Spectrum of magnetic resonance imaging findings in clinical glenohumeral instability

Manisha Jana, Deep Narayan Srivastava, Raju Sharma, Shivanand Gamanagatti, Hiralal Nag1, Ravi Mittal1, Ashish Dutt Upadhyay2

Departments of Radiodiagnosis, 1Orthopaedics, 2Biostatistics, All India Institute of Medical Sciences, Ansari Nagar, New Delhi, India

Correspondence: Dr. Manisha Jana, Department of Radiodiagnosis, All India Institute of Medical Sciences, Ansari Nagar, New Delhi -110 029, India. E-mail: manishajana@gmail.com

Abstract

The glenohumeral joint is the most commonly dislocated joint in the body, and anterior instability is the most common type of shoulder instability. Depending on the etiology and the age of the patient, there may be associated injuries, for example, to the anterior-inferior labro-ligamentous structures (in young individuals with traumatic instability) or to the bony components (commoner in the elderly), which are best visualized using MRI and MR arthrography. Anterior instability is associated with a Bankart lesion and its variants and abnormalities of the anterior band of the inferior glenohumeral ligament (IGHL), whereas posterior instability is associated with reverse Bankart and reverse Hill-Sachs lesions. Cases of multidirectional instability often have no labral pathology on imaging but show specific osseous changes including increased chondrolabral retroversion. This article reviews the relevant anatomy in brief and describes the MRI findings in each type, with the imaging features of the common abnormalities.

Key words: Bankart lesion; Glenohumeral instability; magnetic resonance arthrogram; magnetic resonance imaging

Introduction

The glenohumeral joint is the most mobile and most commonly dislocated joint in the body, and shoulder instability is a common clinical problem, especially in young active individuals. Glenohumeral instability can be classified in many ways, for example, (a) according to degree (subluxation vs dislocation), (b) acute vs recurrent, (c) with respect to direction, i.e., unidirectional (when it may be anterior, posterior, or inferior) or multidirectional or gross instability.

Anterior shoulder instability is much more common than posterior instability. The presentation of patients with posterior shoulder instability is with pain and a click on the posterior aspect of the shoulder.

Instability can also be classified according to the etiology, i.e., traumatic or atraumatic.

Relevant anatomy

The shoulder joint is a ball and socket type of joint that has two main stabilizers: the rotator cuff muscles (dynamic) and the labral-ligamentous complex (static). The primary function of the rotator cuff muscles (supraspinatus, infraspinatus, teres minor, and subscapularis) is to centralize the humeral head, limiting superior translation during abduction.

The glenoid labrum is the ring of fibrocartilage (triangular in cross-section) that provides attachment to the glenohumeral ligaments and the capsule at the glenoid rim and deepens the glenoid fossa. The normal glenoid labrum height and width are 3 mm and 4 mm, respectively, but the shape and size are subject to considerable variation.
The rotator cuff interval (RCI) refers to the discontinuity of the rotator cuff seen between the superior border of the subscapularis and the anterior border of the supraspinatus tendon, which results from interruption of the rotator cuff by the coracoid process.\[7\]

**Imaging technique**

MRI arthrography (MRA) is the imaging method of choice in shoulder instability, especially recurrent instability in the young,\[1\] where labro-ligamentous pathologies are common. Direct MRA is a two-phase procedure in which intra-articular Injection of contrast material (1:200 diluted gadolinium-based contrast material) is performed under image guidance, followed by transfer of the patient to the MRI scanner for diagnostic imaging. Abduction and external rotation (ABER) positioning increases the sensitivity and specificity for the detection of anteroinferior labral and glenohumeral ligament attachment abnormalities.\[8\]

**Findings in anterior instability**

MRI in anterior instability can reveal a large number of abnormalities affecting the soft tissue and the bony constituents of the joint [Table 1].

**Classic and bony Bankart lesion**

Bankart lesion, an avulsion of the anterior-inferior glenohumeral ligament and labral complex from the glenoid rim, with rupture of the scapular peristeum [Figures 1-3], results from injury to the anterior-inferior labro-ligamentous structures in anterior dislocations.\[9-11\] It can either be purely cartilaginous or may involve the underlying bone also.

In Bankart repair, the labral fragment is sutured back to the glenoid rim using suture anchors. Preoperative imaging can delineate the exact extent of the injury in these cases, thereby providing an estimate of the severity of the injury and the level of difficulty to be anticipated by the operating surgeon and also the number of anchors to be used in the procedures.

Bony Bankart lesions are treated by bony Bankart repair or “bony Bankart bridge procedure.” Preoperative imaging can help delineate the extent of bone loss and can be done using CT scan but is also well documented with MRI. MRI has the added advantage of being able to detect the labrocapsular and tendinous pathologies as well.

Chronic bony Bankart lesions with resorption of the detached fragment may need bone grafting and therefore exact assessment of the bony fragment is important.

**Perthes lesion**

Perthes lesion is a variant of Bankart lesion where there is a tear of the glenoid labrum, with an intact scapular periosteum. There is only minimal displacement of the torn anterior labrum, and hence the lesions are difficult to diagnose on routine MRI or MRA. MRA with arm in ABER stretches the anteroinferior joint capsule and IGHL and helps in better delineation of the lesion.\[12,13\] [Figure 4] It is important to detect this on MRA as it can be missed on arthroscopy because of the minimal displacement.

**Anterior labroligamentous periosteal sleeve avulsion (ALPSA)**

ALPSA lesion was first defined by Neviaser et al.\[13\] as avulsion and medial rolling of the inferior labroligamentous complex along the scapular neck [Figure 5]. This is an important diagnosis to make as the lesion can be easily missed on arthroscopy.\[10\] An ALPSA lesion, during an operative procedure, needs to be converted to a Bankart lesion (reapposition of the medially rolled labrum to the Table 1: Imaging findings associated with anterior instability

<table>
<thead>
<tr>
<th>Bankart and Bankart variants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft tissue and osseous Bankart lesion</td>
</tr>
<tr>
<td>Perthes lesion</td>
</tr>
<tr>
<td>ALPSA (Anterior labor-ligamentous periosteal sleeve avulsion)</td>
</tr>
<tr>
<td>GLAD (Glenolabral articular disruption)</td>
</tr>
<tr>
<td>Inferior ALPSA (cul-de-sac lesion)</td>
</tr>
<tr>
<td>SLAP type 5 lesion</td>
</tr>
<tr>
<td>Capsular related lesions</td>
</tr>
<tr>
<td>HAIGL (Humeral avulsion of anteroinferior glenohumeral ligament)</td>
</tr>
<tr>
<td>Bony HAIGL</td>
</tr>
<tr>
<td>The floating AIGHL lesion</td>
</tr>
<tr>
<td>Mid-axillary pouch tears</td>
</tr>
<tr>
<td>Reverse HAIGL lesion</td>
</tr>
<tr>
<td>GAGL (Glenoid avulsion of glenohumeral ligament)</td>
</tr>
<tr>
<td>Bony injuries</td>
</tr>
<tr>
<td>Hill-Sachs lesion</td>
</tr>
<tr>
<td>Greater tuberosity, coracoid process fracture</td>
</tr>
<tr>
<td>Rotator cuff tear</td>
</tr>
</tbody>
</table>

Figure 1 (A,B): Classic Bankart lesion. A 36-year-old male presented with recurrent anterior shoulder dislocation. Conventional axial GRE MEDIC T2W MRI image (A) shows an attenuated anteroinferior labrum (small arrow). The posterior labrum appears intact and is triangular in shape (thick arrow). TSE T1W fat-saturated axial MRA image (B) shows a classic Bankart lesion as intercalation of contrast material (long arrow) beneath the hypointense anteroinferior labrum.
The procedure needs relatively more expertise and more operating time. Preoperative knowledge of the severity of the lesion is useful for the operating surgeon.

**Glenolabral articular disruption (GLAD)**

As described by Neviaser, a GLAD lesion consists of a superficial anterior-inferior labral tear associated with an anterior-inferior articular cartilage injury [Figure 6]. The use of intra-articular contrast in the MRA helps to visualize small tears at the level of the anterior-inferior glenoid rim. GLAD lesions are usually not a cause of instability unless associated with other labral pathologies. They can present with clicking during shoulder joint movement.

**Superior labral anterior posterior (SLAP) type 5 lesion**

The SLAP lesion, described by Snyder et al., is an injury involving the superior aspect of the glenoid labrum, which includes the biceps tendon anchor. SLAP tears were initially classified by Snyder et al. into four distinct but related types of lesions. Maffet et al. added three more types. Currently, ten types or patterns are recognized. A sagittal MRI or MRA can demonstrate the complete extent of the labral tear [Figure 7].

**Humeral avulsion of glenohumeral ligament (HAGL) lesion**

HAGL lesions are much less common than Bankart lesions as a cause of anteroinferior instability. On MRA, or in the presence of a joint effusion, the normal distended axillary pouch is a U-shaped structure, which changes into a J-shape as the anterior band of the inferior glenohumeral ligament (IGHL) droops inferiorly [Figure 8].

**Bony humeral avulsion of the glenohumeral ligaments (BHAGL) lesion**

In BHAGL lesion, there is a small avulsed osseous fragment attached to the torn end of the humeral attachment of the IGHL.

**Glenoid avulsion of the glenohumeral ligaments (GAGL) lesion**

Glenoid avulsion of the glenohumeral ligaments (GAGL) implies an avulsion of the IGHL from the inferior pole of the glenoid, without an associated inferior labral disruption [Figure 9].

**Inferior ALPSA or cul-de-sac lesion**

In this entity, there is medial displacement of both the anterior-inferior labrum and the IGHL under the inferior neck of the glenoid. On coronal MRI images, there is characteristic greater medial displacement of the capsule (IGHL) relative to the antero-inferior labrum [Figure 10].
Figure 4 (A-C): Perthes lesion. A 16-year-old male presented with post-traumatic recurrent anterior shoulder dislocation. TSE T1W fat-saturated axial MRA image (A) and TSE T1W fat-saturated oblique axial MRA image with arm in ABER position (B) show intercalation of intra-articular contrast beneath the anterior labrum (small arrow) with an intact scapular periosteum (long arrow); this suggests a diagnosis of Perthes lesion. TSE T1W fat-saturated oblique sagittal MRA image (C) shows the extent of the lesion (arrows).

Figure 5 (A-C): ALPSA lesion in three different patients with anterior shoulder instability. TSE T1W fat-saturated coronal MRA images (A,B) and axial MRA image (C) show the anteroinferior labrum and antero-inferior glenohumeral ligament rolled back medially along the scapular neck (arrow).

Figure 6 (A-C): GLAD lesion in an 18-year-old male student. TSE T2W fat-saturated axial conventional MRI image (A) and coronal TSE T1W fat-saturated MRA images (B,C) show anterior-inferior labral injury (long arrow) with an articular cartilage defect (small arrow).
Hill-Sachs lesion

Hill-Sachs lesion consists of bony injury [Figure 11] to the posterosuperior humeral head as a result of inferior displacement. In Hill-Sachs and reverse Hill-Sachs lesions, preoperative determination of the extent of bone loss is
surgically important as greater than 30% loss increases the chance of repeated dislocations and necessitates bone grafting.

Greater tuberosity fractures are also associated with traumatic anterior instability [Figure 12]. Rotator cuff tears [Figure 13] associated with anterior and inferior glenohumeral dislocation are commoner in the elderly.

**Findings in posterior instability**

Less common than anteroinferior instability, posterior instability represents only 2%–4% of instability cases.\(^{[20]}\) It can occur as a component of multidirectional instability (MDI) as well as after trauma. The prevalence of posterior labral tears in patients with posterior instability is less and more variable. Ligamentous abnormality involving the posterior band of the inferior glenohumeral ligament may be seen in isolation or in posterior or anteroinferior instability.\(^{[21]}\)

The MRI findings in posterior instability are enumerated in Table 2.

---

**Table 2: Imaging findings in posterior glenohumeral instability**

<table>
<thead>
<tr>
<th>Labral and articular cartilage lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolated posterior labral tear (less common)</td>
</tr>
<tr>
<td>Reverse osseous Bankart lesion</td>
</tr>
<tr>
<td>POLPSA (Posterior labrocapsular periosteal sleeve avulsion)</td>
</tr>
<tr>
<td>Posterior GLAD lesion</td>
</tr>
<tr>
<td>Kim’s lesion</td>
</tr>
<tr>
<td>Posterior superior labral tear as a part of posterior SLAP 2 lesion</td>
</tr>
<tr>
<td>Posterosuperior to posterior labral tear with paralabral cyst</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capsule and ligament related lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reverse HAGL lesion</td>
</tr>
<tr>
<td>Reverse GAGL lesion</td>
</tr>
<tr>
<td>Bennett lesion</td>
</tr>
<tr>
<td>Posterior capsular tear with intact posterior labrum</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bony lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reverse Hill-Sachs lesion</td>
</tr>
<tr>
<td>Glenoid retroversion</td>
</tr>
<tr>
<td>Hypoplasia of glenoid neck</td>
</tr>
<tr>
<td>Posterior glenoid rim deficiency</td>
</tr>
<tr>
<td>Rotator cuff interval (RCI) tear</td>
</tr>
</tbody>
</table>

---

**Figure 11:** Hill-Sachs lesion (arrow) seen as a bony defect in the posterosuperior humeral head on an axial GRE MEDIC T2W MRI image

**Figure 12 (A-B):** Coronal TSE T1W MRI (A) and axial TSE T1W fat-saturated MRA (B) images show a comminuted greater tuberosity fracture (arrow) in this 38-year-old male presenting with traumatic shoulder instability

**Figure 13:** Coronal TSE T1W fat-saturated MRA image of the same patient as in Figure 8 shows a full-thickness supraspinatus tendon tear with retraction (arrow)
Reverse Hill-Sachs lesion
This consists of an anteromedial superior humeral head impaction fracture [Figure 14] that is often associated with a reverse Bankart lesion [Figure 14] (posterior glenoid labrum disruption).

Reverse HAGL lesion
In posterior instability there is sometimes complete avulsion of the posterior attachment of the shoulder capsule and the glenohumeral ligament from the posterior humeral neck[22] [Figure 15].

Posterior GLAD lesion (focal posterior cartilage deficiency)
This lesion has been described recently and can be associated with posterior instability.[23–24]

Posterior glenoid rim deficiency
In recurrent posterior instability, two shapes of the posterior-inferior glenoid – the “lazy J” [Figure 16] and the “delta” shapes – are reported to be more often found than in normal subjects.[25]

Bennett lesion
It is an extra-articular crescentic posterior ossification [Figure 14] associated with posterior labral injury and capsular avulsion. It is best visualized on CT; it may be missed on arthroscopy as it is extra-articular.[6,26]

Rotator cuff interval tear
RCI tears typically do not appear as complete disruption of the fibers of its components but as thinning, irregularity, or focal discontinuity of the rotator interval capsule[7] [Figure 17].
Paralabral cyst. A 22-year-old athlete presented with shoulder pain on overhead throwing movements and instability. TSE T2W fat-saturated axial (A) sagittal (B) MRI images show a well-defined, hyperintense, cystic lesion (arrow) in close relation to the posterosuperior labrum, suggestive of a paralabral cyst. No superior labral pathology is identified. Corresponding axial (C) and sagittal (D) TSE T1W fat-saturated MRA images show a superior labral anteroposterior (SLAP) tear (small arrow); the joint contrast is seen to communicate with the paralabral cyst through the SLAP lesion. The cyst and the insertion of the long head of the biceps tendon are indicated by a thick arrow and a long arrow, respectively.

Figure 18 (A–D): Paralabral cyst. A 22-year-old athlete presented with shoulder pain on overhead throwing movements and instability. TSE T2W fat-saturated axial (A) sagittal (B) MRI images show a well-defined, hyperintense, cystic lesion (arrow) in close relation to the posterosuperior labrum, suggestive of a paralabral cyst. No superior labral pathology is identified. Corresponding axial (C) and sagittal (D) TSE T1W fat-saturated MRA images show a superior labral anteroposterior (SLAP) tear (small arrow); the joint contrast is seen to communicate with the paralabral cyst through the SLAP lesion. The cyst and the insertion of the long head of the biceps tendon are indicated by a thick arrow and a long arrow, respectively.

Posterosuperior labral tear in association with a paralabral cyst may be seen in patients with posterior instability [Figure 18]. The cysts are almost always associated with labral tears, but the communication with the joint space is often not visualized on MRI.

Conclusion

To conclude, the imaging findings in shoulder instability are variable and depend on the etiology of the dislocation as well as the age of the individual. In cases of instability, an MRA is the investigation of choice.

References

glenoid rim deficiency in recurrent (atraumatic) posterior shoulder instability. Skeletal Radiol 2000;29:204-10.


Source of Support: Nil, Conflict of Interest: None declared.

Author Help: Online submission of the manuscripts

Articles can be submitted online from http://www.journalonweb.com. For online submission, the articles should be prepared in two files (first page file and article file). Images should be submitted separately.

1) **First Page File:**
   Prepare the title page, covering letter, acknowledgement etc. using a word processor program. All information related to your identity should be included here. Use text/rtf/doc/pdf files. Do not zip the files.

2) **Article File:**
   The main text of the article, beginning with the Abstract to References (including tables) should be in this file. Do not include any information (such as acknowledgement, your names in page headers etc.) in this file. Use text/rtf/doc/pdf files. Do not zip the files. Limit the file size to 1024 kb. Do not incorporate images in the file. If file size is large, graphs can be submitted separately as images, without their being incorporated in the article file. This will reduce the size of the file.

3) **Images:**
   Submit good quality color images. Each image should be less than 4096 kb (4 MB) in size. The size of the image can be reduced by decreasing the actual height and width of the images (keep up to about 6 inches and up to about 1800 x 1200 pixels). JPEG is the most suitable file format. The image quality should be good enough to judge the scientific value of the image. For the purpose of printing, always retain a good quality, high resolution image. This high resolution image should be sent to the editorial office at the time of sending a revised article.

4) **Legends:**
   Legends for the figures/images should be included at the end of the article file.