



Disclosures

- Consultant: Bioclinica
- Book Royalties: Elsevier
- Contractor: POCUS PRO
- Advisory Board: Philips
- Not relevant to this talk

Syllabus and other educational material can be found at www.jacobsonmskus.com

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Outline:

- Joint
- Tendon sheath
- Bursa
- Cyst
- Calcific tendinitis
- Miscellaneous

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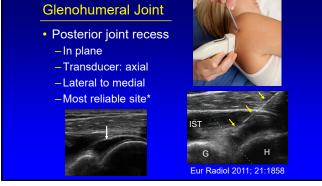
Joint Aspiration and Injection

- Aspiration:
 - -Infection, crystal disease
- Injection:
 - -Anesthetic: Lidocaine, Ropivacaine
- -Steroids
- Therapeutic or diagnostic

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Joint Aspiration and Injection

- Know which joint recesses become distended and which are accessible
- For joint access:
 - -Aim for joint fluid seen at ultrasound
 - -Aim for specific joint recess
 - -If no recess, aim for joint space



Acromioclavicular Joint

- In plane
- Transducer: coronal
- Lateral to medial



Elbow Joint

- Olecranon recess
- Elbow flexed
- In plane
- Lateral to medial





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MCP Joints Dorsal recesses In plane Parasagittal or transverse Sterile gel stand off

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Tendon Sheath

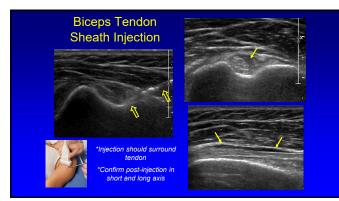
- Axial versus longitudinal to tendon
- Aspiration: look for fluid collection
- Injection with steroids:
 - Do not inject steroids into tendon
 - -Risk of tendon rupture
 - -Test needle location with Lidocaine first

Biceps Brachii: sheath injection

- Ultrasound-guided: highest accuracy¹
 Statistically significant difference in pain relief compared with blind injection at 33 weeks²
- In plane, lateral to medial:
 Deep to tendon: avoid SA-SD bursa
 Avoid anterior circumflex humeral artery
- Glenohumeral joint extension: if 5 ml injected³

¹Hashiuchi et al. J Sho Elb Surg 2011; 20:1069
²Zhang et al. Ultrasound Med Bio 2011; 37:729
³Nwawka et al. AJR 2016; 206:337

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Bursa Aspiration: Infection, crystal disease Injection: Steroids

- Therapeutic

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Subacromialsubdeltoid Bursa

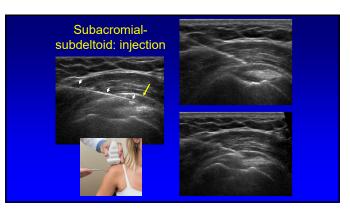
- In plane
- Posterior to anterior or lateral to medial
- Patient supine
- Test inject

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Avoid rotator cuff

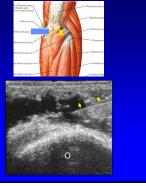




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Olecranon Bursa

- Arm extended
- Axial plane
- Lateral to medial
- Avoid cubital tunnel



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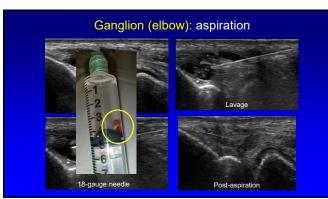
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Radius Capitate Sagittal Capitate



Cyst Aspiration

- Ganglion:
 - -Multilocular, non-compressible
 - -Large bore needle
 - -Fenestrate neck
- Other cysts:
 - -Paralabral cysts: shoulder and hip labrum
 - -Parameniscal cysts







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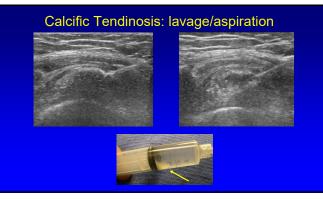
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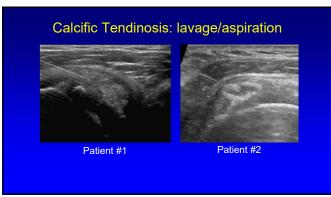
Calcific Tendinosis: aspiration

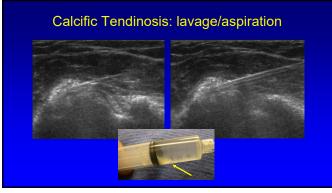
- Percutaneous lavage and aspiration
 Best: rounded amorphous calcification
- Correlate with radiography
- 3- 10 cc syringes: Lidocaine
- 20 22 gauge needle
- Position patient: syringe is dependent

Calcific Tendinosis: aspiration

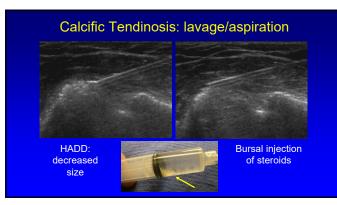
- Inject Lidocaine, then aspirate
 - -Dilute calcification
 - -Syringe dependent
 - -Calcification will flow into needle
 - -Repeat until calcification decreases
- Inject steroids into adjacent bursa

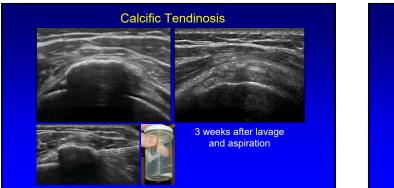


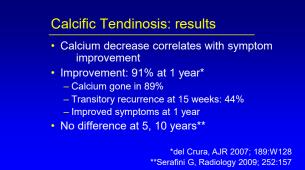












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A1 Pulley Injection

- In or out of plane
- 10 mg triamcinolone, 2% lidocaine
- 90% success rate: 1 year





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Carpal Tunnel Injection

- Axial plane: ulnar to radialSterile gel stand-off
- Begin over ulnar nerve and stay superficial
- Inject adjacent to median nerve
- Cross-sectional area may decrease within 1 week after steroid injection¹
- ¹Cartwright MS et al. Muscle Nerve 2011; 44:25



Take Home Points:

- Joint:
 - -Aim for recess
- Bursa:
- -Know anatomic locations
- Cyst:
- -Large bore needle
- Calcific tendinitis:
 - -One puncture, lavage and aspiration

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