

RADIOLOGY INTERPRETATION REPORT

EXAMPLE – FICTIONAL CASE BASED ON CLINICAL PRACTICE

Any information that could identify a person has been removed or altered.

Patient	Fictional case	Date of birth	—
Sex	—	Case no.	EXAMPLE
Referring dentist	—	Clinic	—
Exam date	—	Report date	—
Acquired at	—	Priority	Routine

EXAMINATION

Panoramic radiographs (1 recent and 1 prior, taken several years earlier), 1 PA and 1 BW **Region of interest: #1.6**

CLINICAL INFORMATION / REASON FOR REFERRAL

Upper right quadrant pain, possibly sinus-related; rule out a dental cause. Teeth 14, 15 and 16 vital.

TECHNIQUE AND LIMITATIONS

The left TMJ appears partially captured. The tongue is not fully positioned against the palate.

FINDINGS

Bitewing and periapical radiographs, and panoramic radiograph, with interval changes since the prior panoramic radiograph provided.

Dentoalveolar:

- Bitewing radiograph: mild generalized marginal bone loss visible in the posterior teeth of quadrants 1 and 4.
- Periapical radiograph: small enamel caries noted at #1.3D.
- Interval changes since the prior panoramic radiograph:
 - o florid cemento-osseous dysplasia lesions noted at the apices of multiple teeth; some lesions appear early/osteolytic (sites #1.3, 1.2, 4.6), while others appear more mature/sclerotic (#1.6, 1.4, 2.1, 3.6, 3.1, 4.1/4.2, 4.3);
 - o restorations replaced in quadrants 1 and 4.

Temporomandibular joints: no notable change since the prior panoramic radiograph.

Maxillary sinuses and nasal cavities: maxillary sinuses partially opacified bilaterally, relatively stable in appearance since the prior panoramic radiograph; the bilateral mucosal thickening along the maxillary sinus floors does not appear to be clearly odontogenic in origin – if symptoms persist more than 2 weeks after image acquisition, ENT referral is recommended.

Cervical spine: not captured.

Soft tissues, airway and other structures: no notable change since the prior panoramic radiograph.

IMPRESSIONS AND RECOMMENDATIONS

1. No definite radiographic evidence of dental or periapical pathology at tooth 16.
2. **Uncomplicated florid cemento-osseous dysplasia (FCOD) noted: lesions at multiple apical sites, at slightly varying stages of maturation. The evolution of some sites since the prior panoramic**

This report is based on the images provided and should be interpreted in correlation with the clinical examination and patient history. The entire imaged volume has been reviewed.

radiograph is consistent with the natural maturation of FCOD (Nemec et al., 2024). Confirmed pulp vitality of teeth 14, 15 and 16 supports the diagnosis and rules out an endodontic origin (Delai et al., 2015). Benign, self-limiting process: no intervention or biopsy is indicated, except in the case of osteomyelitis secondary to local infection, which does not appear to be the case at present (Fenerty et al., 2017). Periodic clinical and radiographic follow-up is recommended. To prevent osteomyelitis in dysplastic bone, rigorous oral hygiene should be maintained and caution exercised with any extraction, surgery or implant placement in the affected areas (Decani et al., 2024). If dental symptoms arise, look for an occult periapical or periodontal inflammatory source.

3. Mild generalized marginal bone loss visible. Clinical correlation and periodontal management are recommended, all the more important in the context of FCOD.
4. Bilateral sinusitis of non-odontogenic origin. The bilateral involvement and the absence of a dental source adjacent to the sinus floor suggest a rhinogenic etiology. If symptoms persist more than 2 weeks after image acquisition, referral to family medicine or ENT is recommended.

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