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Fwd: MRI shoulders

1 message

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To: Emma Mailler <emma@kinelli.com.au>

The main differences between the shoulders is the inflammation in the subacromial and subdeltoid bursa, the small anterior osteophyte and subscap. muscle issues on the right. I think the impingement on the R) is coming from the bursal thickening/inflammation and possible a little from the osteophyte, however since you can create a clear motion then I do not think to osteophyte is the main issue. A few more specific and careful rotator cuff and scapular patterning exercises should start to make more of a difference now.

They do not tend to inject tendon tears, possibly tendinitis, but I will leave that up the Dr Duncan to decide. He is usually happy to inject the bursa and yes that may help it along the rehab path a bit quicker. My referral should do to get that done. I think I wrote please inject as required on it?

I have seen worse, so I do expect it to continue to get better

MRI BILATERAL SHOULDERS**Referral notes**

Left shoulder impingement? Subacromial bursitis? Rotator cuff tear? AC joint degenerative change? Glenohumeral joint change

If possible please assess right shoulder.

TECHNIQUE: 3 Tesla MRI bilateral shoulders (coronal and axial PD and PD fat sat, sagittal T2 fat sat and PD)

Report

Right shoulder:

There are moderate osteoarthritic changes of right AC joint. The undersurface of the acromion is flat. There is no anteriorly pointing osteophyte. The CA ligament and the CC ligament are intact and normal.

There is no loss of subacromial distance.

There is no os acromiale.

There is a partial thickness articular surface tear of the supraspinatus measuring 7.3 mm anterior to posterior. There are no full thickness tears. The muscle bulk of the supraspinatus is preserved. There is associated mild tendinosis.

There is tendinosis of infraspinatus with no discrete tears. There are changes of insertional enthesopathy at the medial facet of the greater tubercle.

The muscle bulk is preserved.

There is tendinosis of the sub scapularis with partial thickness undersurface tear of the superior and mid fibres. There is slight medialisation of the long head of biceps tendon from the bicipital

groove. The intracapsular portion of the long head of biceps tendon demonstrate mild changes of tendinosis.

There is anatomical variation of sub labral foramina. Separate to this is a tear of the superior labrum which progresses into the long head of biceps tendon and posteriorly down to 9 o'clock with anterior extension to 3 o'clock. Findings are consistent with type II slap tear. There are no tears of the anterior inferior and posterior inferior labrum.

There is no glenoid hypoplasia. There is mild thinning of the articular cartilage at the inferior glenoid. Normal appearance of the suprascapular and speno glenoid notch.

There is no thickening of the inferior joint capsule. The anterior and posterior band of the inferior glenohumeral ligament are preserved.

Left shoulder:

There are moderate osteoarthritic changes of the left AC joint. The undersurface of the acromion is flat. There is a small anteriorly pointing osteophyte. No os acromiale. The CA ligament and the coracoclavicular ligament are intact and normal.

There is tendinosis of the supraspinatus with a partial thickness articular surface tear measuring 6.5 mm anterior to posterior. There is small amount of subacromial subdeltoid bursal fluid.

There is tendinosis of the infraspinatus with no discrete tears.

There is incomplete full-thickness partial width tear of the superior fibres of sub scapularis which extends down to the musculotendinous junction. The tear has been filled by joint fluid. There is slight medialisation of the extracapsular portion of the long head of biceps tendon.

There is small amount of fluid in the biceps tendon sheath. There is also tendinosis of the intracapsular portion of the long head of biceps tendon with abnormal signal undercutting the biceps anchor with tear of the superior labrum the tear extends posteriorly down to 9 o'clock and anteriorly to 3 o'clock. Findings are consistent with type II slap tear.

There are no tears of the anterior inferior or posterior inferior labrum.

There is mild thinning of the articular cartilage at the inferior medial humeral head and inferior glenoid.

There is no thickening of the inferior joint recess. The anterior and the posterior band of inferior glenohumeral joint are intact.

Normal appearance of the suprascapular notch and speno glenoid notch. The muscle bulk around the shoulder joint is preserved.

Conclusion

Right shoulder:

Moderate osteoarthritis AC joint with no active synovitis. Partial thickness tear of supraspinatus with tendinosis. Type II SLAP tear.

Left shoulder:

Moderate osteoarthritis AC joint with no active synovitis. Tear of the sub scapularis as described. Type II slap tear.

All the Key findings have been saved as PACS images for your perusal.

Radiologist: Dr J. Shekhawat