

SHOULDER

HISTORY

1. Occupation; Right or left handed, Age

2. Pain: Site. Any referred pain to the deltoid insertion
Any localizing pain at Acromio-clavicular joint

How long?

Continuous or not

Night pain

How does it affect you? Work

Sleep

3. ADL's

Disabilities: Bra, hanging out clothes.

Reach top shelf, carrying weight

4. Any weakness and tingly in the hand

Previous treatment: medication, Steroid injections, History of injury

Co-morbidities: Diabetes, Chronic renal failure, Coronary problem

INSPECTION

Front Sterno-Clavicular joint [SCJ], Clavicle, Supraclavicular region,
Acromio-clavicular joint[ACJ], Deltoid contour

Lateral Deltoid musculature
Position of the humeral head

Back Supraspinatus and Infraspinatus fossa for wasting

Any Scar

Any deformity of biceps muscle

Look for any elevation of the scapula: Sprengel's shoulder

PALPATION

Warmth, Tenderness (Impingement)

Feel all bony prominence and SCJ and ACJ

Acromion

Greater tuberosity

Biceps tendon in the bicipital sulcus:

Shoulder in 15° of Internal rotation and 4 cm below the acromion



RANGE OF MOVEMENT

First perform the active movements and then the passive movements.

If there is disparity between passive movement and active movement i.e., passive more than active then a **“lag of movement is present”**.

This means either tendon is tore or muscle is paralysed

Fixed deformity: opposite movement is absent. I.e., when 30° of external rotation deformity of the shoulder means: no internal rotation is possible.

But patient may further rotate externally.

ABDUCTION OF THE SHOULDER

Examiner stands behind the patient

Patient actively abducts the arm

Watch for the:

Range of movement

Rhythm [Glenohumeral or Scapulothoracic]

Any pain on abduction range

Look for any early winging as in Shoulder dyskinesia

Normal: Abduction 180 ° [Rhythm: 2:1]

In frozen shoulder, abduction predominantly Scapulothoracic joint



How to isolate abduction at Glenohumeral joint?

Examiner stands behind the patient

Stabilize the inferior pole of the scapula

Now ask to abduct actively

All abduction now occurs at the Glenohumeral joint



Note:

In arthritis of shoulder all movements are terminally limited

In Frozen Shoulder all movements are severely limited particularly external rotation and abduction [Normal X rays]

In massive cuff tear: active abduction and flexion are grossly limited

OTHER MOVEMENTS

Normal Flexion	180 °
External rotation	60 °
Internal rotation	90°[up to T6]
Extension	30 °
Adduction	60 °

MUSCLE STRENGTH

SUPRASPINATUS

90° Flexion of the shoulder

30° abduction of the shoulder

0° at the elbow

Thumbs down

Resistance against the forearm

Jobe's Test



INFRASPINATUS

Arms close to the chest

Elbow at 90°

Examiner's hand against the forearm

Patient is asked to external rotation forcefully

Usually this causes pain in rotator cuff tear



SUBSCAPULARIS

Lift off test

Should be done only if internal rotation is possible

Ask the patient take back of the hand first off the back

Make sure arm is well adducted

If he can: test the strength against resistance

Lift Off



Belly press test [Napolean Sign]

It is the test for Subscapularis, when internal rotation is limited.

Make sure elbow stays anterior and the wrist stays straight and forceful internal rotation against examiner's hand

Belly Press



BICEPS

Yargason's test

Arm close to the chest; Elbow in 90° of flexion: Supination of the forearm; Examiner tries to pronate forearm against resistance



Speed test

Elbow straight and shoulder 90° of flexion

Examiner's resistance of upward pull of supinated forearm and extended elbow

Speed Test



Abbott's test

This test is for instability of the long head biceps tendon in the Groove.

The examiner grasps the patient's arm and brings into Abduction and external rotation.

While palpating the bicipital groove, the examiner then internally rotates the shoulder.

Subluxation or dislocation of the tendon produces a palpable or audible snap

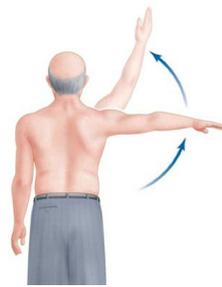
Painful Arc Syndrome

Patient actively abduction

Pain is precipitated between 60° to 120°

Pain at terminal abduction is absent

Pain can be abolished by local anaesthesia



Positive in: Rotator cuff tear

Impingement syndrome

NEER'S IMPINGEMENT SIGN

Forward flexion of the shoulder by the examiner

Shoulder in external rotation

Note any pain due to impingement of the cuff



HAWKINS SIGN

Flexion of the shoulder to 90° with shoulder

in 90° internal rotation

Elbow is kept at 90° flexion

Now examiner passively rotates internally

This causes pain in cuff problems

