The Federal Government has recently introduced new Medicare MRI items for Paediatric patients. These items are available for General Practitioner referred patients under the age of 16 years. This Paediatric MRI Update outlines our imaging recommendations for some common paediatric conditions.

MIA Radiology is the largest provider of quality MRI services in Victoria with 15 MRI facilities across Melbourne. Staffed by highly experienced MRI Radiologists and Technologists, we provide the highest quality and most appropriate imaging with minimum stress to both children and their parents. Our Radiologists, including 4 sub-specialist Paediatric Radiologists, are always available for consultation should you have any questions.

We are committed to providing quality patient care and the highest level of service and support to our referring medical practitioners.

Table 1: GP Eligible MRI scans for under 16yrs

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<th>SCAN OF HEAD for the following:</th>
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<tr>
<td>• Unexplained seizure(s)</td>
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<th>SCAN OF SPINE following radiographic examination of any of the following:</th>
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<tr>
<td>• Significant trauma</td>
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<td>• Unexplained neck or back pain where neurological signs are suspected</td>
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<td>• Unexplained back pain where significant pathology is suspected</td>
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<th>SCAN OF KNEE following radiographic examination for:</th>
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<td>• Internal joint derangement</td>
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<tr>
<td>• Suspected septic arthritis</td>
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<td>• Suspected slipped capital femoral epiphysis</td>
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<td>• Suspected Perthes disease</td>
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<th>SCAN OF ELBOW following radiographic examination where:</th>
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<td>• Significant fracture or avulsion injury is suspected that will change management</td>
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<th>SCAN OF WRIST following radiographic examination where:</th>
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<tr>
<td>• Scaphoid fracture is suspected</td>
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If this is the case then children should either have a CT, which is faster, without general anaesthesia or be referred to a specialist centre with Play Therapy and paediatric anaesthetic services such as The Royal Children’s Hospital or Monash Medical Centre. A CT should not be performed if MRI is the appropriate test unless the MRI cannot be performed in a timely manner.

MRI in children is a very powerful diagnostic tool that can replace CT in many instances, frequently providing more diagnostic information without radiation. It is useful for all the indications of adults, however, if possible should be used as the primary tool in the investigation of conditions such as seizures and headaches rather than CT which historically has been more frequently utilised.

**Performing the Test Correctly**

Paediatric patients should be referred to centres that are experienced in dealing with children so that the appropriate imaging is obtained at a high quality and accurately reported. Performing the investigation correctly is a combination of using the best equipment and staff trained and experienced in caring for children. High quality equipment (including digital plain X-ray, Ultrasound, Low Dose CT and MRI) enables high resolution images to be obtained rapidly, which is important because children’s organs are small and the children themselves move. The latest equipment therefore increases the likelihood of the imaging being diagnostic and improved detectors means that it does so at significantly lower radiation doses.

Having well trained experienced staff improves a child’s cooperation and reduces the time required for the particular study making a diagnostic scan more likely and reducing the stress to the child and parent. Experienced and highly trained staff can also ensure that the equipment is used appropriately at the lowest most appropriate radiation doses.

The paediatric commitment of MIA Radiology is unique in private practices in Australia. In Melbourne, MIA has 4 dedicated Paediatric Radiologists. The equipment is state of the art and the staff are aware of the needs of children and their parents to ensure that the imaging is of the highest quality, with the minimal amount of radiation and appropriately interpreted.
Fall on the outstretched hand – Scaphoid Fracture

This is a common clinical presentation in General Practice.

The child is usually older than 5 years of age and presents with “painful distal forearm/wrist.” Sometimes the clinical history is hard to obtain due to the age of the child but usually history of a fall can be elucidated.

Clinical examination is very useful to assess if the child has pain over their distal radius/ulna or in the anatomic snuffbox. X-ray is usually indicated if the pain is ongoing to exclude a fracture of the radius or ulna as well as the carpal bones including the scaphoid.

If the patient is tender in the anatomic snuffbox this should be indicated on the request form and we will also perform dedicated scaphoid views, which include oblique views to better assess the scaphoid for a fracture.

If a radius or ulna fracture is demonstrated then this should be treated as appropriate with immobilisation/backslab. If scaphoid fracture is detected (Fig 1 and 2) a plaster is indicated as well as Paediatric Orthopaedic review to monitor follow up.

Difficulty is encountered when the patient has continued tenderness in the anatomic snuffbox with a normal X-ray. Previously we would have advised immobilisation in plaster and re X-ray again in 7-10 days, which is a little limiting/annoying for the patient and family, particularly if no fracture is found subsequently.

From November 1st 2012, a General Practitioner can order an MRI scan if they feel that a scaphoid fracture cannot be excluded after initial X-ray assessment to avoid the previous pathway of immobilisation and re X-ray in 7-10 days. It also removes the need for a CT, which may have previously been performed to better assess the scaphoid.

To undergo the MRI, the child must lie still for about 15 minutes for a full study but we will get most of the information regarding the scaphoid in the first 5 minutes.

MRI accurately assesses for a scaphoid fracture, is more accurate than a CT and uses no radiation. It also is excellent to assess other carpal bone injuries such as bone bruising (Fig 3) and further fractures (Fig 4). The ligaments are well demonstrated as is the articular cartilage and triangular fibrocartilage. We assess the growth plate and soft tissues as well as distal radio ulnar joint. (Fig 5).

If the MRI study demonstrates no scaphoid fracture the child does not need the 7-10 day immobilisation and re x-ray like previously. The injuries detected at MRI are treated on their merits and with a normal study no further management or imaging is necessary.

References:
2. MR imaging of clinically suspected scaphoid fractures. AJR 1997;168: 1287-1293

Dr Murray Bartlett
MBBS, FRANZCR
Paediatric Radiologist
MIA Radiology and Royal Children’s Hospital
“Mum my back hurts” – when and how should you investigate the paediatric spine?

In adult practice degenerative disease of the spine is common and imaging frequently performed. Serious spinal pathology in children is uncommon and rarely is there a requirement for radiological investigation. Such investigation is usually reserved for cases of suspected trauma, persistent back or neck pain, scoliosis, and/or neurological deficit.

Scenarios:

Suspected trauma
Trauma to the spine in adults causes bone injury, whereas children usually sustain soft tissue injury. Most often this is not serious but on occasions can lead to neural impairment. This is known as SCIWORA (spinal cord injury without radiological abnormality). On that basis if a child has substantial trauma to the neck or back then it is appropriate to perform a limited X-ray series to exclude gross deformity followed by Magnetic Resonance Imaging (MRI). Any disruption to bone, ligaments, discs or neural structures can readily be detected on MRI examination.

Persistent back or neck pain
Lower back and neck pain in children often settles in a few days. Investigation is only necessary if pain is persistent, escalating or associated with neurological signs. It is reasonable to perform an initial limited series of plain X-rays through the area of pain as a screening test but if symptoms persist beyond a week or if there is any neurological deficit then MRI is the investigation of choice.

Ruby is a 12 year old elite gymnast. She has had low back and buttock pain for some time made worse by training. X-rays are normal. MRI shows a subtle area of abnormal bone marrow oedema in the left sacral ala (Fig 1). This is consistent with a stress fracture. Treatment involved rest for 6 weeks with an excellent outcome.

Scoliosis
Scoliosis is common in young/adolescent children and usually benign but can be associated with congenital anomalies of the spine. The mainstay of investigation is weight bearing X-rays in order to determine the degree of deformity but it is also important to perform MRI in order to exclude underlying pathology.

Tiffany is a 9 year old girl with a painful curvature of the upper thoracic spine. The anterior X-ray shows a focal scoliosis concave to the right (Fig 2a). MRI demonstrates a congenital hemi vertebra (Fig 2b) that has caused this Scoliosis. This is an important finding for the surgeon who will perform corrective surgery.

Neurological deficit
Any neurological deficit referable to the spine in a child is an important clinical finding and should be thoroughly investigated using MRI.

Jason is a 14 year old boy with long standing low back pain. Recently he has developed numbness in his legs and on examination has absent ankle jerk reflexes. CT scans show a gross anterior spondylolisthesis of L5 on S1 due to bilateral pars interarticularis defects. Although CT shows these bony anomalies to great effect (Fig 3a), MRI is still required to delineate the degree of compression to the thecal sac and its contents, as well as nerve roots within the exit foramina (Fig 3b).

In all 4 of the above scenarios MRI is an appropriate imaging modality. From 1/11/12 General Practitioners will be able to request MRI examinations for such clinical indications. These scans will be fully funded by Medicare without gap payment. MIA Radiology has the equipment, technical staff, and specialist radiological expertise to provide high quality MRI examinations to these very important young patients.
Hip problems are common in the paediatric age group.

Commencing in the post-natal period with Developmental Dysplasia of the Hip (DDH). Ultrasound is the test of choice for this condition.

In early childhood septic arthritis becomes more prevalent. X-ray and Ultrasound are the preferred imaging modalities for these conditions.

Perthes disease, or avascular necrosis of the femoral capital epiphysis develops in late childhood. MRI is the test of choice for this diagnosis (Fig 1). Secondary OA may present later in adolescence or early adulthood (Fig 2).

Slipped capital femoral epiphyses (SCFE), which begin to occur in late childhood and early teens, is often diagnosed with X-ray (Fig 3). In difficult cases MRI is required.

Apophysitis, either acute or chronic may occur, particularly the ischial tuberosity (Fig 4a & b).

**Fig 1:** Perthes treated 10 yr old

**Fig 2:** Perthes 18 yr old secondary OA

**Fig 3:** SCFE 11 yr old X-ray

**Fig 4a:** Axial T1 ischial Apophysitis.

**Fig 4b:** Axial AP ischial Apophysitis.
In severe cases this may lead to hamstring origin avulsion (Fig 5a & b).

Other sites that may be involved include the anterior inferior iliac spine (AIIS) or less likely the lesser trochanter.

Synchondritis between the inferior pubis and ischium may present with pain, swelling or even as a pseudotumour (Fig 6).

Arthritis may also present initially in the hip.

Stress fractures from overuse may occur in any bone about the hip, including the femoral neck.

Femoroacetabular Impingement (FAI) is now thought to be a cause of hip pain and predisposes to premature osteoarthritis. MRI may show the anatomical sites of impingement or show tears in the labrum (Fig 8).

Determination of the cause of hip pain in childhood depends on age and the likely pathology. Ultrasound and X-ray are able to diagnose many conditions. MRI is very useful for soft tissue pathology, bone marrow oedema and cartilage problems.
In the paediatric age group patients present with elbow pain, swelling, deformity and limited motion.

A clinical history and examination will help determine if the likely pathology falls into the following categories:

- Acute trauma
- Repetitive or overuse injuries
- Arthritis
- Tumour
- Infection

The first investigation is the plain film X-ray. Most acute fractures will be diagnosed this way and treated accordingly. Some fractures and growth plate injuries are very subtle indeed, and so, if X-rays are normal then further investigation is warranted. MRI is the next test of choice. CT may be required to diagnose small avulsion fractures, and to help with surgical planning in complex fractures.

Soft tissue injuries are very well defined by MRI. These include ligamentous injuries (Fig 1), tendon tears, nerve entrapment, and also articular cartilage injuries.

Gymnasts and throwing athletes are prone to injuries about the elbow. Osteochondral injuries to the capitellum (Figure 2) are also best studied with MRI.

Repetitive throwing causes an apophysitis of the medial epicondyle, the so-called Little Leaguer’s Elbow (Figures 3a & b).
Paediatric Knee

The knee is one of the most common joints that is injured or symptomatic in the paediatric patient.

Children are quite active and put a large degree of strain/stress on this joint. Their injury pattern and disease presentation is often different to that of the adult patient.

The growth plate is a point of weakness that is often involved in stress injury or fractures. Injury to the growth plate can lead to growth disturbances such as a limb length discrepancy or alignment abnormality (Fig 1).

In paediatric patients the ligaments are strong and often lead to avulsion injuries whereas adults more often suffer a ligament rupture. One example is the anterior cruciate ligament injury which tends to produce an avulsed tibial spine along with an intact ACL (Fig 2) rather than a complete rupture as in the adult.

Ligament injuries (Fig 3) certainly occur and are more likely in the adolescent patient in the mid to late teens. MRI is required for this diagnosis. Ultrasound often underestimates these and will not detect other associated injuries such as bone oedema and cartilage defects.

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Fig 2: The ACL is intact but has avulsed part of the tibial spine.

Fractures are very well identified at MRI (Fig 4) but in most cases an MRI is not required unless a ligament injury is also suspected.

Fig 4: The coronal image demonstrates a fracture line (arrow) that was not visualised on X-ray.

Osgood-Schlatter disease is a clinical diagnosis but an X-ray is usually suggested to exclude an underlying lesion. If this X-ray detects a possible abnormality or you have clinical concern that the case is atypical then an MRI is indicated to exclude mimics. MRI can demonstrate Osgood-Schlatter changes (Fig 5).

Fig 5: Note the fused central growth plate (arrowed) leading to a tilt.

Fig 6: Sagittal image demonstrates thick distal patellar tendon (arrow), oedema in the tibial tuberosity and an effusion in the deep infra-patellar bursa.

Meniscal tears are seen in paediatric patients and are often associated with a discoid lateral meniscus (Fig 6) and often present with ache or a feeling of locking.

Fig 6: Discoid lateral meniscus which is larger than a normal meniscus and also contains a meniscal tear (arrow).
Osteochondral defects occur in children not infrequently. They often present with just persisting pain, locking or an effusion. These are often not visualised on routine X-ray and require an MRI (Fig 7) for the diagnosis. They are treated with rest but sometimes need surgery to stop instability developing.

Symptoms and signs of persistent knee pain are often non-specific and other diagnoses need consideration. Most of these can be detected at MRI. These include Osteomyelitis, Juvenile Idiopathic Arthritis, Vascular malformations, Infiltrative disorders such as Leukemia and tumours particularly Ewing sarcoma (Fig 8) and Osteosarcoma.

Suggested pathway for the approach to knee symptoms is:

1. X-ray – to assess for lesions like fracture or destructive lesions.
2. MRI – next test to order if:
   a. The X-ray is normal, but you are concerned clinically that something else is wrong that hasn’t been detected on the X-ray.
   b. X-ray is abnormal and requires further more detailed assessment such as a periosteal reaction, lytic lesion, osteochondral defect etc.

References:
Imaging in children with headaches, sinus disease and unexplained seizures.

Magnetic Resonance (MR) and Computer Tomography (CT) imaging in children:

MR imaging is ideal, both as a screening and high quality diagnostic test, when there is clinical concern for a structural abnormality causing headache, in assessing unexplained seizures and in sinus disease not responding to conservative therapy.

MR Imaging
- no radiation
- multiplanar, multisequence, most often without contrast
- very sensitive with superior capabilities for defining pathology and anatomy

However, the study takes:
- minimum of 15 mins
- the scanner may be frightening to younger children (Fig 1)
- the child needs to lie in a tunnel with the coil over their head and face (Fig 2)

The child must be able to cooperate and lie still. This usually means children older than 6 years can cope with the study, however we have been successful with children as young as 3.5 yrs but they are generally the exception to the rule.

"Red flags" have been defined as:
- an abnormal neurological exam
- new severe headache, change in headache
- worrisome symptoms where significant pathology is suspected
- parental concern

CT scanning of brain and sinuses
- extremely fast – down to seconds (5 seconds or less)
- radiation dose can be minimised but there still is radiation dose
- scanning technique can be done to try and avoid radiation dose to the orbits when scanning the brain however orbital irradiation is unavoidable when imaging the sinuses
- MIA Radiology has a large installed base of new Low Dose CT scanners
- multiplanar reformats, bone and soft tissue are available but the information provided is not as detailed as MRI, and there is poorer definition of the posterior fossa

When to image in children with:
1. Headaches
2. Sinus disease
3. Unexplained seizures

1. Headaches

Headaches are common in children, occurring in up to 90% of school children (40% by 6 years and 70-90 % by 15 years, from Swedish/Taiwan studies). They may be acute, recurrent or chronic.

Chronic headaches are those that occur for more than 15 days a month for 3 months

There are a variety of causes:
- commonest often follows a viral URTI
- migraine/cluster headaches
- stress/tension
- minor head injury
- infection (meningitis/encephalitis)
- sinus infections, acute is relatively uncommon cause of headache

With a small number caused by:
- Brain tumours
- Hydrocephalus
- Intracranial haemorrhage/vascular malformations

The International Headache Society published a diagnostic and classification scheme for adults, however, included children.

The classifications are:
1. Primary – paediatric migraine, cluster, tension
2. Secondary – associated with underlying CNS pathology, infection, head/neck trauma
3. Cranial neuralgias

Therefore the clinical history and examination are critical in endeavouring to identify a potential cause and the role of imaging depends on the individual signs and symptoms and on the physical examination.

In many situations, imaging (CT or MRI brain) is not indicated (1), however there are red flags (2), where MR or CT imaging is critical.

If the child is unable to cooperate, then sedation or general anaesthesia is required and in these cases the studies are best performed at The Royal Children’s Hospital or Monash Medical Centre.

With an uncooperative child that is moving, images are degraded (Fig 3 and 4). In very acute situations such as trauma or where time is critical such as acute intracranial haemorrhage or ethmoid sinus related periorbital cellulitis, a CT scan of the brain or sinuses would be an appropriate alternative initial test for major pathology.
Role of imaging

Ideally all children with features of a structural headache should undergo MR imaging of the brain.

Fig 5: 11 yr old with normal MRI

Fig 6: 11 yr old with headache. Brain stem tumour evident.

Fig 7: 16yr old with normal ventricles

Fig 8: 5yr old with enlarged lateral ventricles indicating hydrocephalus

Fig 9

Figures 9-11: 7 yr old with a 6 week history of headaches illustrating Vein of Galen vascular malformation with hydrocephalus

Role of imaging

In children with sinus headache/disease, MR and CT of the sinuses are both sensitive tests.

Often, mucoperiosteal thickening in the paranasal sinuses of children is evident on imaging, but it is difficult to determine whether the soft tissue in the sinuses are due to either bacterial infection or inflammation from other causes, such as viral infection, allergy, or chemical irritation. Thus, MRI or CT should not be used to make the diagnosis of sinusitis but, rather, should be obtained in children in whom appropriate antibiotic therapy has not ameliorated symptoms/failed treatment or if there is concern regarding complications such as periorbital cellulitis (related to ethmoid sinus disease) or subdural empyemas (as may be seen in adolescent males with frontal sinusitis).

2. Sinus disease

In children:
- the maxillary and ethmoid sinuses present at birth, continue to grow and start to aerate around 18 to 24 months
- sphenoid sinuses develop after 2 years and start to pneumatise at 8 years
- frontal sinuses develop from the anterior ethmoids at 6 years and begin to pneumatise later

Therefore maxillary and ethmoid sinuses are the commonest sites of infection in children. Sphenoid and frontal sinuses are important with infection in teenage years. Obstruction of the ostiomeatal complex drainage pathway for ethmoid, frontal and maxillary sinuses is often the precursor of sinus disease.

Ethmoid sinusitis frequently causes maxillary and frontal sinusitis and is a cause of periorbital cellulitis.

Fig 10

Fig 11

Fig 12: 5 yr old with normal maxillary sinuses
Seizures are very common and more common in children than adults. A child may have epilepsy if they have 2 or more unprovoked seizures. There are many types of seizures from focal, complex partial, generalised and all its subgroups. Sometimes seizures may be triggered by a disease such as a brain tumour, malformations of brain development, prior head injuries or prior birth trauma. However, for many children there is no detectable cause.

**Role of imaging**
The most appropriate imaging for a child with an unexplained seizure is MRI imaging of the brain.

References:
General Practitioner referred Medicare Eligible MRI items for Children under the age of 16

Effective 01 November, 2012

The Federal Government has recently introduced new Medicare MRI Items for Paediatric patients. These items only apply to scans conducted at a select number of metropolitan MRI locations which have been granted partial Medicare Eligibility (table below).

MIA Radiology is the largest provider of quality MRI services in Victoria with 17 MRI facilities across Melbourne staffed by highly experienced MRI Radiologists and Technologists including 4 sub-specialist Paediatric Radiologists.

GP referred MRI examinations for patients under the age of 16 presenting with specified clinical indications as outlined below will be Bulk Billed at MIA Radiology.

**SCAN OF HEAD** for the following:
- Unexplained seizure(s)
- Unexplained headache where significant pathology is suspected
- Paranasal sinus pathology which has not responded to conservative therapy

**SCAN OF SPINE** following radiographic examination of any of the following:
- Significant trauma
- Unexplained neck or back pain with associated neurological signs
- Unexplained back pain where significant pathology is suspected

**SCAN OF KNEE** following radiographic examination for:
- Internal joint derangement

**SCAN OF HIP** following radiographic examination for any of the following:
- Suspected septic arthritis
- Suspected slipped capital femoral epiphysis
- Suspected Perthes disease

**SCAN OF ELBOW** following radiographic examination where:
- Significant fracture or avulsion injury is suspected that will change management

**SCAN OF WRIST** following radiographic examination where:
- Scaphoid fracture is suspected

**Benefits of MRI**
- No ionising radiation.
- Excellent soft tissue resolution especially in the examination of the central nervous and musculoskeletal systems.
- High sensitivity in demonstrating pathology.
- Images obtained and displayed in multiple planes.

Children between the ages of 1-5 years are best managed in a specialist hospital setting such as The Royal Children’s Hospital or Monash Medical Centre, in the event that sedation is required.

Below the age of 12 months, an MRI examination can be attempted using the “feed and sleep” technique.

Alternate imaging modalities may also be used in this age group – please consult our radiologists.

**Why refer to MIA Radiology**
- BULK BILLING for all GP Requested MRI items that meet the Medicare criteria.
- Same day appointment in majority of cases.
- Largest provider of MRI services in Victoria with 17 MRI scanners conveniently located across Melbourne.
- We have been providing expert services since MRI was first introduced in Victoria.
- Our Radiologists are on site at all times of clinic operation and are readily available to speak with you at anytime.

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**MIA Radiology MRI services**

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<td>Box Hill Hospital, 51 Nelson Road, Box Hill 3128</td>
<td>1.5T</td>
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<tr>
<td>Box Hill Radiology</td>
<td>Epworth Eastern Hospital, Cnr Arnold St &amp; Nelson Road, Box Hill 3128</td>
<td>3T</td>
</tr>
<tr>
<td>Cabrini Hospital</td>
<td>183 Wattletree Road, Malvern 3144</td>
<td>1.5T &amp; 3T</td>
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<tr>
<td>East Melbourne Radiology</td>
<td>St Vincent’s Private Consulting Suites, Level 1, 141 Grey Street, East Melbourne 3002</td>
<td>3T</td>
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<tr>
<td>East Ringwood Radiology</td>
<td>110-114 Mount Dandenong Road, Ringwood East 3165</td>
<td>1.5T</td>
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<tr>
<td>Epping Radiology</td>
<td>Epping Medical and Specialist Centre, 230 Cooper Street, Epping 3076</td>
<td>1.5T</td>
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<td>Frankston Private Hospital, 24-28 Frankston Flinders Road, Frankston 3199</td>
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<td>264 Springvale Road, Glen Waverley 3150</td>
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<td>John Fawkner Hospital</td>
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<td>1.5T</td>
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<td>Lilydale Radiology</td>
<td>355 Main Street, Lilydale 3140</td>
<td>1.5T</td>
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<td>Monash Radiology</td>
<td>Monash Specialist Centre, 212 Clayton Road, Clayton 3168</td>
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<td>Moorabbin Radiology</td>
<td>758-760 Centre Road, Bentleigh East 3165</td>
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<td>The Valley Radiology</td>
<td>The Valley Private Hospital, Cnr Police &amp; Gladstone Roads, Mulgrave 3170</td>
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<tr>
<td>Victoria House Medical Imaging</td>
<td>316 Malvern Road, Prahran 3181</td>
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<td>Warringal Medical Centre, Level 2, 214 Burgundy Street, Heidelberg 3084</td>
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<tr>
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