DAMADIAN MRI IN CANARSIE, P.C.

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MAGNETIC RESONANCE IMAGING OF THE LEFT KNEE

TECHNIQUE: Multiplanar, multisequential MRI was performed in the recumbent position.

HISTORY: The patient complains of left knee pain, s/p trauma.

INTERPRETATION: There is severe medial tibiofemoral joint space abnormality in which there is full thickness chondral surface loss with subcortical bone marrow edema associated with subcortical sclerosis involving the medial half of the weightbearing surfaces of the medial femoral condyle and medial tibial plateau extending more so posteriorly than anteriorly.

There is medial tibiofemoral spur formation extending anteromedially and posteromedially.

There is an obliquely oriented tear involving the body and posterior horn junction of the medial meniscus extending peripherally but also truncating its free margin at the body. The medial meniscal posterior horn is torn and separated from its posterior horn root attachment on the tibia with radial tearing of its remnant.

There is thickening and sprain diffusely involving the medial collateral ligament but most severely at and superior to the level of the joint line with prominent periligamentous edema. The medial collateral ligament is displaced away from the joint by the extruded remnant of the torn medial meniscal body and the medial tibiofemoral spurs that strip the ligament from its proximal tibial attachment site.

The anterior cruciate ligament demonstrates evidence of mucinous and cystic degeneration and high-grade interstitial partial thickness tearing. There is peri-cruciate edema. There is cortical erosion associated with the intercondylar notch primarily superiorly and laterally and there is also cortical fissuring between the tibial spines with small subcortical cystic change.

There is a focal extra-capsular synovial cyst/ganglion cyst measuring 7 mm in size related to a focal defect at the posterior capsule approximately 1 cm superior to the joint line and located slightly medial to midline.

There is lateral tibiofemoral spur formation, less prominent than medially.

There is diffuse intracapsular popliteus tendinosis/tendinopathy and there is also fibular collateral ligament sprain, which is also prominent and diffuse, with iliotibial band insertional sprain at the tibia. There is surrounding edema related to the lateral joint capsule with fluid distention of the lateral capsular margin.

There is a component of lateral subluxation of the tibia with respect to the femur.

There is patellofemoral chondral surface erosion and cortical erosion greater at the lateral patellar facet and both trochlear articular surfaces. There is a large patellofemoral effusion distending the suprapatellar bursa.

There is distal quadriceps and proximal greater than distal patellar tendinosis/tendinopathy with edema in the prepatellar subcutaneous tissues with patellofemoral spur formation.

Osseous signal and morphology are otherwise unremarkable. The lateral meniscus, lateral collateral ligament and posterior cruciate ligament are otherwise unremarkable.

IMPRESSION:

- Severe medial tibiofemoral joint space abnormality in which there is full thickness chondral surface loss with subcortical bone marrow edema associated with subcortical sclerosis involving the medial half of the weightbearing surfaces of the medial femoral condyle and medial tibial plateau extending more so posteriorly than anteriorly.

- Medial tibiofemoral spur formation extending anteromedially and posteromedially.

- Obliquely oriented tear involving body and posterior horn junction of medial meniscus extending peripherally but also truncating its free margin at the body. The medial meniscal posterior horn is torn and separated from its posterior horn root attachment on the tibia with radial tearing of its remnant.

- Thickening and sprain diffusely involving the medial collateral ligament but most severely at and superior to the level of the joint line with prominent periligamentous edema and the medial collateral ligament is displaced away from the joint by the extruded remnant of the torn medial meniscal body and the medial tibiofemoral spurs that strip the ligament from its proximal tibial attachment site.

- Anterior cruciate ligament demonstrates evidence of mucinous and cystic degeneration and high-grade interstitial partial thickness tearing with peri-cruciate edema.

- Cortical erosion associated with the intercondylar notch primarily superiorly and laterally and there is also cortical fissuring between the tibial spines with small subcortical cystic change.

- Focal extra-capsular synovial cyst/ganglion cyst measuring 7 mm in size related to a focal defect at the posterior capsule approximately 1 cm superior to the joint line and located slightly medial to midline.
- Lateral tibiofemoral spur formation, less prominent than medially.
- Diffuse intracapsular popliteus tendinosis/tendinopathy.
- Fibular collateral ligament sprain, which is also prominent and diffuse, with iliotibial band insertional sprain at the tibia with surrounding edema related to the lateral joint capsule with fluid distention of the lateral capsular margin.
- Component of lateral subluxation of the tibia with respect to the femur.
- Patellofemoral chondral surface erosion and cortical erosion greater at the lateral patellar facet and both trochlear articular surfaces.
- Large patellofemoral effusion distending the suprapatellar bursa.
- Distal quadriceps and proximal greater than distal patellar tendinosis/tendinopathy with edema in the prepatellar subcutaneous tissues with patellofemoral spur formation.

Thank you for referring your patient to us for evaluation.

Sincerely,

Steven Winter, M.D.
Diplomate of the American Board of Radiology
Fellowship Trained in Musculoskeletal Radiology
SW/vm