INTRODUCTION

The complex anatomy of the spine and its contents makes its radiological evaluation is probably the most difficult part of the skeletal system. Understanding the mechanism of the trauma makes the evaluation sometimes easier *(Berry et al., 1992).*

Usually the plain films are first step in radiological work up and unrecognized injuries in plain films can result in significant and irreversible neurological deficit *(Labiscchong et al.,1992).*

Although high quality routine plain films reveal the majority of spinal injuries however CT & MRI are adjunct to define bony abnormalities, soft tissue and spinal canal respectively

(Hudgins et al., 1994).

Disc space injuries also include prolapsed of disc material into the adjacent vertebral end plate (Swischuk, 1986). Uncommon injury mimics a destructive lesion of the vertebra, although narrowing of the disc space from which the prolapsed originated suggests the presence of this benign process *(Kochan et al., 1991).*

CT scanning can detect any possible spondylolisthesis when performed with thin (3-5 mm) slices and gantry angulation parallel to the affected disc space and images should include soft tissue and bone windows. Spondylolisthesis can be detected by sagittal re-formatted images which can demonstrate this as pseudo- disc herniation due to the subluxation rather than a trauma herniation and this is difficult on

MRL due to absence of MRL signal from cortical bone *(Grenier, 1989).*

Late sequel of spinal trauma are best evaluated on MRL as post-traumatic syringomyelia and myelomalacia. Focal atrophy, hemosidrin deposition from hematomyelia and frank cord transaction are visualized by MRL *(Teplic, 1986).*