



National Diagnostic
IMAGING

NAME: PATIENT NUMBER:
REF. PHYSICIAN: STUDY DATE: 10/30/2015
DATE OF BIRTH: GENDER: F
EXAM: LT SHOULDER
CLINICAL HISTORY: PAIN IN LT SHOULDER WITH NO KNOWN TRAUMA.

INDICATIONS: Pain without trauma.

PROCEDURE: MR LEFT SHOULDER

TECHNIQUE: T1, proton density, T2, and/or inversion recovery images were obtained in the axial, coronal, and sagittal planes.

FINDINGS:
GH Joint and Labrum: There is no glenohumeral joint effusion. There are no glenohumeral joint degenerative changes. The labrum is normal in appearance.

AC Joint & Impingement: Increased fluid and synovium mildly expand the acromioclavicular joint. There is no widening of the joint or disruption of the coracoclavicular ligaments. The findings are consistent with a moderate active a.c. joint arthropathy which could represent a primary source for pain. There is contact with the underlying supraspinatus.

The acromiohumeral space is normal despite a type II acromion. There is no thickening of the coracoacromial ligament. The distance between the coracoid and humeral head is not narrowed.

Rotator Cuff: Changes in the supraspinatus tendon anteriorly are consistent with moderate tendinopathy. The posterior portion of the tendon is more normal in appearance. There is no partial or full thickness tearing. The infraspinatus, teres minor and subscapularis muscles and tendons are normal.

Bursa: No fluid.

Biceps, Deltoid, other muscles: There are no abnormalities of the biceps or deltoid.

Bones: No osseous abnormalities are present.

Other: No pathology is seen in the spinoglenoid notch, quadrilateral space or axilla.

IMPRESSION:
1. A moderate active a.c. joint arthropathy could represent a primary source for pain.
2. Mild to moderate supraspinatus tendinopathy.
3. Type II acromion.

G. Tuckman, MD

GT/GT

Electronically Signed by and Verified

Date Report Signed: 10/30/2015 4:02:55 PM

COMPLETING YOUR IMAGE

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