

DIAGNOSTIC MUSCULOSKELETAL ULTRASOUND REPORT

Right Shoulder Examination – Complete Evaluation

Patient Name:

Age:

Sex:

DOB:

Date of Examination:

Time:

Facility:

Performing/Interpreting Provider:

Indication

Dominant shoulder pain with overhead activity. Remote history of skiing-related fall. Former competitive gymnast and swimmer.

Examination Performed

Comprehensive bilateral shoulder musculoskeletal ultrasound was performed using a high-frequency linear transducer. Structures were evaluated in long- and short-axis planes. Dynamic assessment was performed during active abduction and ABER positioning. Images were labeled with patient identifiers, laterality, and date/time in accordance with AIUM documentation standards.

Findings

Long Head of the Biceps Tendons

The long head of the biceps tendons are normally positioned within the bicipital grooves bilaterally. Preserved fibrillar echotexture. No tenosynovial effusion or dynamic subluxation identified.

Subscapularis Tendons

Intact bilaterally with preserved fibrillar architecture and normal insertional footprint. No partial or full-thickness tear identified.

Supraspinatus Tendons

Dominant Shoulder:

Supraspinatus tendon thickening with focal articular-sided partial thickness fiber discontinuity involving less than 50% of tendon thickness, consistent with low-grade articular-sided partial tearing in the setting of tendinopathy. Mild surrounding tendinopathic heterogeneity noted. No full-thickness tear. No tendon retraction.

Contralateral Shoulder:

Supraspinatus tendon demonstrates mild articular-sided tendinopathic change with subtle fiber irregularity. No measurable partial thickness defect exceeding 50% tendon depth. No retraction.

Infraspinatus and Teres Minor

Intact bilaterally with preserved echotexture. No focal tear identified.

Posterior–Superior Humeral Head / Greater Tuberosity

Symmetric bilateral posterior–superior cortical irregularity measuring 0.97 cm (9.7 mm) in longitudinal extent. Cortical continuity is preserved without focal depression or compression defect. Findings are consistent with chronic adaptive remodeling related to repetitive overhead loading.

Subacromial–Subdeltoid Bursa

Dominant shoulder demonstrates mild thickening measuring 0.36 cm (3.6 mm) in maximal long-axis dimension. No significant anechoic effusion. No hyperemia observed.

Contralateral bursa within normal limits.

Acromioclavicular Joints

Mild bilateral degenerative changes with cortical irregularity and mild joint space narrowing. No effusion or dynamic instability identified.

Glenohumeral Joint

Humeral head cortical margins are intact. The visualized labral region does not demonstrate a discrete tear. Joint space appears maintained.

Dynamic Assessment

- ABER positioning reproduces discomfort bilaterally.
 - Scapular assist maneuver improves symptoms on the dominant side.
 - Resisted external rotation produces mild discomfort on the dominant side without objective weakness.
 - No superior humeral head migration observed during active abduction.
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Impression

1. Bilateral supraspinatus tendinopathy with low-grade articular-sided partial thickness fiber involvement, more pronounced on the dominant side (<50% tendon thickness), without retraction.
2. Bilateral posterior–superior cortical remodeling measuring 0.97 cm, consistent with chronic overhead athletic adaptation.
3. Mild reactive subacromial–subdeltoid bursopathy on the dominant side (bursal thickness 3.6 mm) without significant effusion.
4. Mild bilateral acromioclavicular degenerative changes.
5. No sonographic evidence of high-grade partial or full-thickness tear.

Overall findings are most consistent with chronic overhead athletic adaptation with dominant-side rotator cuff load intolerance in the setting of scapular dyskinesia.