STAND-UP MRI OF THE BRONX, P.C.
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MAGNETIC RESONANCE IMAGING OF THE LEFT SHOULDER

TECHNIQUE: 30 Degree Tilt: Axial T1, Axial PD STIR, Coronal PD, Coronal T2, Sagittal T2

HISTORY: The patient complains of left shoulder pain, numbness and limited range of motion.

INTERPRETATION: The subdeltoid/subacromial bursae are within normal. There is mild insertional supraspinatus and infraspinatus tendinosis. There is no discrete rotator cuff tear. The subscapularis tendon is maintained. The rotator cuff muscle bulk and signal are within normal.

There is a mild long head of the biceps tenosynovitis. The long head of the biceps tendon is anatomically located within its bicipital groove, demonstrates a normal-appearing intra-articular portion, and originates from an intact biceps labral anchor complex. The glenoid labrum demonstrates a tear of the anterior superior aspect. The glenohumeral cartilage is preserved. The axillary pouch is normal in appearance. The subcoracoid fat is preserved.

There is acromioclavicular (AC) joint ligamentous/capsular stripping and thickening secondary to sequelae of sprain/interstitial tearing. There is a low-lying acromion morphology. The acromion demonstrates a flat morphology in the sagittal plane.

IMPRESSION:

- MRI of the left shoulder demonstrates mild insertional rotator cuff tendinosis.
- Mild long head of the biceps tenosynovitis.
- Anterior superior glenoid labral tear.
- AC Joint Sprain sequelae.

- Low-lying acromion morphology.

Sincerely,

Eric Feldmann, MD
Diplomate, American Board of Radiology
With Fellowship in Musculoskeletal Imaging
EF/ad