Musculoskeletal ultrasonography basics

**ABSTRACT**

Ultrasonography is emerging as a core method to evaluate musculoskeletal problems. It is best used for imaging superficial structures limited to 1 quadrant of a joint. It has several advantages over other imaging methods: lower cost, ability to perform dynamic examinations, higher spatial resolution of superficial structures, better patient comfort, and essentially no contraindications.

**KEY POINTS**

Ultrasonography can be used to evaluate small fluid collections in soft tissue; joint effusions and synovitis; soft tissue masses (≤ 5 cm in diameter); tendon, ligament and muscle injuries; and peripheral nerve entrapment and lesions.

Ultrasonography is not appropriate for survey examinations of vague or diffuse symptoms or for evaluating soft-tissue areas more than a few centimeters in diameter or more than a few centimeters deep.

Musculoskeletal ultrasonography requires specially trained sonographers and interpreting physicians.

**CLASSIC TECHNOLOGY MAKING A RESURGENCE**

The first reports of the use of musculoskeletal ultrasonography appeared in the 1970s for investigating the rotator cuff,1–3 actually preceding reports of its use in obstetrics and gynecology.4 In the 1980s, reports emerged for evaluating the Achilles tendon.5,6 After that, its popularity in the United States plateaued, likely because of the advent of MRI, lower reimbursement and greater variability in interpretation compared with MRI, as well as a lack of physicians and sonographers trained in its use.7,8

Musculoskeletal ultrasonography is currently experiencing a resurgence. Although it remains a specialized service more commonly

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**doi:** 10.3949/ccjm.85a.17014
MUSCULOSKELETAL ULTRASOUND

Musculoskeletal ultrasonography is having a resurgence

Figure 1. In ultrasonography, a trade-off exists between image resolution and penetration depth. The superficial patellar tendon (A, arrow) can be seen with high resolution, demonstrating its fine internal structure. The much deeper iliopsoas tendon cannot be seen with the same high resolution because of its deep location (B, arrow).

available in large hospitals, its use is increasing rapidly, and it will likely become more widely available.

- SPECIAL TRAINING REQUIRED
Musculoskeletal ultrasonography is simply an ultrasonographic examination of part of the musculoskeletal system. But because not all ultrasonographic transducers offer sufficient resolution for musculoskeletal evaluation and not all sonographers and imaging physicians are familiar with the specialized techniques, musculoskeletal ultrasonography often has a separate designation (eg, “MSKUS,” “MSUS”). At Cleveland Clinic, it is offered through the department of musculoskeletal imaging by subspecialty-trained musculoskeletal radiologists and specially trained musculoskeletal ultrasonographers with 4 to 5 years of training in the technique.

Musculoskeletal ultrasonography is also performed by physician groups with specialized training, including sports medicine physicians, rheumatologists, physiatrists, neurologists, and orthopedic surgeons. The American Institute of Ultrasound in Medicine offers voluntary accreditation for practice groups using musculoskeletal ultrasonography. Certification in musculoskeletal radiology is offered to sonographers through the American Registry for Diagnostic Medical Sonography.

- SONOGRAPHY HAS UNIQUE QUALITIES
Ultrasonography uses high-frequency sound waves to generate images. The transducer (or probe) emits sound from the many piezoelectric elements at its surface, and the sound waves travel through and react with tissues. Sound reflected by tissues is detected by the transducer and converted to an image. Objects that reflect sound appear hyperechoic...
(brighter), whereas tissues that reflect little or no sound appear hypoechoic.

**High-resolution imaging of superficial structures**

Ultrasonography involves a fundamental trade-off between image resolution and imaging depth. Higher-frequency sound waves do not penetrate far into tissues but generate a higher-resolution image; lower-frequency sound waves can penetrate much further but yield a lower-resolution image. Although high-resolution imaging of deep structures with ultrasonography is not possible (Figure 1), many musculoskeletal structures are located superficially and are amenable to ultrasonographic evaluation.

**Be aware of artifacts**

Some materials attenuate sound very little, such as simple fluid. Low attenuation results in artifacts on ultrasonography, making tissues behind the simple fluid appear brighter than neighboring tissues. These artifacts may be reported as “increased through transmission” or “posterior acoustic enhancement.” Conversely, metal and bone reflect all sound waves that reach them, rendering any structures beyond them invisible. This “shadowing” creates a problem for imaging of structures in or near bone. Subcutaneous fat also attenuates sound waves, limiting the use of ultrasonography for patients with obesity (Figure 2).

Ultrasonography is also subject to artifacts depending on the direction of the transducer, a phenomenon known as anisotropy. Anisotropy causes highly ordered tissues such as tendons and ligaments to sometimes appear hypoechoic,9,10 which is also the appearance of diseased or disrupted tendons and ligaments (Figure 3).11 Anisotropy is minimized when the transducer is held perpendicularly to the structure of interest.11

**High-frequency linear transducer sharpens images**

High-frequency linear transducers reduce anisotropy because their flat surface keeps sound waves more uniformly perpendicular to the structure of interest.9,7 Their development has allowed imaging of superficial structures that is superior to that of MRI. A high-frequency linear transducer offers more than twice the spatial resolution of a typical 1.5T MRI examination of superficial tissue.12,13

**Operator experience is critical**

Ultrasonography examinations, more than other imaging tests, are dependent on operator experience. A solid understanding of musculoskeletal anatomy is imperative. Because

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**Figure 3.** On ultrasonography, anisotropy causes a hypoechoic defect of the articular supraspinatus tendon fibers (A, arrow). With improved transducer angle, anisotropy is decreased and intact fibers can be seen (B, arrow). Sonographers and interpreting physicians must be careful not to mistake aberrations due to anisotropy for tissue disease.
the probe images only a thin section of tissue (about the thickness of a credit card), referencing adjacent structures for orientation is more difficult with ultrasonography than with CT or MRI.

The accuracy of ultrasonography is highly dependent on acquiring and interpreting images, whereas the accuracy of MRI is dependent primarily on image interpretation. Interpreting physicians must check that sonographers capture relevant targets.

STRENGTHS OF MUSCULOSKELETAL ULTRASONOGRAPHY

Ultrasonography has multiple advantages:

- **No ionizing radiation exposure.**
- **Portability.** Unlike CT or MRI, ultrasonography equipment is portable.
- **Increased patient comfort.** Patient positioning for an ultrasonography examination is more flexible than for MRI or CT, and the examination does not induce claustrophobia.
- **High-resolution imaging.** Ultrasonography provides very-high-resolution imaging of superficial soft tissues—in some cases, higher than MRI or CT.
- **Real-time dynamic examinations** are possible with ultrasonography, unlike with CT or MRI, and may increase test sensitivity.
- **Implanted hardware is less of a problem.** Although ultrasonography cannot image beyond implanted orthopedic metallic hardware, the hardware does not obscure surrounding soft tissues as it does on CT and MRI. Also, ultrasonography is safe for patients with a pacemaker.

WEAKNESSES

The main disadvantages of musculoskeletal ultrasonography are inherent to its limited field of view, making it inappropriate for a survey examination (eg, for ankle pain, knee pain, hip pain). Unlike CT and MRI, ultrasonography does not provide a “bird’s-eye view,” and important abnormalities can be missed during evaluation of large areas (Figure 4).

Ultrasonography also cannot evaluate bone or intra-articular structures such as cartilage, bone marrow, labrum, and intra-articular ligaments; MRI is the standard for evaluating these structures.

Ultrasonography is time-consuming. To perform a detailed examination of the anterior, posterior, medial, and lateral aspects of the hip, knee, or ankle would require 1.5 to 2 hours of scanning time and an additional 10 to 25 minutes of image checking and interpretation.

CURRENT CLINICAL INDICATIONS

Musculoskeletal ultrasonography is best used for clinical questions regarding limited, superficial musculoskeletal problems.
MUSCULOSKELETAL ULTRASOUND

Fluid collections
Ultrasoundography can help evaluate small fluid collections in soft tissue. As is true for a lung opacity on chest radiography, soft-tissue fluid detected on ultrasonography is nonspecific, and results must be correlated with the clinical picture to narrow the differential diagnosis.

Fluid collections can be classified as loculated or nonloculated.

Nonloculated fluid involves more fluid than is simply interposed between tissue planes and has no wall or defined margins. It can be simple or complex in appearance: simple fluid is anechoic, and complex fluid appears more heterogeneous and may contain septations or debris.

Subcutaneous edema, which may occur postoperatively or from trauma, venous insufficiency, or inflammatory or infectious processes, appears on ultrasonography as nonloculated fluid interspersed between subcutaneous fat lobules.

Loculated fluid collections have well-defined margins or a discrete wall that does not follow normal tissue planes. They can also be simple or complex and can be caused by hematoma, abscess, or ganglion. Less commonly, neoplasms can mimic a loculated fluid collection (Figure 4).

A ganglion is a specific type of loculated fluid collection containing synovial fluid arising from a joint or tendon sheath. It tends to occur in specific locations, most commonly around the wrist, most often arising from the dorsal scapholunate ligament and volar wrist between the radial artery and flexor carpi radialis. On MRI, it can be difficult to distinguish between small vascular structures and a small ganglion, especially in the hands and feet.

Ultrasoundography can also help identify a Baker cyst, a specific fluid collection arising from the semimembranosus bursa between the medial head of the gastrocnemius tendon and the semimembranosus tendon. Ultrasoundography can also detect inflammation, rupture, or leaking associated with a Baker cyst.

Power Doppler is an ultrasonographic examination that can detect increased blood flow surrounding a fluid collection and determine the likelihood of an acute inflammatory or infectious cause.

Joint effusion and synovitis
Musculoskeletal ultrasonography can help evaluate joints for effusion and synovitis. It is highly sensitive (94%) and specific (95%) for synovitis, making it superior to contrast-en-
Power Doppler can detect increased blood flow.

The area of concern should be limited to 1 quadrant of a joint (anterior, posterior, medial, or lateral); for problems beyond that, MRI should be considered. A joint effusion appears as a distended joint capsule containing hypoechoic (complex) or anechoic (simple) joint fluid.

Complex joint fluid may contain debris and occurs with hemarthrosis, infection, and inflammation. Hypertrophied synovium is hypoechoic and can mimic complex joint fluid. Power Doppler evaluation can help distinguish synovitis from joint fluid by demonstrating blood flow, a feature of synovitis but not of simple joint fluid. Power Doppler is the most sensitive means of detecting blood flow, although it does not show direction of flow.

Using ultrasonography can help to improve disease control and minimize disabling changes by monitoring synovitis therapy. In addition, subclinical synovitis and enthesis (inflammation of insertion sites of tendons or ligaments into bone) detected by ultrasonography may predict future disease and disease flares.

Ultrasonographic guidance for a wide range of procedures is increasing rapidly. Multiple studies have shown the advantage of ultrasonography-guided aspiration and injection compared with techniques without imaging guidance.

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talofibular ligament may be as high as 100%.50,52,53

Elbow and thumb. The larger of the collateral ligaments of the elbow, especially the ulnar collateral ligament, and the ulnar collateral ligament of the thumb can be effectively evaluated with ultrasonography.54,55

Knee. The collateral ligaments of the knee can be seen with ultrasonography, but injuries of the external ligaments of the knee are often associated with intrinsic derangements that cannot be evaluated with ultrasonography.56,57 Intra-articular ligaments such as the anterior cruciate ligament are also not amenable to ultrasonography.

Dynamic examination of a ligament with ultrasonography can help determine the grade of the injury.

Deeply located ligaments (eg, around the hip) and ligaments surrounded by bone, such as the Lisfranc ligament, cannot be completely seen on ultrasonography.

Muscle
Musculoskeletal ultrasonography is useful for small areas of concern within a muscle (Table 1). It can detect muscle strains and tears, intramuscular collections or lesions, and fascial scarring or fascial injuries such as superficial

<table>
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<tr>
<th>Condition</th>
<th>Characteristics on ultrasonography</th>
<th>Power Doppler</th>
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<tbody>
<tr>
<td>Normal tendon</td>
<td>Hyperechoic, compact internal fibrillar pattern</td>
<td>No signal</td>
</tr>
<tr>
<td></td>
<td>Anisotropy may be present, mimicking tendinosis or tendon tearing</td>
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<tr>
<td>Tendinosis</td>
<td>Hyperechoic, focal or diffuse, abnormally thickened, loss of compact fibrillar structure and possibly regions of fiber disruption48,49</td>
<td>With or without increased power Doppler signal</td>
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<td>Tearing</td>
<td>Can differentiate partial- vs full-thickness tear</td>
<td>Complex fluid and blood can mimic intact tendon fibers; if tear is present, fluid does not move with joint movement as intact fibers would23</td>
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<tr>
<td>Tenosynovitis or peritendinitis</td>
<td>Thickenened tendon sheath or peritendon with increased fluid</td>
<td>With or without increased power Doppler signal</td>
</tr>
<tr>
<td>Normal ligament</td>
<td>Hyperechoic, compact morphology, less ordered fibrillar pattern than tendon</td>
<td></td>
</tr>
<tr>
<td>Low-grade ligament injury</td>
<td>May be normal or thickened, hypoechoic</td>
<td>With or without increased power Doppler signal</td>
</tr>
<tr>
<td>Intermediate or high-grade ligament injury</td>
<td>Fiber disruption, surrounding hematoma or fluid</td>
<td>With or without increased power Doppler signal</td>
</tr>
<tr>
<td>Normal muscle</td>
<td>Mostly hypoechoic, interspersed hyperechoic lines and dots (perimysium and epimysium)</td>
<td></td>
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<tr>
<td>Normal nerve</td>
<td>Less compact-appearing and more varied shape than tendon and ligament</td>
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<td></td>
<td>Semicompact bundle of hypoechoic nerve fascicles surrounded by hyperechoic tissue</td>
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<td>Neuritis (focal or diffuse)</td>
<td>Abnormal nerve enlargement, fascicular swelling, blurring of the interstitium, perineural thickening (in the chronic state), possible scarring in entrapment cases20</td>
<td>With or without increased power Doppler signal</td>
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muscle herniation. Although ultrasonography may yield a definitive diagnosis for a muscle problem, further imaging may be needed.

Nerves

Ultrasonography is useful for peripheral nerve investigation but requires a steep learning curve for sonographers and interpreting physicians. It is best suited for directed questions regarding focal abnormal nerve findings on physical examination.

Ultrasonography can help identify areas of nerve entrapment caused by a mass or dynamic compression. It can detect neuritis, lesions of peripheral nerves (eg, nerve-sheath compression. It can detect neuritis, nerve entrapment caused by a mass or dynamic compression.

Table 1

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<th>References</th>
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ACKNOWLEDGMENT: We would like to sincerely thank Megan Griffiths, MA, for her help in the preparation and submission of this manuscript.


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