perplexity

Why clinicians refuse outside imaging

The "I won't look at that" response is almost certainly about **liability, protocol, and technical compatibility**—not a judgment about you or your history. Here is what is actually happening:

Technical barriers are real. A study on outside imaging found three consistent problem areas: access, importability, and viewing issues. Different hospitals use different PACS systems, DICOM implementations, and viewer software, and files that work on one system often fail on another. A DVD of DICOMs from one province may not even open properly on another hospital's workstation. [1]

Radiologists will not compare images they cannot verify. They have no way to confirm that a DICOM file from another hospital is authentic, was acquired with a comparable protocol, or has not been altered. Comparing an unverified outside study to their own creates a medicolegal risk they are trained to avoid.

"No prior images for comparison" is a system limitation, not a clinical judgment. Each hospital's PACS only sees what has been uploaded into *its own* system. Images from a different province or hospital network simply do not exist in their database, so the radiologist literally has nothing to compare against—unless someone manually imports the outside study, which most will not do for liability reasons.

The offense you perceived was likely defensiveness about a system failure. Pointing out that three separate hospitals never compared each other's images highlights a real gap in care coordination. The clinician may have felt accused of negligence when the real issue is that **no interoperable system exists** to make those comparisons automatic.

What you can do about it

- Ask each hospital for a **CD/DVD in DICOM format specifically labeled as compliant with IHE PDI (Portable Data for Imaging)**. This is the standard that makes cross-hospital viewing more reliable. [1]
- Ask the leak specialist's office to **formally request the prior images through their image-sharing network** (many Canadian hospitals use systems like Diagnostic Imaging or provincial PACS networks) rather than relying on you to hand-carry files.
- If they will not import prior images, ask the radiologist to at least **read the prior reports** (which are text and always transferable) and note the prior findings in their comparison section.

Why a brain-only follow-up MRI makes sense

The leak specialist ordering **brain only** (not full spine + brain) is actually consistent with how CSF leak follow-up works:

Brain MRI is the primary tool for monitoring treatment response in SIH. The key signs of intracranial hypotension—brain sagging, dural enhancement, subdural collections—are all visible on brain MRI. If those signs are improving or resolving, it tells the specialist the leak is closing or being managed, regardless of what the spine looks like. [2] [3] [4]

Spinal MRI is for initial diagnosis and leak localization; brain MRI is for follow-up. The consensus guidance states that "brain MRI with contrast and noninvasive spine MRI" are recommended when assessing treatment response, but for routine follow-up, **brain MRI alone is often sufficient** to track whether the intracranial hypotension is resolving. [4] [5]

A smaller, targeted scan is deliberate, not a downgrade. The specialist is likely asking a specific question—"are the brain sagging/tonsillar descent/dural enhancement signs improving?"—rather than re-searching the entire spine for new leaks. That requires only the brain sequence, which is faster, cheaper, and answers the clinical question at hand.

Older equipment is not necessarily worse for this purpose. For detecting brain sag and dural enhancement, the key sequences (T1 post-contrast, T2) have been standard for years. A 1.5T scanner from 2015 will show these findings just as clearly as a newer 3T machine for this specific question. The specialist likely chose the facility based on availability and scheduling, not because the image quality is inadequate for what they need to see.

What to ask the leak specialist

Before the scan, ask:

- "Are you looking for resolution of brain sag/tonsillar descent, or for new leak signs?"
- "Will you compare this to my prior brain MRI from [hospital/date], and can you request that image through the provincial network?"
- "If the brain MRI shows improvement, does that change the plan for my spinal leaks and syrinx?"

That last question matters because a brain-only follow-up can confirm the leak is responding to treatment, but it cannot assess whether the syrinx or cauda equina involvement is changing. If the brain MRI improves but your leg symptoms or bladder function do not, that is a reason to push for a spinal follow-up as well. [5] [4]

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