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PATIENT'S NAME:	DOE, JOHN	DATE OF REPORT:	05/09/2017
AGE / GENDER:	37/MALE	DATE OF EXAM:	05/08/2017
PATIENT NUMBER:	12345	REFERRING DOCTOR:	YOUR NAME HERE

EXAM: 2 VIEW LUMBAR SPINE

VIEWS: AP LUMBOPELVIC AND LATERAL LUMBOSACRAL

FINDINGS:

Anterolisthesis of L5 on S1 is noted of approximately 5mm. The remaining gross osseous alignment is unremarkable.

The generalized bone density appears adequate; however, the femoral heads bilaterally demonstrate a mottled appearance with areas of patchy sclerosis and lucency. The superior aspects of the femoral heads bilaterally are also flattened in appearance with obvious bony fragmentation seen most prominently on the left. The superior endplate of L1 is not well visualized; however, there is a suggestion of anterior wedging, subchondral sclerosis and osteophyte formation at this location. A zone of condensation and associated step defect cannot be excluded. Pars defects are likely bilaterally at L5. Non-union of the posterior elements is appreciated at S1. Aberrant asymmetric bony morphology of the posterior elements of L5 is seen. There is no other evidence of fracture, dislocation or gross osseous destruction.

The visualized intervertebral disc spaces appear well-maintained. Moderate facet hypertrophy and sclerosis is seen at L4/L5 and L5/S1 bilaterally. Superior loss of joint space and osteophytic proliferation is seen at the coxofemoral joints bilaterally with prominent superolateral migration of the left femoral head. The remaining visualized articulations appear well maintained.

Metallic clothing artifacts are superimposed over the lower pelvic region. There is no radiographic evidence of soft tissue mass or edema.

IMPRESSIONS:

1. Avascular necrosis of the femoral heads bilaterally, more advanced on the left with associated secondary degenerative joint disease of the coxofemoral joints bilaterally. See recommendations.
2. Probable remote vs. acute compression fracture, L1. Correlate clinically. See recommendations.
3. Grade I spondylolytic (probable) spondylolisthesis of L5 on S1. See recommendations.



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4. Moderate facet arthrosis, L4/L5 and L5/S1 bilaterally.
5. Spina bifida occulta, S1.
6. Dysplastic posterior elements, L5.

RECOMMENDATIONS:

1. Orthopedic referral is recommended for further assessment and/or treatment options. Clinical correlation for a history of conditions associated with avascular necrosis. Advanced imaging such as MRI of the hips bilaterally may be useful; however, these will likely be obtained via orthopedic referral. Chiropractic adjusting of the coxofemoral joints is contraindicated at this time.
2. Clinical correlation for a previous history of compression fracture at L1 is recommended. A lateral spot projection of L1 that demonstrates the superior endplate to great advantage would also be useful and likely provide a more definitive diagnosis. MRI of this area could be considered as well, if the spot projection is unfruitful. Chiropractic adjusting at this level is contraindicated until the remote vs. acute nature of the probable compression injury at L1 is established.
3. If deemed clinically significant, or decompression therapy is being considered clinically, oblique projections of the lumbar spine would be useful for better visualization of the pars region at L5.

CLINICAL COMMENTS:

1. Spondylolytic spondylolisthesis is a contraindication to decompression therapy.

Thank you for allowing me to participate in the care of your patient.

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