



433 Teams
ORTHOPEDICS

Osce

Shoulder examination

Video : <https://www.youtube.com/watch?v=IBICRrKZafk>

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Shoulder Exam

STEPS

WIPE, look, feel, move, special tests, neurovascular assess., and joint above & below.

Look from front, side, and back.

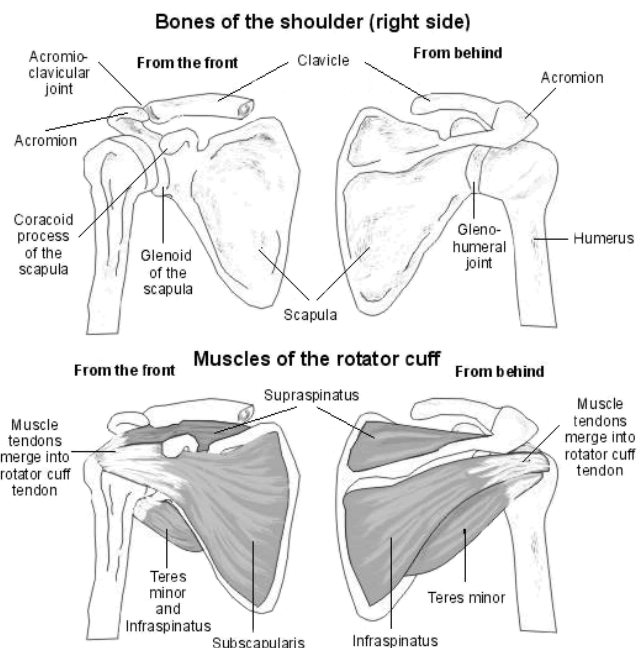
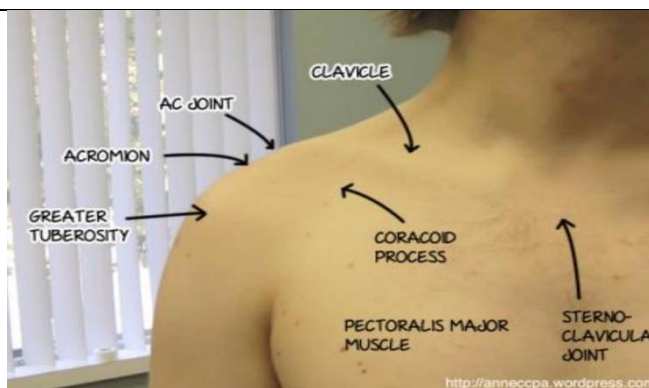
Alignment, deformity, muscle wasting, skin changes, swelling, or scars.

Feel

- **Temperature**
- **Tenderness** of bones and soft tissues:

Bones: sternoclavicular J., clavicle (has two prominences at its two peripheries), acromioclavicular J, acromion, and spine of scapula, medial border of scapula, scapular apex, humeral greater tuberosity & joint line.

Soft tissues: deltoid, supraspinatus & infraspinatus grooves, trapezius, bicipital groove.



Move

Test range of movement both actively and passively. Attempt passive ROM if active ROM is limited or painful.

*if contact active ROM, no need for passive test.

Forward flexion: measured from zero to 180 (or up to 170) degrees.

Flexion muscles: Anterior fibers of deltoid muscle, Pectoralis major, Coracobrachialis (muscle of arm), Short head of biceps.

Extension muscles: Posterior fibers of deltoid, Latissimus dorsi, Teres major.

Abduction: from zero beside body to 180 degrees at maximum.

Abduction muscles: 0- 15 deg. Supraspinatus, 15 -90 deg. middle fibers of deltoid.

External rotation: keep patient arm flat against sides, range from zero to 80-90 degrees.

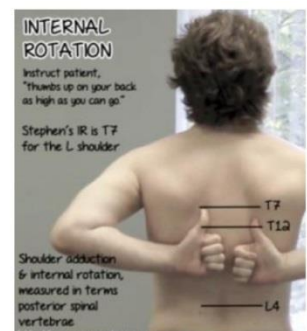
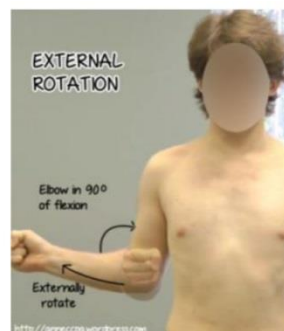
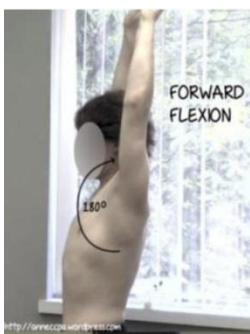
External rotation muscles: Post. Fibers of deltoid, Infraspinatus, Teres minor.

Internal rotation: ask patient to rotate his arm cross his back and walk the fingers as far up the back as possible, record this by vertebral level (inferior tip of scapula = T7, iliac crest = L5).

Internal rotation muscles: Pectoralis major, Latissimus dorsi, Teres major, Ant. fibers of deltoid, Subscapularis.

*Note if painful or painless.

Screening test : ask pt. to put his hands at the back of his head (this test external rotation and abduction), then ask him to rotate his arm cross his back and walk the fingers as far up the back as possible (test internal rotation and adduction)



Special tests**1. Rotator cuff integrity and strength:****Rotator cuff muscles:**

- **Supraspinatus** : Initiates abduction **"the most common tear"**
- **Infraspinatus** :Primary ER
- **Subscapularis**: Primary IR Strongest muscle
- **Teres minor**: Ex. Rotation

A) empty can test/ jobe test (for supraspinatus)

Resisted abduction with arm abducted 90° abduction. 30° of forward elevation in the plane of the scapula and maximally internally rotated.

A positive test when there is pain or weakness.

B) lift-off test for subscapularis

ask patient to rotate his arm cross his back and push against your hand away from his body.

C) resisted external rotation with arm against body sides for infraspinatus and teres minor.

*Rotator cuff muscles (SITS muscles): Supraspinatus, Infraspinatus, Teres minor, Subscapularis.

* their tests is similar to their actions but, at their maximum extension*.

In the young athletic patient the shoulder cuff may be torn as the result of a violent traumatic incident. In the older patient tears may occur spontaneously (e.g. in a cuff weakened as a result of chronic impingement and attrition) or follow more minor trauma, such as sudden arm traction. It may occur in patients suffering from instability of the shoulder joint. Most commonly the supraspinatus region is involved, and the patient has difficulty in initiating abduction of the arm.

2. Impingement syndrome:**A) neer's impingement sign**

Pain with forward flexion with humerus in internal rotation position.

B) hawkin's test

With arm in the throwing position(90 degrees of forward flexion) and flexed forward about 30 degrees, forcibly internally rotate the humerus. Pain suggest impingement of the supraspinatus tendon against the coraco-acromial ligament.

* compression during glenohumeral movement, giving rise to pain. The commonest site is Subacromial, painful bet. 70° and 120° abduction. Also, compression beneath the acromioclavicular joint itself, pain during the last 30° of abduction, or deep to the coracoacromial ligament. Symptoms may occur acutely (e.g. in young sportsmen, especially in activities involving throwing) or be chronic, particularly in the older patient, usually degenerative changes in the acromioclavicular joint which lead to a reduction in size of the supraspinatus tunnel; this may cause attrition and rupture of the shoulder cuff.

3. Instability**A) apprehension test**

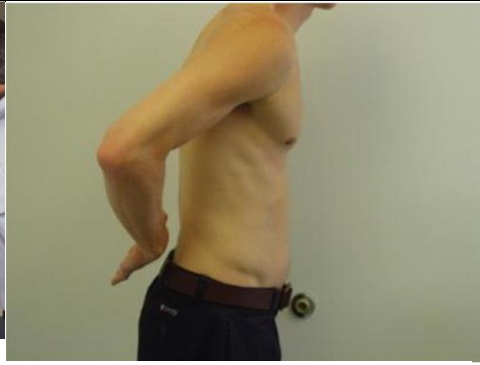
Can be done at any position. Arm in throwing position, 90 deg. abduction and elbow 90 deg. flexion, then push forearm posteriorly while looking to patient face.

A positive test if there is pain or fear(patient feels his shoulder is coming out of place).

*tear in glenoid labrum which deepens the glenoid cavity leads to instability.



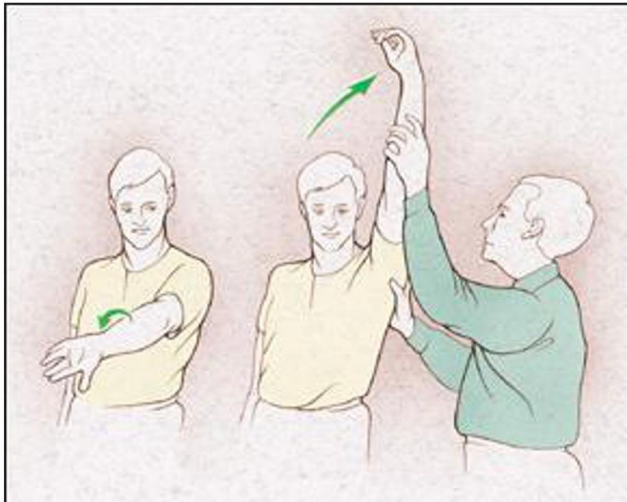
Empty can test



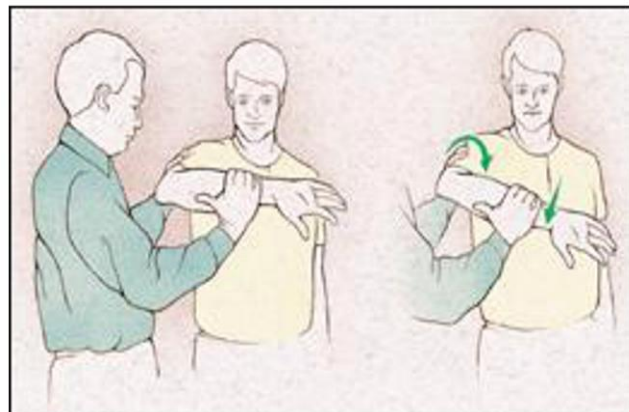
Lift-off test



Resisted external rotation



Neer's test



Hawkin test

Neurolovasclar examination

Examine joint above (cervical spine) and joint below (elbow).

For common shoulder disorder **finding** read this file from 431:

<https://onedrive.live.com/?authkey=%21AljLFQVnND7gCM&cid=B14F43C119CD7EFB&id=B14F43C119CD7EFB%21589&parId=B14F43C119CD7EFB%21569&o=OneUp>

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Sources:	<ul style="list-style-type: none">▪ Clinical Orthopaedic Examination, 6th Edition (mcrae).▪ Examination from ortho dep.▪ Doctors notes.

