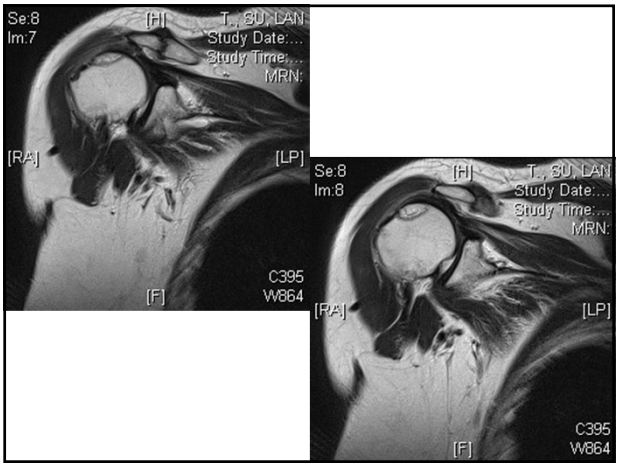
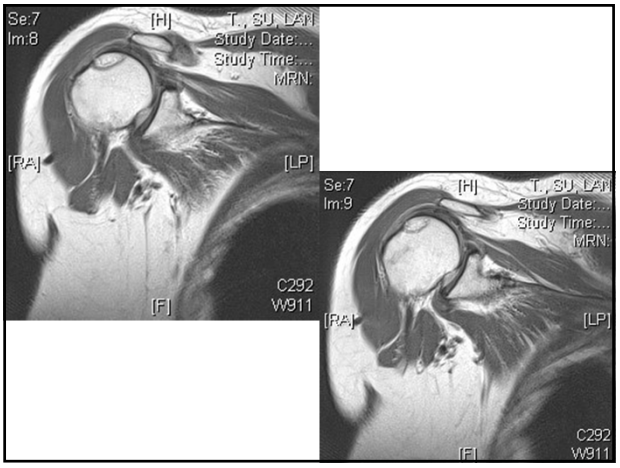
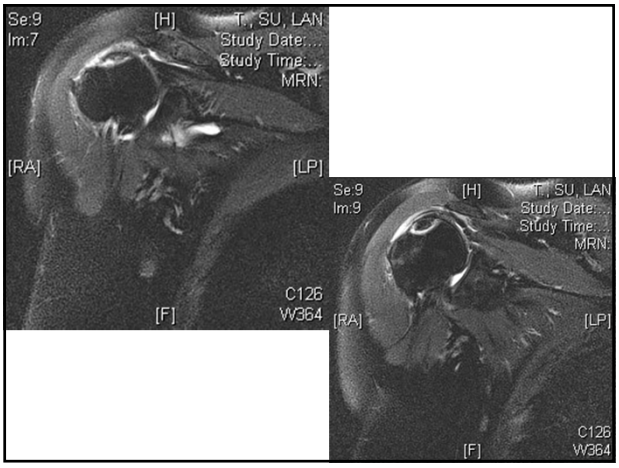
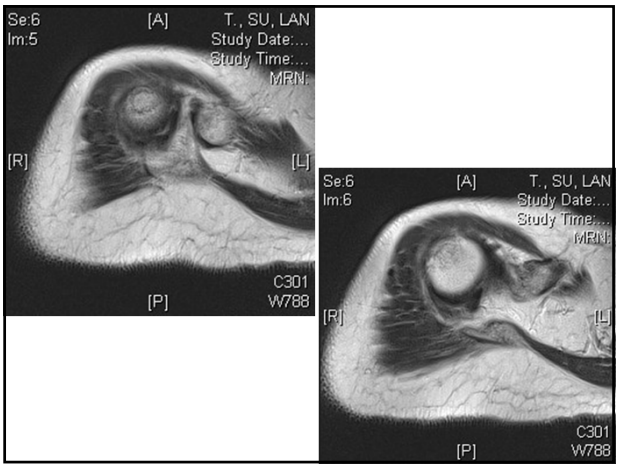
Patient data

- 66 Y/O female
- Right anterosuperior shoulder pain
- Foward elevation and abduction weakness for 1 year
- suspect massive tear supraspinatus + infraspinatus failure
- Underlying dx: DM, hypertension









OCD of humeral head

Etiology

- Local ischemia
- Constitutional predisposition
- Abnormal ossification
- Trauma: acute and repetitive

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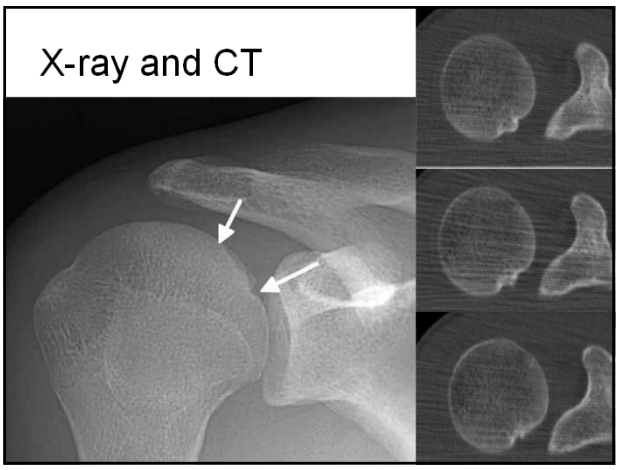
X-ray and CT



MRI

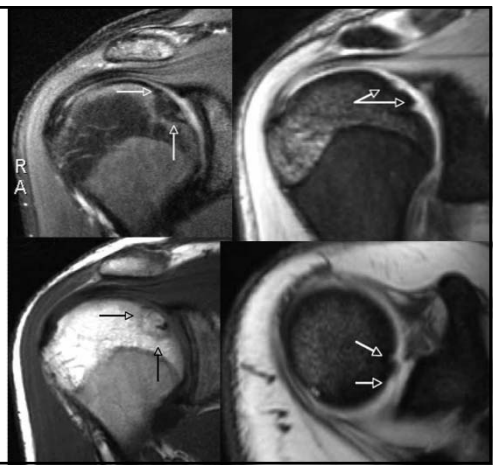


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Table I. — Characteristics of previously reported humeral head OCD cases compared to our case

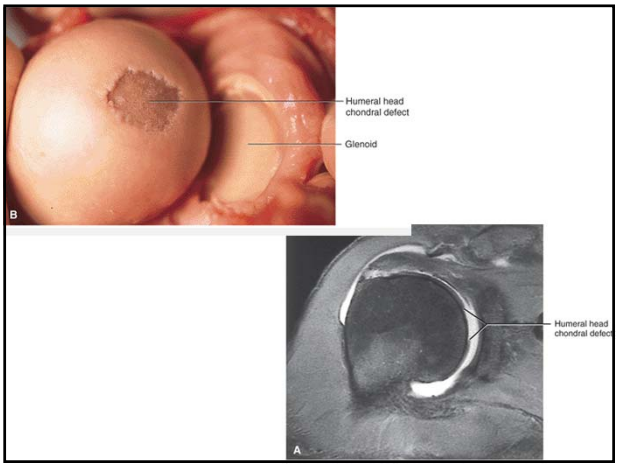
Reference	Sex	Localisation	Sports	Trauma	Treatment
(1)	M	Superior	?	No	Immobilisation
(3)	M	Superior	Handball	No	Drilling
(3)	F	Bilateral ; superior	No	No	None
(4)	M	Posterosuperior	No	No	Removal, curettage, drilling
(5)	M	Medioinferior	Tennis	Yes	Removal, curettage
(6)	M	Anterosuperior	?	Yes	Removal, curettage, drilling
(7)	M	Posterosuperior	No	Yes	Osteochondral allograft
(9)	M	Anterosuperior	?	Yes	Removal, curettage, drilling
(10)	M	Anterosuperior	Tennis	No	Rest
(11)	M	Anterosuperior	Boxing	Yes	Rest
(12)	M	Posteromedial	?	Yes	Removal, curettage, drilling
Our case, 2005	M	Central	No	No	None

Mid stage of OCD

- Xray: sclerotic subchondral bone fragment separated from the underlying bone by a thin radiolucent crescentic line.
- MRI: low T1- and T2-weigthed images.

Terminal stage of OCD

- A. no bright-signalintensity interface between the fragment and the adjacent bone
- B. return of marrow fat signal intensity in the previously necrotic fragment
- C. overlying articular cartilage surface is intact without any residual contour irregularities



Differential Diagnosis

- Hill-Sachs lesion: history, scope finding
- ON: history (corticosteroid therapy, alcoholism or systemic diseases such as sickle cell anemia), scope finding
- Fibrocartilaginous dysplasia: significant deformities of the affected upper limb

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Hill-Sachs lesion

ON

- Sclerotic subchondral bone segment
- Collapse of the subchondral bone.

AVN after fracture