

MRI CASE STUDY RIGHT WRIST

This case study is based on an actual diagnostic interpretation generated by a NationalRad board certified musculoskeletal radiologist.

CLINICAL INFORMATION:

Evaluate right wrist pain and swelling. History of remote injury. Evaluate possible occult fracture.

COMPARISON:

None.

CONTRAST:

None.

TECHNIQUE:

Sagittal T1, sagittal STIR, coronal PD, coronal PD fat-sat, coronal 2D gradient echo, axial PD fat-sat.

IMPRESSION:

- 1. Large amount of fluid in the radiocarpal and distal radioulnar joint compartments. Low signal within the fluid column within the distal radioulnar joint could represent synovial thickening and / or debris.
- 2. No occuit fracture. No evidence of a scaphoid fracture. No evidence of a distal radius fracture.
- 3. Evidence of a complete tear of the scapholunate ligament involving the central volar and dorsal portions. There is widening of the interval. There is no DISI deformity. There are mild SLAC wrist changes.
- 4. There is a large central to radial degenerative type tear of the triangular fibrocartilage. It is associated with a positive ulna and likely a background of ulnocarpal abutment as described above. There is a tear involving the central and dorsal aspect of the lunate triquetral ligament corresponding to this.
- 5. Mild extensor carpi ulnaris tendinosis. There are flexor tenosynovial changes within the carpal tunnel.

