

**Plexopathy
EVIDENCE TABLE**

Reference	Study Type	Patients/ Events	Study Objective (Purpose of Study)	Study Results	Strength of Evidence
1. Maravilla KR, Bowen BC. Imaging of the peripheral nervous system: evaluation of peripheral neuropathy and plexopathy. <i>AJNR Am J Neuroradiol</i> 1998; 19(6):1011-1023.	12	N/A	To review imaging of peripheral neuropathy and plexopathy.	Preliminary results of high-resolution MRI are promising—individual normal nerves can be imaged, and features of intraneural topography displayed. The morphology and signal intensity characteristics that distinguish abnormal from normal nerves are shown, but the accuracy, sensitivity, and clinical utility of these findings is unknown.	4
2. Bilbey JH, Lamond RG, Mattrey RF. MR imaging of disorders of the brachial plexus. <i>J Magn Reson Imaging</i> 1994; 4(1):13-18.	10	64	To evaluate the role of MRI in suspected brachial plexus abnormalities.	Follow-up was available for 43 patients. MRI was 63% sensitive, 100% specific and 77% accurate. Sensitivity increased to 81%, and accuracy to 88% (specificity unchanged) when patients with neoplastic and traumatic disorders were considered separately. Study recommends MRI for a wide range of brachial plexus abnormalities.	3
3. Collins JD, Shaver ML, Disher AC, Miller TQ. Compromising abnormalities of the brachial plexus as displayed by magnetic resonance imaging. <i>Clin Anat</i> 1995; 8(1):1-16.	13	85	Review reports on MRI of the brachial plexus.	MRI and 3-D reconstruction increased the definition of the clinical anatomy and resulted in greater knowledge of patient care management.	3
4. van Es HW, Witkamp TD, Ramos LMP, et al. MR imaging of the brachial plexus using a T1-weighted three-dimensional volume acquisition. <i>Int J Neuroradiol</i> 1996; 2:264-273.	10	55	To assess the use of T1-weighted 3D-volume acquisition in the evaluation of anatomy and pathology of the brachial plexus.	Normal anatomy seen in 26 patients. Abnormal morphology in 29 patients. T1-weighted 3D-volume acquisition demonstrated well the anatomy of the brachial plexus.	3
5. Reeder SB, Yu H, Johnson JW, et al. T1- and T2-weighted fast spin-echo imaging of the brachial plexus and cervical spine with IDEAL water-fat separation. <i>J Magn Reson Imaging</i> 2006; 24(4):825-832.	9	5	To compare the iterative decomposition of water and fat with echo asymmetry and least-squares estimation (IDEAL) method with fat-saturated T1-weighted (T1W) and T2W fast spin-echo (FSE) and short-TI inversion recovery (STIR) imaging of the brachial plexus and cervical spine.	<ul style="list-style-type: none"> • T1W and T2W IDEAL-FSE showed superior fat suppression (P<0.05) and image quality (P<0.05), compared to T1W and T2W fat-saturated FSE, respectively. • Compared to STIR, T2W IDEAL-FSE showed superior image quality (P<0.05), comparable fat suppression (excellent, P=1.0), and higher signal to noise ratio (SNR) performance (P<0.001). 	4
6. Zhang ZW, Song LJ, Meng QF, et al. High-resolution diffusion-weighted MR imaging of the human lumbosacral plexus and its branches based on a steady-state free precession imaging technique at 3T. <i>AJNR Am J Neuroradiol</i> 2008; 29(6):1092-1094.	13	N/A	To define structures of the human lumbosacral plexus (LSP) with 3D diffusion-weighted steady-state free precession imaging (3D DW-SSFP).	3D DW-SSFP clearly revealed detailed anatomy of the LSP and its branches. Results suggest that the sequence based on 3D DW-SSFP can be used for high-resolution MRI of the peripheral nervous system.	3

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7. Tsuchiya K, Fujikawa A, Tateishi H, Nitatori T. Visualization of cervical nerve roots and their distal nerve fibers by diffusion-weighted scanning using parallel imaging. <i>Acta Radiol</i> 2006; 47(6):599-602.	13	13	To report a technique developed for visualization of cervical nerve roots and their distal nerve fibers by diffusion-weighted scanning using parallel imaging. A maximum intensity projection for a stack of isotropic axial diffusion-weighted images obtained with parallel imaging applying a motion-probing gradient in 6 directions with a b-value of 500 s/mm ² was performed.	Method was useful for visualizing the spinal cord and majority of the nerve roots, the dorsal root ganglia, and proximal peripheral nerves.	3
8. Chappell KE, Robson MD, Stonebridge-Foster A, et al. Magic angle effects in MR neurography. <i>AJNR Am J Neuroradiol</i> 2004; 25(3):431-440.	13	10 volunteers 2 patients with rheumatoid arthritis	To examine the hypothesis that signal intensity from peripheral nerves is increased when the nerve's orientation to the constant magnetic induction field (B (0)) approaches 55 degrees.	Signal intensity of peripheral nerves changes with orientation to B (0). Differences in signal intensity with orientation may simulate disease and be a source of diagnostic confusion.	3
9. Bertelli JA, Ghizoni MF. Use of clinical signs and computed tomography myelography findings in detecting and excluding nerve root avulsion in complete brachial plexus palsy. <i>J Neurosurg</i> 2006; 105(6):835-842.	9	32	Prospective study to determine the usefulness of clinical signs and CT myelography findings in detecting and excluding nerve root avulsion in total brachial plexus palsy.	Clinical examination and CT myelography allowed correct surgical planning in more than 90% of the cases.	3
10. Walker AT, Chaloupka JC, de Lotbiniere AC, Wolfe SW, Goldman R, Kier EL. Detection of nerve rootlet avulsion on CT myelography in patients with birth palsy and brachial plexus injury after trauma. <i>AJR</i> 1996; 167(5):1283-1287.	14	8	Retrospective study to evaluate the value of thin-section high-resolution CT myelography for revealing cervicothoracic nerve rootlet avulsion in patients with birth palsy and brachial plexus injury after trauma.	Of 21 imaged levels, 20 were correctly revealed on CT myelography with 95% sensitivity and 98% specificity.	4
11. Hathaway PB, Mankoff DA, Maravilla KR, et al. Value of combined FDG PET and MR imaging in the evaluation of suspected recurrent local-regional breast cancer: preliminary experience. <i>Radiology</i> 1999; 210(3):807-814.	9	10 patients 9 patients had breast cancer metastases	Retrospective study to assess the value of combined FDG-PET and MRI in the evaluation of suspected recurrent local-regional breast cancer.	MRI was diagnostic for tumor in 5 and indeterminate in 4 with axillary or chest wall metastases. For FDG-PET, metastatic tumor was positively identified in all 9. MRI and FDG-PET are complementary in detecting and characterizing local-regional breast cancer metastases.	4
12. Planner AC, Donaghy M, Moore NR. Causes of lumbosacral plexopathy. <i>Clin Radiol</i> 2006; 61(12):987-995.	12	N/A	Review role of imaging (MRI and CT) in diagnosing structural lesions affecting the lumbosacral plexus.	Clinical history and tissue sampling are necessary in achieving accurate diagnosis.	4
13. Beekman R, van den Berg LH, Franssen H, Visser LH, van Asseldonk JT, Wokke JH. Ultrasonography shows extensive nerve enlargements in multifocal motor neuropathy. <i>Neurology</i> 2005; 65(2):305-307.	13	21	To evaluate use of US in patients with multifocal motor neuropathy (MMN).	US and electrophysiologic studies revealed more abnormalities. US showed nerve enlargement without clinical or electrophysiologic abnormalities.	3

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14. Cash CJ, Sardesai AM, Berman LH, et al. Spatial mapping of the brachial plexus using three-dimensional ultrasound. <i>Br J Radiol</i> 2005; 78(936):1086-1094.	13	10	To examine the role of 3D US in mapping the orientation of the brachial plexus in relation to the first rib, carotid and subclavian arteries.	3D reconstructions showed the plexus, changing its orientation from a vertical alignment in the interscalene region to a more horizontal alignment in the supraclavicular fossa. Spatial mapping of the brachial plexus is possible with 3DUS using the subclavian artery and first rib as landmarks.	3
15. Graif M, Martinoli C, Rochkind S, et al. Sonographic evaluation of brachial plexus pathology. <i>Eur Radiol</i> 2004; 14(2):193-200.	9	28	To examine the role of preoperative US in recognizing lesions in the brachial plexus and comparing them to surgical findings.	Abnormal US findings were detected in 20/28 patients. US depicted a spectrum of lesions of traumatic, neoplastic, and inflammatory nature in the brachial plexus. It provided useful information regarding the lesion site, extent, and anatomic relationships.	3
16. Gruber H, Glodny B, Galiano K, et al. High-resolution ultrasound of the supraclavicular brachial plexus--can it improve therapeutic decisions in patients with plexus trauma? <i>Eur Radiol</i> 2007; 17(6):1611-1620.	10	12 patients 168 plexus elements	Prospective, observational study to evaluate the impact of high-resolution US on recruitment for non-delayed surgery in patients with plexus trauma.	Major plexus lesions were correctly detected by high-resolution US in 9 patients (20 plexus elements). Analysis revealed PPV (1.0) and NPV (0.92) for the grading of traumatic plexus lesions. 9/11 patients with objective major lesions would have undergone early surgery based on high-resolution US findings alone.	3
17. Binder DK, Smith JS, Barbaro NM. Primary brachial plexus tumors: imaging, surgical, and pathological findings in 25 patients. <i>Neurosurg Focus</i> 2004; 16(5):E11.	9	25	Retrospective review of imaging, surgical, and pathological findings in patients with primary brachial plexus tumors. Compared findings with those obtained in similar series.	Signs and symptoms revealed were palpable mass (60%), numbness/paresthesias (44%), radiating pain (44%), local pain (16%), and weakness (12%). Primary tumors arising in the brachial plexus are rare. Treatment can be improved by careful workup, surgical technique, and attention to pathological diagnosis.	3
18. Saifuddin A. Imaging tumours of the brachial plexus. <i>Skeletal Radiol</i> 2003; 32(7):375-87.	12	N/A	Review imaging features of brachial plexus tumors with emphasis on MRI.	Benign neurogenic tumors are well characterized with preoperative MRI. Benign non-neurogenic tumors, such as lipoma and fibromatosis, are also well characterized by MRI.	4
19. Aagaard BD, Maravilla KR, Kliot M. MR neurography. MR imaging of peripheral nerves. <i>Magn Reson Imaging Clin N Am</i> 1998; 6(1):179-194.	12	N/A	To describe appearance of normal peripheral nerves together with imaging characteristics of various types of nerve pathology.	MR neurography techniques permit imaging detection of peripheral nervous system pathology that in some cases allow earlier and more accurate diagnosis.	4
20. Britz G, West G, Daily A, et al. Magnetic resonance imaging in evaluation and treating peripheral nerve problems. <i>Perspect Neuro Surg</i> 1995; 6:53-66.	12	N/A	Review MRI in evaluation and treating peripheral nerve problems.	MRI can help to assess the location, extent and grade of a peripheral nerve injury.	4

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21. de Verdier HJ, Colletti PM, Terk MR. MRI of the brachial plexus: a review of 51 cases. <i>Comput Med Imaging Graph</i> 1993; 17(1):45-50.	13	51	To retrospectively review cases of MRI of the brachial plexus.	T1-weighted sequences and double-echo (intermediate- and T2-weighted) spin-echo images. 20 had proven pathological brachial plexus involvement. 31 no brachial plexus involvement. 4 MRI were not in agreement.	3
22. Posniak HV, Olson MC, Dudiak CM, Wisniewski R, O'Malley C. MR imaging of the brachial plexus. <i>AJR</i> 1993; 161(2):373-379.	12	N/A	Review MRI of the brachial plexus, anatomy, and illustrate normal and abnormal findings.	The brachial plexus is well indicated by MRI. MRI has direct multiplanar imaging capability and superior soft-tissue resolution.	4
23. Pierce SM, Recht A, Lingos TI, et al. Long-term radiation complications following conservative surgery (CS) and radiation therapy (RT) in patients with early stage breast cancer. <i>Int J Radiat Oncol Biol Phys</i> 1992; 23(5):915-923.	3c	1,624	Retrospective study to examine long-term radiation complications following conservative surgery and radiation therapy in patients with early stage breast cancer.	The risk of significant complications following conservative surgery and radiation therapy for early stage breast cancer is low.	2
24. Varma DG, Mouloupoulos A, Sara AS, et al. MR imaging of extracranial nerve sheath tumors. <i>J Comput Assist Tomogr</i> 1992; 16(3):448-453.	13	32 tumors 23 benign and 9 malignant	To retrospectively review MRI of extracranial nerve sheath tumors (NSTs).	MRI cannot distinguish schwannomas from neurofibromas, and benign tumors may mimic malignant NSTs.	3
25. Duggins AJ, McLeod JG, Pollard JD, et al. Spinal root and plexus hypertrophy in chronic inflammatory demyelinating polyneuropathy. <i>Brain</i> 1999; 122(Pt 7):1383-1390.	13	14	To evaluate MRI on the spinal roots, brachial and lumbar plexuses in patients with chronic inflammatory demyelinating polyneuropathy (CIDP).	Spinal root and plexus hypertrophy may be seen on MRI, especially in CIDP of long duration, and gadolinium enhancement may be present in active disease.	3
26. Van den Bergh PY, Thonnard JL, Duprez T, Laterre EC. Chronic demyelinating hypertrophic brachial plexus neuropathy. <i>Muscle Nerve</i> 2000; 23(2):283-288.	14	1	To examine a case of chronic demyelinating hypertrophic brachial plexus neuropathy.	MRI disclosed marked brachial plexus hypertrophy.	4
27. Van Es HW, Van den Berg LH, Franssen H, et al. Magnetic resonance imaging of the brachial plexus in patients with multifocal motor neuropathy. <i>Neurology</i> 1997; 48(5):1218-1224.	10	9 patients- MNN 8patients- LMND 174-Controls	To determine whether MRI of the brachial plexus is useful to distinguish MMN from lower motor neuron disease (LMND) and whether abnormalities resemble those of CIDP.	MRI abnormalities of the brachial plexus in patients with MMN resemble those seen in CIDP and may be useful to distinguish MMN from LMND.	2
28. Masuda N, Hayashi H, Tanabe H. Nerve root and sciatic trunk enlargement in Dejerine-Sottas disease: MRI appearances. <i>Neuroradiology</i> 1992; 35(1):36-37.	14	1	Case report on MRI and chest radiographs findings of a 23-year old female with weakness of upper and lower limbs since infancy.	<ul style="list-style-type: none"> • Chest radiograph showed bilateral rounded soft tissue density masses at the apices. • MRI showed marked enlargement of cervical and lumbar spinal nerve roots and revealed that the masses seen on chest radiograph were enlarged nerve roots; it also demonstrated enlarged sciatic trunks. 	4

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29. Tachi N, Kozuka N, Ohya K, et al. MRI of peripheral nerves and pathology of sural nerves in hereditary motor and sensory neuropathy type III. <i>Neuroradiology</i> 1995; 37(6):496-499.	14	2	To examine patients with hereditary motor and sensory neuropathy type III based on nerve pathology and MRI of the sciatic nerve.	MRI of the sciatic nerve may be helpful for characterization of demyelinating disease and its prognosis.	4
30. Weiland TL, Scheithauer BW, Rock MG, Sargent JM. Inflammatory pseudotumor of nerve. <i>Am J Surg Pathol</i> 1996; 20(10):1212-1218.	14	2	To describe cases of inflammatory pseudotumor.	Inflammatory pseudotumors must be included in the differential diagnosis of tumor-like lesions of peripheral nerve.	4
31. van Alfen N, van Engelen BG. The clinical spectrum of neuralgic amyotrophy in 246 cases. <i>Brain</i> 2006; 129(Pt 2):438-450.	15	246 patients 199 patients- INA 47 patients- HNA	To examine the symptoms, course and prognosis of neuralgic amyotrophy (NA) in patients with idiopathic neuralgic amyotrophy (INA) and hereditary neuralgic amyotrophy (HNA) to understand the clinical spectrum of the disorder.	No correlation was seen between the distribution of motor and sensory symptoms. Overall recovery was less favorable, with persisting pain and paresis in approximately two-thirds of the patients who were followed for 3 or more years.	3
32. Seddon HJ. Three types of nerve injuries. <i>Brain</i> 1943; 66:238-283.	15	650 cases	Review the three types of nerve injuries leading to loss of function.	Methods of investigation: Anatomical approach: Naked-eye and histological examination of lesions is of value after complete or partial division. Experimental approach: Compare the results of clinical with those of experimental observation when the clinical classification has been completed.	3
33. Sunderland S. A classification of peripheral nerve injuries producing loss of function. <i>Brain</i> 1951; 74(4):491-516.	15	Over 300 cases	Review Seddon's (1943) classification of peripheral nerve injuries leading to loss of function and propose a new classification system.	Classify peripheral nerve injury based on the extent of the damage to the normal anatomy of the nerve trunk. 5 degrees of injury, in ascending grades of severity, have been defined. These affect successively conductivity, the continuity of the axon, the endoneurial tube and its contents, the funiculus and its contents and continuity of the nerve trunk	3
34. Millesi H. Brachial plexus injuries: management and results. In: Terzis JK, ed. <i>Microreconstruction of nerve injuries</i> . Philadelphia, Pa: WB Saunders; 1987:347-359.	15	N/A	Book chapter.	N/A	N/A

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35. Rankine JJ. Adult traumatic brachial plexus injury. <i>Clin Radiol</i> 2004; 59(9):767-774.	12	N/A	Describe the anatomy and pathophysiology of adult traumatic brachial plexus injury and review merits of MRI and CT myelography.	MRI has made possible high-resolution images, which can demonstrate root avulsion, making CT myelography unnecessary. The main disadvantage of MRI in patients who usually have other injuries is motion artifact.	4
36. Tsai PY, Chuang TY, Cheng H, Wu HM, Chang YC, Wang CP. Concordance and discrepancy between electrodiagnosis and magnetic resonance imaging in cervical root avulsion injuries. <i>J Neurotrauma</i> 2006; 23(8):1274-1281.	9	37	Compared findings in patients with cervical root avulsion injuries to clarify the relationships between electromyography (EMG) and MRI.	Nerve root repair with C4-T1 hemilaminectomy was performed on 19 patients. Both EMG and the MRI are useful in preoperative assessment, and may complement each other.	3
37. Carvalho GA, Nikkiah G, Matthies C, Penkert G, Samii M. Diagnosis of root avulsions in traumatic brachial plexus injuries: value of computerized tomography myelography and magnetic resonance imaging. <i>J Neurosurg</i> 1997; 86(1):69-76.	9	135 cervical roots	Prospective study to determine the value of CT myelography and MRI in the diagnosis of root avulsions in traumatic brachial plexus injuries.	CT myelography-based diagnosis was 85%. MRI had accuracy of 52%. CT myelography using 1-3-mm axial slices is the most reliable method to evaluate preoperatively the presence of complete or partial root avulsion in traumatic brachial plexus injuries.	2
38. Doi K, Otsuka K, Okamoto Y, Fujii H, Hattori Y, Baliarsing AS. Cervical nerve root avulsion in brachial plexus injuries: magnetic resonance imaging classification and comparison with myelography and computerized tomography myelography. <i>J Neurosurg</i> 2002; 96(3 Suppl):277-284.	9	35 patients with brachial plexus 10 healthy patients	To assess accuracy and reproducibility of a MRI-derived classification for diagnosis of nerve root avulsion compared with those of myelography combined with CT myelography. Retrospectively evaluate results and classify into 4 groups. 8 observers prospectively assessed MRI based classification.	<ul style="list-style-type: none"> • Retrospective study: sensitivity of detection of the cervical nerve root avulsion was the same (92.9%) for both modalities. • Prospective study: no statistically significant difference between MRI and myelography/CT myelography and accuracy is same as retrospective study. • MRI is a reliable and reproducible method for detecting nerve root avulsion. 	2
39. Gasparotti R, Ferraresi S, Pinelli L, et al. Three-dimensional MR myelography of traumatic injuries of the brachial plexus. <i>AJNR Am J Neuroradiol</i> 1997; 18(9):1733-1742.	9	20	To determine the accuracy of 3D MR myelography in the evaluation of traumatic injuries of the brachial plexus. 3D MR myelographic was compared with at cervical myelography and CT myelography.	3-D MR myelography had 89% sensitivity, 95% specificity, and 92% diagnostic accuracy. 3D MR myelography is recommended for patients with traumatic brachial plexus palsy.	2
40. Ochi M, Ikuta Y, Watanabe M, Kimori K, Itoh K. Ochi M, Ikuta Y, Watanabe M, et al. The diagnostic value of MRI in traumatic brachial plexus injury. <i>J Hand Surg [Br]</i> 1994; 19(1):55-59.	9	34	Compare findings of patients with traumatic brachial plexus injury documented by surgical exploration and intra-operative somatosensory-evoked potentials with that of myelography and MRI to determine if MRI can identify nerve root avulsion.	MRI had accuracies of 73% for C5 and 64% for C6 while that of myelography was 63% for C5 and 64% for C6.	2
41. Sherrier RH, Sostman HD. Magnetic resonance imaging of the brachial plexus. <i>J Thorac Imaging</i> 1993; 8(1):27-33.	12	N/A	Describe MR anatomy of the brachial plexus in the axial, coronal, and sagittal planes and review MR characteristics of brachial plexopathy.	MRI has multiplanar capability and ability to differentiate nerves from vessels and surrounding soft tissues.	4

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42. Beltran J, Rosenberg ZS. Diagnosis of compressive and entrapment neuropathies of the upper extremity: value of MR imaging. <i>AJR</i> 1994; 163(3):525-531.	12	N/A	To review value of MRI in the diagnosis of compressive and entrapment neuropathies.	MRI is the best technique for accurate delineation of soft-tissue lesions, and is suitable for the diagnosis of compressive and entrapment neuropathies.	4
43. Cherington M, Wilbourn AJ, Schils J, Whitaker J. Thoracic outlet syndromes and MRI. <i>Brain</i> 1995; 118 (Pt 3):819-821.	15	N/A	Comment to Panegyres et al (1993) to dispute their article, 'Thoracic outlet syndromes and magnetic resonance imaging'. Disagreed with their conclusions and the assumption that a common type of neurological thoracic outlet syndrome along with the true form exists and their interpretations of MRI.	In an attempt to correlate clinical symptoms with MRI abnormalities, Panegyres et al went too far, since there is no clear evidence of MRI abnormalities. Clinicians must use caution before making a diagnosis of neurological thoracic outlet syndromes and caution in 'over-reading' brachial plexus 'abnormalities' on MRI.	4
44. Panegyres PK, Moore N, Gibson R, Rushworth G, Donaghy M. Thoracic outlet syndromes and magnetic resonance imaging. <i>Brain</i> 1993; 116 (Pt 4):823-841.	10	20	To examine the role of MRI of the brachial plexus in patients with suspected thoracic outlet syndrome. Blind interpretation of MRI.	Deviation of the brachial plexus (sensitivity 79%). Absence of distortion (specificity 87.5%). False positive rate was 9.5%.MRI demonstrates deviation or distortion of nerves or blood vessels; suggest the presence of radiographically invisible bands; disclose other causes of thoracic outlet syndrome apart from ribs or bands.	3
45. Thyagarajan D, Cascino T, Harms G. Magnetic resonance imaging in brachial plexopathy of cancer. <i>Neurology</i> 1995; 45(3 Pt 1):421-427.	9	71	Retrospectively review clinical records of patients with cancer and brachial plexopathy who had an MRI of the brachial plexus. MRIs were reevaluated in a blinded fashion. MRI was compared with CT.	MRI was highly predictive of tumor infiltration. MRI was very sensitive for brachial plexus abnormalities. MRI is better than CT.	2
46. Wittenberg KH, Adkins MC. MR imaging of nontraumatic brachial plexopathies: frequency and spectrum of findings. <i>Radiographics</i> 2000; 20(4):1023-1032.	13	104 patients 136 MRI studies	Retrospective study to evaluate the frequency and findings of MRI in patients with nontraumatic brachial plexopathy.	Findings: thickening and diffuse enhancement of the brachial plexus without focal mass and soft-tissue changes with low signal intensity on both T1- and T2-weighted images.	2
47. Wouter van Es H, Engelen AM, Witkamp TD, et al. Radiation-induced brachial plexopathy: MR imaging. <i>Skeletal Radiol</i> 1997; 26(5):284-288.	14	3	To describe the MRI appearance of radiation-induced brachial plexopathy.	Radiation fibrosis can have either low or high signal intensities on T2-weighted images.	4
48. American College of Radiology. <i>Manual on Contrast Media</i> . Available at: http://www.acr.org/SecondaryMainMenuCategories/quality_safety/contrast_manual.aspx .	15	N/A	Guidance document on contrast media to assist radiologists in recognizing and managing risks associated with the use of contrast media.	N/A	3

Evidence Table Key

Study Type Key

Numbers 1-7 are for studies of therapies while numbers 8-15 are used to describe studies of diagnostics.

1. Randomized Controlled Trial — Treatment
2. Controlled Trial
3. Observation Study
 - a. Cohort
 - b. Cross-sectional
 - c. Case-control
4. Clinical Series
5. Case reviews
6. Anecdotes
7. Reviews

8. Randomized Controlled Trial — Diagnostic
9. Comparative Assessment
10. Clinical Assessment
11. Quantitative Review
12. Qualitative Review
13. Descriptive Study
14. Case Report
15. Other (Described in text)

Strength of Evidence Key

- Category 1 - The conclusions of the study are valid and strongly supported by study design, analysis and results.
- Category 2 - The conclusions of the study are likely valid, but study design does not permit certainty.
- Category 3 - The conclusions of the study may be valid but the evidence supporting the conclusions is inconclusive or equivocal.
- Category 4 - The conclusions of the study may not be valid because the evidence may not be reliable given the study design or analysis.