Shoulder Examination

Introduction, consent, any pain, any problems with shoulder

Inspection

Asymmetry
Skin changes – erythema, sinus, lacerations, surgical scars
Bones – clavicular irregularity, sterno-clavicular joint, ac joint
Scapular winging
Muscle bulk – posteriorly looking at supra and infraspinatus – ie rotator cuff wasting

Palpation

Clavicle – any irregularity, tenderness, callus, step (#)
SC joint – tenderness, irregularity
AC joint – tenderness, irregularity
Proximal humerus
Scapula – acromion, spine

Palpate from behind

Biceps tendon?

Cervical spine and paraspinal muscles

Movement

Neck – flexion, extension, lateral flexion, rotation

Shoulder – if FROM, then no need to assess passive

- Flexion
- Extension
- Abduction
  - (first 15 degrees unable to initiate – supraspinatus tear, upto 120 degrees may be impingement, partial tear, greater than 120 degrees suggests acromial OA)
- External rotation (frozen shoulder limits)
- Internal rotation (how high can hand reach up back)

Special tests

Supraspinatus – Jobes test – hold can, pour out, slightly flex elbow, move up against resistance

Infraspinatus and teres minor – External rotation against resistance

Subscapularis – Goebers lift off test – hands behind back and lift off against resistance

Acromioclavicular OA – passively adduct arm across opposite shoulder

Impingement of supraspinatus tendon – 1) 90 degree arm flexion and shoulder abduction, then internally rotate to bring greater tuberosity under acromion 2) abduct with pressure on the acromion to exacerbate impingement

Sulcus sign test – pull arm inferiorly looking for sulcus suggestive of laxity of the glenohumeral joint capsule

Apprehension test – looking for anterior displacement. Abduct elbow to 90 degrees, then combination of external rotation and extension – apprehension relieved by pressure anteriorly.

To complete the examination:

I would like to fully evaluate the joints above and below (i.e. cervical spine and elbow) and would like to assess neurovascular status of the arm.

Pathology

Young – think about laxity anterior > posterior

Middle aged – rotator cuff / OA

Rotator cuff tear – inability to initiate abduction – or using manoeuvres to achieve, e.g. lean to one side to initiate swing. Passive movements possible, then also demonstration of drop by passively abducting, allowing deltoid to take over, and ask to lower arm – gets to point and drops. This is consistent with a complete tear of supraspinatus.

Impingement – painful arc 60 – 120 degrees. Watch carefully abduction, as patients can use manoeuvres to avoid abduction, over this range.

Adhesive capsulitis – reduction of ability to move roatator cuff. The reason external rotation is most sensitive, is because it is a movement only involving the glenohumeral joint – ie other movements can be compensated with scapular movement thus not appearing so restricted. (freezing, thawing, defrosted!)