



Patient Name	: Mr.MOHAMMAD SAFIOULLAH IBNE FAESAL PEEROO	UHID	: C0185647
DOB/Age/Sex	: 21-Jul-2001/22 YRS 7 MONTHS/Male	App. On	: 02-Mar-2024
Doctor	: Dr. KARUNAGARAN Sammandam	Visit Type	: First Visit
Mobile No.	: 59725664	Doc.Speciality	: ORTHOPAEDICS
Panel	: CASH		

Chief Complaint : 3 years post right sternoclavicular joint injury persistent pain when he does efforts

Examination Findings : right sternoclavicular joint- subluxation and anterior instability +

Provisional Diagnosis : right sternoclavicular joint anterior instability

Doctor Advice : plan:

he need to decide if the present symptoms are severe enough to need a surgical joint stabilization or fusion if the symptoms persists

he can also see a neurologist if there is any other reason why he should feel that his right upper limb is weak
avoid heavy efforts with right upper limb



Dr Sammandam Karunakaran
MBBS, MS. ORTHOPEDICS
SENIOR CONSULTANT
ORTHOPEDICS AND SPINE
SURGERY

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24/7 Emergency & Ambulance Services Dial 121

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IMAGING SERVICES

Barcode No.	: A016697		Age / Sex	: 22.6 YRS / Male
Patient Name	: Mr. MOHAMMAD SAFIOULLAH IBNE FAISAL PEEROO		Registration Date	: 31-Jan-2024 12:36 PM
IPD No.	:		Acceptance Date	: 31-Jan-2024 01:07 PM
UHID	: 20011748		Reporting Date	: 02-Feb-2024 03:40 PM
Referring Doctor	: Dr. KHOOSHUND RAMLUGON		Approved Date	: 02-Feb-2024 03:40 PM

MRI**MRI NECK**

MRI SCAN

CERVICAL SPINE

Follow up Neck region to previous report 20 04.2021

ROUTINE SEQUENCES PERFORMED IN T1WI AND T2WI in axial and sagittal planes, STIR

alignment is maintained ,

straightening of normal curvature of spine

Vertebral bodies reduced height of C3,4,5,6 ,

Partial disc desiccation

Posterior elements : normal

Disc spaces are maintained

Anterior CSF column is narrowed at C3 to C5 level

No obvious disc bulge , no foraminal stenosis and no canal stenosis

Para spinal soft tissue normal

Normal cord signal

Impression

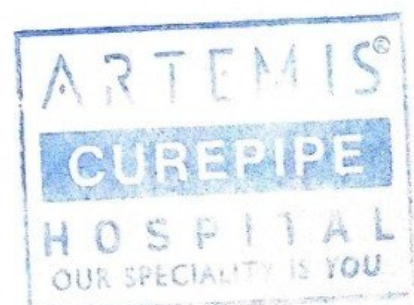
Straightening of cervical spine

RADIOLOGIST**OUR SPECIALIZED RADIOLOGY SERVICES:**

Bone Densitometry | CT scan | Digital Mammography | Digital Xray | Echography | MRI

Printed Date: 03-Feb-2024

Printed By: Miss. Shiyama Ramgoolam



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MRI

No obvious radiculopathy

No obvious abnormality in soft tissue of neck

No nodes , no collection and no mass seen

Bilateral medial end of clavicle show bone odema

No fluid at Sterno clavicular and costo sternal region bilaterally

Manubrium sterni is normal

Regards

Regards,

Dr A. S. Naojee

Senior Consultant Radiologist

This report is digitally approved. No signature required


Date: 02-Feb-2024 15:39:49

*** End Of Report ***





Patient Name : Mr.MOHAMMAD SAFIOULLAH IBNE FAESAL PEEROO	UHID : C0185647
DOB/Age/Sex : 21-Jul-2001/19 YRS 9 MONTHS/Male	App. On : 22-Apr-2021
Doctor : Dr. KARUNAGARAN Sammandam	Visit Type : Followup Visit
Mobile No. : 59725664	Doc.Speciality ORTHOPAEDICS :
Panel : CASH	

	<p>Chief Complaint : right medial clavicle end injury with some pain on and off cannot do heavy activities with right upper limb</p> <p>Examination Findings : mild depression + at the medial sternoclavicular joint on right side sensory and motor- normal</p> <p>Provisional Diagnosis : right sternoclavicular joint mild subluxation</p> <p>Doctor Advice : 1. not to do boxing/heavy weight lifting 2. activities as tolerated 3. physiotherapy- please teach him neck and shoulder exercises 4. tab jointace omega 3 once daily for 3 months 5. review sos 6. can consult ENT specialist also to rule out any ENT issue</p> <div style="text-align: right;"> Dr Sammandam Karunakaran MBBS, MS. ORTHOPEDICS SENIOR CONSULTANT ORTHOPEDICS AND SPINE SURGERY</div>
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Barcode No. : W0109302
Patient Name : Mr. MOHAMMAD SAFIOULLAH IBNE FAESAL PEEROO
IPD No. :
UHID : C0185647

Age / Sex : 19.9 YRS / Male
Registration Date : 20-Apr-2021 09:06 AM
Reporting Date : 20-Apr-2021 03:17 PM
Approved Date : 21-Apr-2021 10:58 AM

DEPARTMENT OF MRI

MRI NECK

MRI NECK WITH UPPER THORAX

PROCEDURE

Multiplanar MR imaging of the neck and upper thorax was carried out using a neck spine coil on a 1.5 Tesla system. T1WI, T2WI and STIR images were obtained in appropriate planes.

FINDINGS

Bilateral parotid, submandibular, sublingual, buccal, masticator, parapharyngeal, carotid, anterior and posterior cervical spaces are unremarkable.

The trachea is unremarkable.

Laryngeal cartilages are unremarkable.

The glottic and subglottic spaces are unremarkable.

Bilateral thyroid lobes including isthmus are unremarkable.

Bilateral parotid and submandibular glands show normal morphology and MR signal pattern.

Bilateral sternocleidomastoid (SCM) and other muscles are unremarkable. No focal area of altered signal intensity seen within these muscles.

Rest of soft tissue of cervical region are unremarkable.

Marrow signal of mandible appears unremarkable.

Most flow voids are unremarkable.

No evidence of significant soft tissue collection /enlarged lymphadenopathy seen.


Cranio-vertebral junction is unremarkable.

Cervical vertebrae are unremarkable with normal signal on both T1W and T2W images.

Spinal cord is unremarkable in calibre and signal intensity.

This is an electronic generated report and does not require signature.

NOTE : All diagnostic tests have their inherent limitations. This report must be interpreted by a qualified physician only and in correlation with clinical, biochemical, and other relevant reports to the case findings

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DEPARTMENT OF MRI

Linear hyperintensity on T2 and STIR is seen in right sterno-clavicular joint and anterior sterno-clavicular ligament.

Also, Fraying of few right costoclavicular ligament is seen.

Left sterno-clavicular, left costo-clavicular and Interclavicular ligaments appear normal.

IMPRESSION: Grade II sprain of right right anterior sternoclavicular and costoclavicular ligaments.

Dr. Indraneel Bandopadhyaya MD DNB
Senior Consultant Diagnostic and Interventional Radiologist

2/3

*** End Of Report ***



Dr Andja Jasovic
Senior Consultant
Radiologist

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Age / Sex : 19.9 YRS / Male
Registration Date : 20-Apr-2021 09:06 AM
Reporting Date : 20-Apr-2021 04:01 PM
Approved Date : 21-Apr-2021 10:57 AM

DEPARTMENT OF CT SCAN

CT NECK PLAIN AND CONTRAST

CECT NECK

PROCEDURE

Thin axial sections were taken for the neck with & without administration of intravenous contrast. 0.6 mm reconstructions were also made.

FINDINGS

Oro/naso/hypopharynx & parapharyngeal spaces are unremarkable.

Bilateral parotid, submandibular, sublingual, buccal, masticator, parapharyngeal, carotid, anterior and posterior cervical spaces are unremarkable.

Glottis, supra/infra glottis, paralaryngeal fat planes, anterior/posterior commissure and laryngeal cartilages are unremarkable.

Both lobes of thyroid including isthmus is unremarkable in architecture, attenuation and enhancement.

Bilateral parotid & submandibular glands are unremarkable.

Neurovascular bundle is unremarkable.

The sterno-cleidomastoids and digastric muscles on either side are normal.

No significant cervical lymphadenopathy seen.

No significant peri-vertebral or other soft tissue collection seen.

Vertebral body & their appendages are unremarkable.

Bilateral sterno-clavicular and costo-clavicular joints appear unremarkable on CECT.

No fracture, periosteal avulsion or subluxation/dislocation in neutral position..

IMPRESSION: No significant abnormality detected.

Dr. Indraneel Bandopadhyaya MD DNB

Senior Consultant Diagnostic and Interventional Radiologist

*** End Of Report ***



Dr Andja Jasovic

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