



Patient Name:
Referring Physician:
Procedure: MRI LUMBAR WO

Patient ID: [REDACTED]
Date of Study: 15-Oct-2025 11:19 AM

EXAM: MRI LUMBAR WO

HISTORY: Pain after a motor vehicle accident 10/01/25.

TECHNIQUE: Axial and sagittal multi-weighted images of the lumbar spine were obtained.

COMPARISON: None.

FINDINGS:

CONUS: Terminates in normal position and demonstrates normal signal characteristics.

OSSEOUS STRUCTURES: Vertebral bodies are normal height without fractures.

ALIGNMENT: No vertebral body listhesis is present.

BONE MARROW: Normal bone marrow signal. No focal osseous lesion is seen.

PARASPINAL SOFT TISSUES: Paraspinal soft tissues are unremarkable.

T12-L1: No disc herniation, central canal, or foraminal stenosis.

L1-L2: No disc herniation, central canal, or foraminal stenosis. Joint effusion without underlying arthritis bilateral facet joint(s). This can be seen in the setting of a capsular sprain or instability series 10,001 image 28.

L2-L3: No disc herniation, central canal, or foraminal stenosis. Joint effusion without underlying arthritis bilateral facet joint(s). This can be seen in the setting of a capsular sprain or instability, series 10,001 image 23, 22..

L3-L4: There is a 2.2 mm left foraminal/far lateral protrusion type disc herniation resulting in mild left foraminal stenosis, series 10,001 image 16, series 10,002 image 11. No central canal or right foraminal stenosis.

L4-L5: 2 mm left foraminal/extraforaminal protrusion type disc herniation, series 2001 image 11. This results in mild left foraminal stenosis, series 10,002 image 4.

L5-S1: Mild age-appropriate disc desiccation without disc height loss or degenerative endplate changes. There is a 5.3 mm left lateralizing protrusion type disc herniation impinging the thecal sac and resulting in mild central canal stenosis and resulting in moderate left foraminal stenosis impinging the exiting left L5 nerve root, series 10,002 image 12, series 10,001 image 8, series 2002 image 8. Mild right foraminal stenosis. This narrows the left subarticular recess impinging the traversing left S1 nerve root, series 2001 image 7.

There are no significant underlying degenerative changes. No significant disc desiccation or disc height loss. No facet arthropathy. No osteophyte formation.

IMPRESSION:

1. L5-S1 demonstrates a left lateralizing disc herniation impinging the exiting left L5 nerve root and traversing left S1 nerve root.
2. Left foraminal/extraforaminal disc herniations L3-L4 and L4-L5 as above.

If you would like to speak to a radiologist regarding this report, please call: 1-855-723-8255



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3. Joint effusion without underlying arthritis bilateral facet joint(s). This can be seen in the setting of a capsular sprain or instability.
4. Based on the imaging findings and within a reasonable degree of medical probability, the observed disc herniations may be temporally and causally related to a recent traumatic event rather than solely attributable to a chronic, degenerative process. Features that support a traumatic etiology may include the absence of significant endplate changes or large posterior osteophyte formation, presence of focal annular disruption, and morphology or location of the herniation that is atypical for age-related degeneration. Additionally, the lack of multilevel degenerative change or disc space narrowing at the affected level may further suggest that the pathology is more likely to be post-traumatic in nature. This interpretation should be considered in conjunction with the clinical history, mechanism of injury, and absence of prior comparable imaging for direct comparison.

The descriptions/nomenclature of any reported disc pathology, specifically with respect to the definitions of a disc bulge or disc herniation (protrusion type disc herniation and/or extruded disc herniation), is based on the recommendations from the following peer reviewed journal article: Lumbar Disc Nomenclature: version 2.0: Recommendations of the combined task forces of the North American Spine Society, the American Society of Spine Radiology, and the American Society of Neuroradiology. Spine J. 2014 Nov 1;14(11):2525-45. Any references to causation and permanency follow the guidelines established by the American Medical Association Guides to the Evaluation of Permanent Impairment, Sixth Edition, 2023. It should be noted that a normal MRI does not exclude certain pathologies that may be difficult to diagnose radiographically including certain pathologies involving small localized nerves and facet joints. A normal MRI does not exclude the possibility of certain abnormalities that may only be detected with a thorough physical examination and clinical history.

Electronically signed by:
Darren Buono, MD
10/19/2025 12:03 PM EDT

Electronically Signed: Date: 19-Oct-2025 12:03 PM

Darren Buono M.D.
Board Certified: American Board of Radiology
NPI: 1912004698

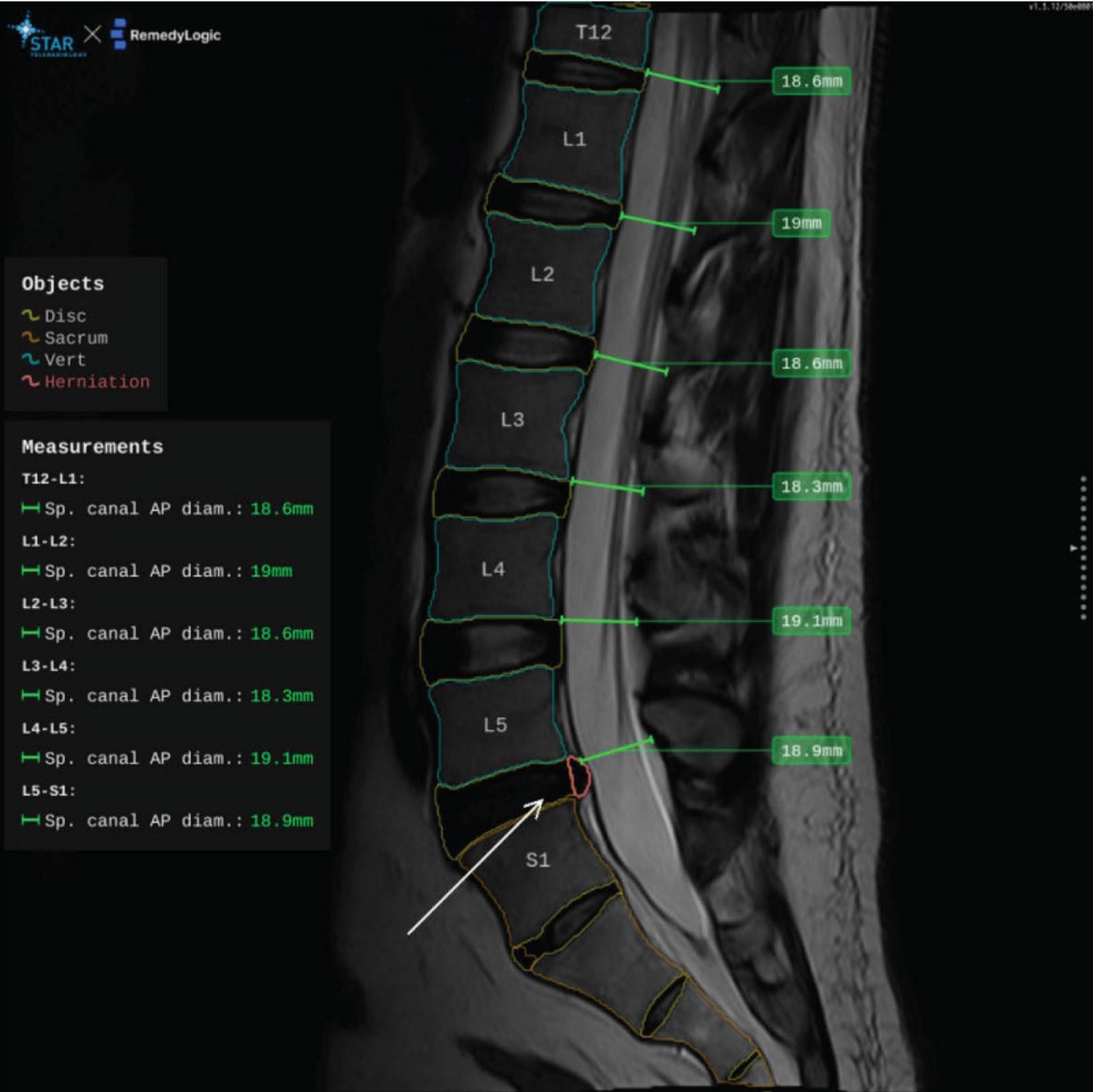
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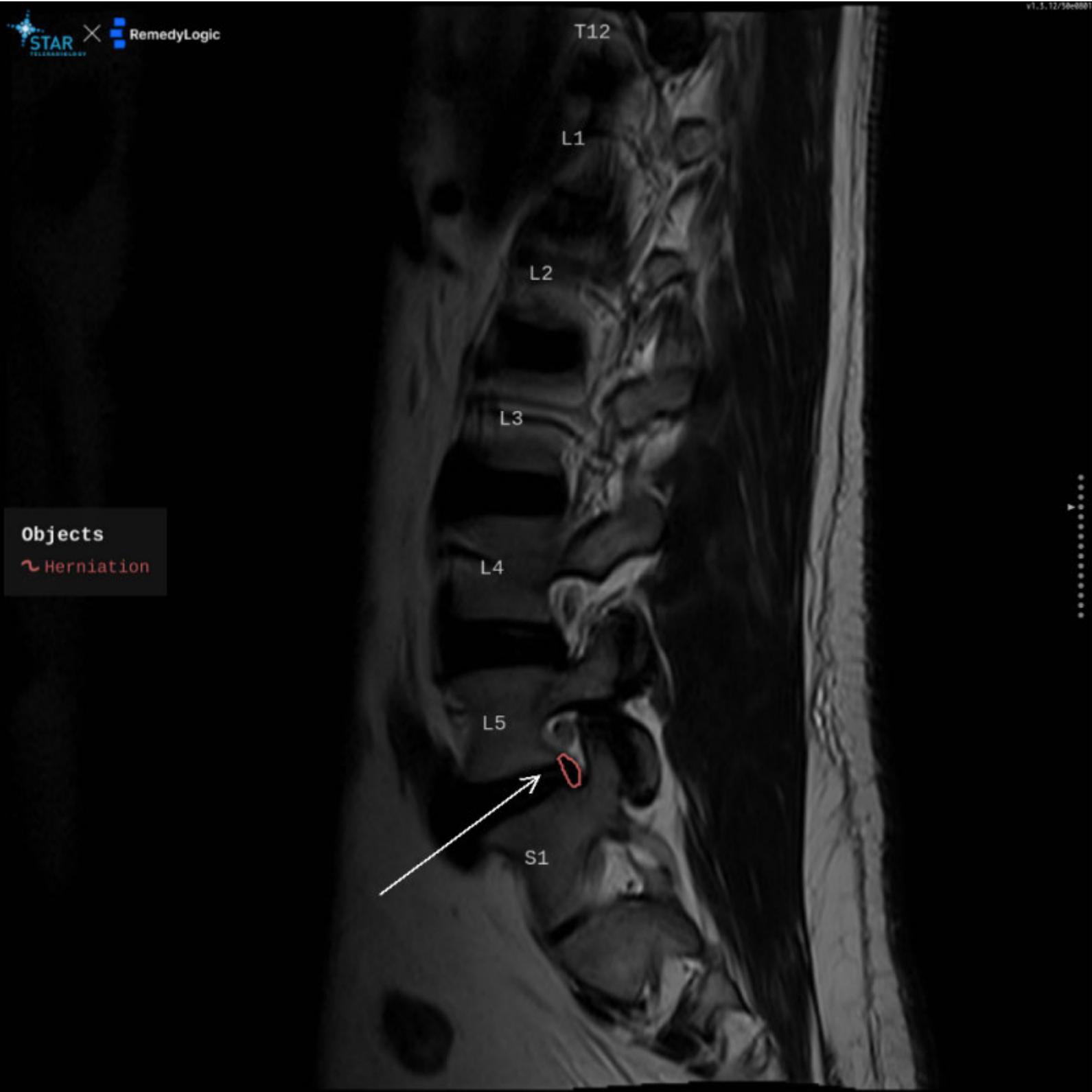


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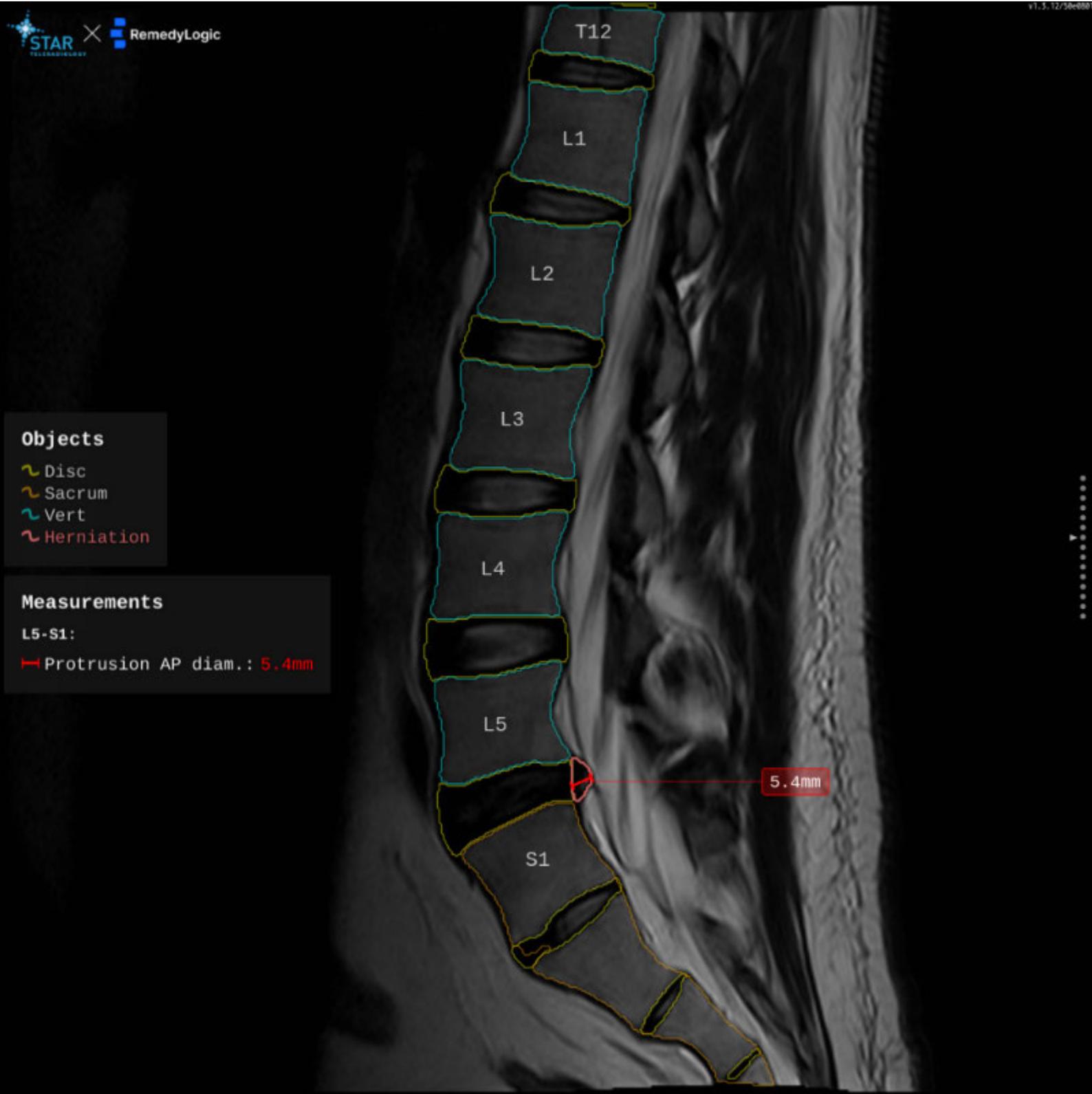
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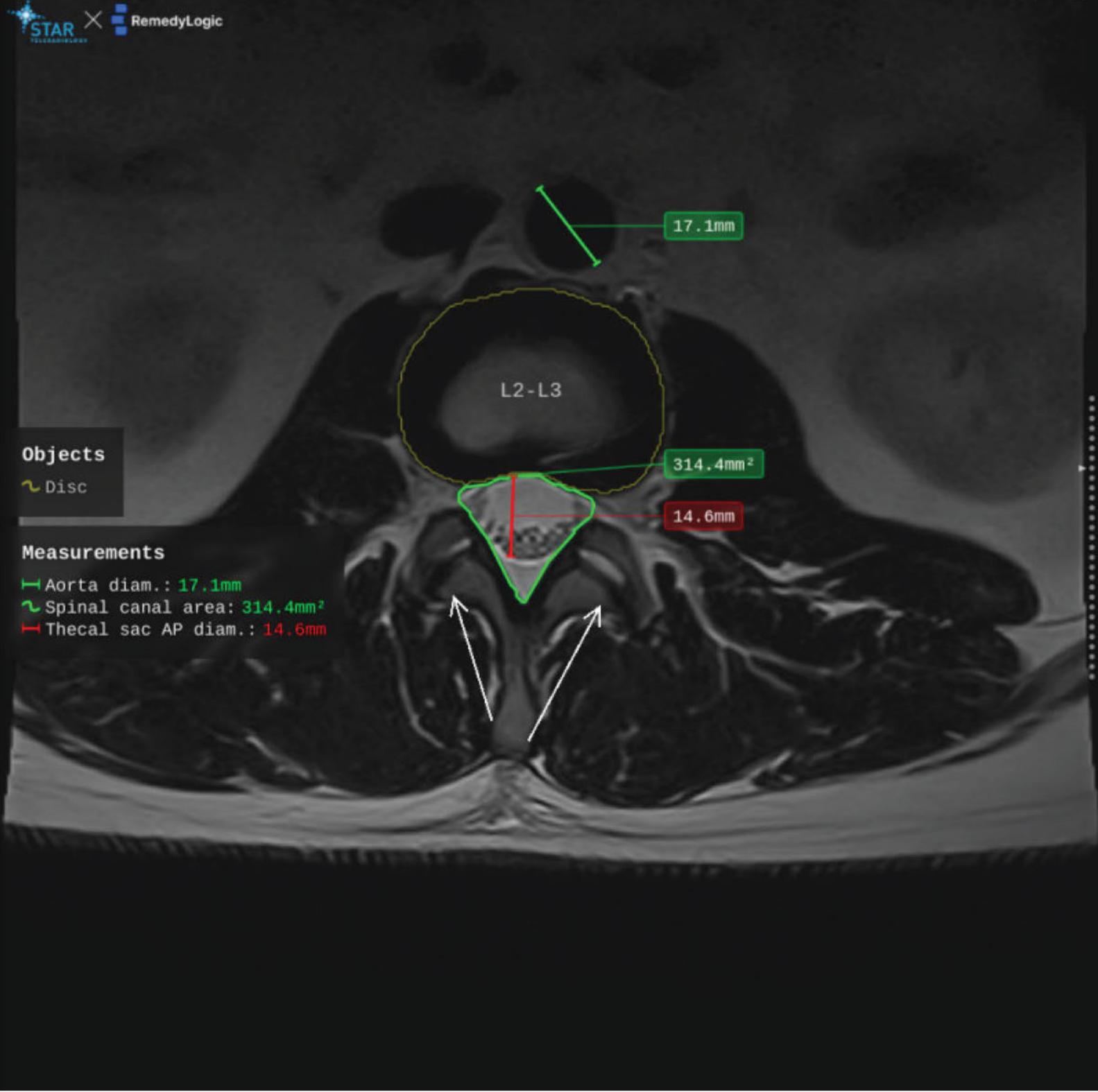






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Objects

Disc

Measurements

- Aorta diam.: 17.1mm
- Spinal canal area: 314.4mm²
- Thecal sac AP diam.: 14.6mm

