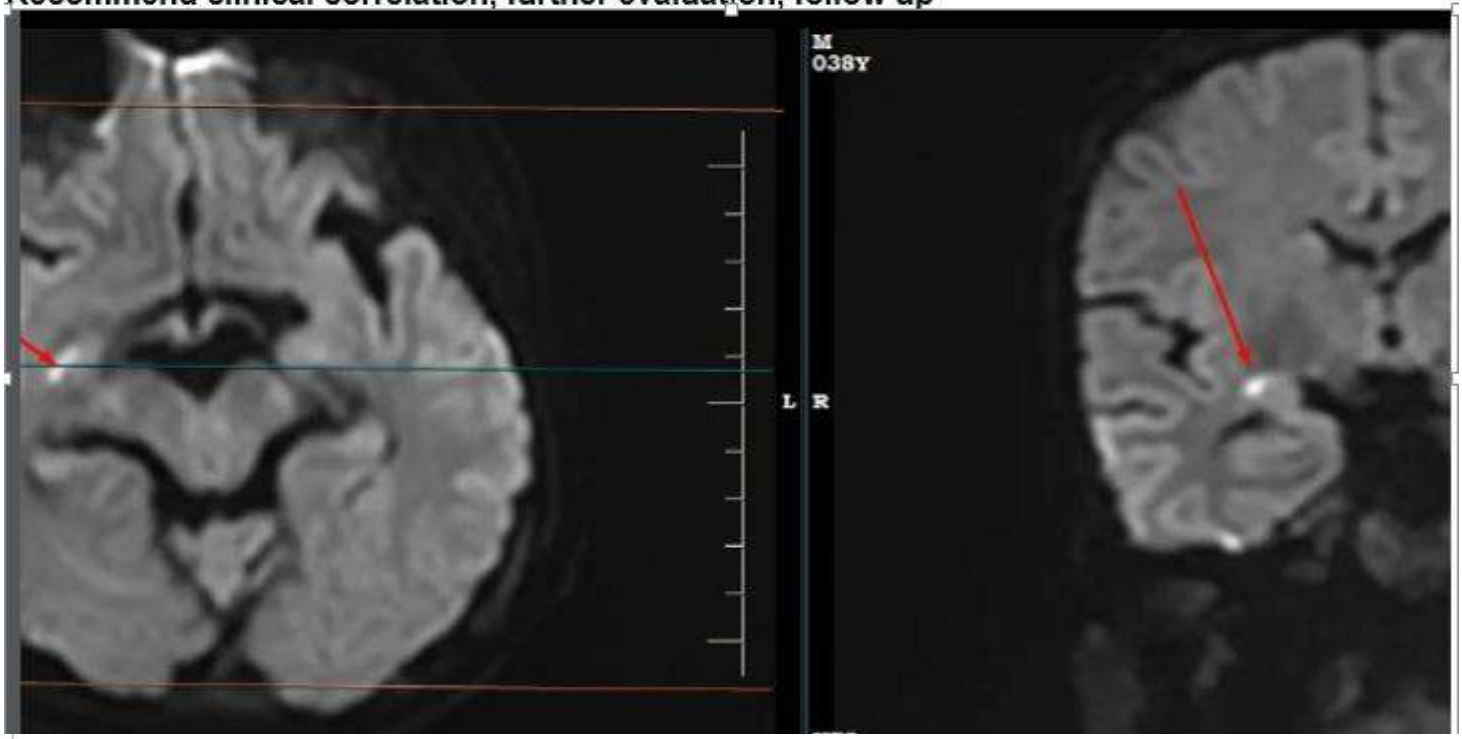
No evidence of significant mass effect or mid line shift.
Recommend MRI brain , MRS, immune status evaluation, follow up.



A tiny restricted diffusion on DWI is noted in right medial temporal cortex , almost involving the CA1 area of right hippocampus – **suggestive of a Transient Global Amnesia versus tiny acute embolic infarct versus post ictal signal changes* .*

(PN : Transient Global Amnesia could be related to epileptic phenomena or focal ischemia)

Recommend clinical correlation, further evaluation, follow up

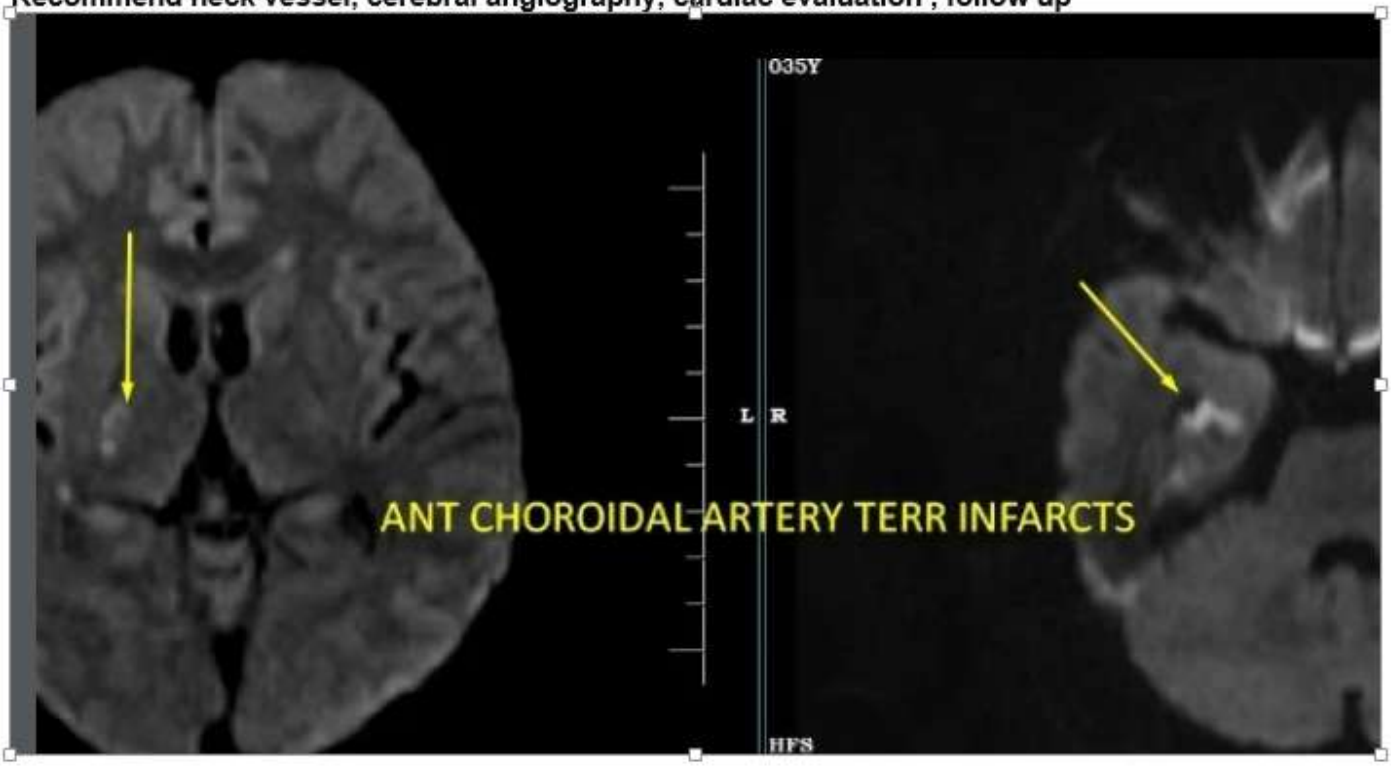


] Small hyperacute infarcts in posterior limb of right internal capsule and medial cortex of right temporal lobe extending to the hippocampus (within anterior choroidal artery territory).

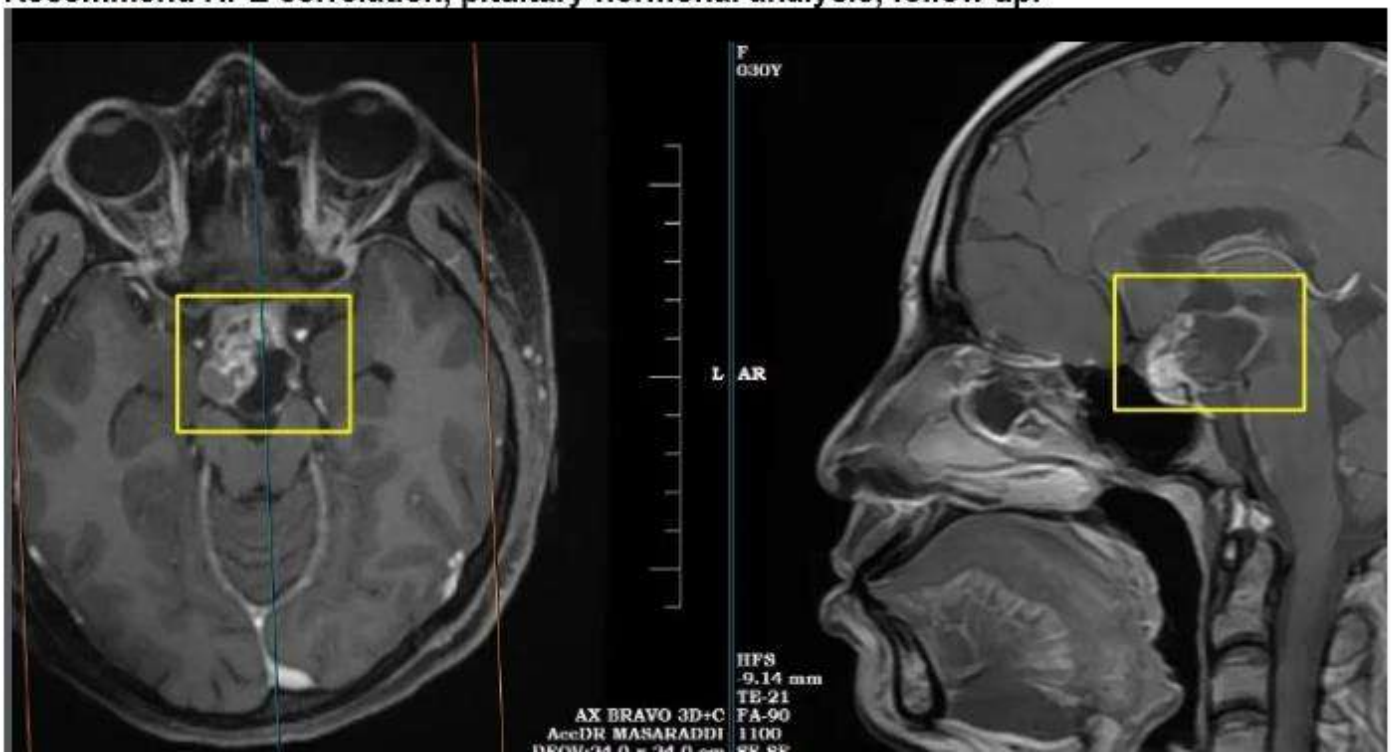
• No evidence of significant mass effect or mid line shift.

• A few tiny non confluent T2 / FLAIR hyperintensities in bilateral frontoparietal subcortical white matter likely suggestive of chronic microvascular ischemic changes

Recommend neck vessel, cerebral angiography, cardiac evaluation , follow up

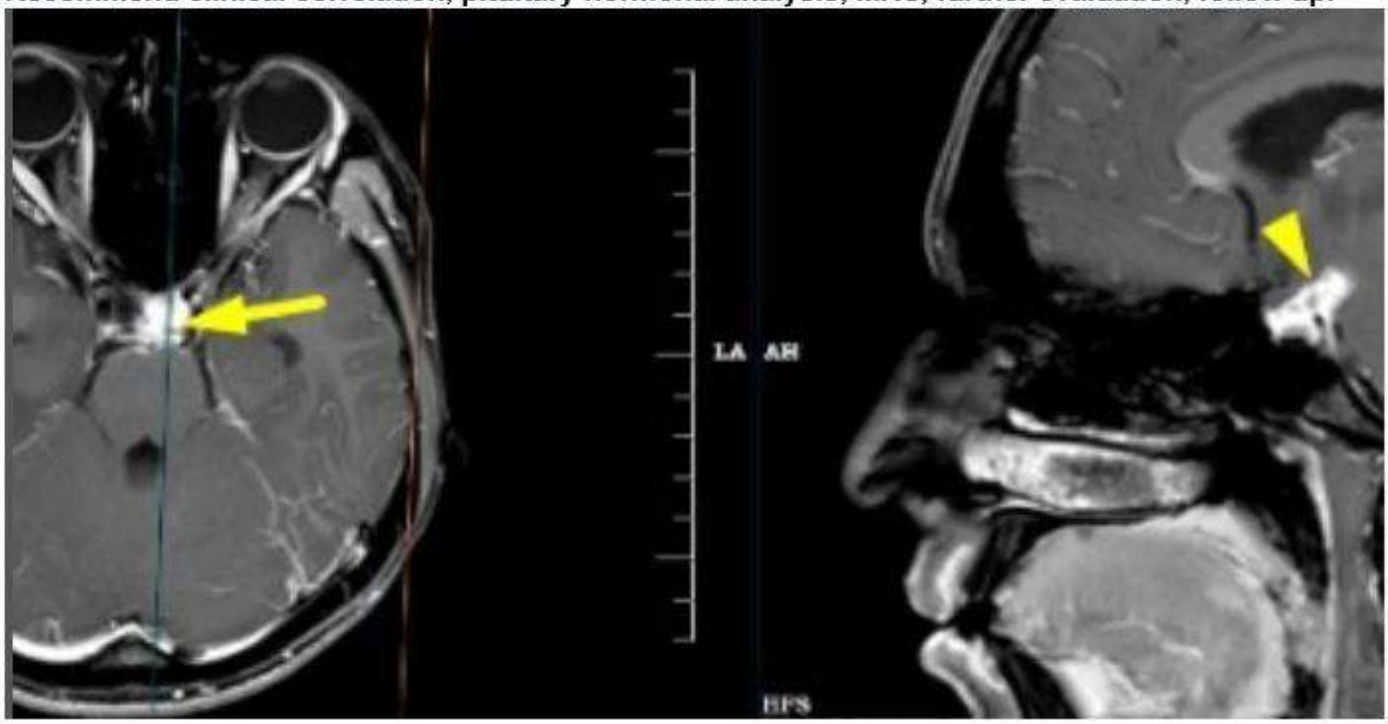


Widened sella with evidence of bone remodeling.
An approximately 2.8 x 2.2 x 2.7 cm complex cystic mass lesion arising from the sella turcica extending into the suprasellar cistern demonstrating irregular rim enhancement with nodular enhancing eccentric solid components with blooming along the margins on GRE sequence (calcified rim) – **represents craniopharyngioma (likely adamantinomatous)**
The mass lesion is extending superiorly into the suprasellar cistern, protruding into interpeduncular Cistern indenting the floor of third ventricle. Displacement of the optic chiasm due to mass effect.
The pituitary gland , infundibulum is displaced and obscured
Recommend HPE correlation, pituitary hormonal analysis, follow up.



Marked nodular enhancing thickening of the pituitary stalk/hypophysis, slightly to the left of midline , extending from the mammillary body to the pituitary gland sparing the perisellar regions, cavernous sinuses - likely differentials would be Dysgerminoma versus Langerhans cell histiocytosis versus lymphocytic / inflammatory hypophysitis.

Recommend clinical correlation, pituitary hormonal analysis, MRS, further evaluation, follow up.



Marked temporal dominant cerebral atrophy with grade III hippocampal volume loss - of concern for Alzheimer's disease.

No evidence of acute infarct or restricted diffusion on DWI.

Recommend clinical correlation, further evaluation, follow up



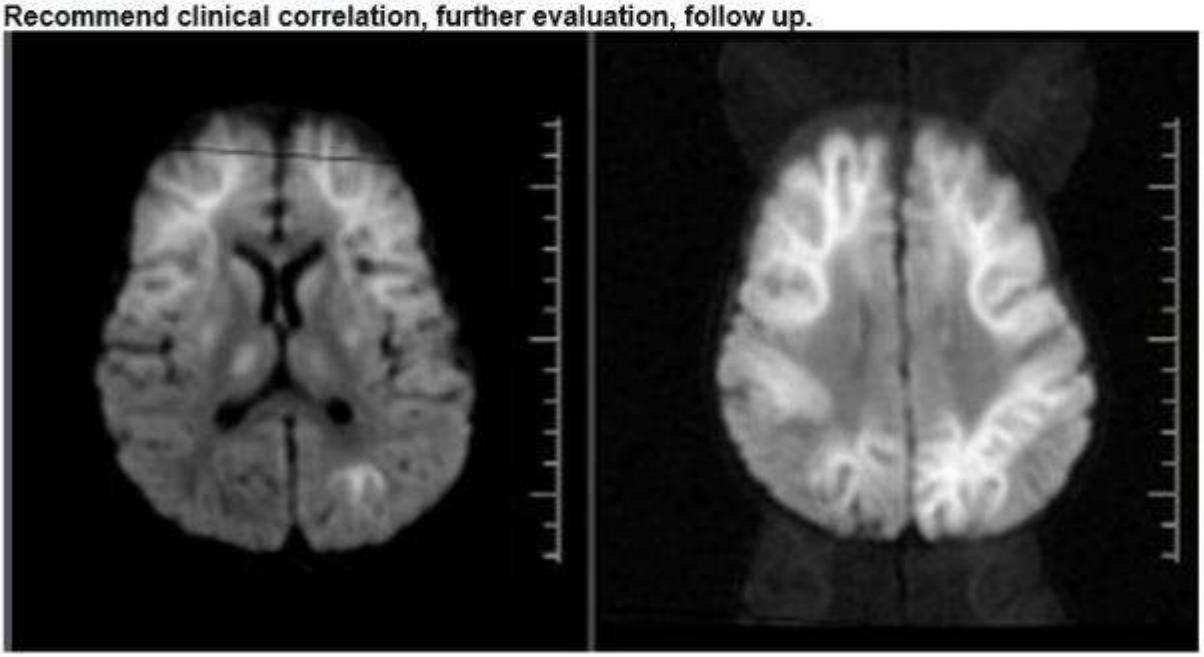
Diffuse type of acute leukoencephalopathy with restricted diffusion (ALERD)

Multifocal patchy and areas of restricted diffusions involving bilateral frontal , parietooccipital subcortical white matter, bilateral thalami and lentiform nuclei (not well evident on any other sequences) – likely suggestive of diffuse type of acute leukoencephalopathy with restricted diffusion (ALERD) versus acute hypoxic ischemic encephalopathy.

Differential considerations also include:- Acute viral encephalitis.

No evidence of significant mass effect or mid line shift.

Recommend clinical correlation, further evaluation, follow up.



MELANOMA METASTASIS

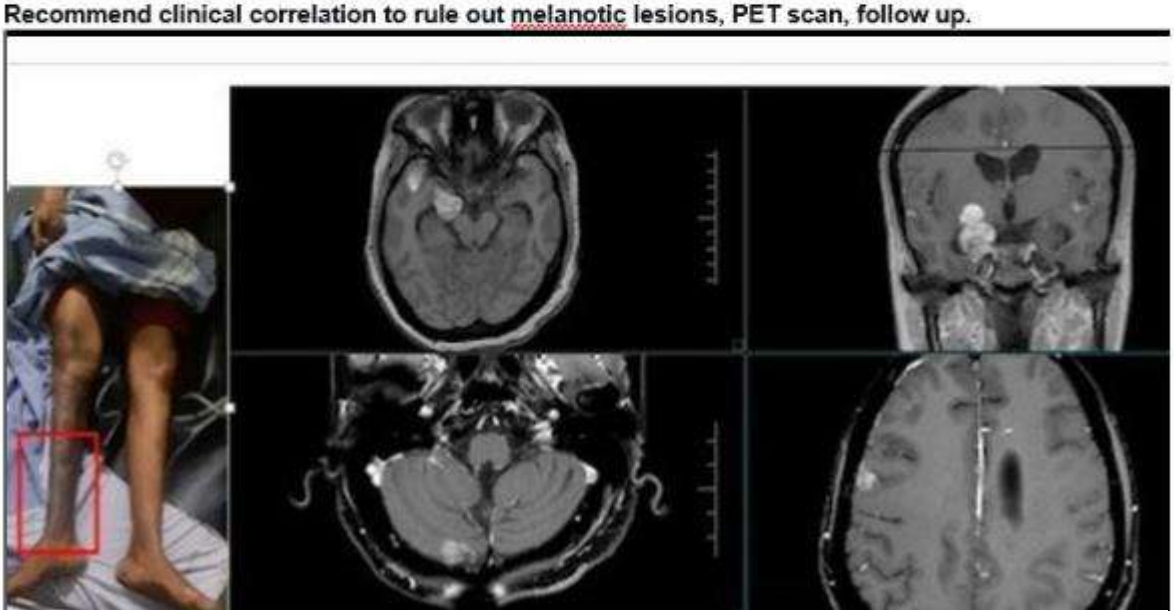
Multifocal altered signal intensity heterogeneously enhancing mass lesions of varying sizes and signa intensities involving the right inferior temporal lobe, left temporal lobe, right frontal lobe, bilateral cerebellum which are predominantly hyperintense on T1Wt images, hypointense on T2 with blooming on GRE sequences as described above –of concern for 'Melanoma metastasis' versus hemorrhagic metastasis.

A tiny nodular enhancing metastatic lesion involving the intracranial portion of the left optic nerve.

Mild communicating hydrocephalus with mild leptomeningeal enhancement.

No evidence of significant mass effect or mid line shift.

Recommend clinical correlation to rule out melanotic lesions, PET scan, follow up.

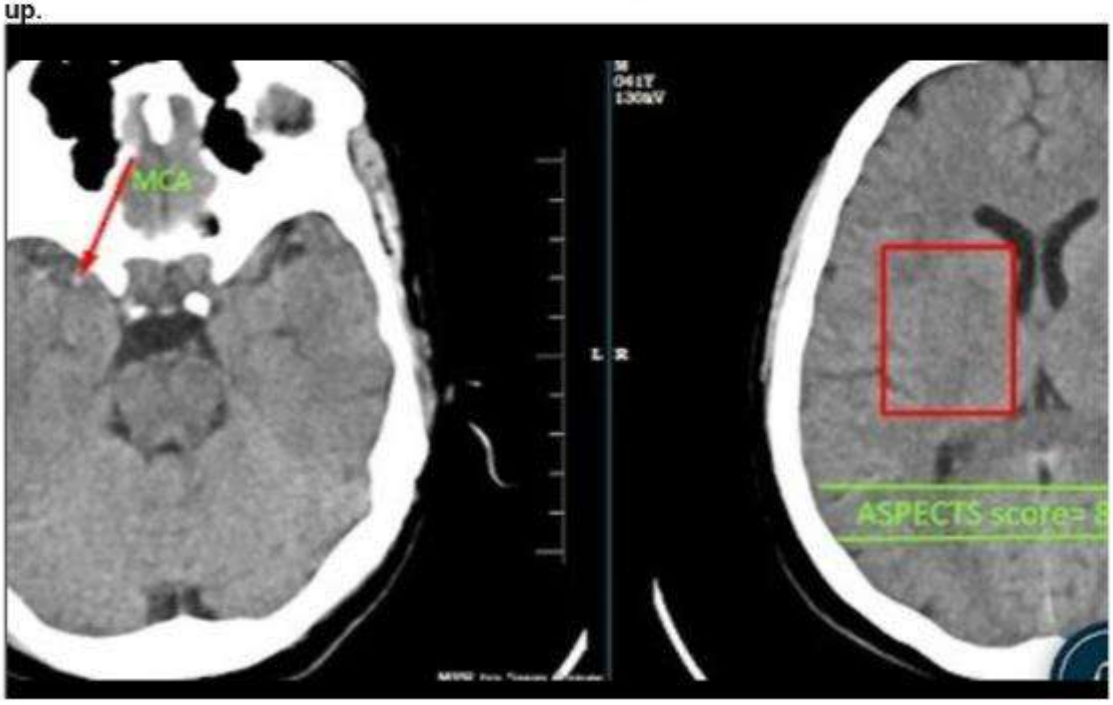


HYperacute MCA territory infract

The right MCA and tip of periclinoid ICA appears slightly hyperdense at M1 – may suggest acute thrombosis.

Obscured gray white junction involving the right lentiform nucleus, adjoining insular region – likely suggestive of hyperacute MCA territory infarct (ASPECTS score = 8).

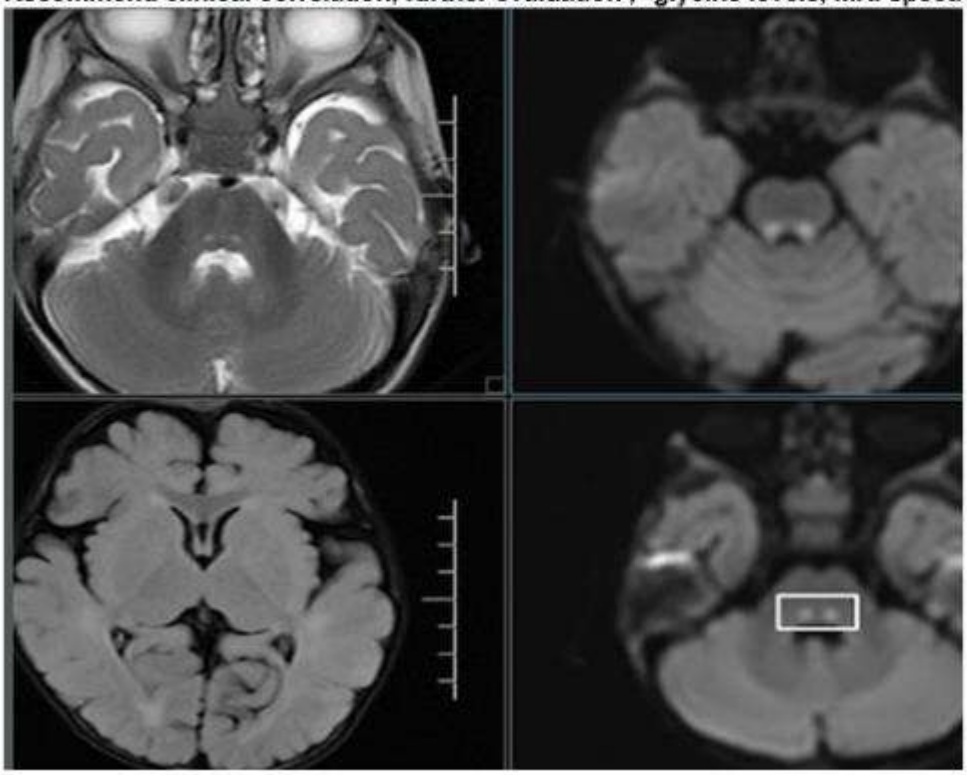
Recommend MRDWI for further evaluation, cerebral angiography , cardiac evaluation , follow up.



Nonketotic hyperglycinemia (NKH)

Tiny almost symmetric T2 hyperintensities involving the dorsal part of midbrain and pons at the level of tectum, colliculus with restriction of diffusion on DWI – likely suggestive of inborn error or metabolism such as Neonatal Nonketotic Hyperglycinemia (NKH) versus mitochondrial disorder / Leigh syndrome

Recommend clinical correlation, further evaluation , *glycine levels, MRI spectroscopy, follow up.

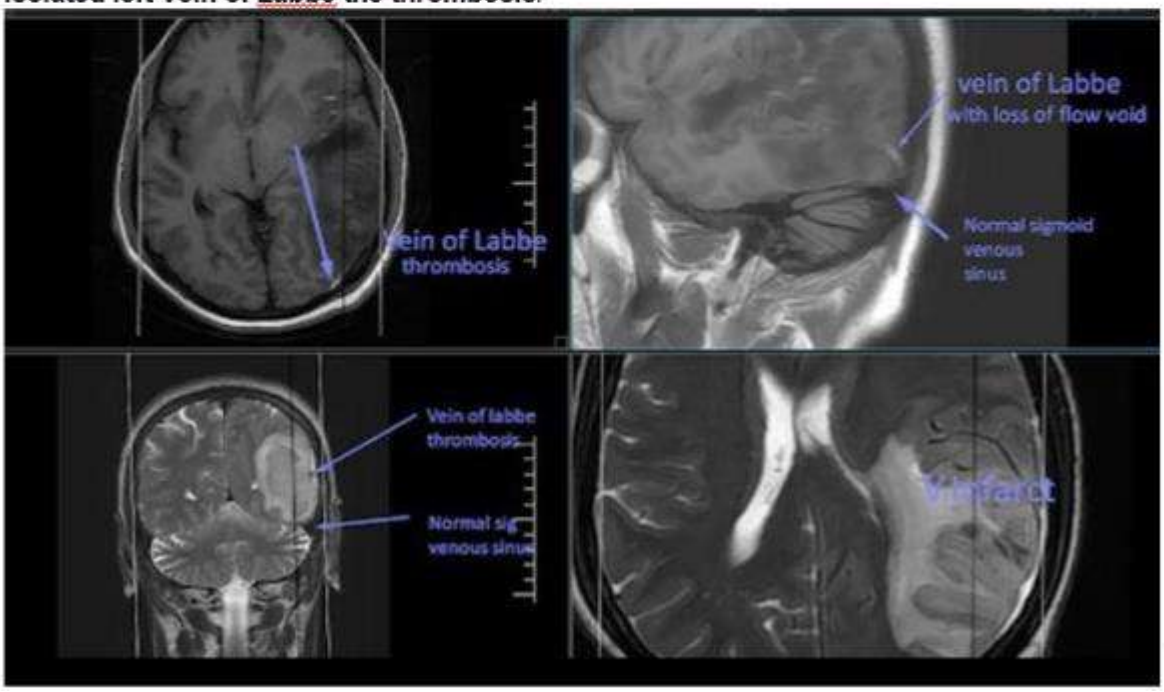


ISOLATED VEIN OF LABBE THROMBOSIS (with normal venous sinuses) WITH LARGE VENOUS INFARCT

An extensive gyriform area of blooming involving the left posterior temporal lobe extending t adjoining fronto-temporal lobes (including the left Wernicke's area 22) with marked surrounding vasogenic exhibiting mass effect – likely suggestive of hemorrhagic venous infarct

0.8 cm midline shift to the right due to mass effect.

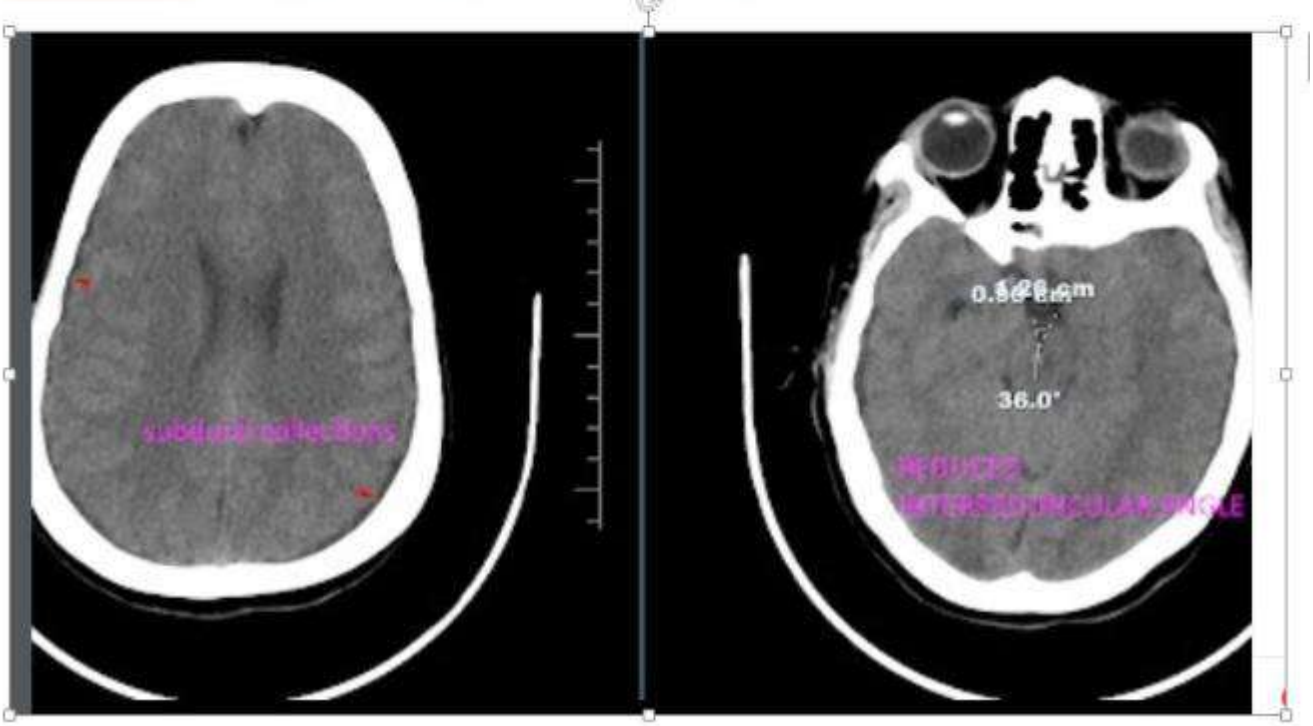
Normal appearing superior sagittal, transverse and sigmoid venous sinuses with cord like thickening of the left vein of Labbe draining into the left transverse sinus - may suggest isolated left Vein of Labbe the thrombosis.



DIAGNOSISNG SPONTANEOUS INTRACRANIAL HYPOTENSION ON AXIAL CT SCAN BRAIN IMAGES

Thin bilateral fronto-temporo-parietal hypodense subdural hygromas measuring less than 0.3 cm in maximum thickness with diffuse cerebral edema, reduced interpeduncular angle (36°) with partial effacement of Suprasellar cistern and fourth ventricle as described - likely suggestive of spontaneous intracranial hypotension (SIH).

Recommend clinical correlation MRI brain for further evaluation, MRI total spine with myelography as indicated clinically to rule out CSF leak.



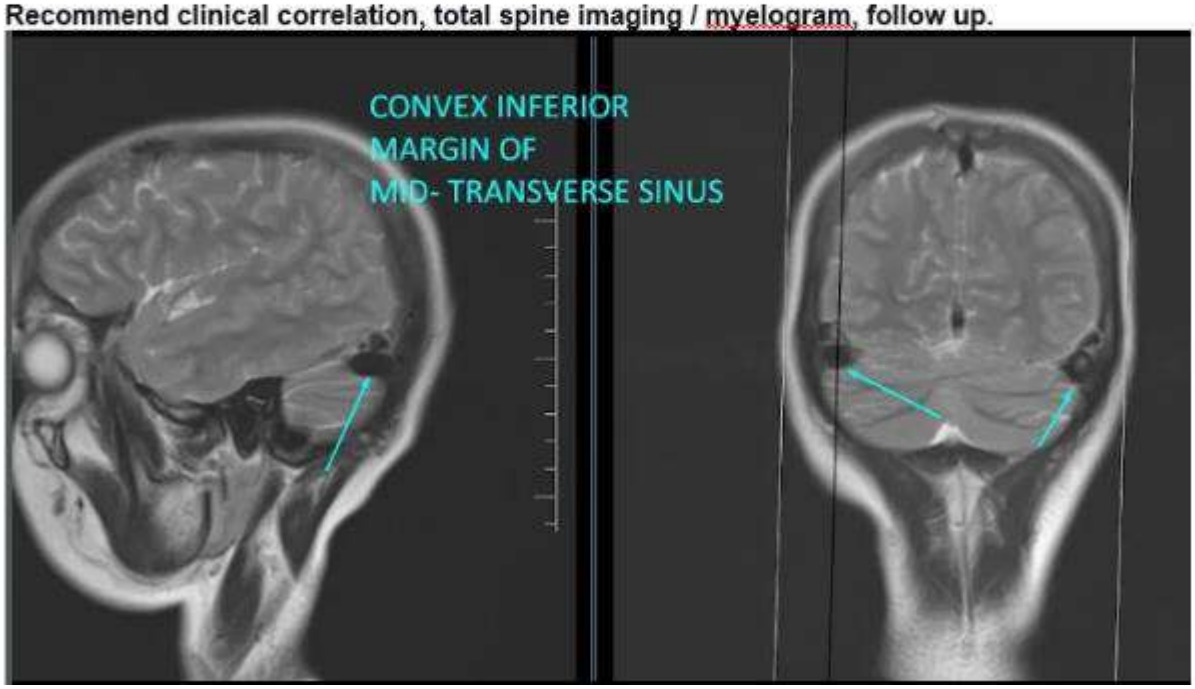
Convex inferior Wall at mid transverse sinus - early sign of spontaneous intracranial hypotension (SIH)

Marked distention of bilateral transverse sinuses with normal flow voids, demonstrating Convex inferior Wall at mid transverse level with abnormally distended superior sagittal sinus, straight sinus with normal flow voids – of concern for early signs of spontaneous intracranial hypotension (SIH)

The pituitary gland is slightly protruding superiorly.

No evidence of sagging of brainstem or subdural collections in this study.

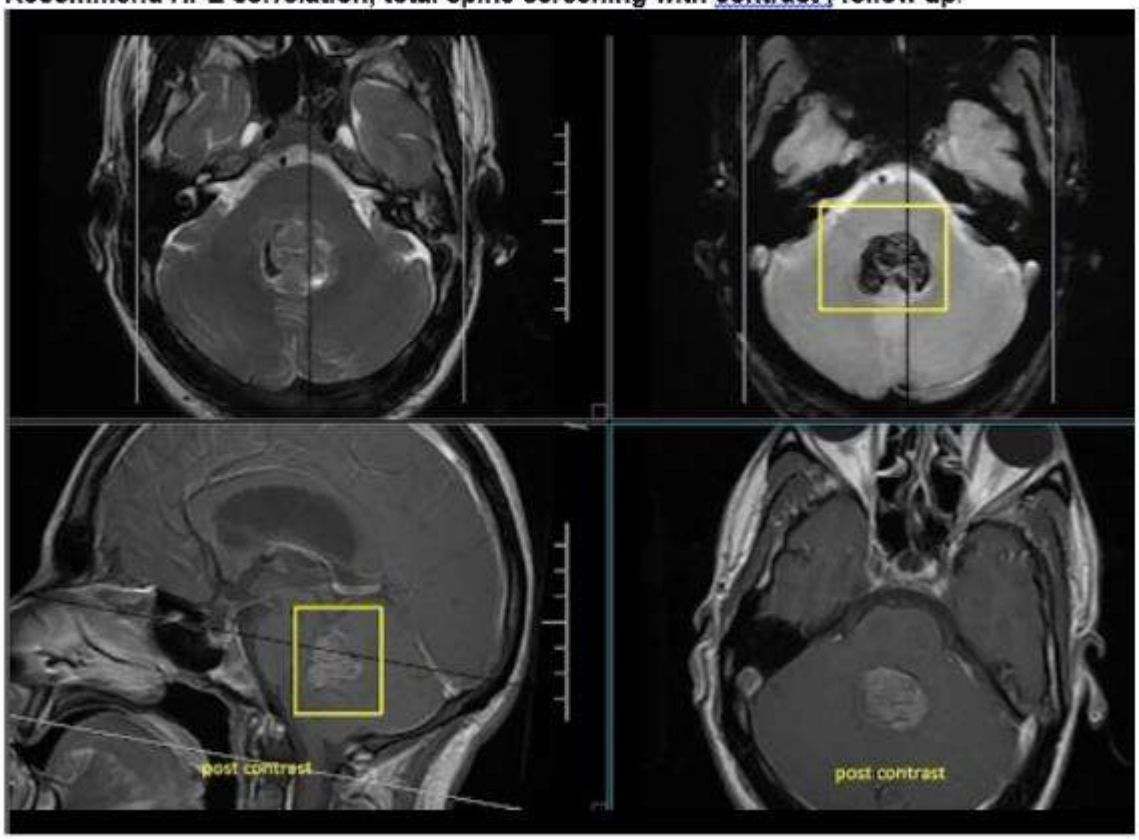
Recommend clinical correlation, total spine imaging / myelogram, follow up.



An approximately 2.3 x 3 x 2.3 cm heterogeneously enhancing low T2 intensity fourth ventricular mass lesion demonstrating blooming on GRE sequence from hemorrhage as described above - suggestive of fourth ventricular Ependymoma.

Resultant mild obstructive hydrocephalus. No evidence of extension along the foramina of luschka

Recommend HPE correlation, total spine screening with contrast , follow up.

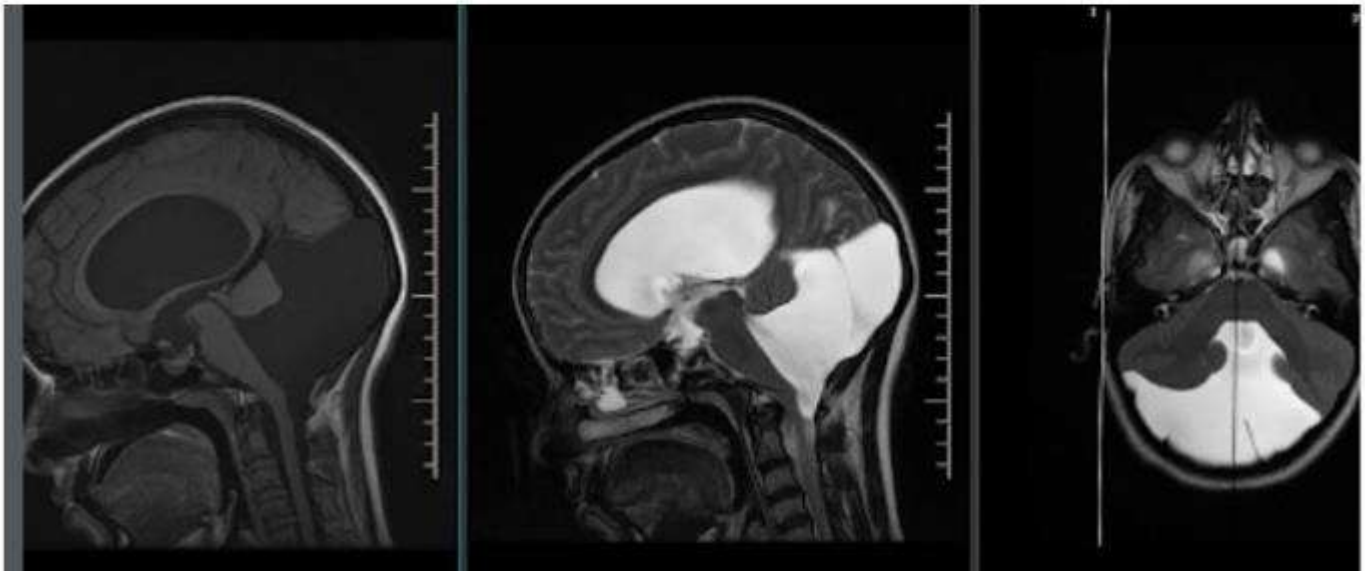


Dandy-Walker malformation

Enlarged posterior fossa with a large unilocular CSF intensity extra-axial cystic lesion in the posterior fossa displacing the hypoplastic Cerebellar Vermis superiorly, communicating with the fourth ventricle from posterior aspect associated with mild to moderate communicating hydrocephalus with thin corpus callosum – suggestive of Dandy-Walker malformation.

Partial empty sella appearance with vertically tortuous bilateral optic nerves demonstrating dilated optic sheath in the retrobulbar segment – suggesting raised ICT.

Recommend clinical correlation, further evaluation, follow up

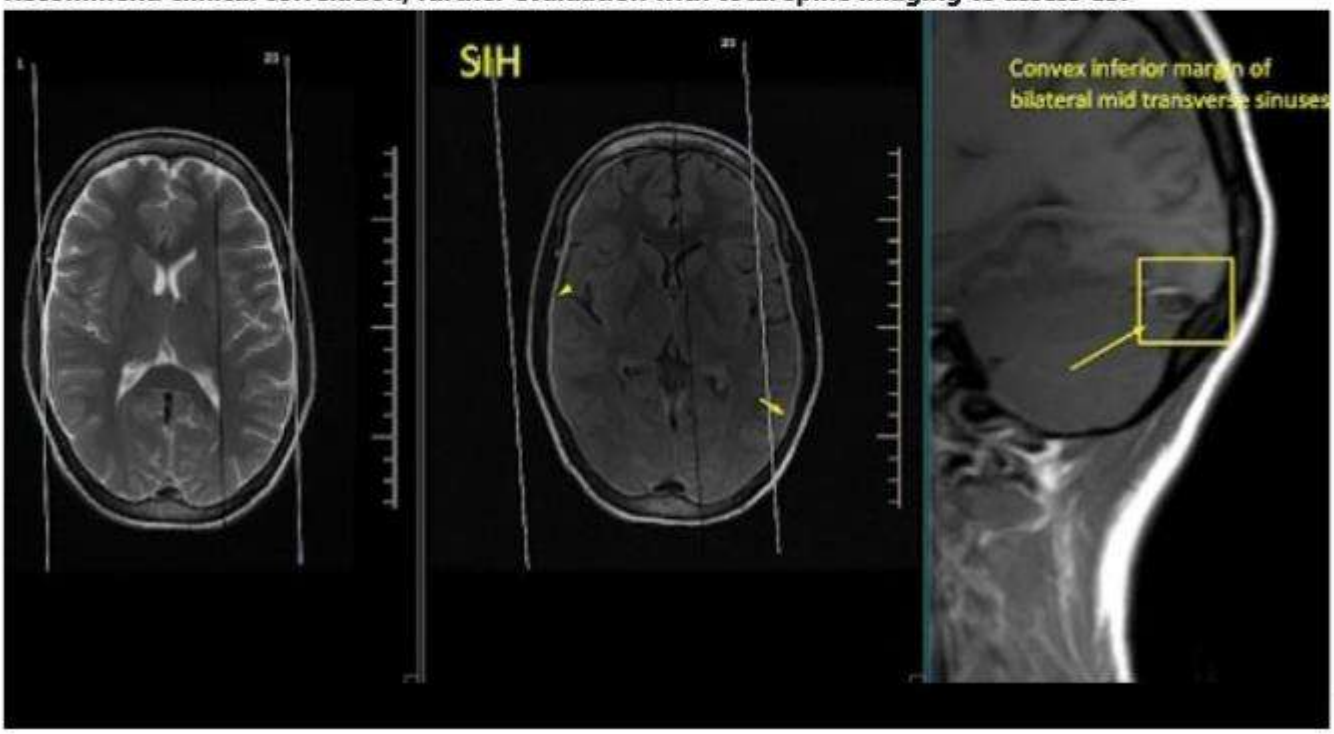


SPONTANEOUS INTRACRANIAL HYPOTENSION (SIH)

Thin spontaneous bilateral fronto-temporo-parietal convexity as well as bilateral tentorial subdural collections associated with marked distention of dural venous sinuses with Convex inferior margin of bilateral mid transverse sinuses – suggestive of spontaneous intracranial hypotension (SIH)

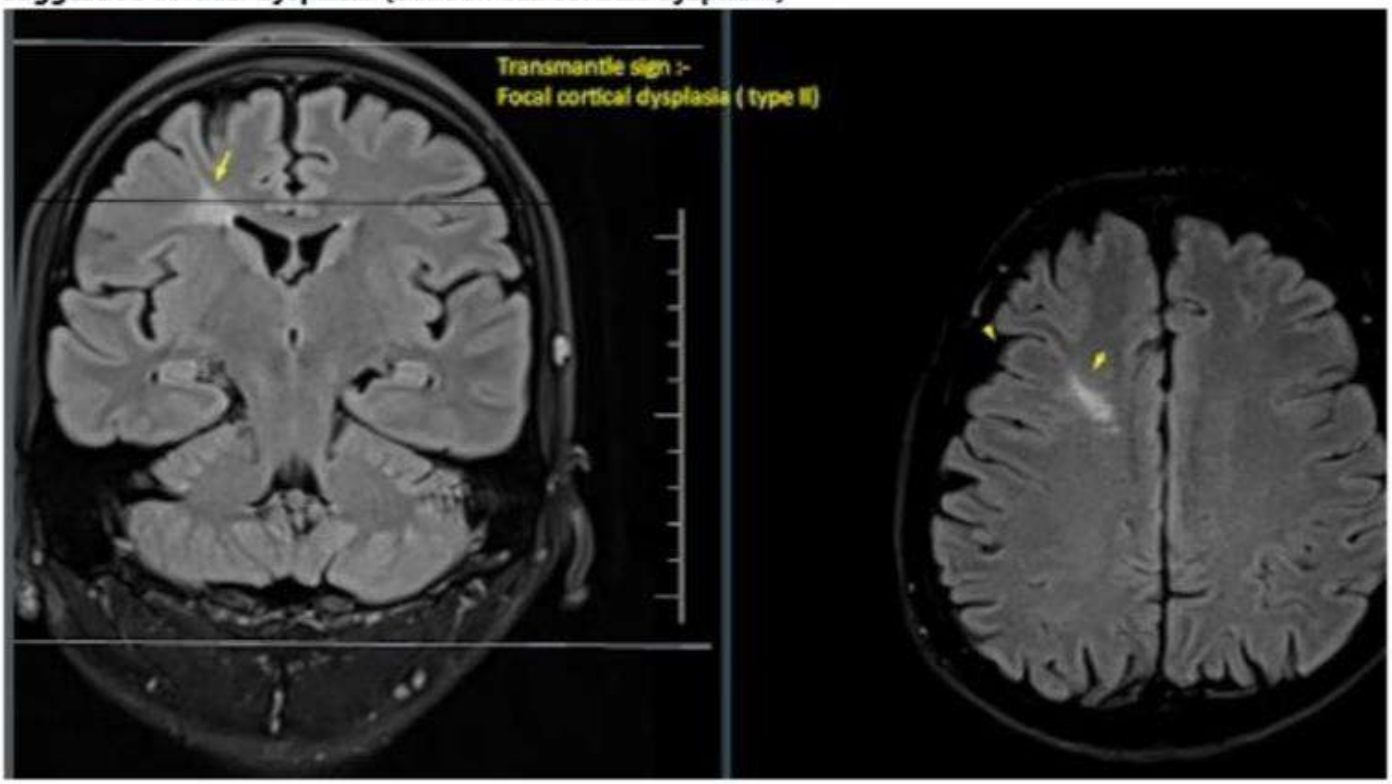
No evidence of significant sagging of brainstem in this study.

Recommend clinical correlation, further evaluation with total spine imaging to assess CSF



FOCAL CORTICAL DYSPLASIA (TYPE II) - TRANSMANTLE SIGN

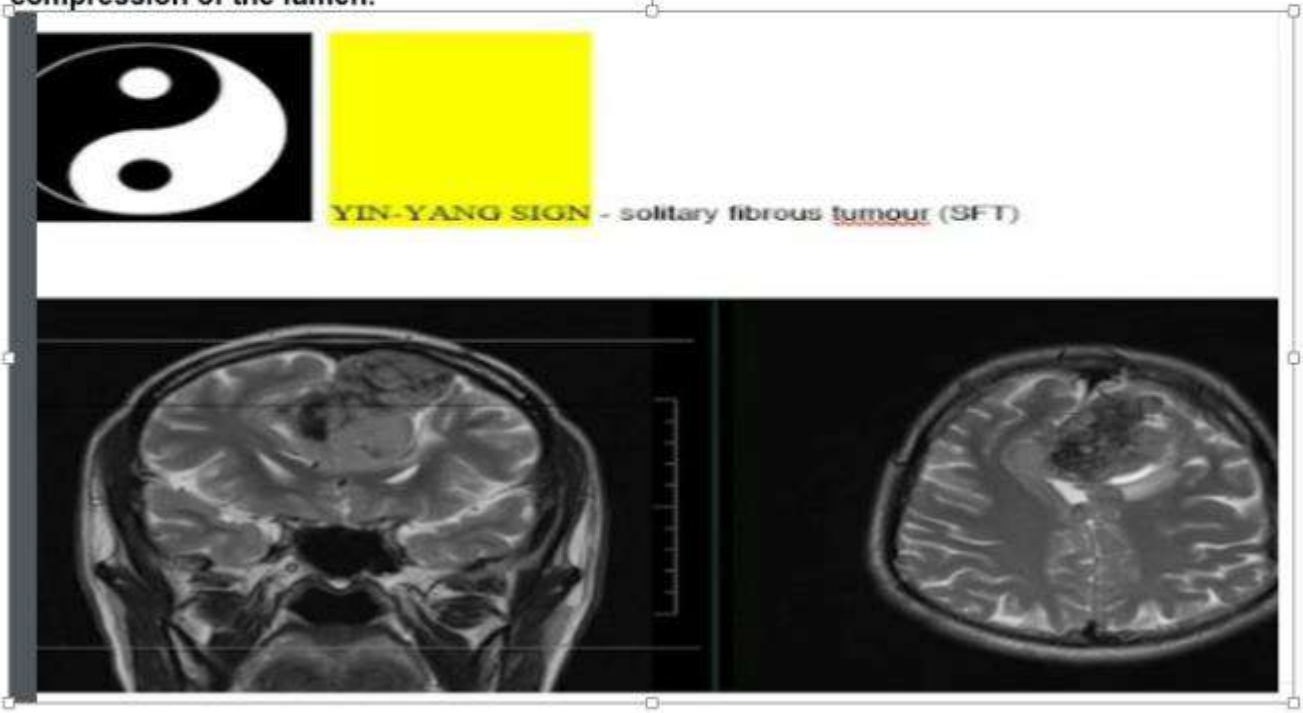
A small radial band like FLAIR hyperintensity is noted involving the right frontal subcortical white matter at the anterior part of centrum semiovale extending from the frontal cortex toward the right lateral ventricular margin (apparent transmantle sign, evaluation is limited due to lack of coronal and sagittal sequences)- likely suggestive cortical dysplasia (balloon cell cortical dysplasia)



YIN-YANG SIGN - Solitary Fibrous tumour (SFT)

A large left frontal paramedian multilobulated mixed intensity (two separate hypo and isointense solid components- yin yang pattern) extra-axial mass lesion, broad based along the frontal falx, demonstrating bilateral frontal parafalcine components (larger on the left) with evidence of thin surrounding CSF cleft with perilesional vasogenic edema, displacing the corpus callosum inferiorly (evaluation is limited due to lack of IV contrast study) – likely suggestive of solitary fibrous tumour (SFT) versus meningioma

It is impinging on the superior sagittal sinus from inferior aspect with partial compression of the lumen.



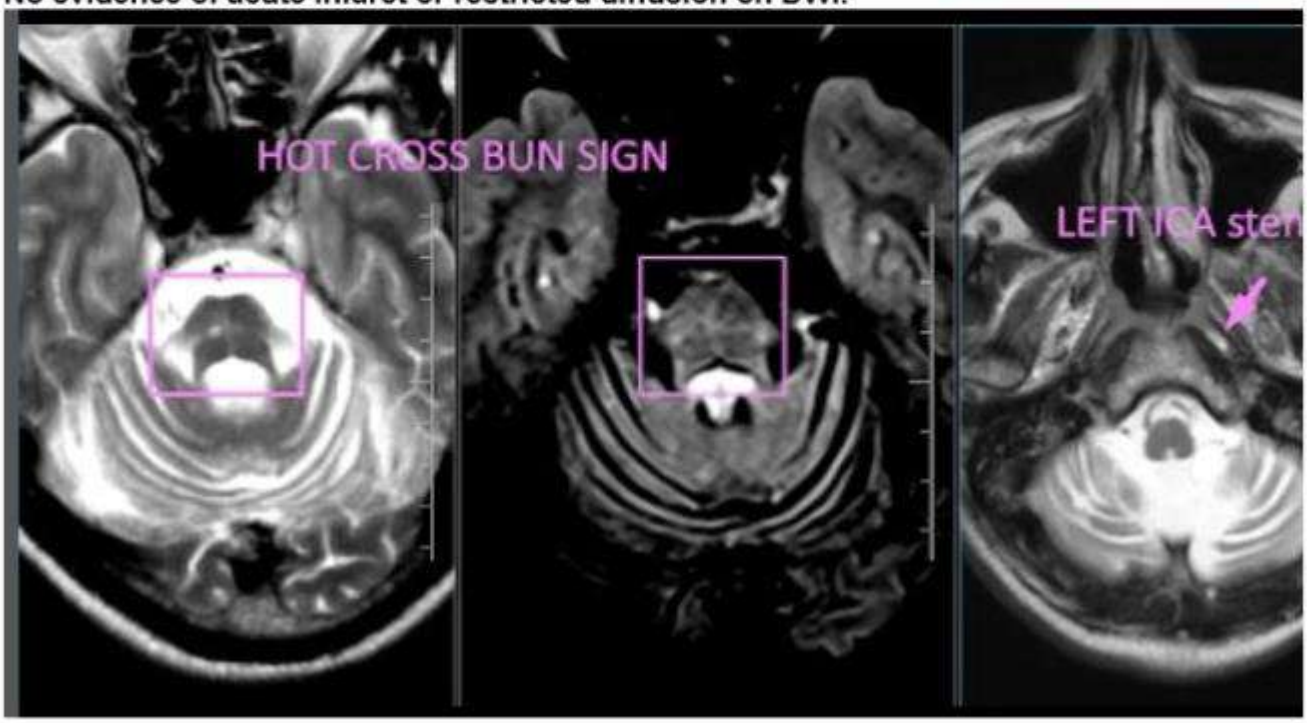
Marked cerebellar, brainstem atrophy with evidence of suspicious hot cross bun sign at the pontomedullary junction - likely suggestive of MultiSystem Atrophy (MSA-c)

Multiple old lacunar infarcts in right capsuloganglionic region, pons, bilateral cerebellum

Wedge large old infarct involving left superior parietal cortex

***Left ICA stenosis**

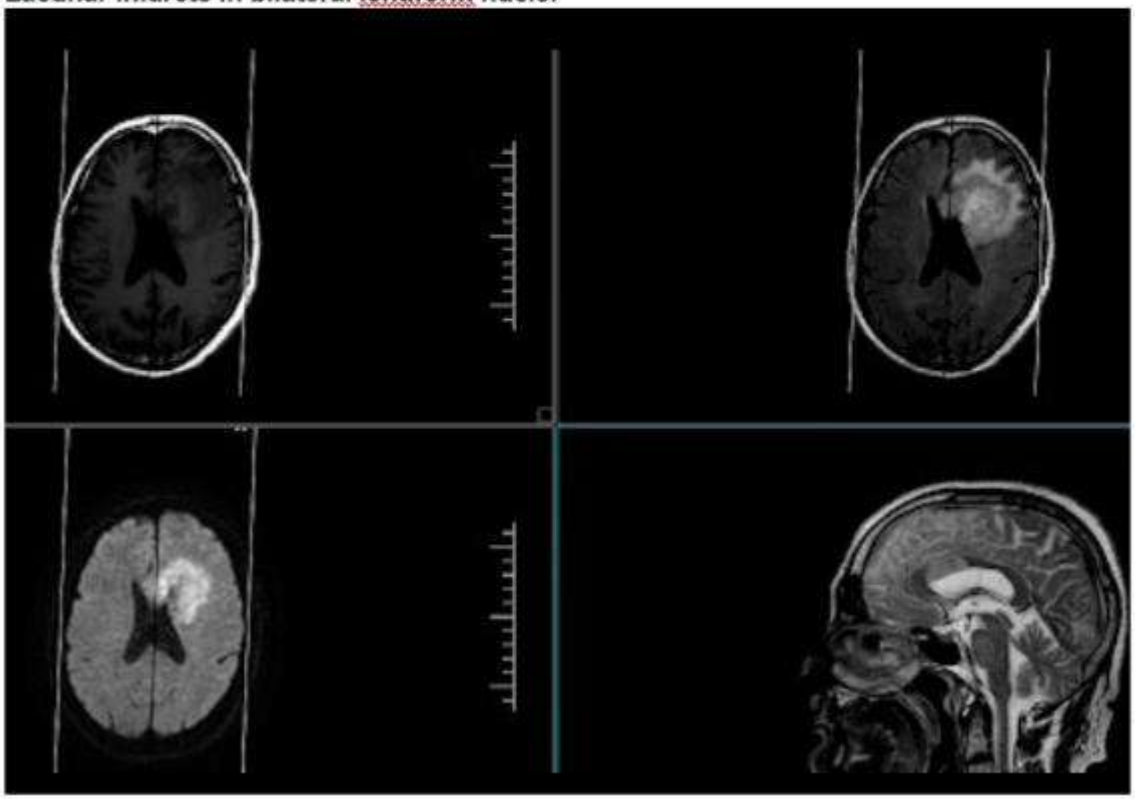
No evidence of acute infarct or restricted diffusion on DWI.



A large lobulated low T2 intensity periventricular mass lesion (4.4 x 5.0 x 4.0 cm) in the left frontal region, involving the white matter, ependymal margins involving the left caudate nucleus, left lateral part of genu and body of corpus callosum with perilesional vasogenic edema and relative restricted diffusion on DWI (evaluation is limited due to lack of IV contrast) – of concern for neoplasm , likely CNS lymphoma

0.5 cm midline shift to the right due to mass effect.

Lacunar infarcts in bilateral lentiform nuclei



cerebral amyloid angiopathy

Large irregularly marginated subacute intracerebral hemorrhages are again noted involving the right occipital, left temporo-parietal - occipital lobes with mild interval increase in extent since prior study - suggestive of cerebral amyloid angiopathy.

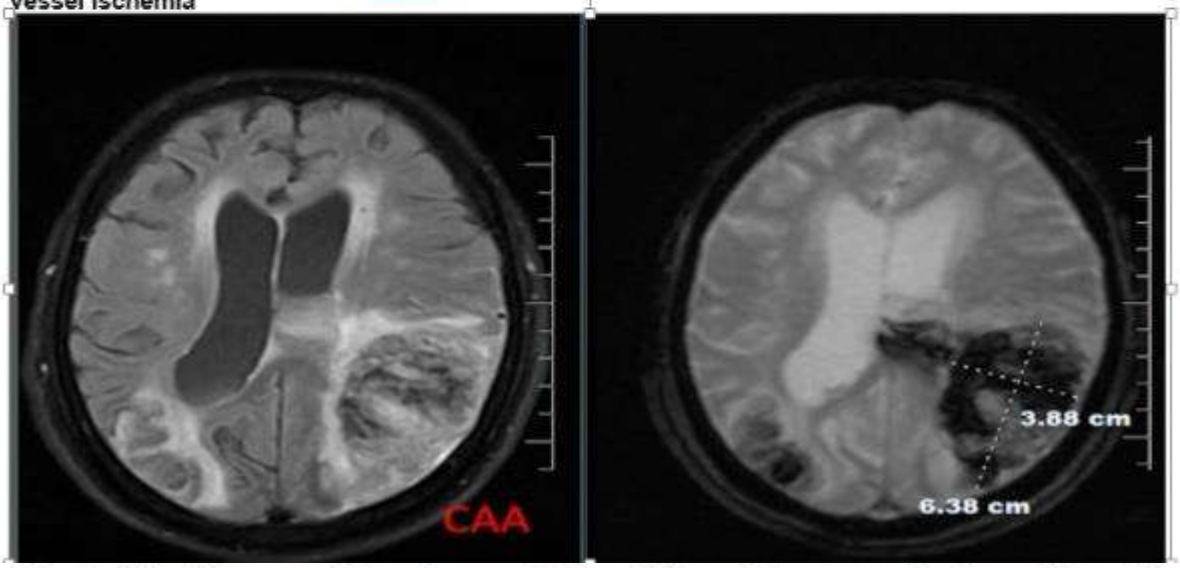
Mild bowing of septum pellucidum is again noted to the right due to mass effect – unchanged since prior study.

Again noted is a tiny acute embolic infarct in left superior frontal parafalcine cortex (supplementary motor cortex), now demonstrating interval decrease in the intensity on DWI

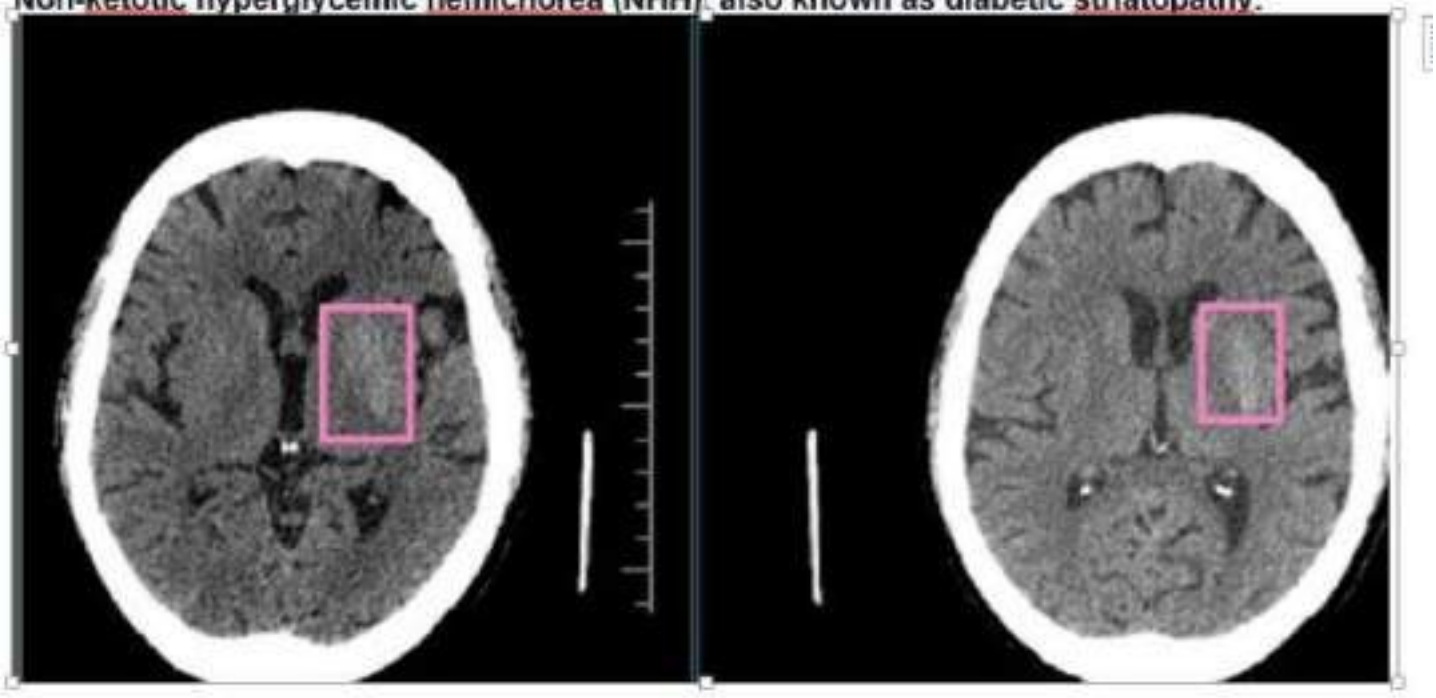
*There is interval development of Intra ventricular bleed in bilateral occipital horns, body of left lateral ventricle, new since prior study.

There is interval development of minimal lateral ventricular dilatation, new since prior study.

Age related volume loss with Fazekas grade II periventricular, subcortical white matter chronic small vessel ischemia



The left lentiform nucleus demonstrates diffusely increased attenuation – likely suggestive of Non-ketotic hyperglycemic hemichorea (NHH), also known as diabetic striatopathy.

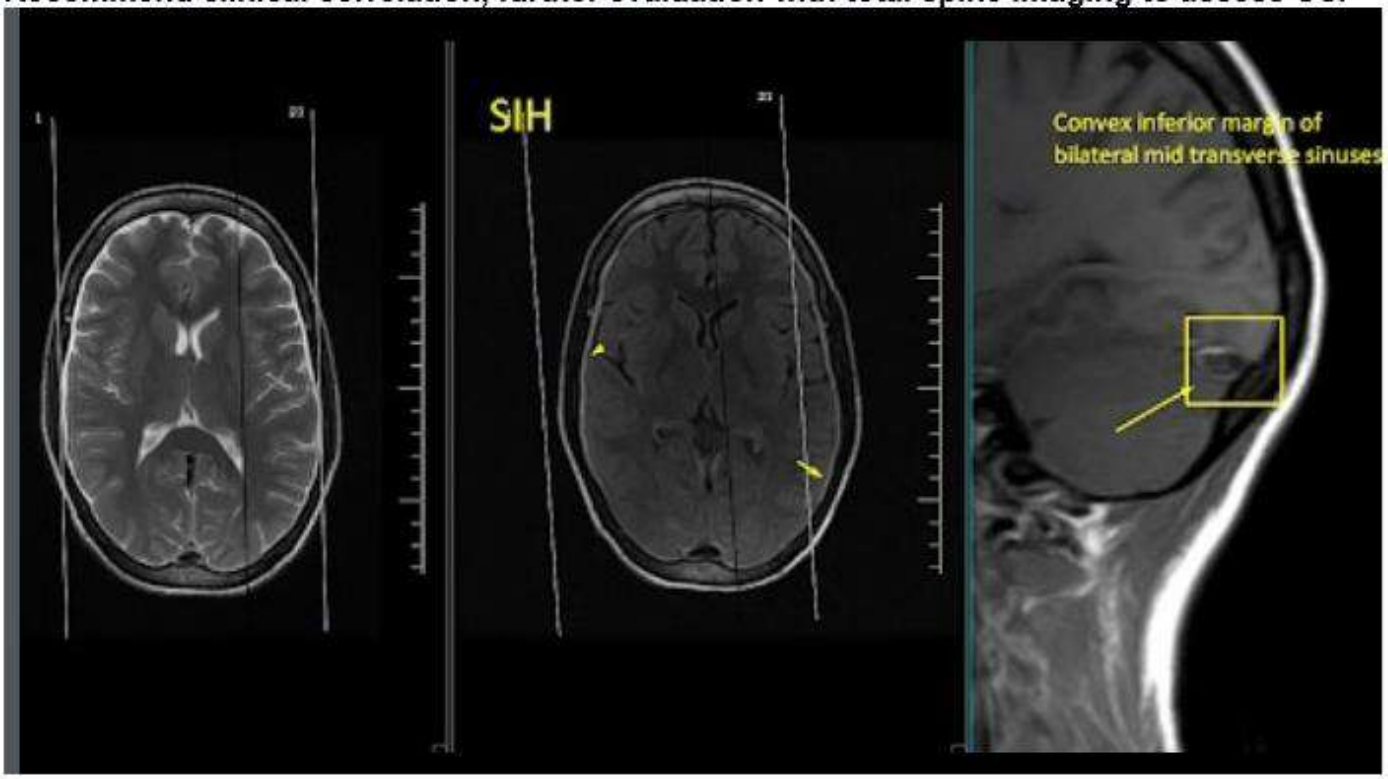


SPONTANEOUS INTRACRANIAL HYPOTENSION (SIH)

Thin spontaneous bilateral fronto-temporo-parietal convexity as well as bilateral tentorial subdural collections associated with marked distention of dural venous sinuses with Convex inferior margin of bilateral mid transverse sinuses – suggestive of spontaneous intracranial hypotension (SIH)

No evidence of significant sagging of brainstem in this study.

Recommend clinical correlation, further evaluation with total spine imaging to assess CSF

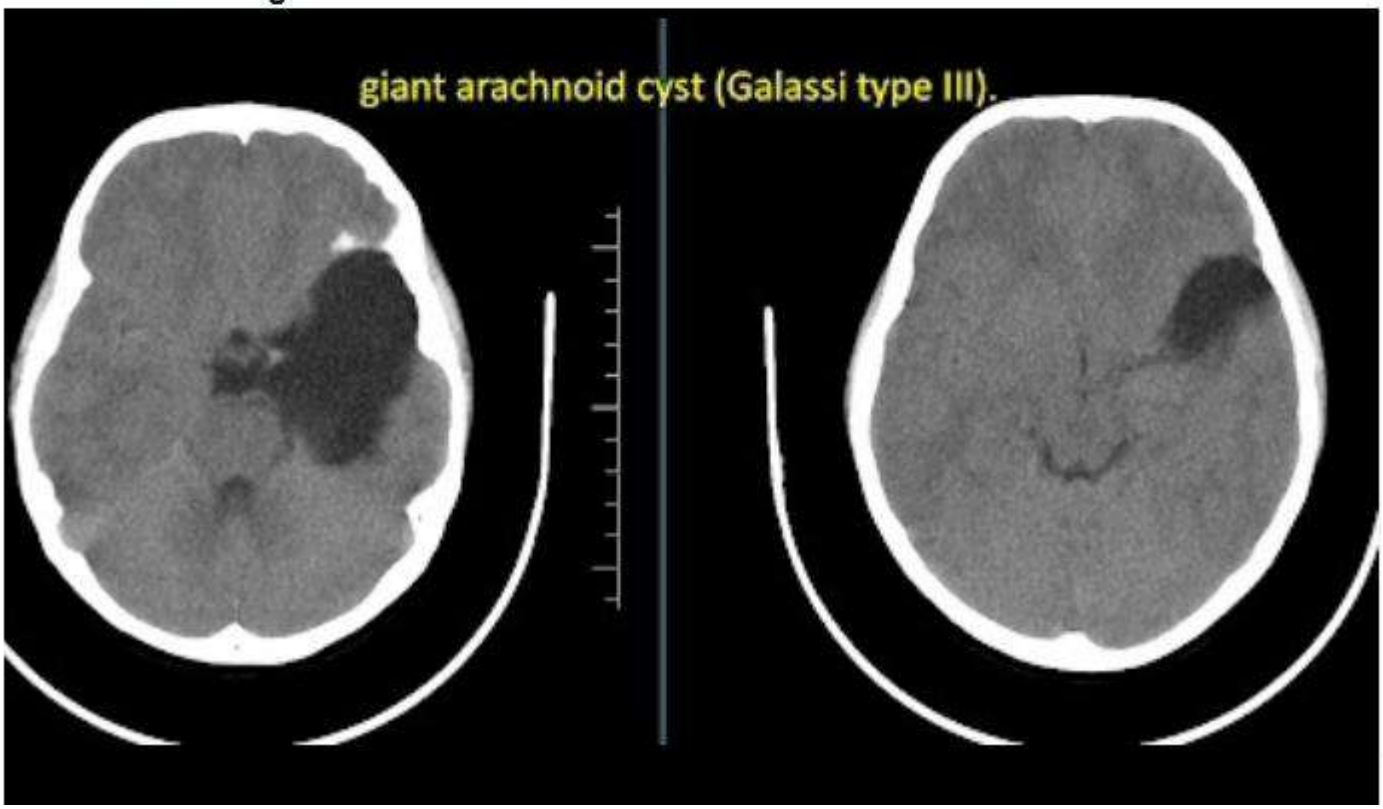


Galassi Type III arachnoid cyst

An approximately 6 x 4.2 cm large CSF density extra-axial cystic lesion in the left inferior, anterior temporal region, causing widening of the left sylvian fissure with displacement of fronto-temporal lobes – suggestive of giant arachnoid cyst (Galassi type III).

No evidence of intracystic haemorrhage or fluid levels.

No evidence of significant mid line shift.



Progressive supranuclear palsy (PSP)

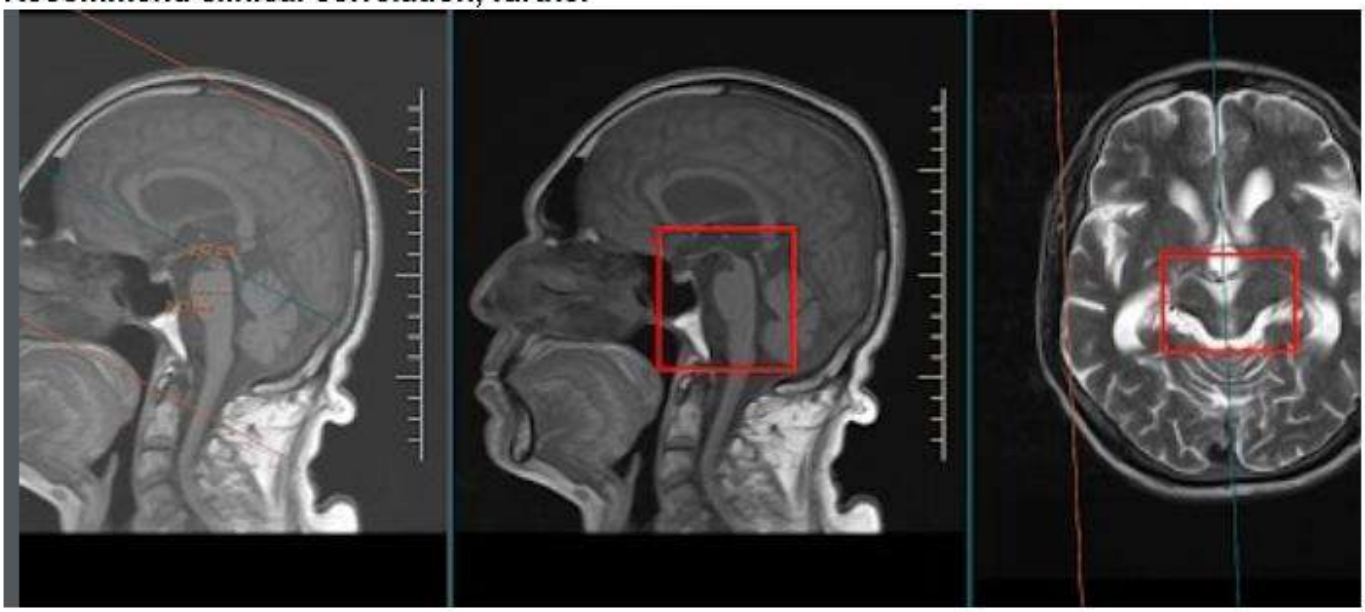
Moderate generalized cerebral , cerebellar atrophy with mild to moderate ventriculomegaly

Focal midbrain atrophy with reduced midbrain width to 0.7 cm in midsagittal plane , demonstrating reduced midbrain to pons width ratio of 0.33. (hummingbird sign) – of concern for a neuro degenerative disorder , likely Progressive supranuclear palsy (PSP)

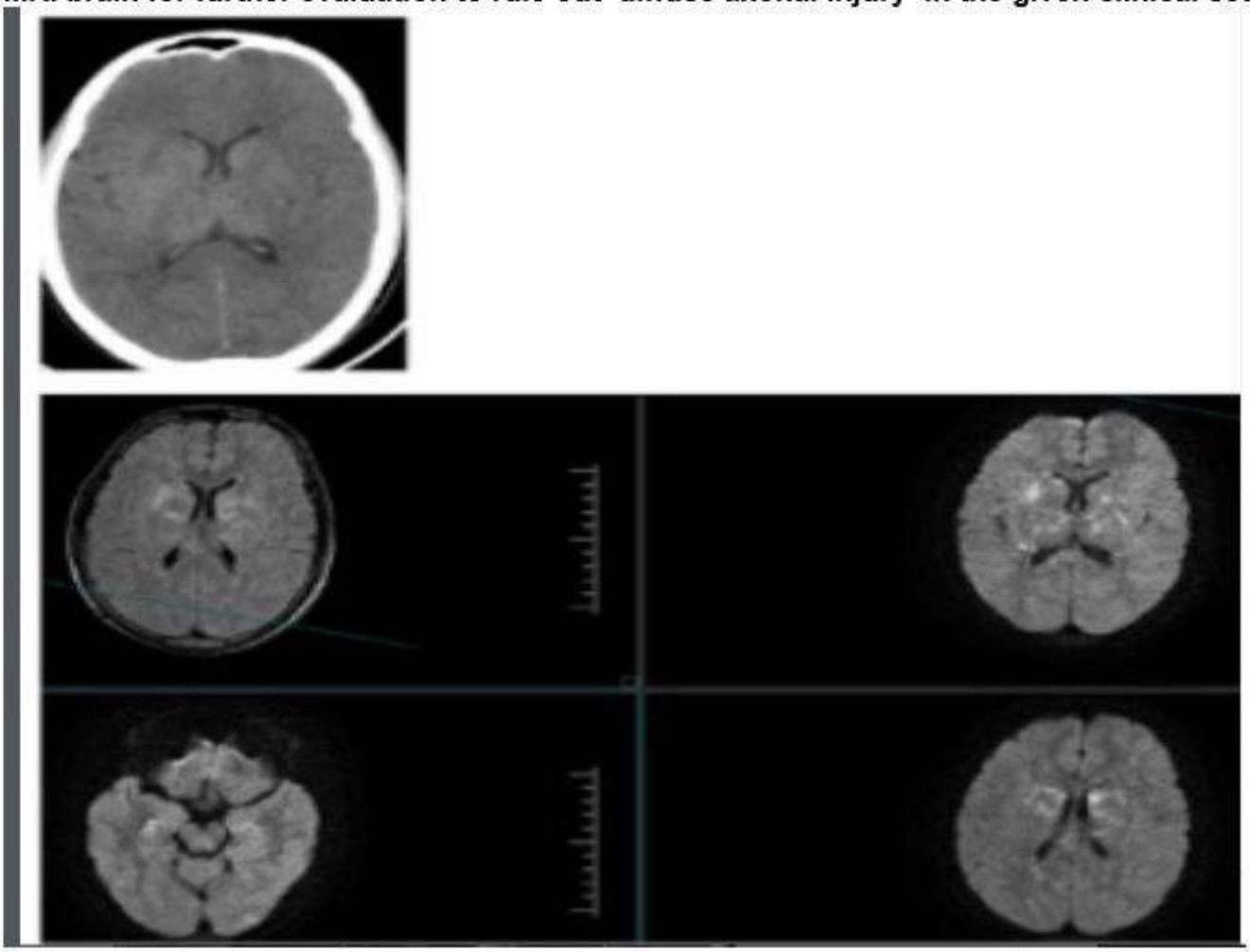
Other possibility of multisystem atrophy (MSA) cannot be ruled out.

No evidence of focal parenchymal lesion. No evidence of acute infarct or restricted diffusion on DWI.

Recommend clinical correlation, further



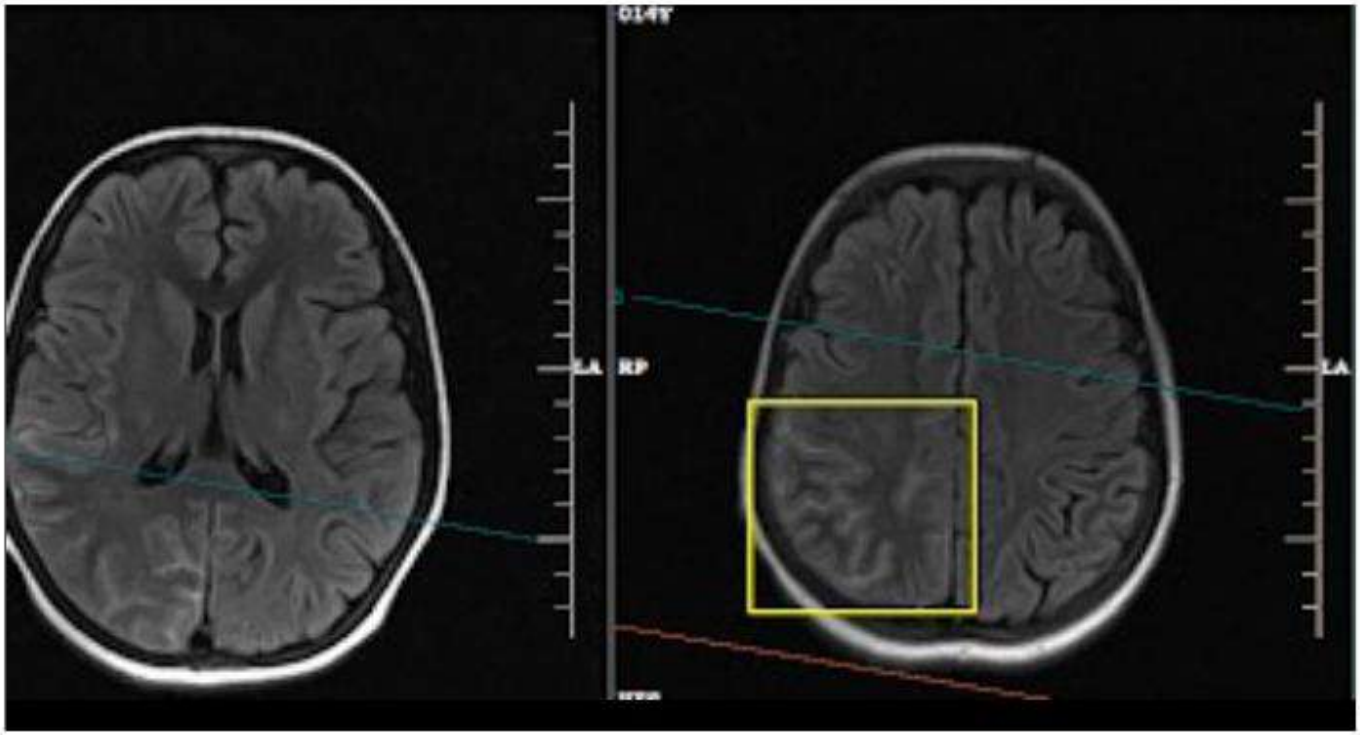
No evidence of acute intracranial haemorrhage.
Suspicious lacunar infarcts in bilateral corona radiata, body of corpus callosum – Recommend MRI brain for further evaluation to rule out 'diffuse axonal injury' in the given clinical settings.



Thin FLAIR hyperintensities involving the right superior parietal, occipital and posterior temporal sulci with few similar thin FLAIR hyperintensities in the left temporo occipital region as well – likely suggestive of Reversible cerebral vasoconstriction syndrome (RCVS).

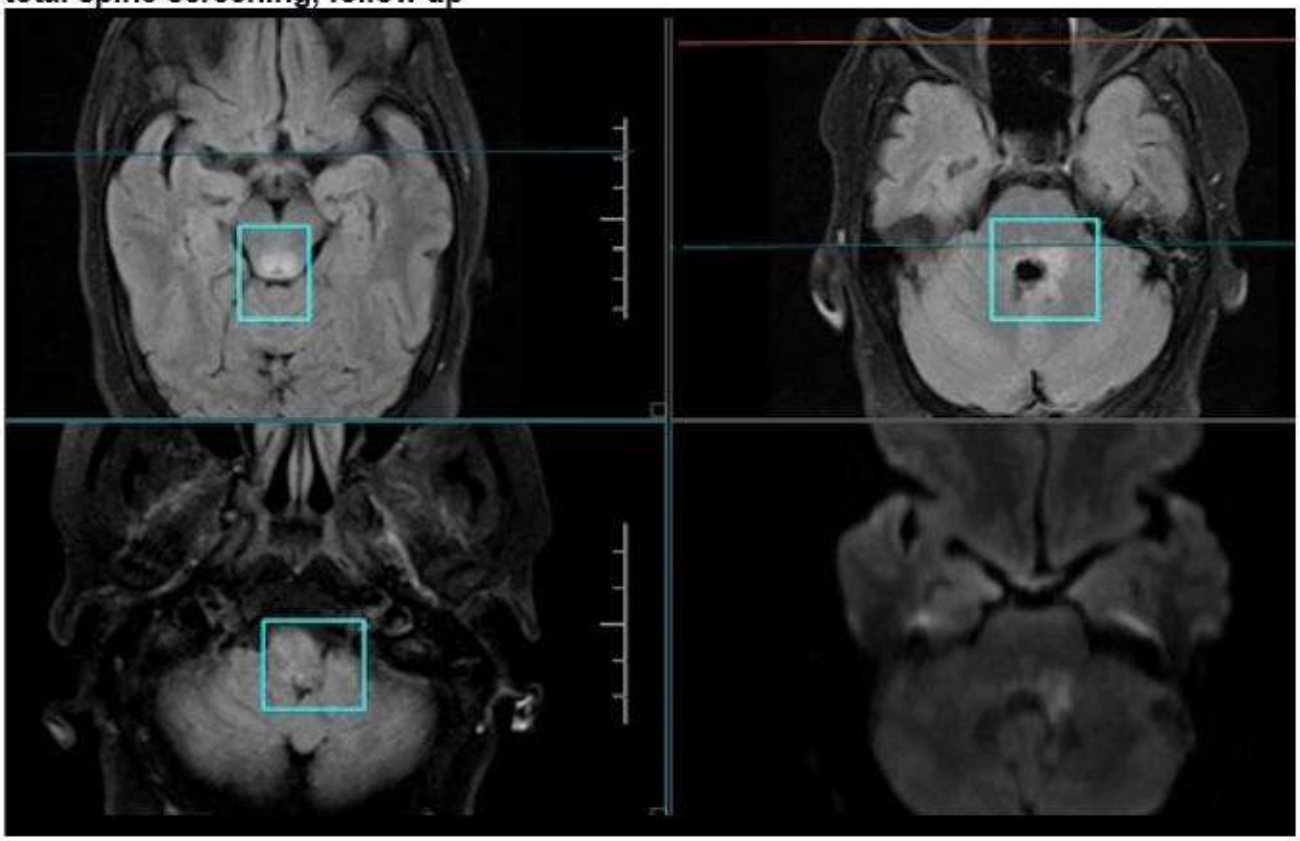
No evidence of restriction of diffusion. No evidence of blooming on GRE sequence.

Recommend MRI SWI, CT sections, follow up.



Multifocal patchy T2 / FLAIR hyperintensities involving periaqueductal region , colliculi, posterior border of pons, left middle cerebellar peduncle, the medulla with evidence of relative restricted diffusion on DWI in the left middle cerebellar peduncle – likely possibilities would be Neuromyelitis optica spectrum disorder (NMO) Wernicase encephalopathy

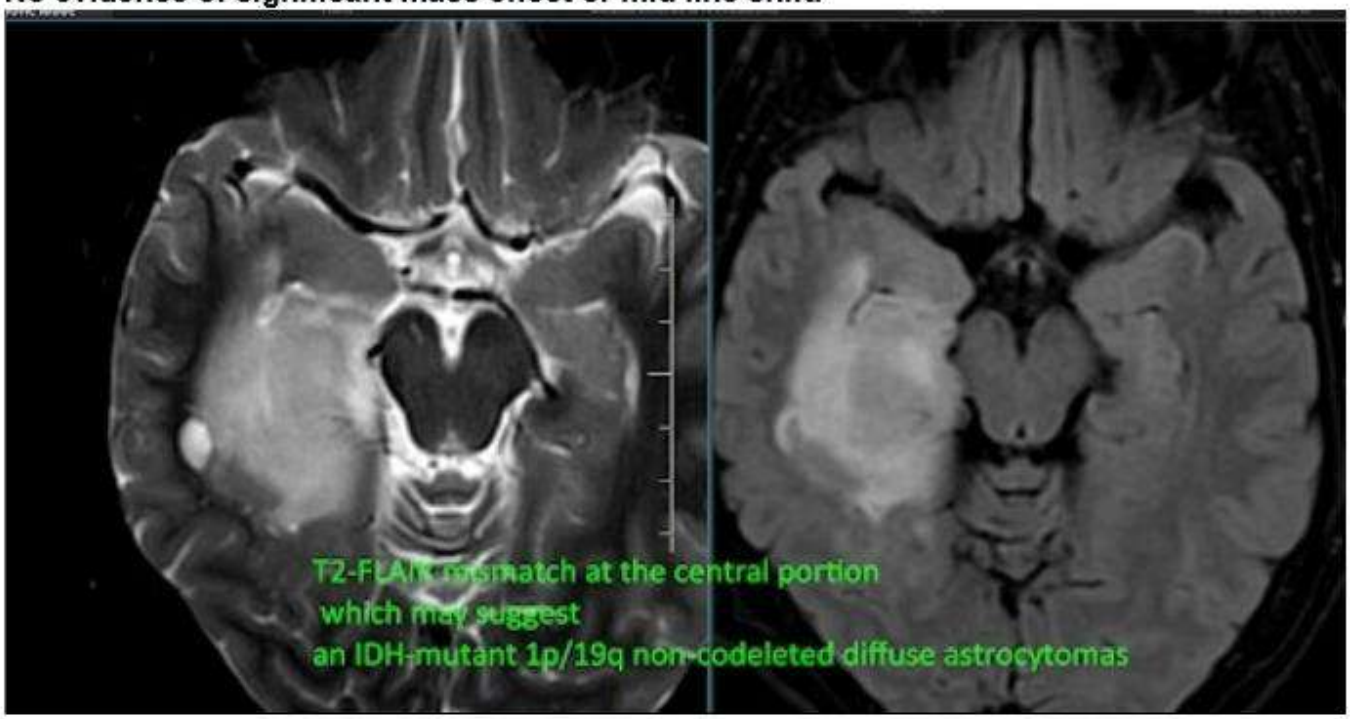
Recommend clinical correlation, further evaluation with Thiamine levels, Aqp4 antibody levels, total spine screening, follow up



An approximately 3 x 5.8 x 3.3 cm ovoid poorly enhancing altered signal intensity lesion involving the right inferomedial temporal lobe, involving part of amygdala, hippocampus and the uncus with minimal perilesional vasogenic edema – represents low grade diffuse astrocytoma (WHO grade I to II)

The lesion demonstrates T2-FLAIR mismatch at the central portion – which may suggest an IDH-mutant 1p/19q non-codeleted diffuse astrocytomas

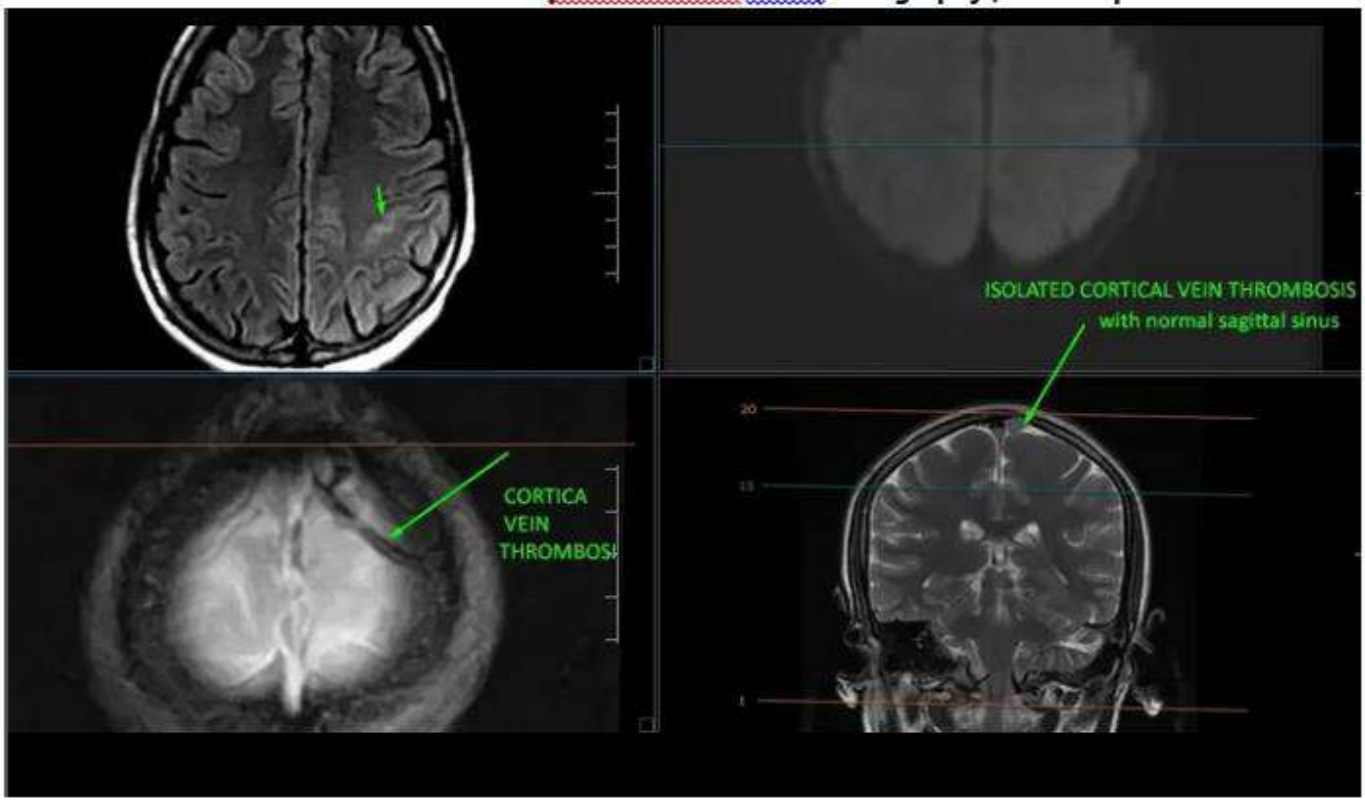
No evidence of significant mass effect or mid line shift.



Very subtle gyriform T2 / FLAIR hyperintensity in the left precentral gyrus without restriction of diffusion – suggestive of early non-hemorrhagic venous infarct

Focal thickening of adjoining left superior frontal draining cortical vein demonstrating blooming on GRE sequence – isolated draining cortical vein thrombosis with normal superior sagittal sinus.

Recommend further evaluation in view of prothrombotic state , venography , follow up



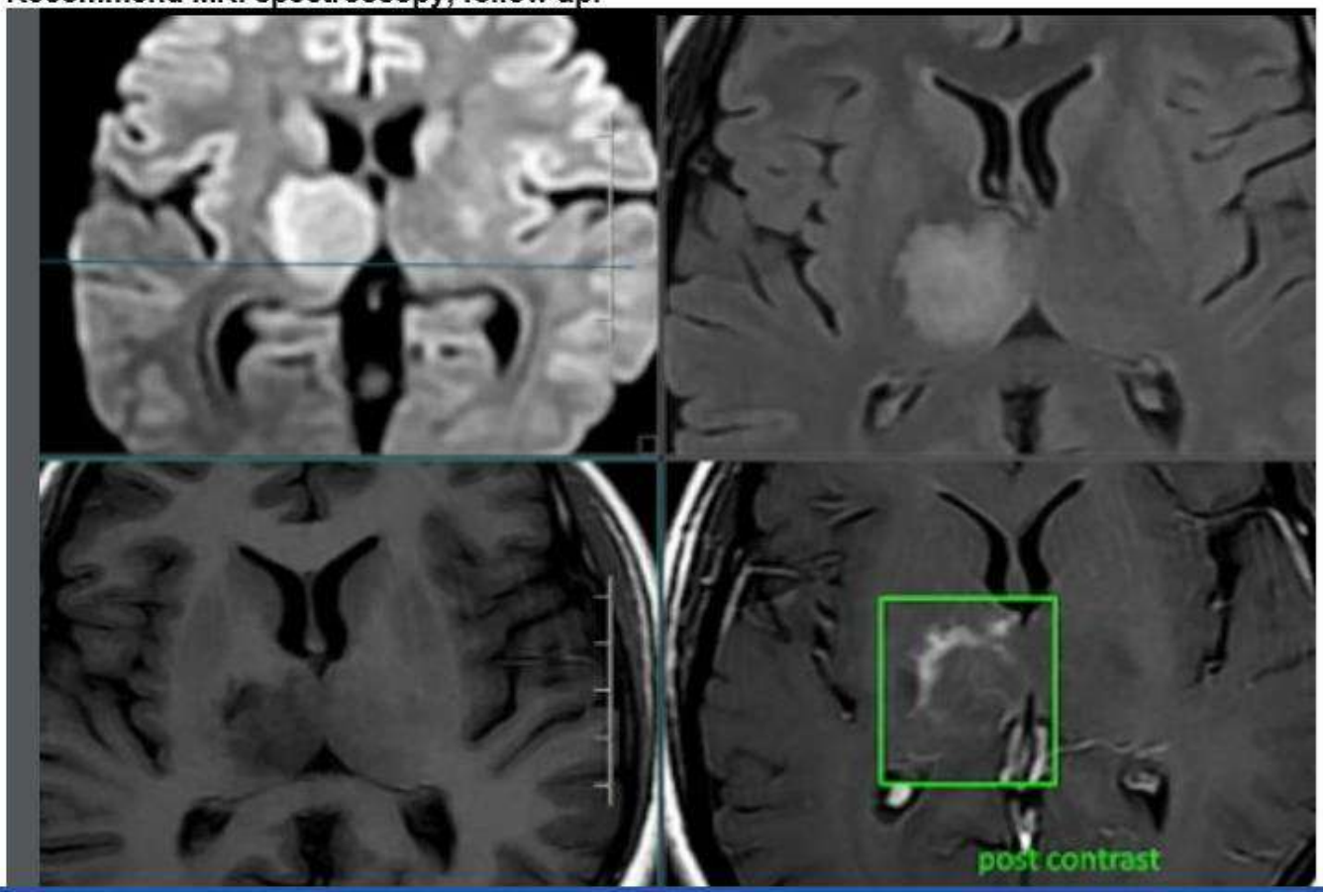
A focal T2 / FLAIR hyperintensity involving right thalamus demonstrating mixed signal intensity on T2 with partial rim enhancement causing mild thalamic expansion indenting 3rd ventricle –*may suggest focal thalamic tumefactive demyelinating lesion*

Other differentials would be subacute infarct versus ? neoplasm.

No evidence of blooming on GRE. The lesion is relatively hyperintense on DWI .

No evidence of midline shift .

Recommend MRI spectroscopy, follow up.



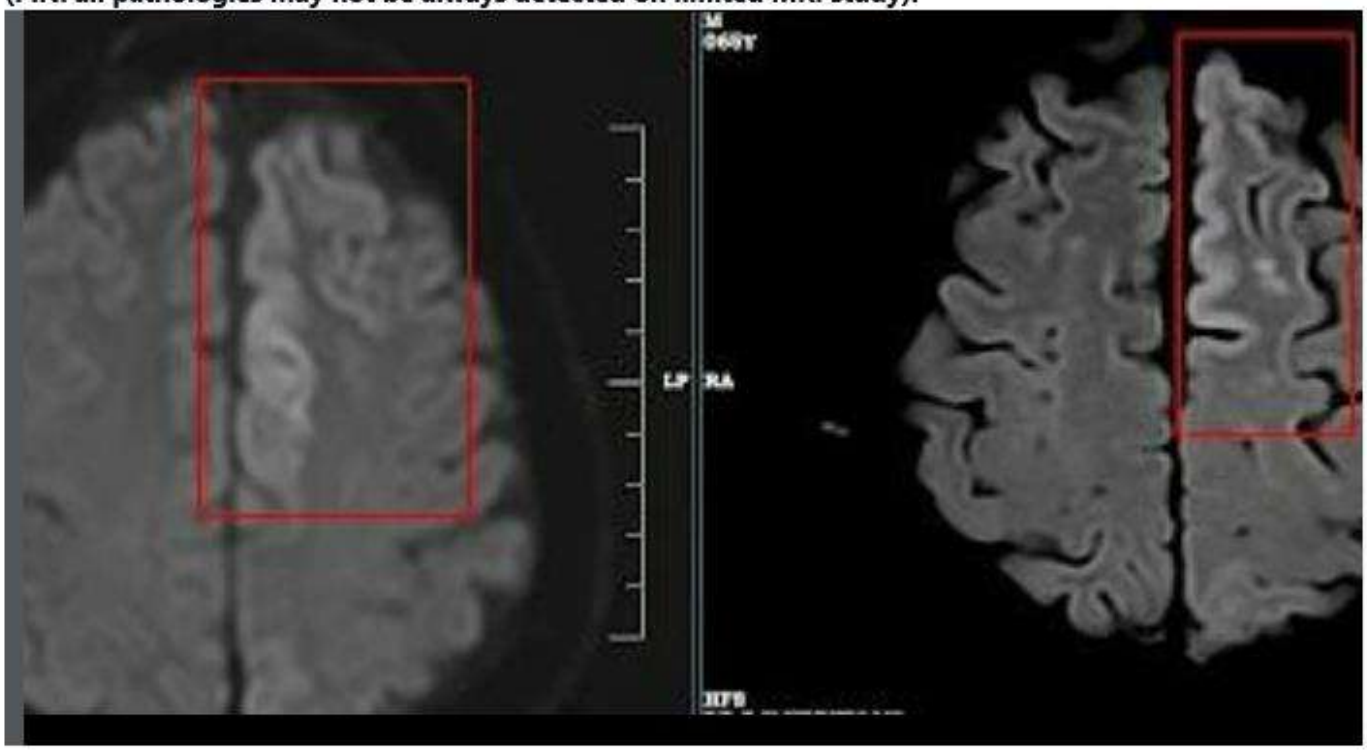
Gyriform FLAIR hyperintensity involving left superior frontal lobe at parafalcine region (superior frontal gyrus) with relative restricted diffusion on DWI – *likely suggestive of Subacute encephalopathy with seizures in alcoholics (SESA syndrome) versus status post epilepticus signal changes.*

No evidence of significant mass effect or mid line shift.

Age related volume loss with Fazekas grade I periventricular white matter chronic small vessel ischemia.

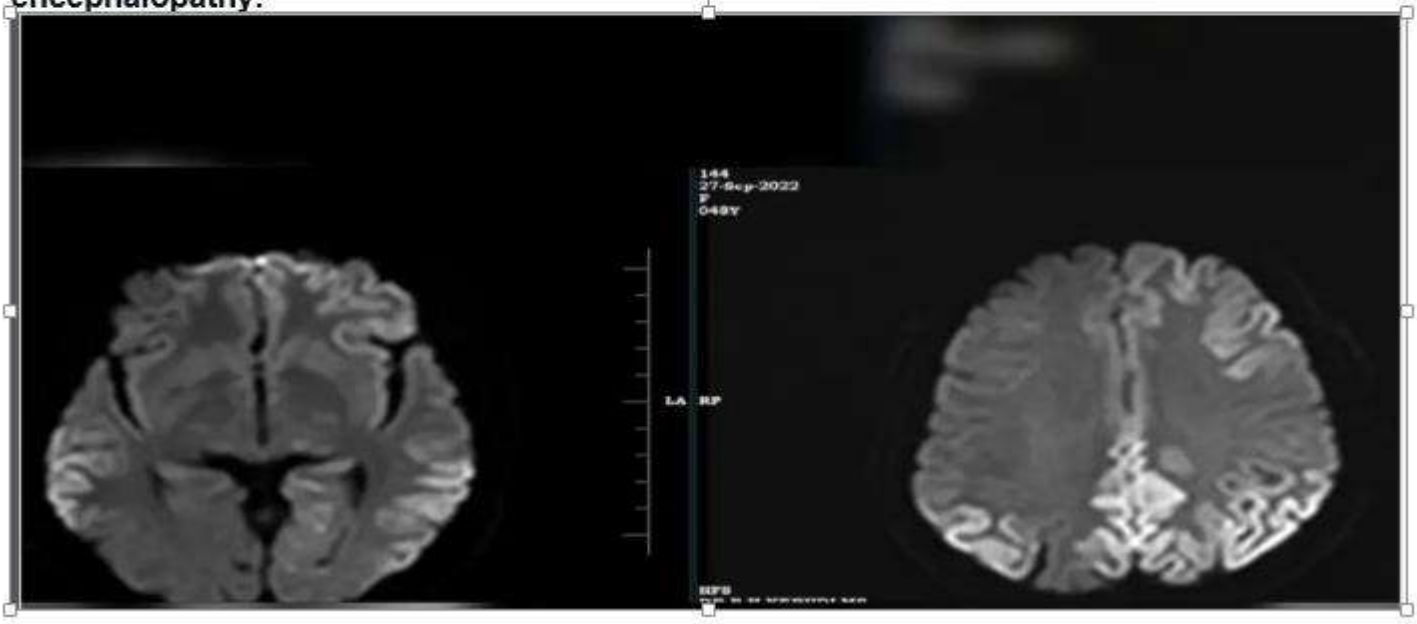
Recommend detailed MRI brain study for complete evaluation, EEG correlation, follow up.

(P.N: all pathologies may not be always detected on limited MRI study).



'Creutzfeldt-jakobdisease'
(CJD,a transissible spongiform encephalopthy)

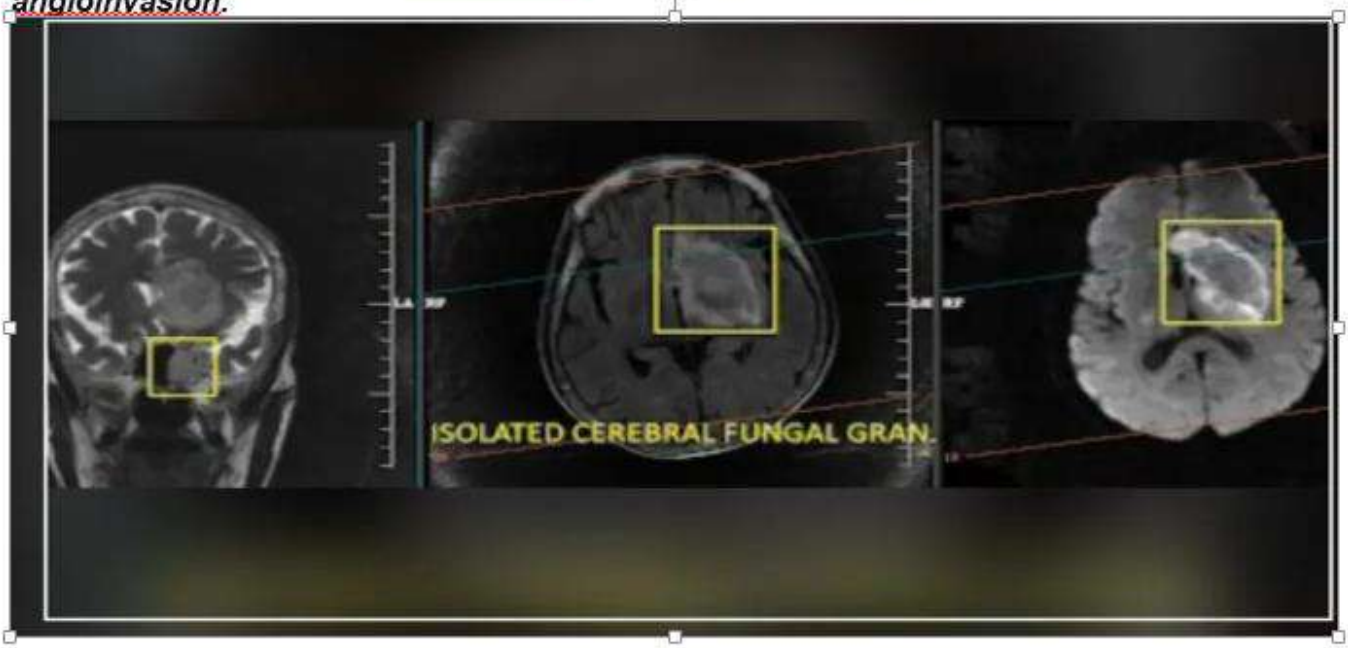
Other likely possibilities would be acute hypoglycemic encephalopathy versus acute hypoxic encephalopathy.



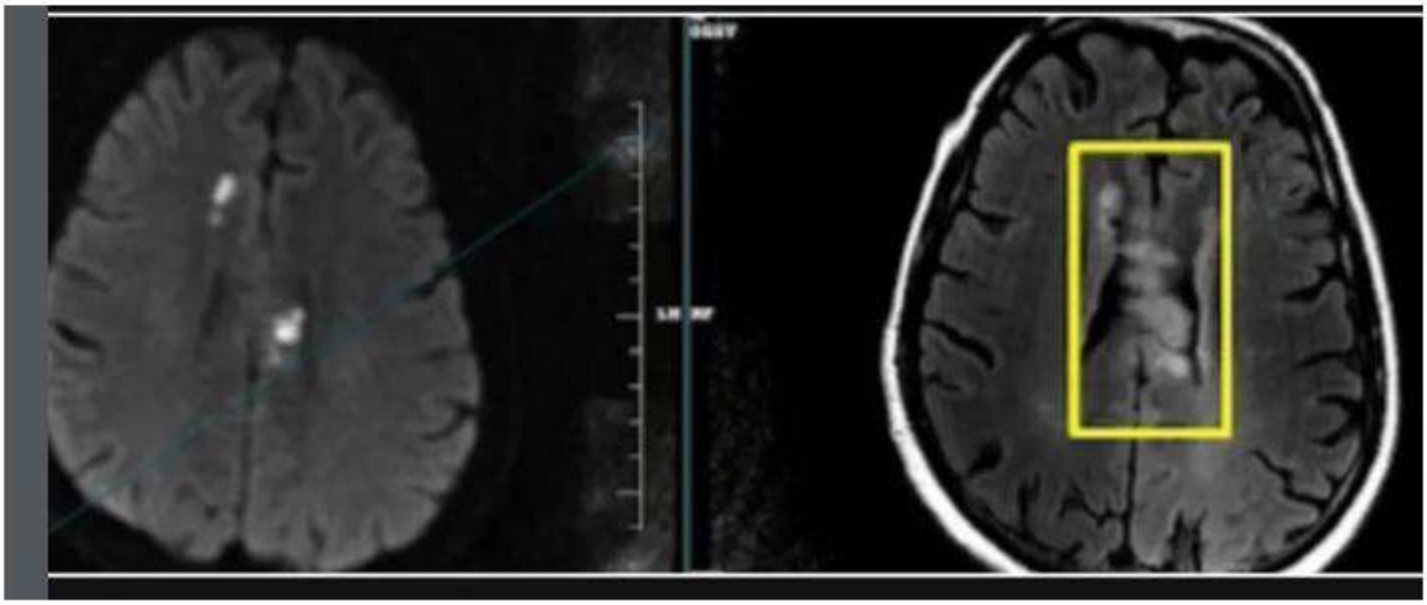
Marked low intensity soft tissue involving the left sphenoid sinus with slightly obscured and a tiny suspicious soft tissue protrusion into the left cavernous sinus region.

An extensive altered signal intensity lesion involving left capsuloganglionic region, thalamus, corona radiata and adjoining body and genu of corpus callosum with blooming on GRE – **suggestive of an isolated cerebral fungal granuloma with hemorrhagic transformation**

Sight narrowing of the left paraclinoid ICA compared to the right – *suggesting early angioinvasion.*



Multifocal acute infarcts involving body of corpus callosum , adjoining right parafalcine . pericallosal frontoparietal cortex - *likely suggestive of multifocal acute infarcts within bilateral ACA (pericallosal artery) territories in the given clinical settings.*



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Lacunar infarct in pons

Age related mild volume loss with minimal periventricular white matter chronic small vessel ischemia.

No evidence of acute infarct or restricted diffusion on DWI.

The basilar artery and left distal vertebral artery (V4) appear slightly ectatic and tortuous, abutting the left trigeminal and 7th-8th nerve complexes – suggestive of vertebro basilar dolicoectasia with suspicious neurovascular conflict

Cranial evaluation is limited due to lack of appropriate GRE sequences

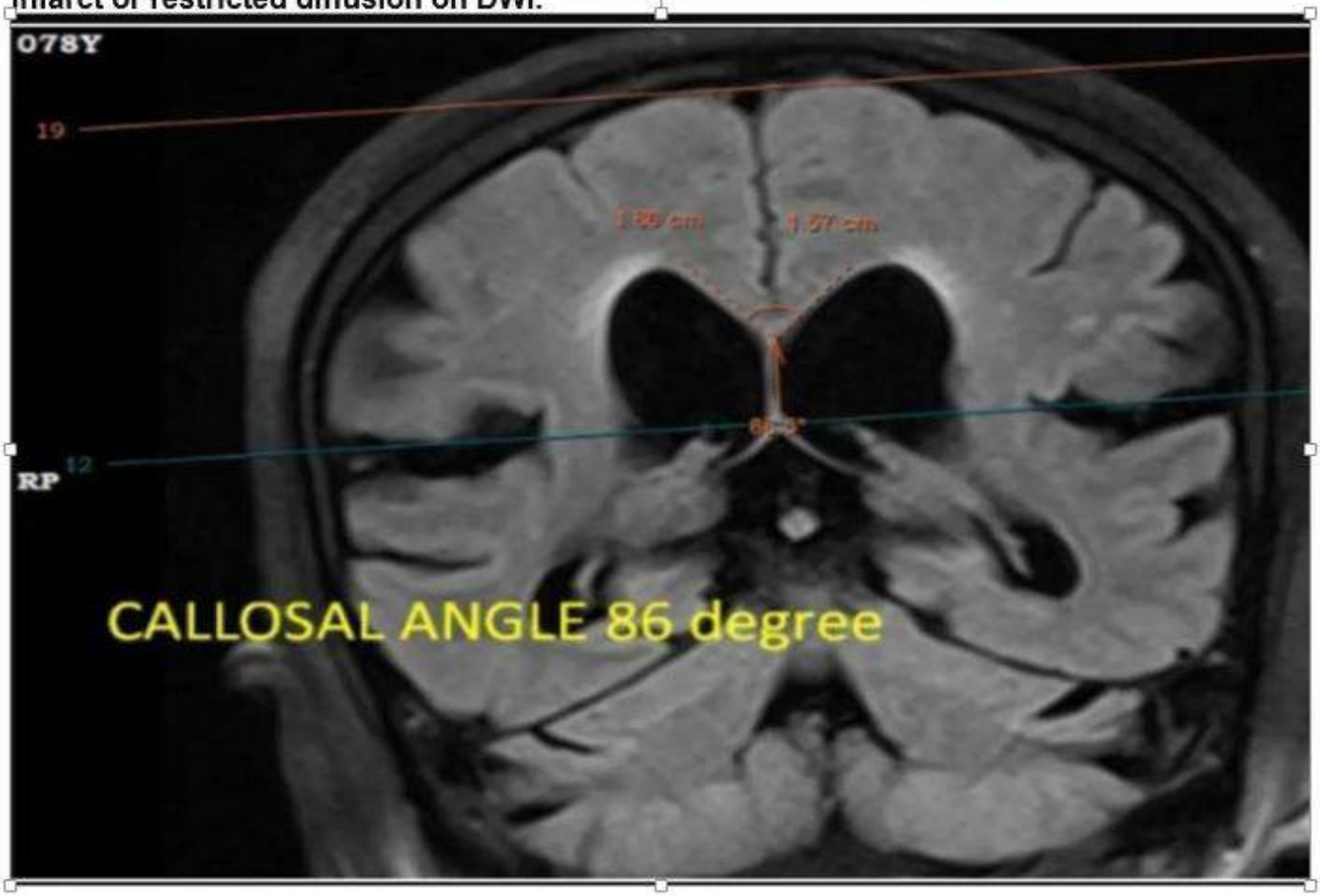


ATES)

Age related volume loss with Fazekas grade II periventricular, subcortical white matter chronic small vessel ischemia.

Disproportionate lateral ventricular prominence with features suggestive of suprasylvian subarachnoid block and decreased callosal angle- clinical correlation is recommended to rule out Normal Pressure Hydrocephalus

Lacunar infarcts in bilateral capsuloganglionic regions, corona radiata. No evidence of acute infarct or restricted diffusion on DWI.



A large diffuse irregularly marginated hypodensity involving right capsuloganglionic region, thalamus, insular cortex adjoining medial temporal lobe infiltrating the genu , anterior body of corpus callosum associated with patchy small hypodensity involving left caudothalamic region , right cerebral peduncle adjoining part of midbrain – **of concern for neoplastic etiology , likely CNS lymphoma versus diffuse astrocytoma with gliomatosis growth pattern**

Suspicious thickening of optic chiasm

Extrinsic compression of right lateral ventricle , 3rd ventricle due to mass effect with obscured right frontal horn and 0.3 cm midline shift to the left

Obscured grey white junction in right superior frontotemporal lobe – may suggest tumour infiltration versus secondary acute infarct

Mild obstructive hydrocephalus .



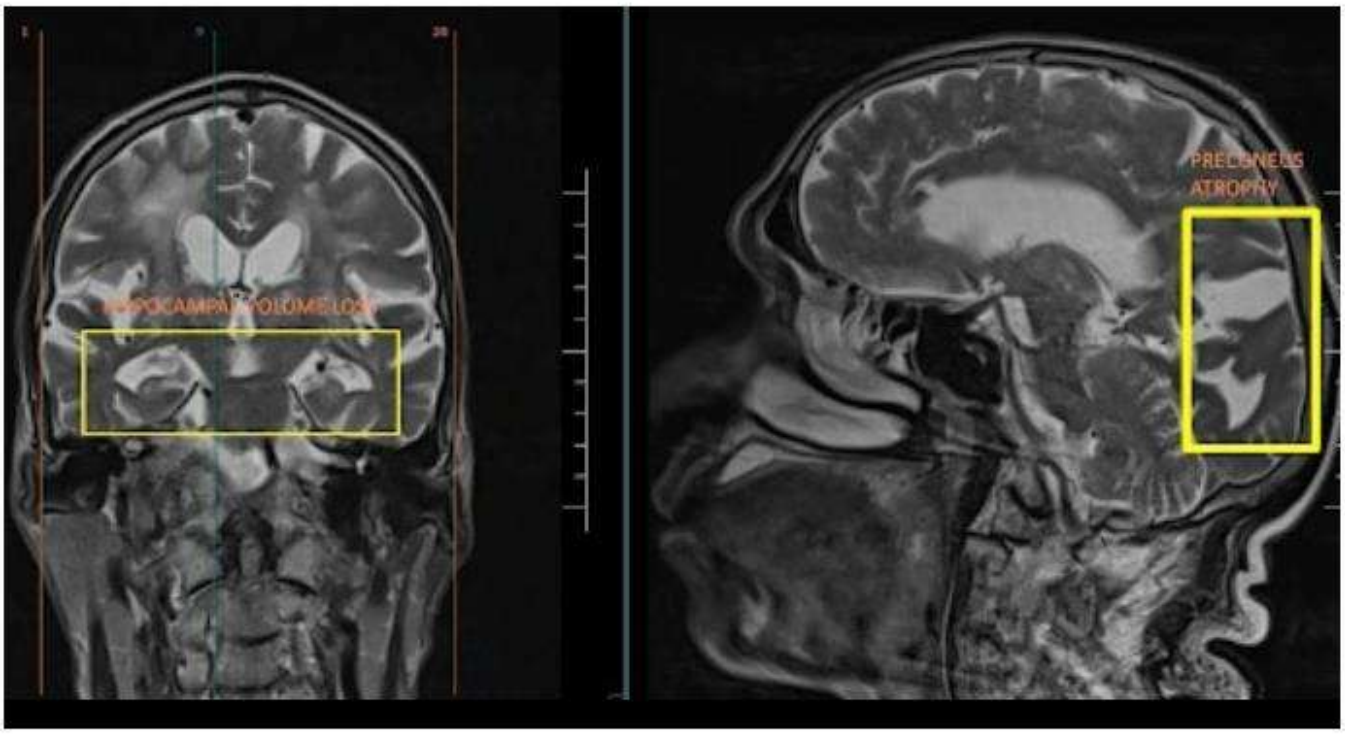
Marked bilateral precuneus atrophy with grade II to III hippocampal , medial temporal volume loss

Age related volume loss with extensive periventricular white matter chronic small vessel ischemia (Fazekas grade III) associated .

A tiny restricted diffusion on DWI in right occipital lobe – may suggest tiny acute embolic infarct versus post ictal signal changes

Lacunar ischemic changes in bilateral capsuloganglionic regions, corona radiata , thalami, corpus callosum

Recommend clinical correlation, further evaluation, follow up.

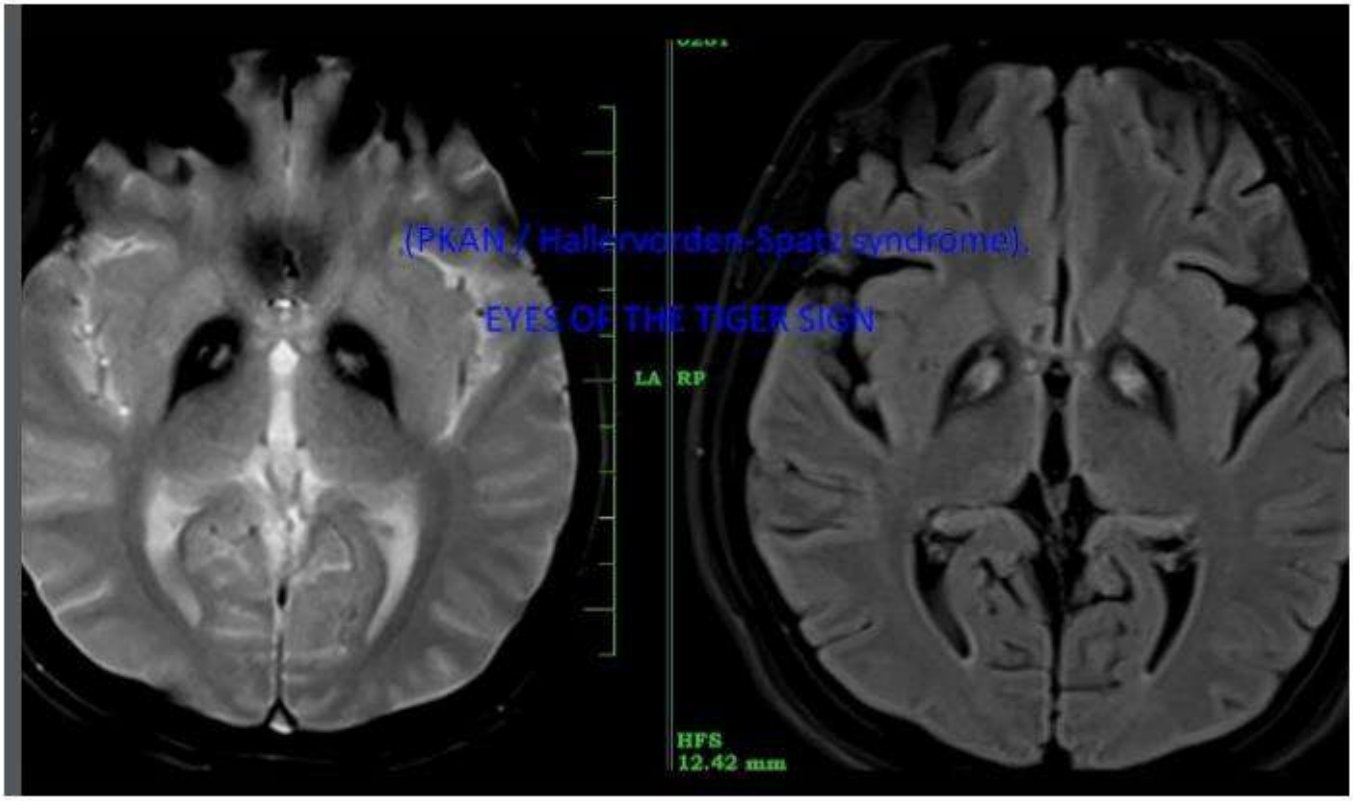


Multifocal patchy confluent, coalescent T2/FLAIR hyperintensities involving bilateral fronto-parietal subcortical white matter, centrum semiovale and adjoining lateral margins of anterior body, genu, splenium of corpus callosum with restricted diffusion on DWI , low ADC and central patchy areas of early cavitation on FLAIR as described suggestive of '*Progressive Cavitating Leukoencephalopathy*'

(a mitochondrial DNA depletion neurodegenerative disorder)



Well defined, focal, ovoid altered signal intensities involving bilateral globus pallidii of the lentiform nuclei (predominantly hypointense on T2Wt sequences at the periphery with blooming on GRE, containing small central areas of T2 hyperintensity - (eye of the tiger sign) associated with tiny blooming on GRE in bilateral substantia nigra regions of the midbrain –suggestive of a neuro degenerative disorder , likely Pantothenate kinase-associated neurodegeneration (PKAN / Hallervorden-Spatz syndrome).



Extensive T2/FLAIR hyperintensities involving bilateral periventricular deep white matter and bilateral frontal, parietal and temporo occipital subcortical white matter - likely suggestive of cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL) versus Fazekas grade III chronic small vessel ischemia

Multiple lacunar infarcts in bilateral capsulogangiionic regions, corona radiata as described above



Acute bilateral PCA territory infarcta involving occipital lobes extending to postero-medial temporal region associated with large bilateral thalamic infarcts demonstrating small central hemorrhagic transformation – Top of the Basilar Artery Syndrome

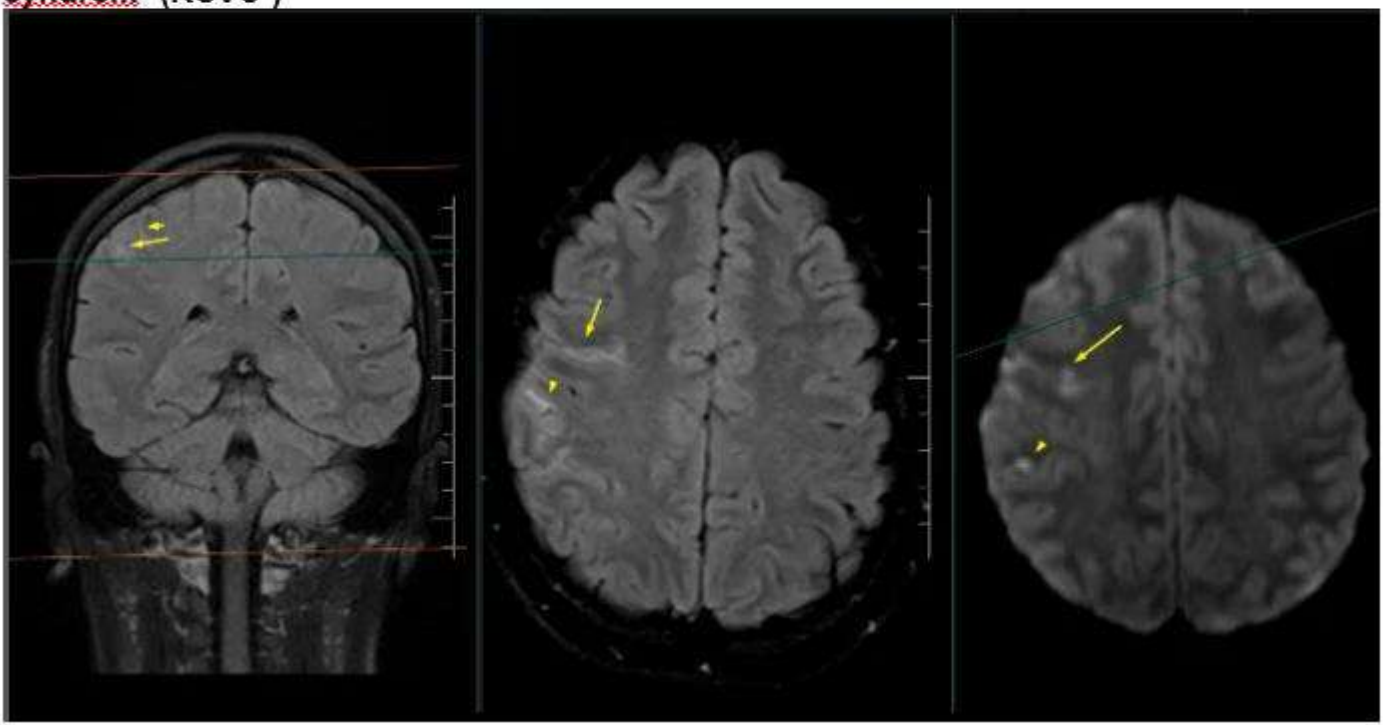
Small focal thrombo occlusion at tip the tip of basilar artery – could be cardioembolic

No evidence of significant mass effect or mid line shift.



29 yr

Increased sulcal FLAIR signals in right frontal, temporal and parietal region with evidence of multiple tiny areas of restricted diffusion in right superior fronto-parietal lobe without obvious blooming on GRE sequence – *likely suggestive of Reversible cerebral vasoconstriction syndrom* (RCVS*)



Patchy , gyriform areas of restricted diffusions are noted involving cingulate gyrus, insular cortex , adjoining frontotemporal , parietal cortex , right medial temporal cortex , right hippocampus, right thalamus – likely suggestive of Subacute encephalopathy with seizures in alcoholics (SESA syndrome)

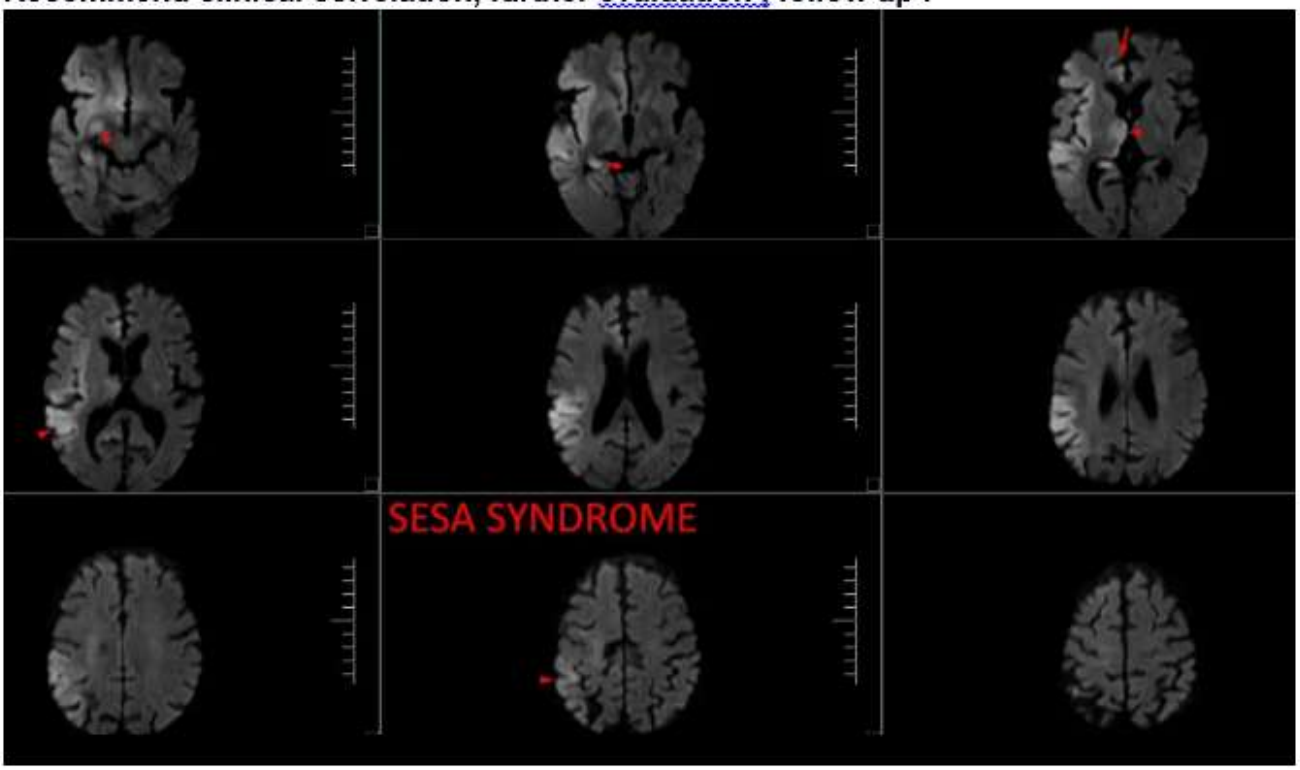
Other possibility of acute right ICA territory infarcts is less likely

A tiny acute embolic infarct in left cerebellum

Wedge shaped old infarct involving the right parietal cortex , right cerebellum

Age related volume loss with periventricular white matter chronic small vessel ischemia.

Recommend clinical correlation, further evaluation , follow up .

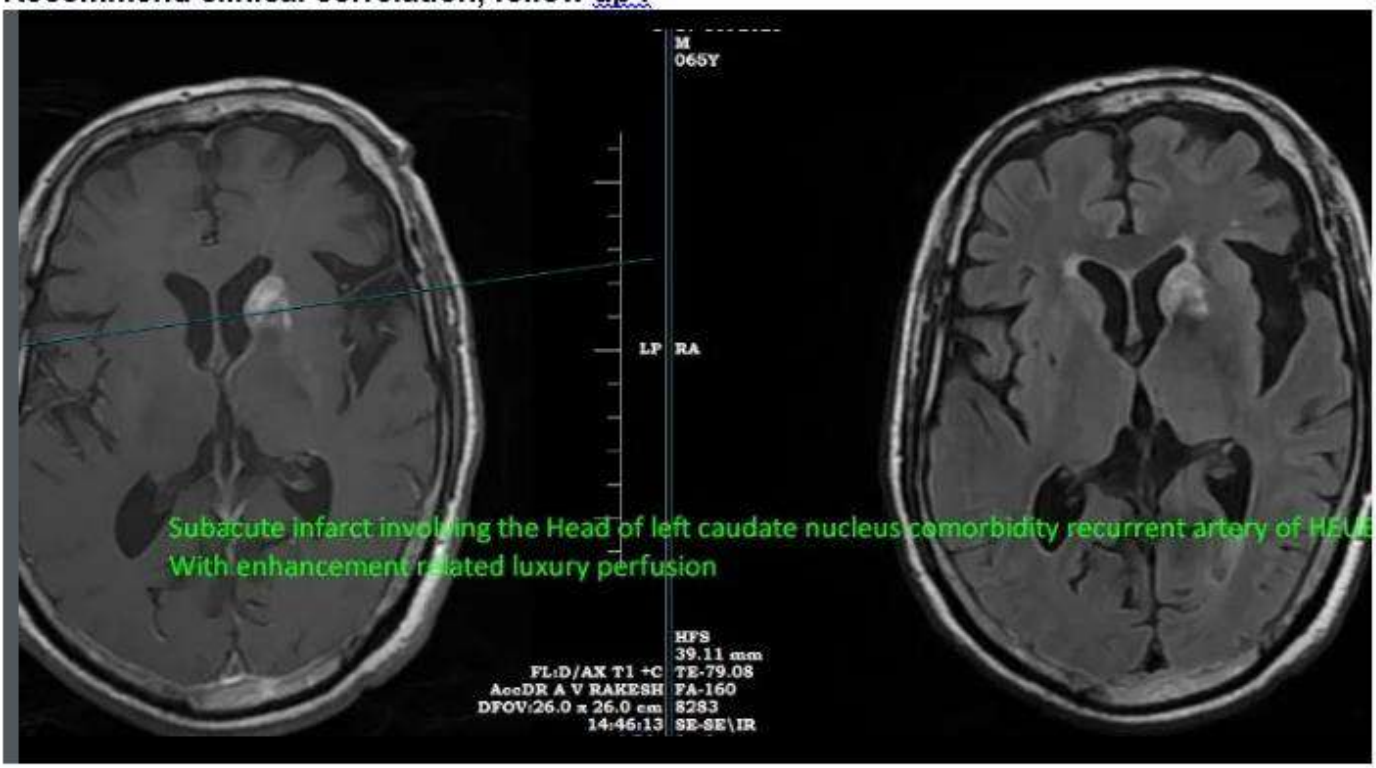


• A focal subacute infarct in head of left caudate nucleus demonstrating luxury perfusion related enhancement (within Recurrent artery of Heubner territory)

• Age related mild volume loss with Fazekas grade I periventricular white matter chronic small vessel ischemia.

• No evidence of acute infarct or restricted diffusion on DWI.

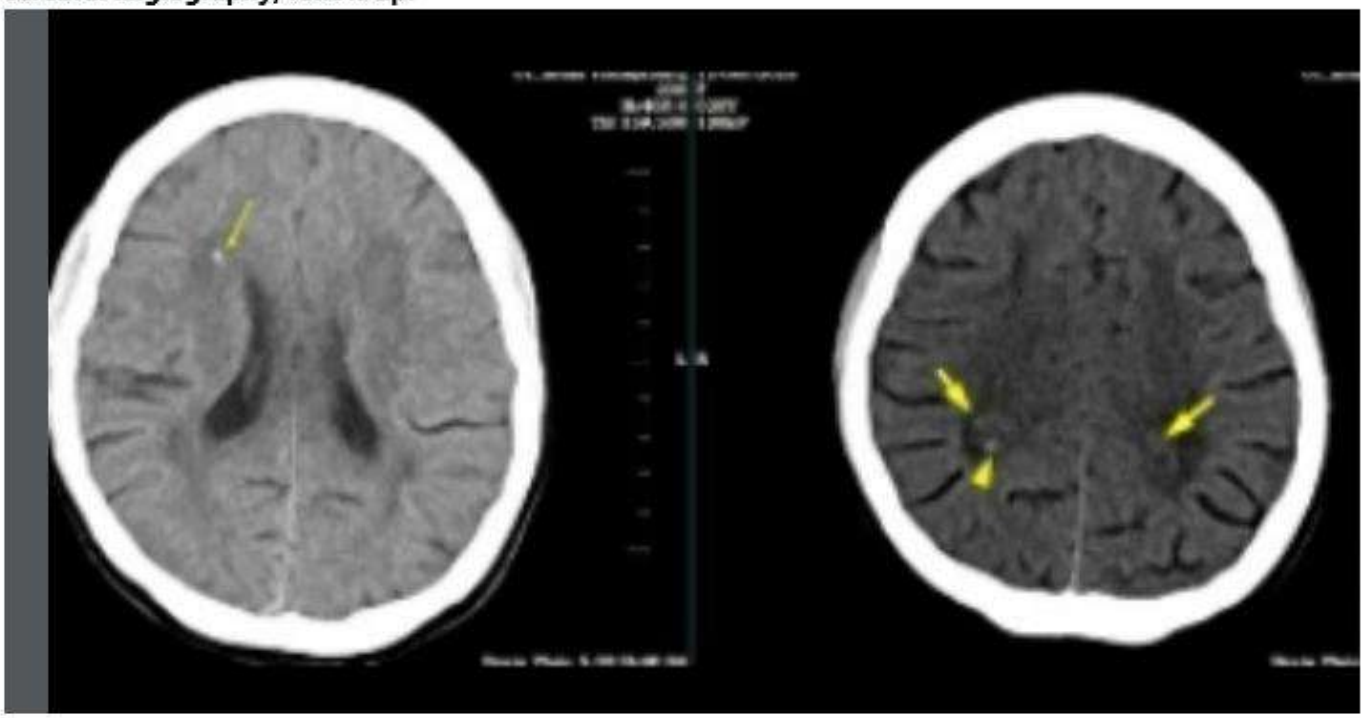
Recommend clinical correlation, follow up .



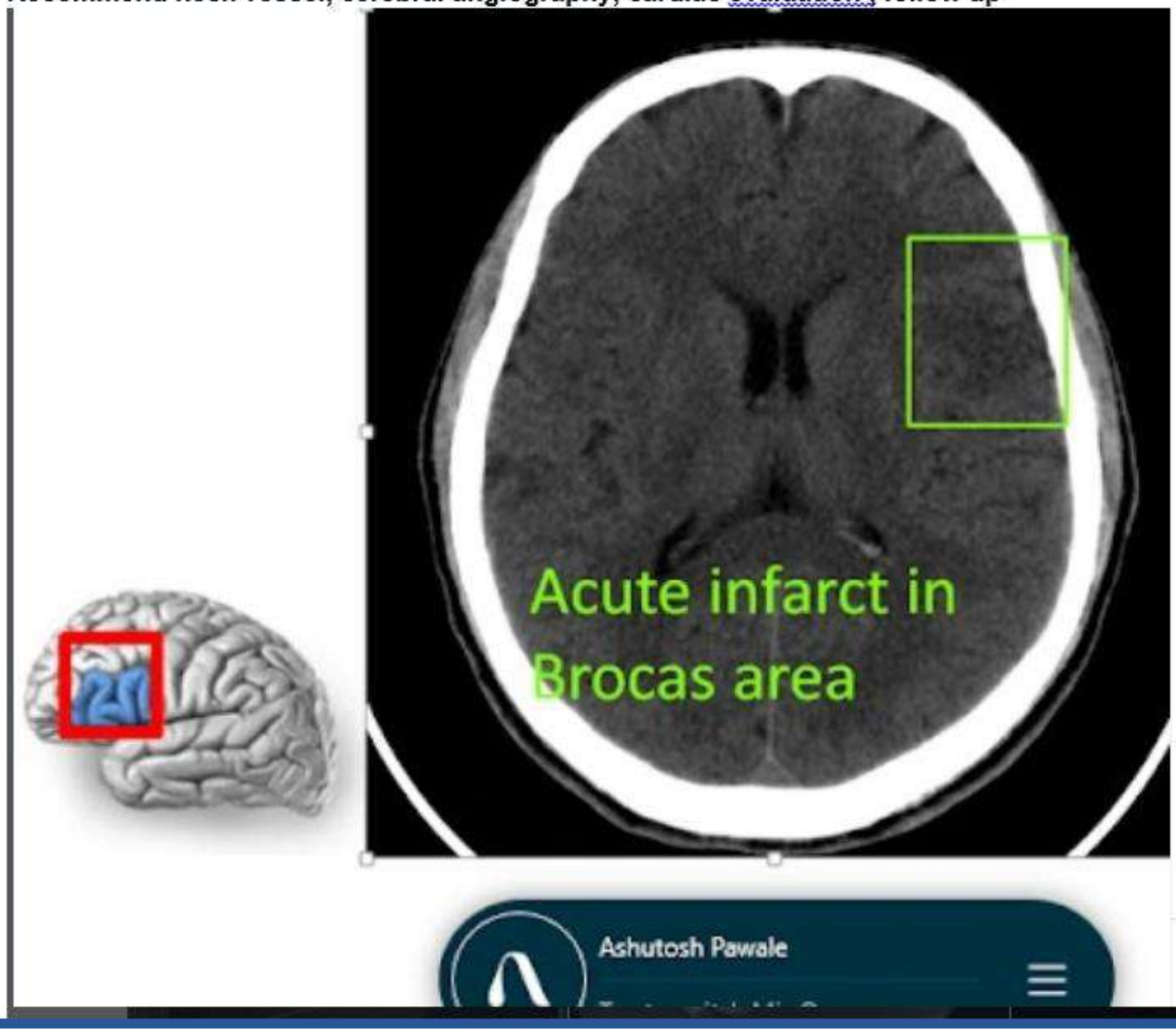
Patchy subcortical hypodensities in bilateral frontal, temporoparietal lobes associated with tiny hyperdensities (tiny haemorrhages) in right frontal and bilateral parietal peritrigonal white matter – likely suggestive of Reversible cerebral vasoconstriction syndrome (RCVS) versus other CNS vasculitis

No evidence of significant mass effect or mid line shift.

Recommend further evaluation with MRI brain , vasculitis work up , correlation with blood pressure level, MRI cerebral angiography, follow up.



A focal acute infarct involving the left middle frontal gyrus extending up to the suprainsular region , the inferior frontal gyrus apparently involving the *left Broca's area (ASPECTS score =8)*.
Recommend neck vessel, cerebral angiography, cardiac evaluation , follow up



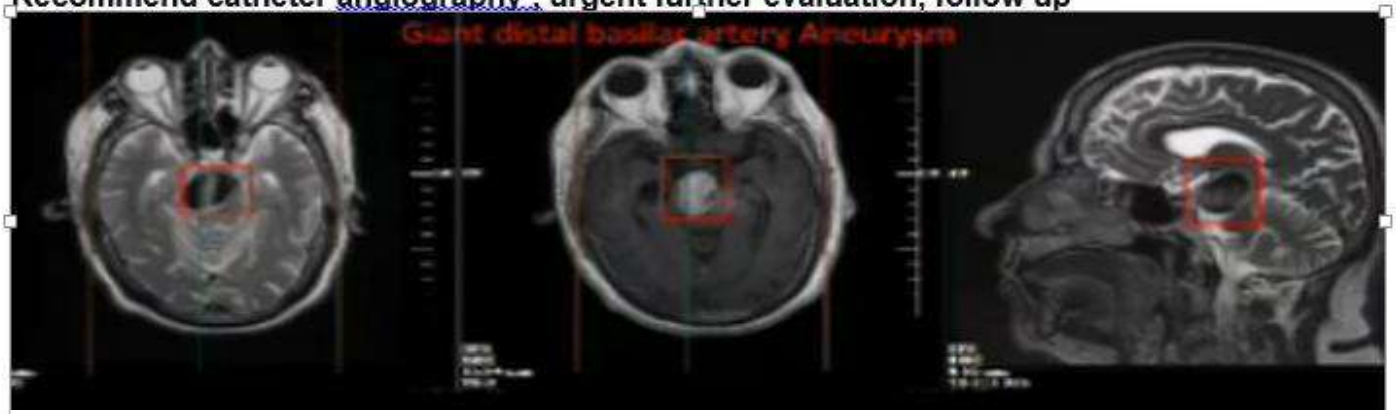
An approximately 2.8 x 3.3 x 2.7 cm ovoid intensely enhancing extra-axial mass lesion epicentered at the suprasellar, prepontine cistern fat slightly right paramedian aspect, impinging on the anterior margin of midbrain and pons, apparently communicating with distal basilar artery - *suggestive of a giant narrow neck distal basilar artery Aneurysm*.

The aneurysm is impinging on the anterior wall of midbrain, upper pons, slightly displacing the brainstem posteriorly and mammillary bodies superiorly

Bilateral posterior cerebral arteries are apparently arising from the neck of aneurysm.

***No evidence of identifiable intracranial hemorrhage on given images. No evidence of blooming on GRE sequence. No evidence of acute infarct or restricted diffusion on DWI*.**

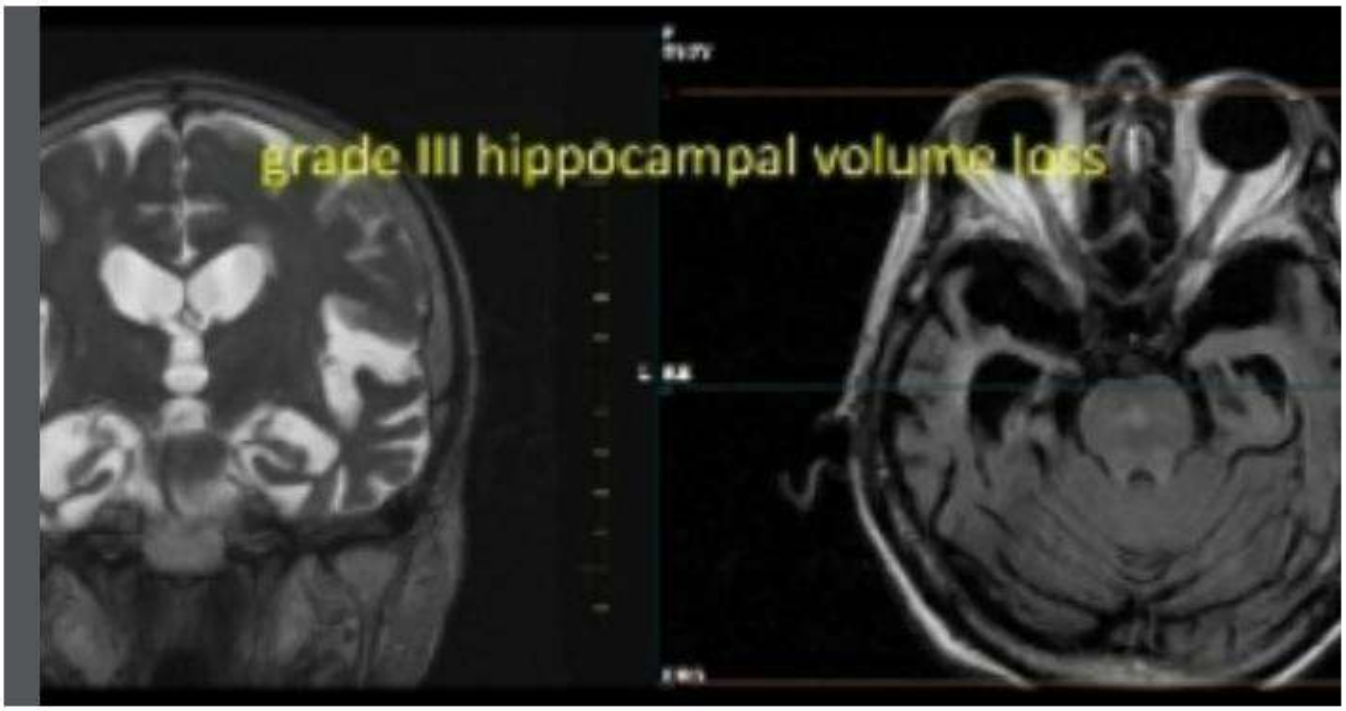
Recommend catheter angiography , urgent further evaluation, follow up



Marked temporal dominant cerebral atrophy with grade III hippocampal volume loss - of concern for Alzheimer's disease.

No evidence of acute infarct or restricted diffusion on DWI.

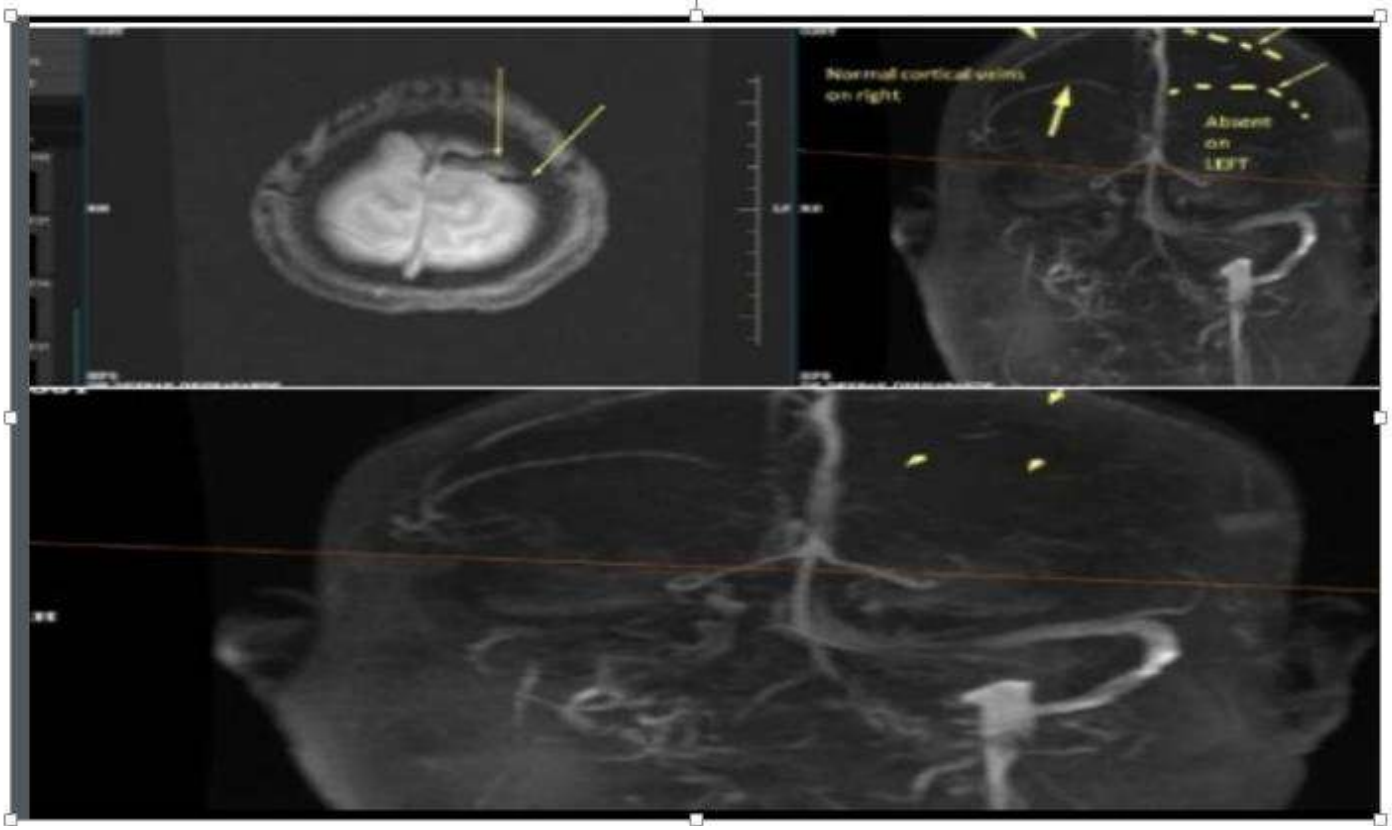
Recommend clinical correlation, further evaluation, follow up



FLAIR axial and GRE images demonstrates blooming on GRE along the course of two left superior frontal draining cortical veins with lack of flow signals on venography – suggestive o isolated left superior frontal cortical vein thrombosis

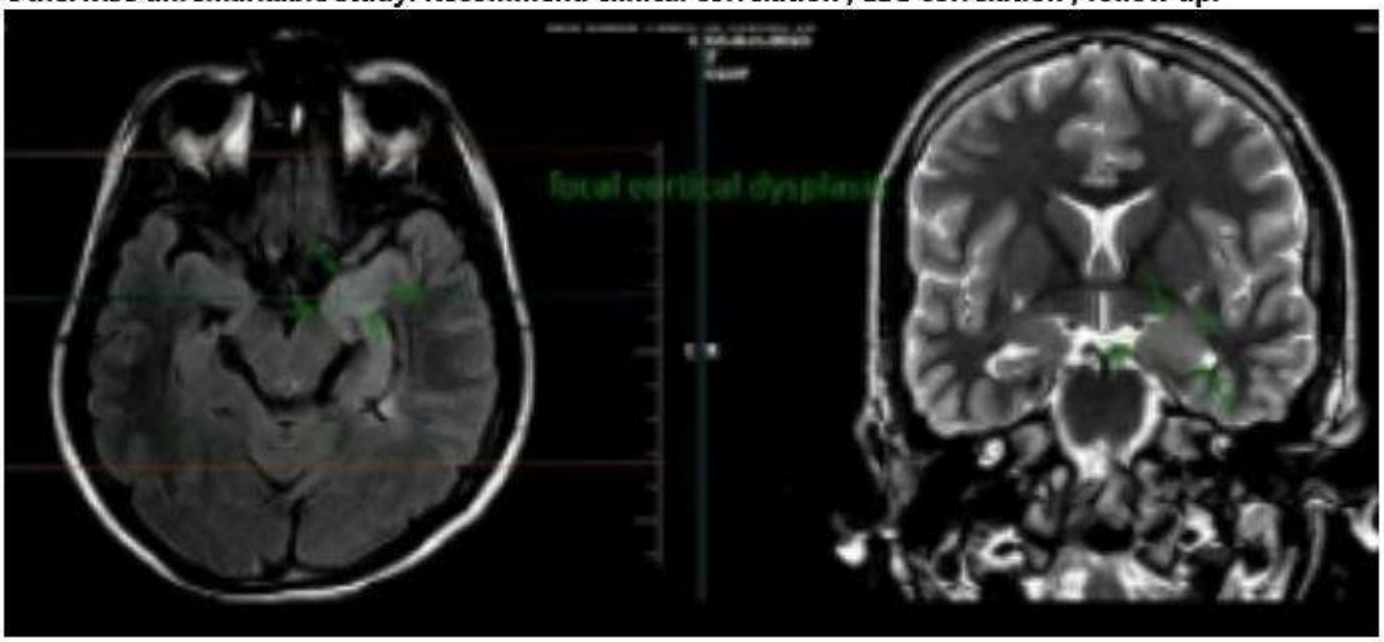
Narrow right sigmoid, transverse venous sinus, - likely suggestive of Hypoplasia.

Recommend further evaluation in view of prothrombotic state , follow up



Evidence of mild focal thickening of the left medial temporal cortex/ uncal cortex demonstrating near normal signal intensity – *likely suggestive of focal cortical dysplasia* No evidence of restricted diffusion on DWI.

Otherwise unremarkable study. Recommend clinical correlation , EEG correlation , follow up.

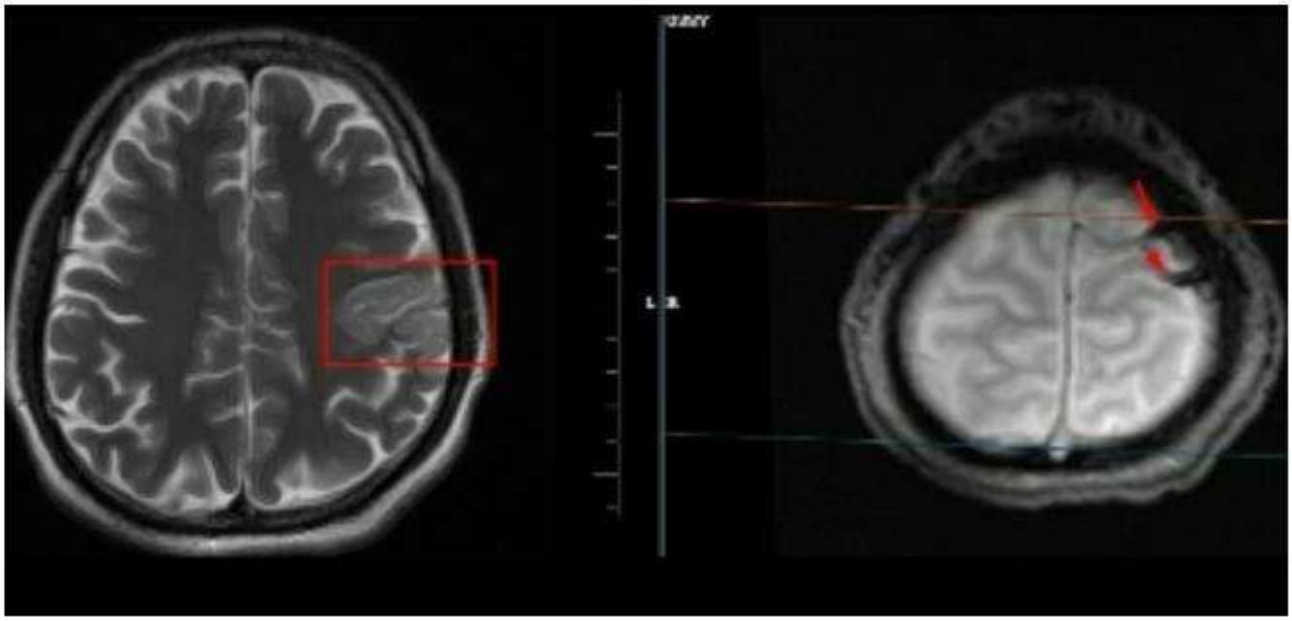


Patchy and gyriform T2/FLAIR altered signal intensities involving the left superior frontal cortex associated with marked blooming along the course of adjoining distended, left frontal draining cortical veins traversing toward the superior sagittal sinus with loss of intraluminal flow voids - represents 'isolated draining cortical vein thrombosis' with surrounding focal venous infarct in left superior frontal lobe.

The superior sagittal sinus appears unremarkable with normal flow voids on T2Wt sequence.

No evidence of significant mass effect or midline shift in this study.

Recommend further evaluation in view of prothrombotic state , venography , follow up

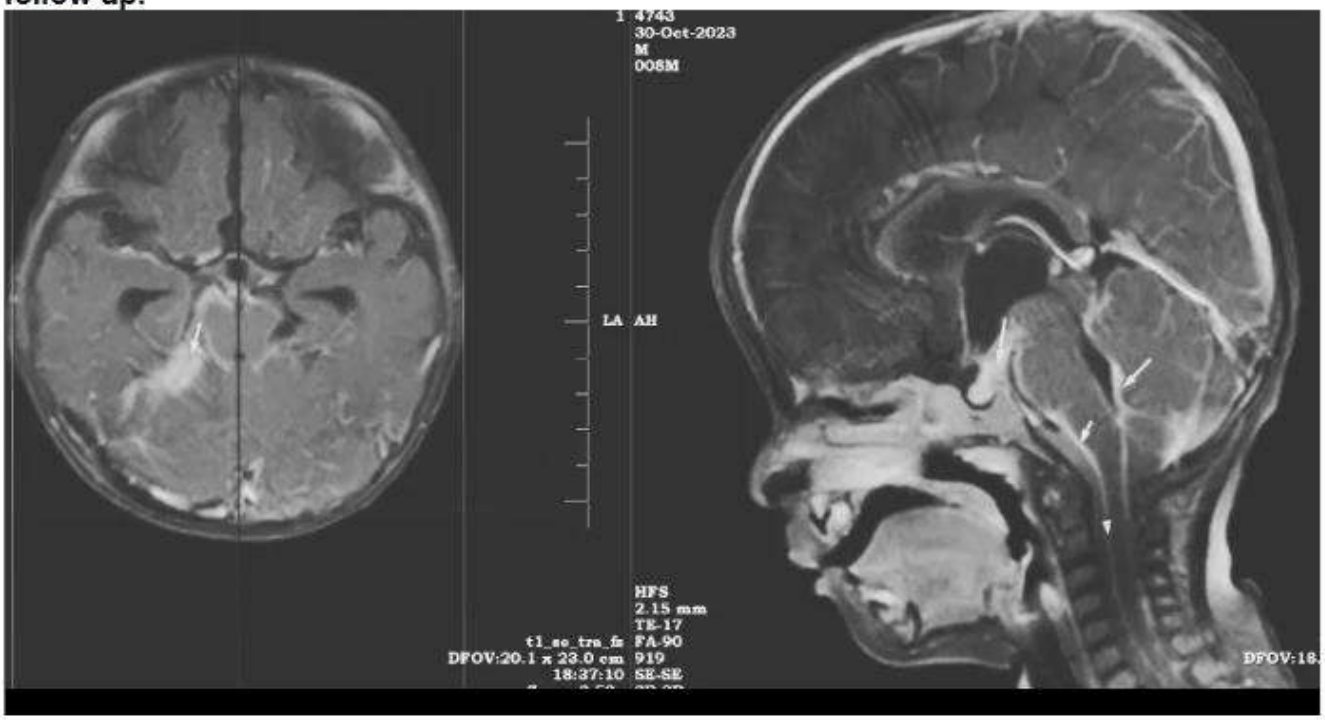


Diffuse pachy meningeal enhancement along the tentorium cerebelli, posterior fossan and the brainstem, proximal cervical cord associated with thick enhancing pituitary stalk.

Small patchy T2 / FLAIR hyperintensity involving right superior cerebellum – vermis with dense focal meningeal enhancement at the adjoining right tentorium cerebelli

Findings likely suggestive of dural metastasis versus meningitis or granulomatous disease versus IgG4 related disease.

Recommend CSF analysis, total spine screening, hematological correlation, further evaluation, follow up.

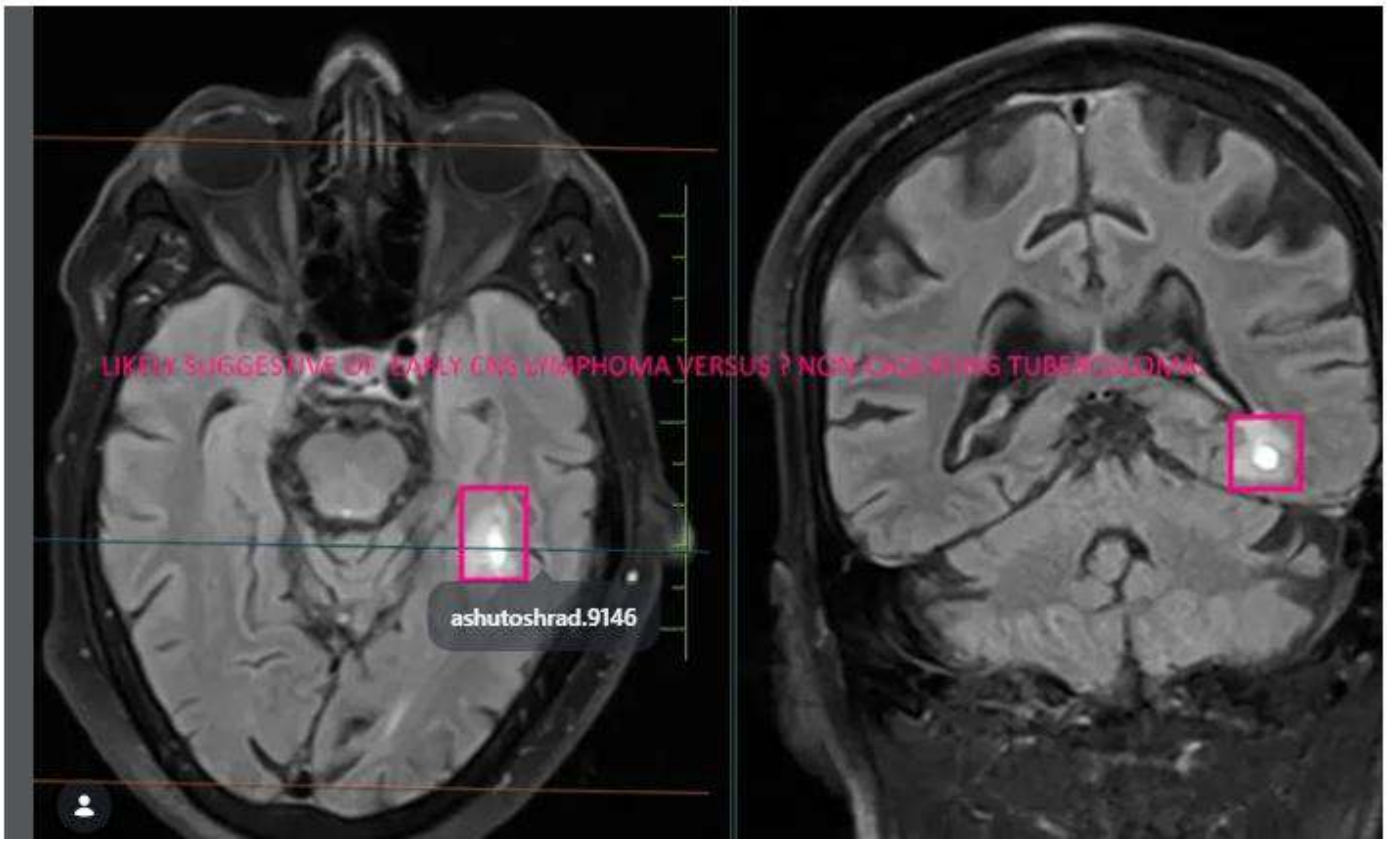


A small (1.3 x 1.6 x 1.2 cm) nodular enhancing T2 hyperintense lesion in left posteromedial periventricular temporal region demonstrating central restricted diffusion on DWI with minimal perilesional vasogenic edema – *likely suggestive of early CNS lymphoma versus ? non-caseating tuberculoma*.

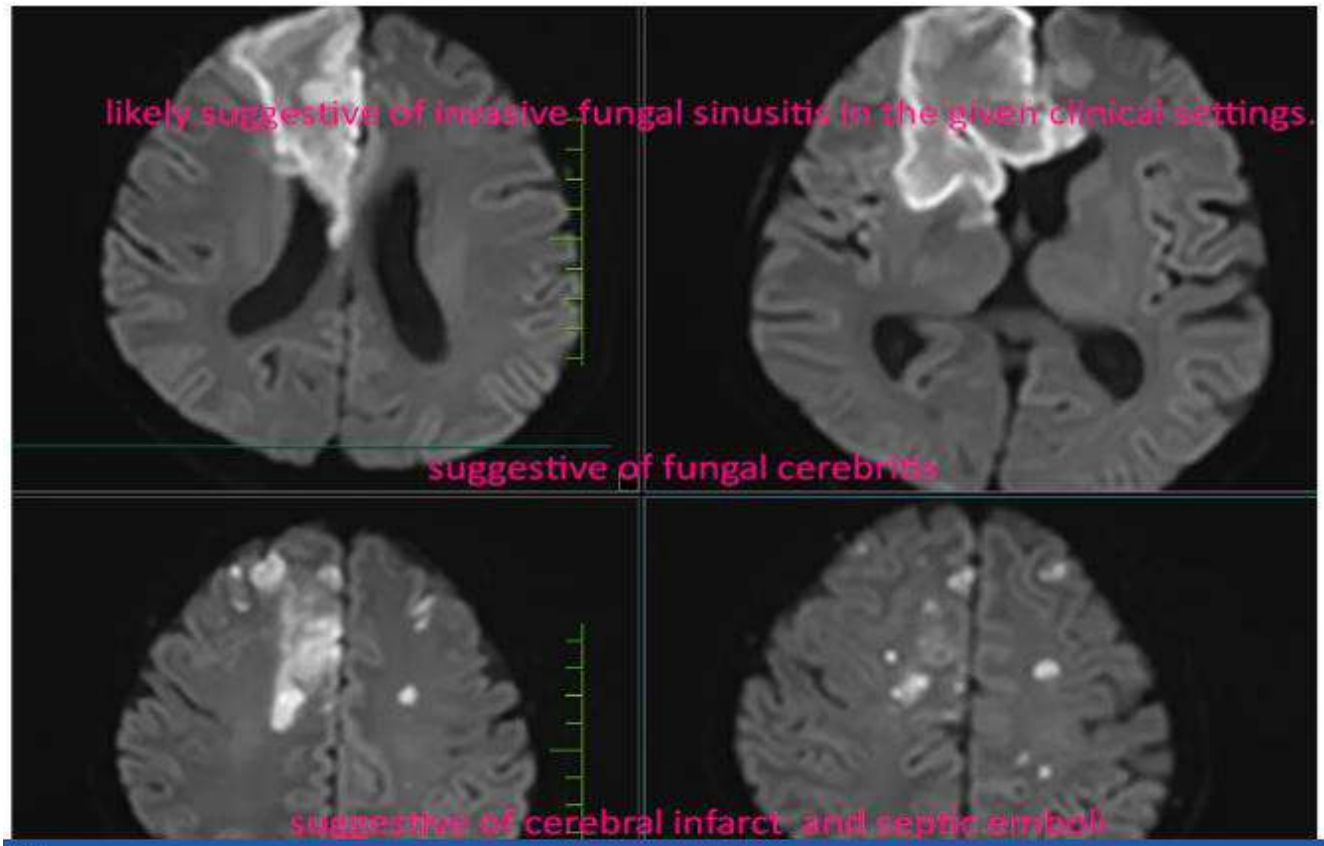
No evidence of significant mass effect or mid line shift.

Age related volume loss with periventricular white matter chronic small vessel ischemia.

Recommend clinical correlation, further evaluation, follow up.



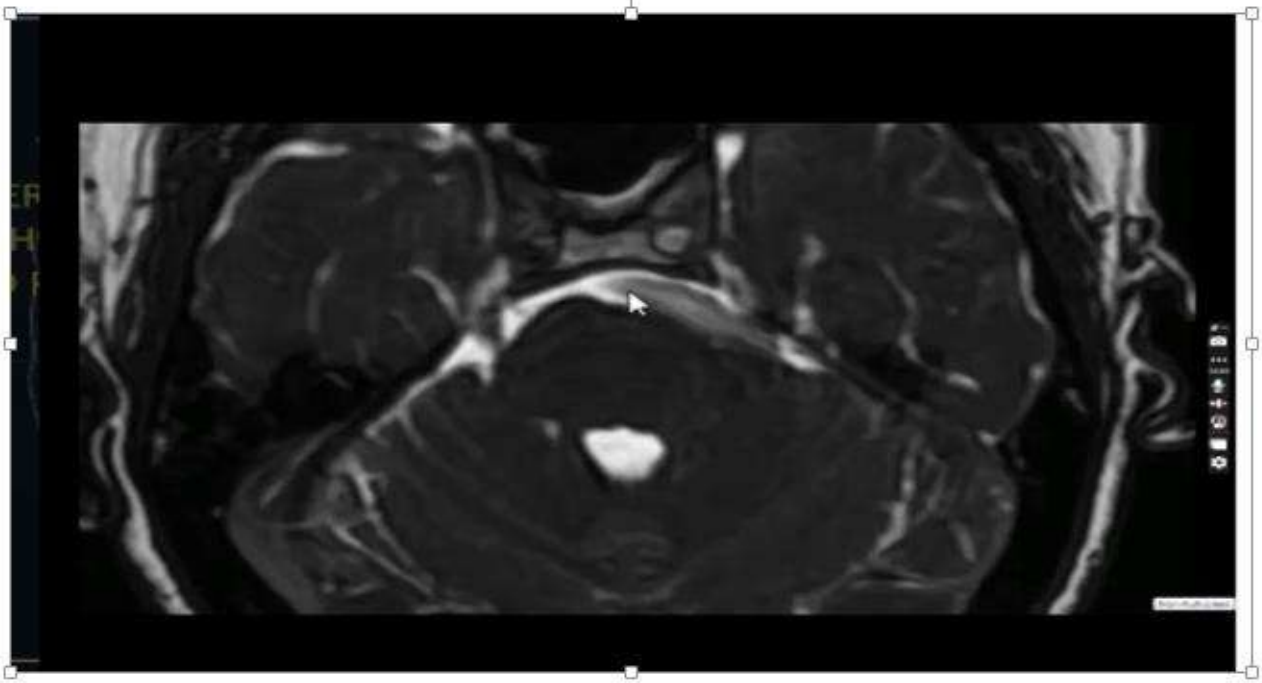
Extensive low T2 intensity irregularly marginated altered signal intensity lesion involving the right capsuloganglionic region, basifrontal lobe extending superiorly along the right anterior parafalcine cortex with invasion of genu, anterior body of corpus callosum to the right of midline further extending to the contra lateral (left) frontal lobe with restricted diffusion on DWI involving the entire lesion – suggestive of fungal cerebritis
Multiple tiny areas of restricted diffusion in bilateral anterior, superior frontal lobe, centrum semiovale suggestive of cerebral infarct and septic emboli
Complete lack of fluid along the course right anterior cerebral artery, likely related to angioinvasion and related thrombosis.
No evidence of midline shift
Features suggestive of SINONASAL-ORBITAL-CEREBRAL-MUCORMYCOSIS
Recommend tissue biopsy for KOH mount, blood sugar le\vels, follow up



ATES)

The basilar artery, right vertebral artery at L3-L4 appear static and markedly tortuous traversing along the left cerebello-pontine Cistern, displacing the left 7 - 8th as well as left fifth cranial nerves – suggestive of vertebrobasilar dolicoectasia

Otherwise unremarkable study. No evidence of acute infarct or restricted diffusion on DWI. Recommend clinical correlation, further evaluation, follow up.



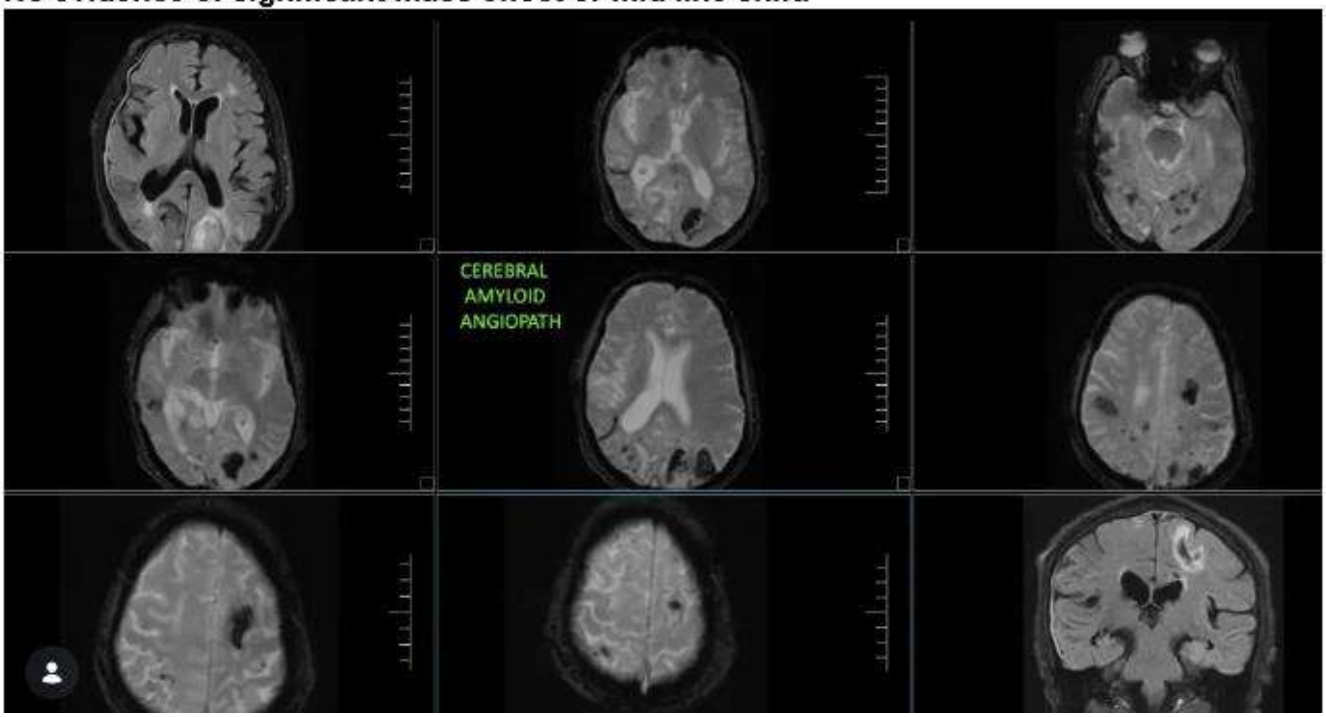
Multifocal intracerebral haemorrhages involving the left superior frontal, parietooccipital lobes at the subcortical white matter with mild focal perilesional vasogenic edema associated with numerous tiny hemosiderin deposits scattered in bilateral fronto-temporo-parietal, occipital lobes at gray white junction – represents cerebral amyloid angiopathy

A thin rim of subdural hemorrhage along right frontotemoporoparietal convexity measuring 0.4 cm in maximum thickness

A tiny acute embolic infarct in left occipital lobe

Lacunar infarcts in bilateral centrum semiovale , frontal subcortical white matter with age related volume loss with periventricular white matter chronic small vessel ischemia.

No evidence of significant mass effect or mid line shift.

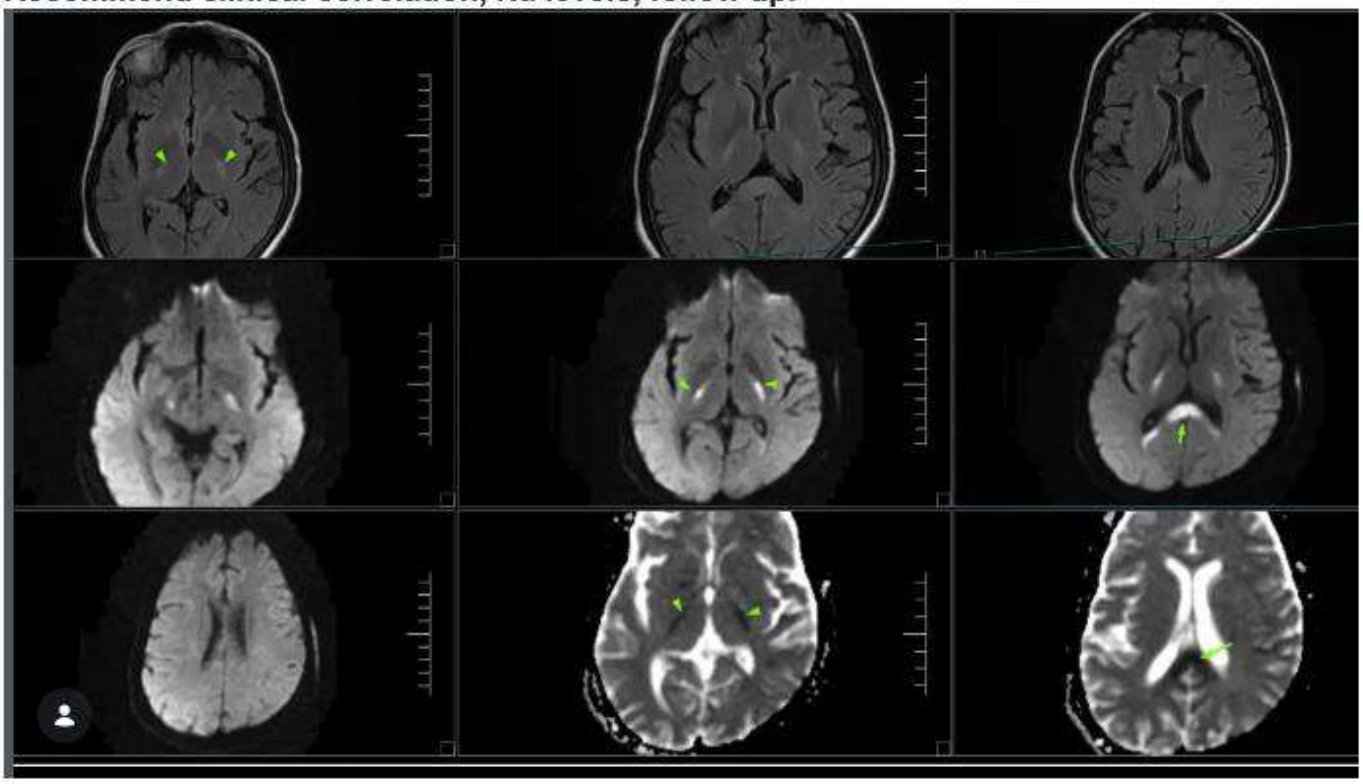


Clinical History provided: both upper and lower limb weakness and fever since 4 days (*sstatus post partum*)

Linearly oriented, almost symmetric T2/FLAIR hyperintensities involving posterior limbs of bilateral internal capsule, extending up to the anterolateral aspect of midbrain, along the course of bilateral cortical spinal tracts with restriction of diffusion on DWI associated with restricted diffusions in splenium – likely suggestive of *post-partum hypernatremic osmotic demyelination* in the given clinical settings.

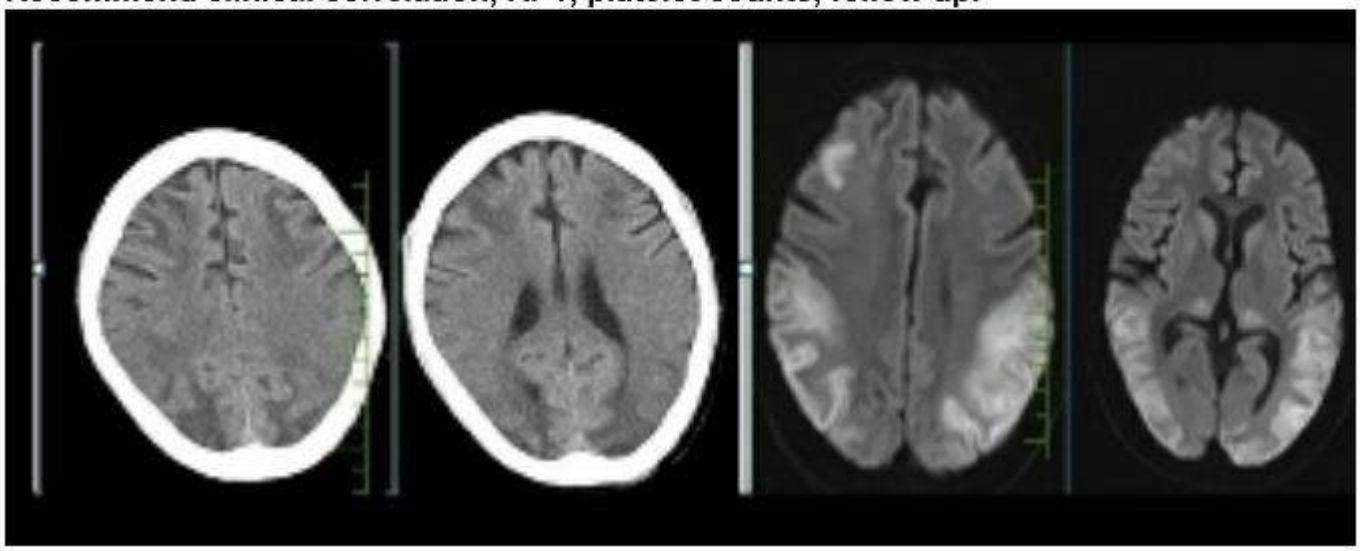
No evidence of significant mass effect or midline shift in this study. .

Other possibility of acute viral encephalitis versus post ictal changes can be considered. Recommend clinical correlation, Na levels, follow up.

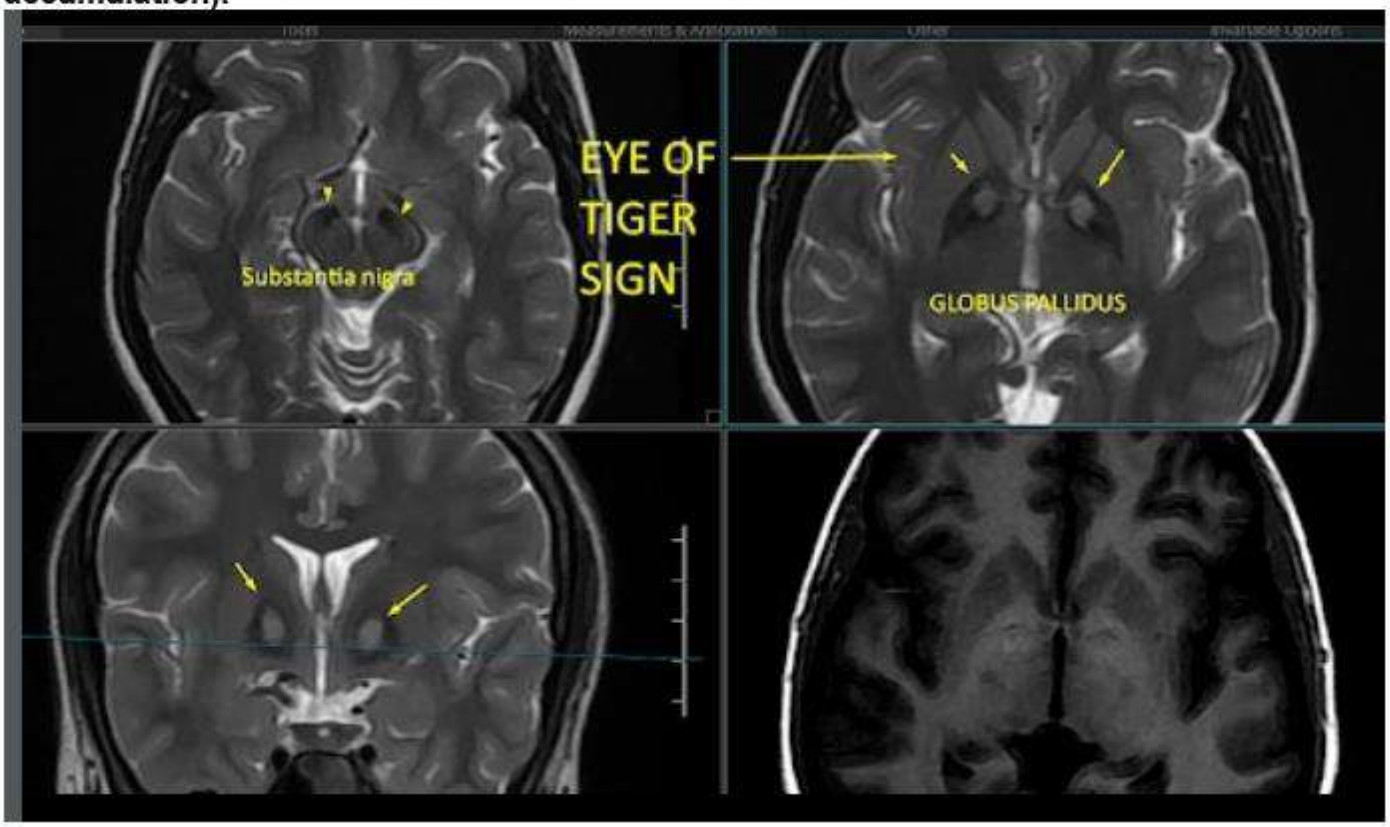


Multifocal patchy T2 / FLAIR hyperintensities with relative restricted diffusions involving bilateral anterior frontal, superior parietal, occipital, posterior temporal lobes and posterior thalamic margins (pulvinar) without significant mass effect – Likely possibilities would be hemolytic uremic syndrome (HUS) versus posterior reversible encephalopathy syndrome (PRES).

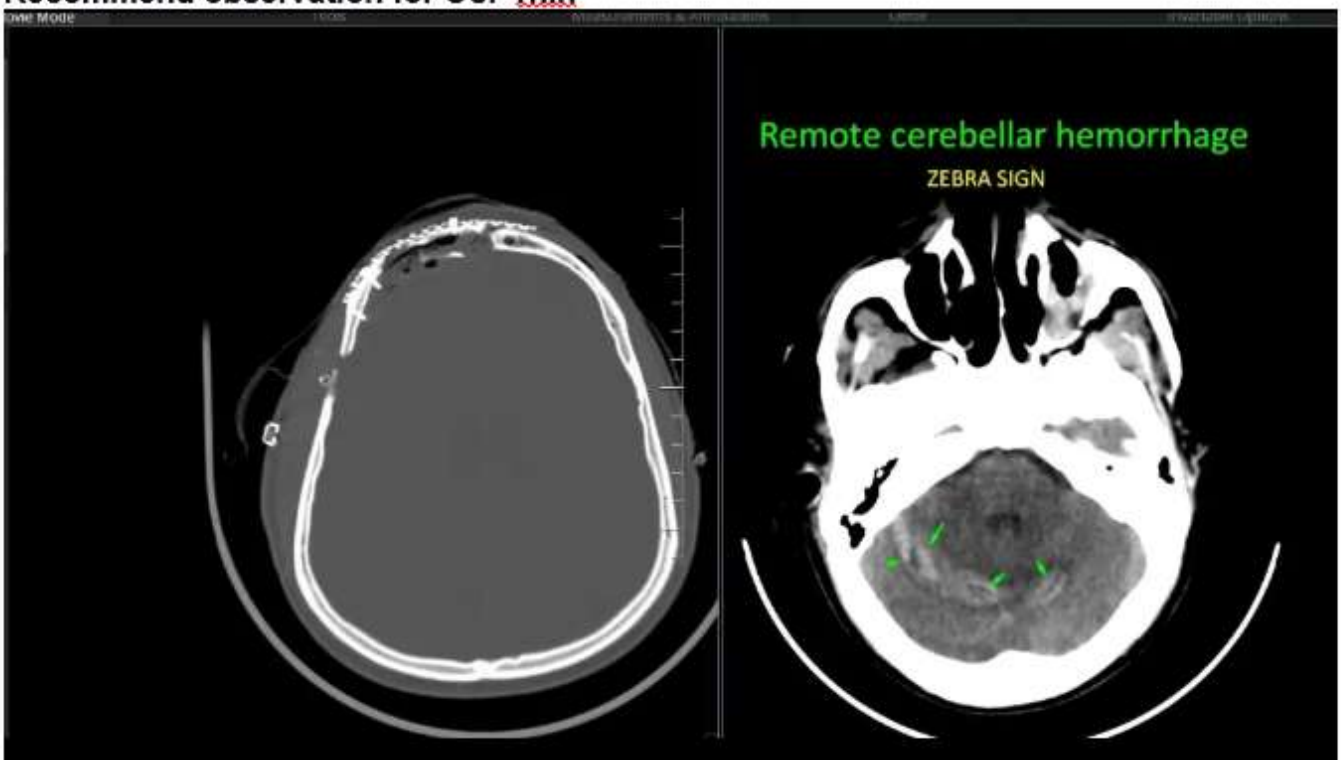
Recommend clinical correlation, RFT, platelet counts, follow up.



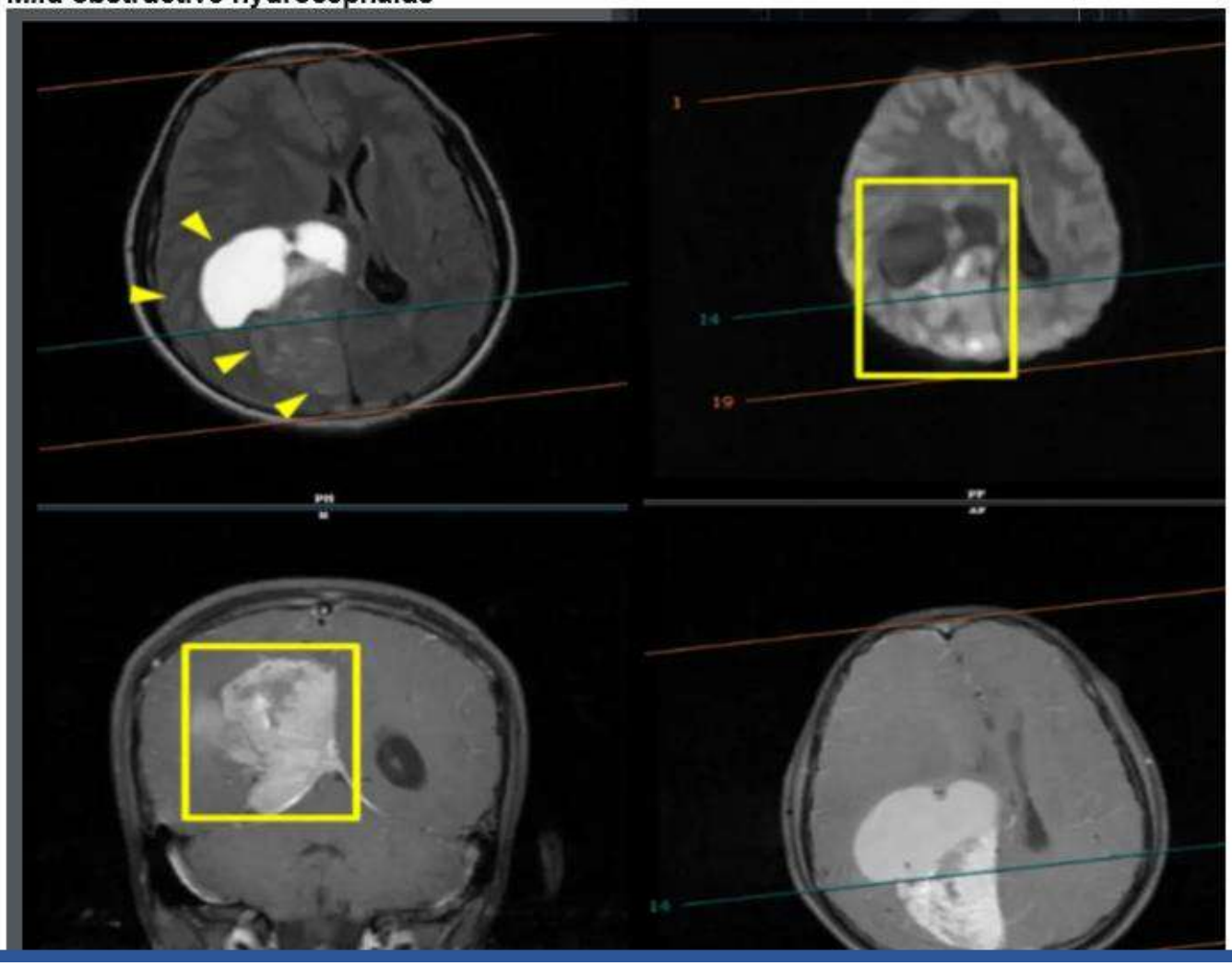
The T2W images demonstrates focal low signal intensities involving bilateral globus pallidus with central area of high T2 signals referring to eye of the Tiger sign associated with focal low T2 signal intensities involving the substantia nigra of midbrain – suggestive of Pantothenate kinase-associated neurodegeneration (PKAN , a neuro degenerative disorder with brain iron accumulation).



Compared with prior study dated 20-Mar-2023
There is status post right frontal mesh cranioplasty with post surgical changes
Thin residual acute extra dural hemorrhage is again noted in right anterior basi frontal region measuring 0.5 cm in maximum thickness with tiny pneumocephalus
Patchy right cerebellar haemorrhage is noted with zebra sign suggestive of remote cerebellar haemorrhage, new since prior study.
Otherwise both the cerebral parenchyma demonstrates normal attenuation values. Bilateral capsuloganglionic region, thalami appear unremarkable. The brainstem appear unremarkable.
No evidence of significant mass effect or mid line shift.
Comminuted displaced fractures are again noted involving right anterior frontal calvarium, bilateral basi frontal calvarium , right orbital roof, supraorbital ridge, lamina papyracea, cribriform plate, walls of bilateral maxillary sinuses, orbital floors, right zygomatic arch arch, bilateral nasal bones. Bilateral frontal frontal, ethmoid, sphenoid, left maxillary hemosinus is again noted
No evidence of significant mass effect or mid line shift.
Recommend observation for CSF rhin



An approximately 6 x 7.6 x 5.2 cm large complex cystic mass lesion in right occipital, posterior parietal lobe demonstrating an eccentric anterior cystic component which is hyperintense on T1, T2 sequences and vividly enhancing posterior solid component which is broad based along the Falx with perilesional vasogenic oedema - *represents neoplasm, likely a 'supratentorial ependymoma' versus pleomorphic xanthoastrocytoma (WHO grade I to 2*). .
Extrinsic compression of right lateral and third ventricle due to mass effect with 0.6 cm midline shift to the left.
Mild obstructive hydrocephalus

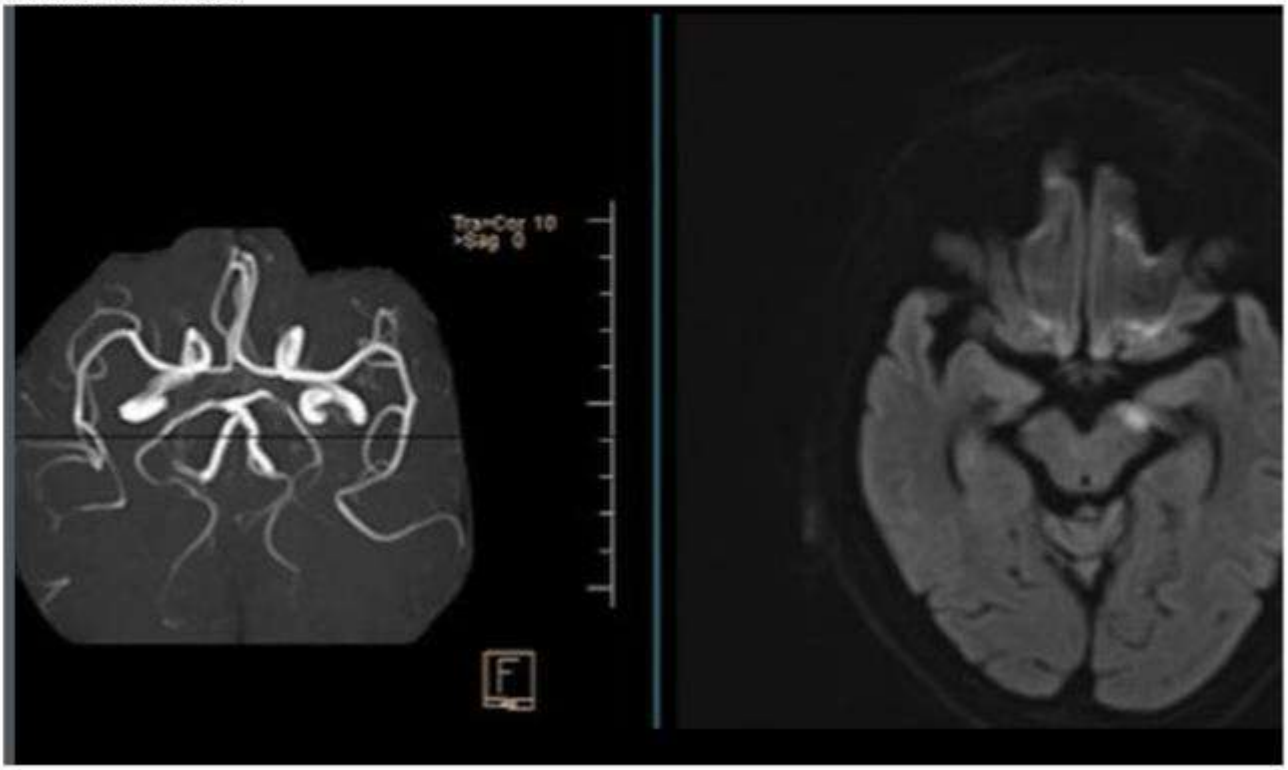


Infarct in left cerebral peduncle with focal stenosis of left PCA ambient segment (P2)

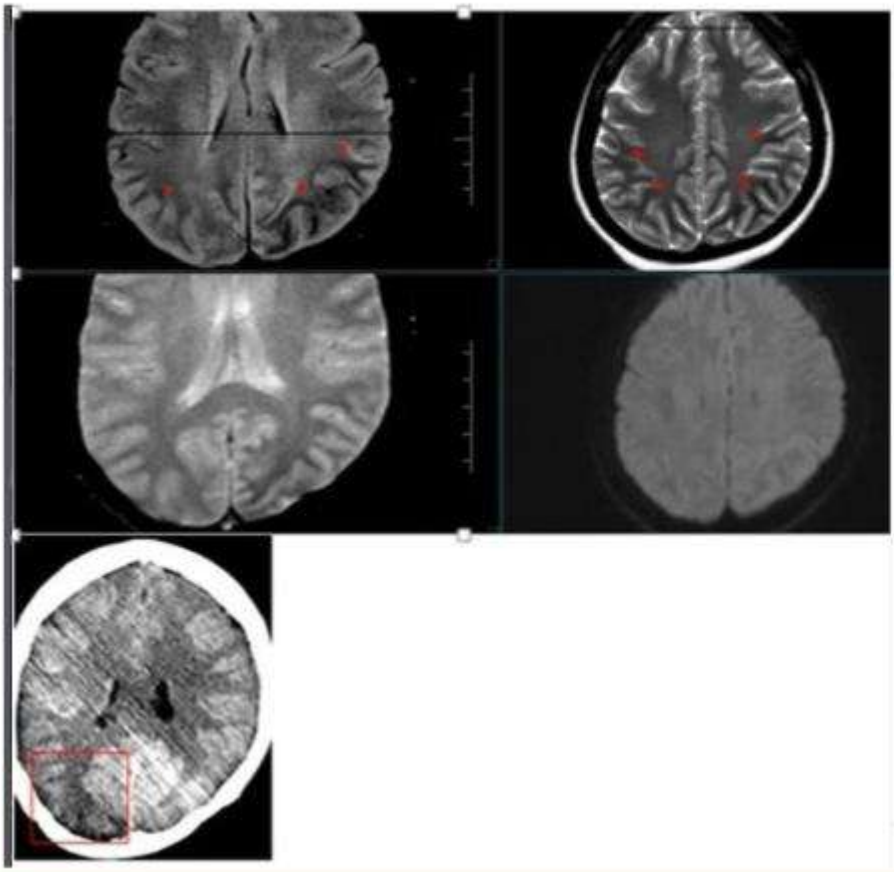
Small acute embolic infarct involving left cerebral peduncle (within perforating branch territory of left P1/ P2 segments of PCA)

No evidence of significant mass effect or mid line shift.

Age related volume loss with Fazekas grade I to II periventricular white matter chronic small vessel ischemia.

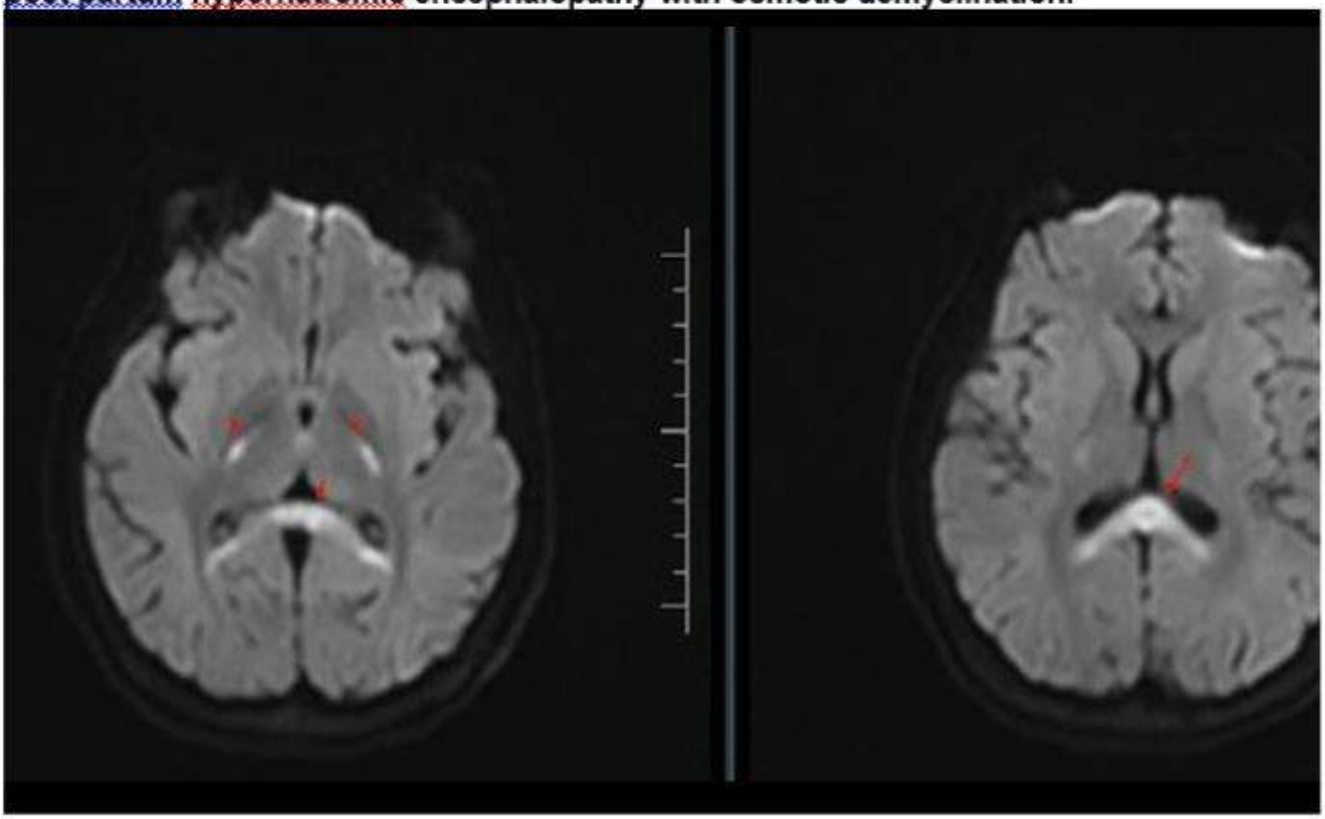


Acute hyperglycemic encephalopathy,
Diffuse cerebral edema with subtle gyriform T2 hypointensities involving bilateral occipital, posterior temporal lobes predominantly involving the cortex and subcortical region (not evident on any other sequence) – suggestive of acute hyperglycemic encephalopathy,
No evidence of acute infarct or restricted diffusion on DWI. No evidence of significant mass effect or mid line shift.



Post partum hypernatremic encephalopathy with osmotic demyelination.

Multifocal symmetric FLAIR hyperintensities with restricted diffusion on DWI involving the splenium of corpus callosum, posterior limbs of bilateral internal capsules–likely suggestive of post partum hypernatremic encephalopathy with osmotic demyelination.



A small well corticated midline calvarial defect at the superior occipital region containing a linearly oriented antero-posterior T2/T1
Atretic cephalocele
hypointense structure apparently communicating with posterior wall of torcula with slight posterior peaking of the tentorium – likely suggestive of atretic cephalocele.



Lissencephaly-pachygyria spectrum (type I)

Marked thickening and broadening of bilateral fronto-temporo-parietal, occipital gyri with gross simplification, poor formation of the sulci causing smooth outer surface with figure of 8 appearance – suggestive of lissencephaly-pachygyria spectrum (type I)

A layer of heterotopic subcortical Gray matter predominantly in superior fronto-parietal, occipital region suggesting band heterotopia.

