Xrays and Tests

Report Date: 4-24-20

Local, Wife

Indian Creek, NE 69333

Colglazier Clinic
945 Washington Ave PO Box 97
Grant NE 69140

Date:	*Test Name:* *Test Site:*	*Edited Brief Impression:*
8-16-2016	**MRI Head** Great Plains,	Impression: Right occipital lobe neoplastric mass with interval improvement in size, edema and mass effect. No acute abnormality.
6-20-2016	**MRI Brain** Great Plains,	IMPRESSION: Significant change from prior examination with 4 cm new enhancing component adjacent to site of prior surgical resection as well as significant increase in vasogenic edema, Suspected early subependymal spread of tumor.
3-21-2016	**MRI Head** Great Plains,	Right parietal postsurgical changes with rim enhancement. Two small areas of slightly more prominent contrast enhancement which require follow-up to exclude any residual tumor Stable nonenhancing demyelinating lesions
1-18-2016	**MRI Head** Great Plains,	IMPRESSION: Surgical changes from resection of a reported glioblastoma multiform involving the right parietal lobe. 4 narn nodular focus of enhancement at the anterior inferior aspect of the resection is suspicious for residual disease. This should serve as an excellent baseline for future follow-up unless there are additional recent prior examinations available for comparison..
9-30-2015	Kearney Hosp,	IMPRESSION: 1. IRREGULAR RIGHT PARIETO-OCCIPITAL MASS IS MOST SUSPICIOUS OF A HIGH-GRADE PRIMARY CNS NEOPLASM. 2. THERE IS NONENHANCING T2 HYPERINTENSITY AROUND THE MASS WHICH MAY REFLECT VASOGENIC EDEMA AND/OR NONENHANCING INFILTRATIVE TUMOR. 3. THERE ARE CHRONIC WHITE MATTER CHANGES SUGGESTIVE OF CHRONIC DEMYELINATING DISEASE, BUT I DO NOT THINK THE RIGHT PARIETO-OCCIPITAL LESION IS LIKELY TO REFLECT TUMEFACTIVE DEMYELINATION.
9-27-2015	**MRI Head** Great Plains,	IMPRESSION: 1, There is a right-sided posterior inferior parietal masssuspicious for a high-grade glioma. The tiny adjacent additional lesions extending more anteriorly. Tbi le sclerosis There is some differential diagnosis would include a area in usual case of a turriefactive multiP moderate to severe associated vasogenic edema and mild-moderate mass effect upon the right occipital born, A few tiny hemorrhagic foci are noted within the mass. 2.There are areas of demyeliTtation in the periventricular regions with Dawson's finger type appearance which however do not enhance. Asessment with spectroscopy and/or neurosurgical consultation and biopsy suggested.
11-26-2014	**ANKLE COMPLETE 3** PCCH,	Soft tissue swelling about the right ankle. No evidence of an acute bony abnormality.
6-18-2013	**MRI Cervical Spine** NP Radiology,	IMPRESSION: Multifocal demyclinating plaques seen within the cervical cord without significant change from 7/26/2012. No abnormal enhancement.
6-18-2013	**MRI Head** NP Radiology,	Numerous dernyelinating plaques involving the brain compatible with the given clinical history of multiple sclerosis. No significant change from 6/18/2013.
1-04-2013	**ANKLE 2 VIEWS LEFT** PCCH,	DISCUSSION: Two views of the left ankle show a small calcaneal traction spur at the insertion of the Achilles. Left ankle fracture dislocation with medial malleolar fracture and comminuted, angulated distal tibial fracture. The dome of the talus is dislocated laterally with respect to the distal tibia. The distal tibiofibular syndesmosis is widened as well. DIAGNOSIS: Left ankle fracture/dislocation.

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8-15-2012	**Colonoscopy** PCCH,	PREOP:Need for screening colonoscopy. POSTOP:Few scattered left colon diverticulum. PROCEDURE: Normal risk screening Medicare total colonoscopy SURGEON: James C. Schiefen, Following the procedure, discussed findings at length with the patient and recommended followup colonoscopy in ten years.
10-04-2010	**Venous doppler - leg** NP Radiology,	IMPRESION: No findings to suggest deep venous thrombosis of the left lower extremity venous system.
8-23-2007	**Ultrasound Renal/Kidney** NP Radiology,	HISTORY: Incontinence, incomplete emptying of the bladder. IMPRESSION: Unremarkable renal sonogram. Residual bladder volume is 42.3 cc with incomplete bladder emptying.
2-10-2007	**MRI Cervical Spine** NP Radiology,	Moderate and mild disc degeneration C5-C6 and C6-C7, respectively. No central canal or neural foraminal stenosis. No disc herniation demonstrated.
2-10-2007	**MRI Head** NP Radiology,	No change in supratentorial deep white matter disease. Interval resolution of the right cerebellar hemispheric lesion.
6-21-2005	**Xray Foot** PCCH,	RIGHT FOOT: No fractures or dislocations identified. Degenerative changes at the first MTP joint. Right foot is otherwise negative. No significant change since 6/16/2005.
6-16-2005	**Xray Foot** PCCH,	Three views of the right foot show moderate hallux valgus. There is no evidence of fractures or dislocation. There is mild osteoarthritis in the first MP joint.
6-16-2005	**Xray Ankle** PCCH,	X ray of the ankle is negative for fracture
6-16-2005	**Xray Knee AP/Lat** PCCH,	X ray of the right knee is negative
4-07-2004	**MRI Head** PCCH,	Multiple areas of high T2 signal in the deep white matter, similar in appearnace to the previous study. Findings would be compatible with history of multiple sclerosis. The high signal area seen at the level of the left pons previously is not seen on the current study.
11-12-2003	**Xray Foot** PCCH,	3 views of the left foot show hallux valgus deformity with degenerative changes at the first MTP. There does appear to be a small degenerative cyst in the base of the base of the proximal phalanx of the great toe. No fracture is identified.
2-27-2002	**RPR Syphilis Serology** NP Pathology,	RPR SCREEN NONREACTIVE
2-27-2002	**SLE Profile (SLPA)** NP Pathology,	SLE PROFILE (A) ANTI-RIBONUCLEAR PR NEGATIVE ANTI-SMITH ANTIGEN NEGATIVE Anti-Histone ABS PENDING SJOGREN'S ANTI-SS-A NEGATIVE SJOGREN'S ANTI-SS-B NEGATIVE ANTI-DNA (DS) ABS NEGATIVE ALBUMIN ALPHA-1 GLOBULIN PENDING ALPHA-2 GLOBULIN PENDING BETA GLOBULIN PENDING GAMMA GLOBULIN PENDING GLOBULIN, TOTAL PENDING A/G RATIO
10-16-2001	**Xray Shoulder** PCCH,	RIGHT SHOULDER: X-rays include a transscapular, Y and axillary views. These show that the greater tuberosity fragment is anatomically lined up and that the joint is reduced anatomically.

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4-24-2001	**Mammogram** NP Radiology,	There are no signs of malignancy and no change since the last exam of 02-17-2000. Category 2---Benign
12-29-2000	**Bone Scan** Mack,	Her lumbar spine is quite close to being osteoporotic. In 2 more years, if she had a similar magnitude decrease she would easily be considered osteoporotic. I think we should intervene with antiresorptive therapy in a maintenance dose such as 35 mg q week of Fosamax or 30 mg of Actonel weekly. I believe weekly doses are tolerated better. F/U study in 24 months.
2-17-2000	**Mammogram** NP Radiology,	Negative mammogram
2-08-2000	**Xray Leg** PCCH,	Previously noted fx appears unchanged in position. Healing reaction is not yet identified.
2-01-2000	**Xray Leg** PCCH,	Left tibia, fibula=Fx of promimal shaft of the fibula, extending obliquely. Not significantly displaced.
4-27-1999	**Ultrasound Gallbladder** NP Radiology,	Negative ultrasound exam of the gallbladder, liver, kidneys, spleen and pancreas. Normal caliber abdominal aorta. No cholelithiasis or ductal dilatation seen.
4-24-1999	**Stress Test** Prevedel, John	Exercised for 7 min 19 sec on Bruce Protocol. Leg fatigue. No chest pain HR = 152Baseline ECG shows NSR with rate of 60 bpm. Stress ECG shows J point depression and upsloping ST segments. No arrhythmias. Imrpession: Normal exercise stress test. Functional class II
9-10-1997	**Mammogram** NP Radiology,	No change since the exam of 08-15-96. There are no radiographic signs of malignancy.
8-15-1996	**Mammogram** PCCH,	There are several small densities in each breast, but we think these are unchanged. Multiple benign appearing calcifications, left breast.No suggestion of malignancy.
8-05-1996	**Xray Lumbar Spine** NP Radiology,	Narrowing of the disc spaces at L4-L5 and L5-S1. Retained pantopaque in the neural canal. No other significant abnormalities are noted.
2-20-1995	**Xray Knee** PCCH,	Negative

END OF REPORT