Shoulder Examination

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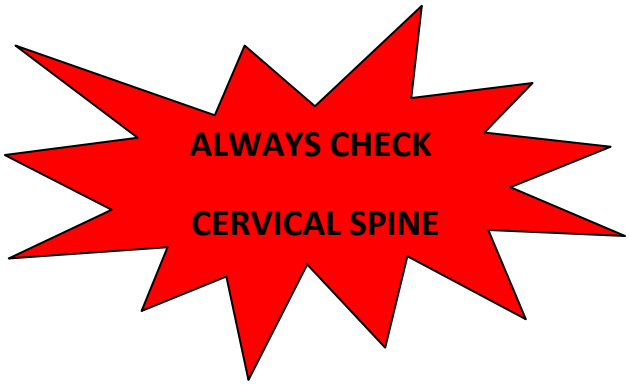
LOOK

Swellings – SCJ, ACJ

Scars – shoulder but also neck!

Muscle wasting – deltoid, supraspinatus fossa

Scapula winging



FEEL

SCJ and ACJ tenderness

Step at ACJ – dislocated ACJ

Acromion – unstable Os Acromiale

Biceps groove and cuff lateral to acromion

Any lumps

MOVE

Do **active** first then **passive** movements

Forward flexion

Arm elevated to front

Abduction

Reduced active movement but very good passive = ?large cuff tear

Reduced active and further passive movement painful = ?impingement/bursitis/arthritis

Reduced active and no further passive movement possible = frozen shoulder / arthritis

mid arc pain = impingement / glenohumeral arthritis

high arc pain = ACJ pain or internal impingement (cuff, biceps).

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Also inspect from behind to assess scapula during abduction (scapula moves with any arm abduction = consider frozen shoulder) and may also see winging of scapula.

External rotation

With elbow at side

Zero degrees = forearm pointing forward

always compare to other side

THE 3 CAUSES FOR LOSS OF EXTERNAL ROTATION:

1. FROZEN SHOULDER
2. ARTHRITIS
3. POSTERIOR DISLOCATION

Internal rotation

hand behind back (record highest hand can reach up back - buttock, sacrum, vertebral level)

SPECIALS

CUFF

Supraspinatus

Jobe's test / Empty Can test - arm abducted, internally rotated and in plane of scapula ie. 20-30 degrees forward from side, thumb pointing down, resist further active abduction

Infraspinatus

Elbow at side and flexed 90 degrees, resist external rotation.

External Rotation Lag sign - Externally rotate pt's arm at side with elbow flexed 90 degrees. Pt is unable to maintain this position if infraspinatus weak/torn

Subscapularis

Belly Press -patient puts hand on belly with elbow forwards then tries to push hand into belly while maintaining elbow in forward position. If pt flexes wrist or elbow drops backwards to facilitate hand being pressed into belly = positive test for weak subscapularis

Napolean's Test – patient's hand on belly, ask patient to actively bring elbow forwards while maintaining hand on belly

Lift Off Test – patient puts dorsum of hand behind back on lumbar spine, resist the patient pushing their hand away from their back.

Bear Hug Test – patient places hand on contralateral shoulder and resists examiner trying to pull patient's hand away from that shoulder

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IMPINGEMENT

Hawkins-Kennedy Test - Hold patients arm 90 degrees forward flexed and internally rotated so forearm horizontal. Hold patient's elbow with one hand and the patient's wrist with your other. Now quickly internally rotate the arm further. Positive if pain in subacromial region.

Neer Impingement Sign - Maximally internally rotate arm at patient's side, now maximally abduct the arm. Pain in subacromial region with arm fully abducted = positive, 88% sensitive, 30% specific

INSTABILITY

Anterior Apprehension test – lie patient on couch inclined 30 degrees, hold patient's arm and bring it up into abduction and external rotation slowly – if pt becomes apprehensive that shoulder will dislocate anteriorly then this is a positive test for anterior instability. With the arm held in this position use your other hand push on anterior region of shoulder to 'relocate' it and ask if by applying this pressure the patient feels better – if so then this is a positive *Jobe's Relocation Test*.

ACROMIOCLAVICLUR JOINT ARTHRITIS

Cross Arm test / Scarf test – forward flex to 90 degrees then adduct patient's arm as much as possible towards the contralateral shoulder. Test positive if pain experienced and well localised to the ACJ (not deltoid region or posterior shoulder).

BICEPS

Yergasons test – elbow flexed and forearm pronated, resist against supination (moderate sensitivity and specificity)

Speed test – elbow extended and forearm supinated, resist forward flexion at 60 degrees, pain biceps groove / anterior shoulder. (very sensitive but highly non-specific)

SLAP (Superior Labrum Antero Posterior lesion)

O'Briens Test - Patient forward flexes 90 degrees and adducted 15 degrees with elbow fully extended. Patient resists you pushing arm down. Positive = pain felt in joint. NB pt may get pain at ACJ if concurrent ACJ pathology (poor sensitivity and specificity)

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SHOULDER EXAMINATION

Look

Swellings
ACJ, SCJ

Scars
Usually front or side
Also Neck

Muscle wasting

Scapula winging

ALWAYS CHECK CERVICAL SPINE

Feel

ACJ
tenderness
dislocation

Acromion
unstable os acromiale

Biceps groove
feel front of shoulder with forearm pointing forward

Lumps

Move

ACTIVE then **PASSIVE**

Forward flexion
(arm striaght out in front)

Abduction
(arm striaght sideways from body)
mid arc = impingement or OA
high arc = ACJ pain
scapula moves with any arm movement
= frozen shoulder
dec active but good passive movement
= ?big cuff tear
dec active + further passive movement painful = impingement/bursitis/arthritis
dec active and no further passive movement
= ?frozen shoulder/arthritis

External rotation
with elbow at side and flexed 90degrees
ALWAYS COMPARE TO OTHER SIDE

3 causes for loss of ER:
Frozen shoulder
Arthritis
Posterior dislocation

Internal rotation
hand up back

Specials

Cuff
Supraspinatus = empty can test (Jobe) - resist abduction with arm straight and internally rotated in plane of scapula
Infraspinatus = resist ER
Subscapularis = Belly press with elbow held forward

Impingement
Neer impingement sign
(with arm straight internally rotate then maximally abduct)
Hawkin Kennedy Test

Instability
Apprehension tests
Anterior apprehension when arm in abduction + ER
Relocation tests

ACJ arthritis
Cross arm Test (Scarf)
= pain localised to ACJ when arm elevated across chest

Biceps
Speeds test
elbow extended and forearm supinated, resist forward flexion
Yergasons test
resist supination with elbow flexed and forearm pronated

QUICK EXAM

LOOK FOR SWELLINGS, WASTING AND SCARS

FEEL ACJ TENDERNESS

MOVE FORWARD FLEXION, ABDUCTION + EXTERNAL ROTATION

IMPINGEMENT SIGN

EMPTY CAN FOR SUPRASPINATUS

ANTERIOR APPREHENSION

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