NAME: XXXXXXXXX
DOB: 05/12/1951
REFERRING: XXXXXXXX
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MRN: 8413
Exam Date: 08/11/2011

PROCEDURE: **MRI OF THE RIGHT WRIST WITHOUT CONTRAST**

HISTORY: Right wrist pain for 10 years. Progressive decrease in range of motion.

COMPARISON: None.

TECHNIQUE: Multi-sequence/multiplanar MRI of the right wrist was obtained without intravenous contrast.

FINDINGS: There is no fracture or dislocation. The bone marrow signal is remarkable for edema in the distal ulna which is nonspecific. This could be related to resolving bone contusion if the patient has a history of previous trauma to dislocation. This could also be reactive as there is cystic change along the dorsal ulnar aspect. There is osseous destruction of the dorsal aspect of the distal ulna with marked chronic appearing synovitis and the large distal radial joint effusion. The findings are compatible with inflammatory type of arthritis.

There is moderate to severe radial carpal and mid carpal synovitis as well.

Carpal bone alignment is normal and there is no evidence of subluxation or dislocation.

The muscles are normal in signal intensity and there is no evidence of muscle strain or muscle atrophy.

The flexor and extensor tendons are remarkable for mild second extensor compartmental tendinopathy and tenosynovitis. There is mild fourth extensor compartmental tenosynovitis as well. The ECU demonstrates mild tendinopathy.

The contents of Guyon canal and the carpal tunnel are radiographically normal.

The scapholunate and lunotriquetral ligaments and TFCC including the radial attachment, meniscoid portion and ulnar styloid and foveal attachments are intact. There is degeneration of the ulnar styloid and foveal attachments of the TFCC.

CONCLUSION:

1. **There is synovitis of the wrist as described above. Osseous obstruction of the dorsal aspect of the distal ulna with a large distal radial ulna joint effusion suggests an underlying inflammatory arthritis. Clinical correlation is recommended.**

2. Mild tendinopathy and tenosynovitis of the second and fourth extensor compartments as described above. There is also mild ECU tendinopathy.
3. Bone marrow edema in the distal ulna. This most likely is reactive in etiology.

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