APPENDIX 1. Various Shoulder Examinations

The list of tests is given for those who have a special interest in shoulder problems, or perhaps do a lot of shoulder injections. For clinicians who wish a quick shoulder assessment method, Appendix 3 may be more suitable. Many of these tests are hard to describe in words, and a short video on each is provided on the following site: http://www.arthritisresearchuk.org/health-professionals-and-students/video-resources/rem/ examination-of-the-shoulder.aspx looking at this before or during a PBSGL meeting, possibly by examining each other, might be beneficial for group members who have a special interest in this topic.

<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
<th>Potential indicators</th>
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<tbody>
<tr>
<td>Empty-can (Jobe's or SS muscle strength test)</td>
<td>Arm fully extended, abducted to 90°, flexed forward 30°, internally rotated. Examiner applies downward force.</td>
<td>Potential RC tear (supraspinatus) (SN 63–95; SP 55–68)</td>
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<td>Lift-off (or push-off)</td>
<td>Patient adducts and internally rotates arm behind back; resistance is provided against attempt to push arm away from body.</td>
<td>Pain or weakness suggests tendinopathy or tear</td>
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<tr>
<td>Drop-arm</td>
<td>Examiner passively abducts patient's arm to 90° and then releases.</td>
<td>Test is positive for supraspinatus tear with pain and inability to keep arm up Sudden drop = impingement</td>
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<tr>
<th>Subacromial Impingement</th>
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<tr>
<td>Hawkins</td>
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<tr>
<td>Neer</td>
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Hawkins, Neer, painful arc, empty can, resisted external rotation; 3 or more positive tests =SN 75; SP 74 for subacromial impingement¹

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<thead>
<tr>
<th>Labrum &amp; Biceps (because of biceps attachment to labrum)</th>
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<tbody>
<tr>
<td>O’Brien’s</td>
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<tr>
<td>Crank</td>
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<td>Speed</td>
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<td>Yergason’s</td>
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<table>
<thead>
<tr>
<th>Instability</th>
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<tr>
<td>Apprehension &amp; relocation</td>
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<table>
<thead>
<tr>
<th>A/C joint</th>
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<td>Cross-body adduction</td>
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<tr>
<th>C-spine</th>
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<tbody>
<tr>
<td>Spurling’s</td>
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</table>

Sources
1) Hegedus EJ, Goode AP, Cook CE, Michener L, Myer CA, Myer DM et al. Which physical examination tests provide clinicians with the most value when examining the shoulder? Update of a systematic review with meta-analysis of individual tests. Br J Sports Med 2012. PM:22773322

APPENDIX 2. Resources


UK website. Patient handout with descriptions of exercises for frozen shoulder, right from the painful phase through the thawing phase. Unfortunately, no images included, but a number of different exercises provided. http://www.sheffieldshoulderpain.com/assets/info%20leaflets/Frozen%20shoulder%20exercises.pdf
APPENDIX 3. Diagnosis of Shoulder Problems in Primary Care

Diagnosis of Shoulder problems in Primary Care:
Guidelines on treatment and referral

Is it Neck or Shoulder?
• Ask the patient to first move the neck and then move the shoulder.
• Which reproduces the pain?

Shoulder
History of Instability?
• Does the shoulder ever partly or completely come out of joint?
• Is your patient worried that their shoulder may dislocate during sport or on certain activities?

Instability
Common age 10 - 35 yrs
• Physio if Atraumatic

Refer to Shoulder Clinic

Primary Care
Instability
• Traumatic dislocation
• Ongoing symptoms
• Atraumatic with failed physio

Neck
• Follow local spinal service guidelines

Neck
• Is the pain localised to the AC joint and associated with tenderness?
• Is there high arc pain?
• Is there a positive cross arm test.

Acromioclavicular Joint Disease
Common age >35 yrs
• Rest/NSAIDS/analgesics
• Steroid injection
• Physio
• X-ray if no improvement

Glenohumeral Joint
Frozen shoulder
Common age 35-65 years
Arthritis
Common age >60 years
• X-ray – to differentiate.
• Rest
• NSAIDS/analgesics.
• Patient information
• Cortisone injection

Rotator Cuff Tendinopathy
Common age 35-75 years
• Rest / NSAIDS / analgesics
• Subacromial injection
• Physiotherapy

Glenohumeral Joint
• If frozen shoulder with normal x-ray – refer if atypical and/or severe functional limitation.
• Refer if arthritis on x-ray and poor response to analgesics and injection.

Rotator Cuff Tendinopathy
• Transient or no response to injection and physiotherapy

N.B. Massive cuff tears in patients > 75 years are generally not repairable.

No
Yes

Other cause of Neck or Arm pain

Red Flags = Urgent Referral
1. Trauma, pain and weakness - ? Acute cuff tear
2. Any mass or swelling - ? Tumour
3. Red skin, fever or systemically unwell - ? Infection
4. Trauma / epileptic fit / electric shock leading to loss of rotation and abnormal shape - ? Unreduced dislocation

N.B. A history of trauma with loss of abduction in a younger patient = Red Flag 1

Yes

No

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The British Elbow and Shoulder Society supports
Best Practice Patient Pathways for the Shoulder

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