



STERLING

MEDICAL GROUP

PATIENT ID:	64563	DATE OF BIRTH:	12/01/1959
PATIENT:	HUMINSKI, SCOTT	AGE / SEX:	63 y.o. / M
DATE OF EXAM:	09/21/2023	ORDERED BY:	KATHRYNE GUNN DO

Study: MRI LUMBAR SPINE

HISTORY: Neck and back pain since injury 08/22/2023.

TECHNIQUE: A variety of pulse sequences were performed in the parasagittal and axial planes to emphasize T1- and T2-weighted imaging parameters. A coronal scout series was also performed.

FINDINGS: There is Grade I spondylolisthesis at L4-5. There is Grade I retrolisthesis at L5-S1. No compression fractures are seen.

There is patchy heterogeneous marrow signal throughout the vertebral bodies likely indicative of osteoporosis. If there is known history of malignancy or clinical suspicion of neoplasm, further workup with whole-body nuclear bone scan would be advised to exclude the low likelihood of diffuse neoplastic infiltration of the spine.

There is normal signal within the visualized spinal cord. There is no evidence of syrinx.

There is significant disk pathology within the visualized thoracic spine. Dedicated thoracic spine MRI is recommended for further evaluation.

The conus medullaris lies at the level of the L1-2 interspace. There is age-appropriate generalized spurring and osteophyte formation. There is disk desiccation at all levels. There is intervertebral disk space narrowing at L2-3, L3-4 and L4-5.

There is a mild to moderate right convex scoliotic curve.

There is no significant disk disease at L1-2. The thecal sac and neural foramina appear widely patent at this level. There is no evidence of spinal stenosis or exiting nerve root impingement.

There is moderate to severe disk bulging at L2-3. There is a radial tear within the posterior L2-3 disk. There is bilateral facet hypertrophy. There is severe impingement upon the left lateral recess. There is moderate impingement upon the right lateral recess. There is mild spinal stenosis.

There is moderate to severe disk bulging at L3-4. There is bilateral facet hypertrophy.

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There is severe impingement upon the left lateral recess. There is no significant spinal stenosis or right neural foraminal stenosis.

There is moderate to severe disk bulging at L4-5. There is a radial tear within the posterior L4-5 disk. There is ligamentum flavum hypertrophy and bilateral facet hypertrophy. There is moderate spinal stenosis. There is severe impingement upon the bilateral lateral recesses.

There is a midline posterior disk herniation at L5-S1 as seen on parasagittal image #9 and axial images #32 and #33. There is abnormal signal involving the herniated portion of the disk compatible with a radial tear. There is effacement of the ventral epidural fat. There is bilateral facet hypertrophy. There is mild bilateral neural foraminal stenosis. There is no significant spinal stenosis.

IMPRESSION:

Significant disk pathology within the visualized thoracic spine. Dedicated thoracic spine MRI is recommended for further evaluation.

Patchy heterogeneous marrow signal throughout the vertebral bodies likely indicative of osteoporosis. If there is known history of malignancy or clinical suspicion of neoplasm, further workup with whole-body nuclear bone scan would be advised to exclude the low likelihood of diffuse neoplastic infiltration of the spine.

Grade I spondylolisthesis at L4-5.

Grade I retrolisthesis at L5-S1.

Right convex scoliosis.

Disk bulge and associated radial tear at L2-3.

Disk bulging at L3-4.

Disk bulge and associated radial tear at L4-5.

Midline posterior disk herniation and associated radial tear at L5-S1.

Spinal stenosis at L2-3 and L4-5.

Neural encroachment as detailed above.

Thank you for referring this patient.

Digitally signed by: Dr. Ronald Landau, MD on September 21, 2023 02:50:02 PM

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Date Dictated: September 21, 2023

Date Transcribed: September 21, 2023 by Jennifer Lippincott

FINAL REPORT

VOLUSIA COUNTY

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PATIENT: HUMINSKI, SCOTT **AGE / SEX:** 63 y.o. / M
DATE OF EXAM: 09/21/2023 **ORDERED BY:** KATHRYNE GUNN
DO

Study: MRI CERVICAL SPINE

HISTORY: Neck and back pain since injury 08/22/2023.

TECHNIQUE: A variety of pulse sequences were performed in the parasagittal and axial planes to emphasize T1- and T2-weighted imaging parameters.

FINDINGS: There is no evidence of acute fracture or dislocation.

Normal signal is demonstrated within the vertebral bodies. There is no evidence of marrow replacement within the vertebral bodies.

Normal signal is demonstrated within the visualized brainstem and spinal cord. There is no evidence of syrinx or tonsillar ectopia.

There is reversal of the normal cervical lordosis suggestive of underlying muscular spasm.

There is congenital narrowing of the spinal canal on the basis of short pedicles.

There is age-appropriate generalized spurring and osteophyte formation. There is intervertebral disk space narrowing from C3-4 through C6-7.

There is mild disk bulging at C2-3. There is bilateral facet hypertrophy. There is severe right neural foraminal stenosis. There is moderate left neural foraminal stenosis. There is approximation of the dorsal spinal cord.

There is moderate disk bulging at C3-4. There is bilateral facet hypertrophy. There is severe bilateral neural foraminal stenosis. There is no evidence of cord compression.

There is moderate to severe disk bulging at C4-5. There is bilateral facet hypertrophy. There is approximation of the ventral and dorsal spinal cord. There is severe bilateral neural foraminal stenosis.

There is moderate to severe diffuse disk bulging at C5-6. There is bilateral facet hypertrophy. There is ventral and dorsal impingement upon the thecal sac. There is approximation of the ventral and dorsal spinal cord. There is severe bilateral neural foraminal stenosis.

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There is severe diffuse disk bulging at C6-7. There is a radial tear within the posterior C6-7 disk. There is elevation of the posterior longitudinal ligament and impingement upon the ventral thecal sac. There is bilateral facet hypertrophy. There is mild ventral and dorsal cord compression. There is severe left neural foraminal stenosis. There is mild right neural foraminal stenosis.

There is no significant disk pathology at C7-T1. There is no evidence of cord compression or exiting nerve root impingement at this level at this time.

There is a round cystic appearing lesion involving the right neural foramen at C7-T1. This lesion likely reflects a perineural cyst, however, repeat MRI with contrast may be considered to exclude the possibility of a nerve sheath tumor in this location.

There is a 12 mm ovoid cystic appearing lesion which lies anterior to the atlantoaxial joint on the right. This lesion is of uncertain etiology and significance. Repeat MRI with contrast would be of value. Follow-up is recommended to ensure long-term stability.

Doctor was unavailable at the time of dictation and STAT results were transmitted.

IMPRESSION:

Reversal of the normal cervical lordosis suggestive of underlying muscular spasm.

Congenital narrowing of the spinal canal on the basis of short pedicles.

Disk bulging at C2-3, C3-4, C4-5 and C6-7, most severe C6-7.

Radial tear within the posterior C6-7 disk.

Cord compression at C6-7.

Neural encroachment as detailed above.

Possible perineural cyst involving the right neural foramen at C7-T1. Repeat MRI with contrast may be considered to exclude the possibility of a nerve sheath tumor in this location.

12 mm ovoid cystic appearing lesion which lies anterior to the atlantoaxial joint on the right. This lesion is of uncertain etiology and significance. Repeat MRI with contrast would be of value. Follow-up is recommended to ensure long-term stability.

Thank you for referring this patient.

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