Sample Report

Patient Name: XXXXX XXXXXXX
MR Number: 553928
Referred By: XXXX XXXXXX, DPM
Date of Birth: XX/XX/1962
Exam Date: 1/16/14
Exam Type: Right Ankle joint

Location:
Office Fax:

Accession #: 173909

CLINICAL INFORMATION: 51-year-old female without any recent history of trauma with lateral ankle pain and midfoot pain for two months.

TECHNIQUE: A multi-planar and multi-sequence examination was performed of the right ankle and midfoot including sagittal STIR, T1 and axial PD, T2, and coronal T2 images.

FINDINGS:

Edema about the tarsometatarsal articulation include the mid to lateral cuboid suggesting a cuboid contusion or microtrabecular fracture. No fracture line, cortical disruption, or incongruity of the tarsometatarsal articulations. No tearing of the intermetatarsal ligaments. No divergence of Lisfranc's joint or tearing of Lisfranc's ligament. Subtle marrow edema extends along the cubital tunnel. No fracture of the metatarsals or MPJs. No tearing of the plantar aponeurosis or plantar intrinsic foot muscles at the level of the midfoot.

No divergence of Lisfranc's joint or tearing of Lisfranc's ligament.

A 10 mm eversion contusion or similar osteochondral injury is noted at the inferomedial head of the talus. No macrotrabecular fracture of the hindfoot or OCD lesion of the talar dome. The middle and posterior subtalar joints, anterosuperior calcaneal process, and bifurcate ligament are normal. Minimal dorsal talonavicular spurring.

There is moderate inflammation of Kager's fat pad.

Moderate Achilles tendon enlargement suggests mild Achilles tendinosis without tearing or advanced tendinopathy.

An 8 mm plantar calcaneal spur is identified. Moderate enlargement of the medial border of the central

cord of the plantar aponeurosis suggests chronic plantar fasciitis with interstitial mucoid degeneration or periaponeurotic edema with thickening to 9 mm. The lateral cord is less thickened and not detached.

No impinging tarsal tunnel mass.

Mild posterior tibial paratendinitis without tearing of the medial flexor tendons or an os tibiale externum at the medial pole navicular insertion of the PTT. No tearing of the extensor tendons. The dorsalis pedis and deep peroneal nerves are intact.

Low grade peroneus brevis tendinopathy is characterized by retromalleolar and inframalleolar fattening and fraying of the peroneus brevis tendon of slightly bilobed appearance without a displaced longitudinal split tear. The peroneus brevis tendon normalizes as it approaches its insertion at the base of the fifth metatarsal. No tearing of the peroneus longus tendon.

The medial and lateral plantar neurovascular bundles of the tarsal tunnel are normal.

Normal superficial and deep components of the deltoid ligament, tibiospring ligament, cervical and talocalcaneal interosseous subtalar ligaments, anterior and posterior tibiofibular syndesmotic ligaments, talofibular and calcaneofibular ligaments.

IMPRESSION (MRI OF THE RIGHT ANKLE AND MIDFOOT):

A 10 mm osteochondral injury or inversion contusion at the inferior medial head of the talus is associated with underlying marrow edema; however, no tear of the syndesmotic, talofibular, calcaneofibular, deltoid, or subtalar ligaments evident. The tibiotalar joint is normal without an OCD lesion of the talar dome. There is a small effusion. Mild edema extends toward the middle subtalar joint. The posterior subtalar joint is normal. Mild degenerative changes are noted along the dorsal talonavicular ligament.

Chronic plantar fasciitis is associated with enlargement of the central cord of the plantar aponeurosis and an 8 mm edematous plantar calcaneal spur with low grade interstitial tearing, but no rupture or fluid-filled gap. The lateral cord is neither thickened nor detached. No evidence of Baxter's neuritis.

Mild Achilles tendinosis and moderate-to-marked inflammation of Kager's fat pad without a tear.

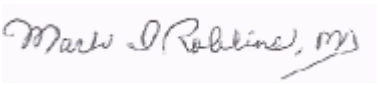
No tearing of the medial flexor or extensor tendons.

Low grade peroneus brevis tendinopathy at the level of the ankle includes retromalleolar flattening, inframalleolar surface fraying, and a slightly bilobed appearance of the tendon representing possible very low grade interstitial changes without a displaced longitudinal split tear. The peroneus brevis tendon normalizes as it extends toward its insertion. The peroneus longus tendon is normal. No subluxation or retinacular stripping.

Additional images of midfoot demonstrate contusion or stress-related edema within the cuboid including along the cubital tunnel and cubo-metatarsal articulations. There is also mild marrow edema within the cuneiforms greater laterally and about the tarsometatarsal articulations. A low grade midfoot sprain without tearing of the intermetatarsal ligaments or mild stress-related edema, each are possible. There is no specific manifestation of neuropathic arthropathy. No divergence of Lisfranc's joint or tearing of Lisfranc's ligament.

The extensor, flexor, and peroneal tendons at the right midfoot are intact.

Thank you for your referral and the opportunity to provide your interpretation. If you have any questions about this report, please call 888.ART.4MRI (278.4674).



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THIS REPORT WAS ELECTRONICALLY SIGNED
Mark I. Robbins, M.D.

MIR / pd

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