















Unit Two Shoulder Special Tests







Technique	Objective / Tissue implicated	Set-up	Procedure	Comments
RC Impingement				
Neer test (p. 293, Magee)	Supraspinatus	- Pt may sit or stand - Therapist stands to patient's side and slightly behind	- Passively elevate pt's UE in scapular plane with medial rotation; support under pt's straight elbow - Stabilize pt's scapula with other hand - At end of motion, therapist applies overpressure into elevation	(+) test = pain with overpressure. Implies Supraspinatus m. and sometimes biceps m. involvement 
Hawkins-Kennedy test (p. 293)	Supraspinatus	- Pt stands - Therapist forward flexes arm to 90 deg in ~20 degrees of horizontal abduction	- Therapist passively IR pt's shld to end feel. If no pain then horiz add to 0 deg and repeat IR. If no pain then horiz add ~20 degrees and repeat IR	(+) test = pain with IR of shoulder. Thought to be more severe if pain in earlier positions 
Yocum test (p. 293)	Supraspinatus, Long head biceps	- Pt stands, places hand on opposite shoulder	- Therapist flexes pt's arm to 90 degrees	(+) test = pain with therapist elevating arm 



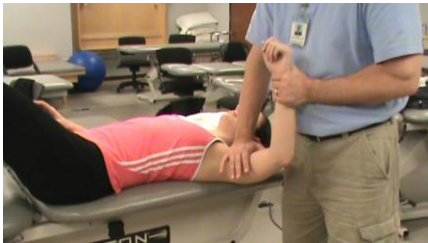

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IRRST test (p. 295)	Intra-articular (IR weak) Sub-acromial impingement (ER weak)	- Pt stands with arm abducted to 90 deg and ER 80-85 deg	- Therapist applies isometric IR resistance followed by isometric ER resistance	(+) test for internal impingement when strength in ER is good and IR weak. (+) external impingement weak ER > IR 
Muscle / Tendon Pathology				
Empty Can test (p. 310)	Supraspinatus	- Pt standing, arm abducted to 90 deg, full IR and horizontally abducted ~30 degrees. - Thumbs should be pointed down	- Therapist applies resistance to elevation	(+) test = pain and/or weakness 
Drop Arm test (p. 313)	Supraspinatus	- Pt standing	- Therapist abducts pt's shld to 90 deg and asks pt to slowly lower arm to the same side	(+) test = pt unable to return arm down slowly or severe pain attempting to lower arm 





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Hornblower Sign (p. 313)	Teres minor	- Pt standing with arms at sides	- Therapist elevates pt arm 90 degrees in scapular plane - Therapist flexes pt elbow 90 deg - Pt asked to ER shoulder against resistance	(+) test = weakness of shoulder ER indicates tear of teres minor 
Lift-Off sign (p. 311)	Subscapularis	- Pt standing , places dorsum of hand on back pocket or mid-lumbar spine	- Pt lifts hand away from the back	(+) test = inability to lift hand away from back indicating subscapularis lesion 
Belly Press test (p. 312)	Subscapularis	- Pt standing - Examiner places hand on pt's abdomen with pt's hand on top of examiner's hand	- Pt presses into belly as hard as he can - Some apply resistance to this IR pressure, looking for pain.	(+) test = Pt unable to maintain pressure on without moving into shoulder extension. Could be due to tear in subscapularis 
Speed's test (p. 308)	Long head biceps, SLAP	- Pt standing -Pt's forearm is supinated, elbow extended	Test may be done with a concentric or eccentric motion - (Ecc) Pt flexes shoulder to 90 degrees - Examiner applies force to pt's raised arm asking the pt to "slowly lower the arm down to your side" (eccentric lowering) - Apply moderate pressure (this is not a 'break test')	(+) test = pain/tenderness in bicipital groove and weakness. Indicates bicipital paratenonitis or tendinosis. May also be (+) in patients with a SLAP lesion 

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Yergason test (p. 309)	Long head biceps (LHB), Transverse humeral ligament	<ul style="list-style-type: none"> - Pt standing, elbow flexed to 90 degrees, forearm pronated and arm stabilized against the thorax - Examiner to palpate bicipital groove during test 	<ul style="list-style-type: none"> - Examiner resists supination while the pt also laterally rotates the arm against resistance 	<p>(+) test = examiner feels “popping” at the bicipital groove during the test; tenderness at the groove.</p> <p>May indicate rupture of the transverse humeral ligament.</p>  <p>Tenderness without “popping” of the tendon may indicate bicipital paratenonitis/tendinosis</p>
Labral Injury				
O’Brien test (p. 298)	SLAP, AC jnt, LHB	<ul style="list-style-type: none"> - Pt standing with arm flexed to 90 degrees and elbow extended - Horizontally adduct arm 10-15 degrees (start position) and IR shoulder so thumb is down 	<ul style="list-style-type: none"> - PT stands behind pt applying downward force and pt eccentrically lowers arm - Bring pt arm back up but with palm up/supinated, repeat downward force and eccentric lowering 	<p>(+) test = Pain or painful clicking inside shoulder with first position and eliminated or decreased in second position the test is (+) for Labral abnormalities</p>  
Crank test (p. 301)	SLAP, Bankart	<ul style="list-style-type: none"> - Pt is supine or sitting - Examiner elevates pt arm to 160 degrees in scapular plan 	<ul style="list-style-type: none"> - Examiner applies axial load through humerus and applies IR/ER motion to shoulder 	<p>(+) test = pain on rotation, especially ER with or without a click</p> 

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SLAPrehension test	SLAP	<ul style="list-style-type: none"> - Pt sitting or standing - Pt arm is abducted to 90 degrees with elbow extended and forearm pronated (thumb down and shoulder IR) 	<ul style="list-style-type: none"> - Pt asked to horiz adduct arm - Repeat movement with forearm supinated and shoulder ER 	<p>(+) test = pain in bicipital groove with first position and pain decrease in second position</p> <p>Indicates SLAP lesion</p>
Biceps Load test (p. 299)	SLAP		NEEDS TO BE CORRECTED THEREFORE TEXT REMOVED	
AC/SC Joints				
Cross-over test	AC joint	<ul style="list-style-type: none"> - Pt standing or sitting - Examiner stabilizes pt back and holds pt's elbow 	<ul style="list-style-type: none"> - Examiner raises pt arm to 90 deg flexion - Move pt arm into horizontal adduction as far as possible 	(+) test = pain over the AC joint – pt may feel pain at SC joint which implicates SCJ
A/P Shear test	AC joint	<ul style="list-style-type: none"> - Pt seated - Examiner cups the hands over the deltoid muscle with one hand on the lateral clavicle and one hand on the spine of the scapula 	<ul style="list-style-type: none"> - Examiner squeezes hands together 	(+) test = abnormal movement at the AC joint

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GH Instability				
Sulcus at 0 degrees	Superior capsule, superior GH ligament, rotator interval	- Pt standing or sitting, arm relaxed at the side	- Examiner grasps the elbow and gently tractions the humerus distally. Feel for motion at the Acromial-GH space	(+) test = inferior motion of the hh 1+ = < 1cm motion 2+ = 1 – 2 cm motion 3+ = > 2 cm motion 
Rockwood test (p. 281, 283)	Anterior band, Inferior GH ligament 	- Pt sitting or supine, elbow is flexed to 90 degrees 	- Examiner passively ER the GHJ at 0, 45, 90 and 120 degrees of abduction 	(+) test = Posterior pain and apprehension at 90 degrees > 45 and/or 120 with 0 degrees symptomless 
Anterior Load and Shift (p. 275)	Anterior capsule, middle GH ligament, IGHL	- Pt sitting with upright posture in chair/stool with no back support; hand of test arm resting on ipsilateral thigh - Examiner is behind pt, stabilizing pt shld with hand over clavicle and scapula	- Examiner's other hand holds head of humerus with thumb over posterior humeral head (hh) - Move pt's hh ant/post to be sure it is "seated" in glenoid fossa - Examiner moves hh anteriorly and posteriorly noting the amount of translation	(+) test – anterior translation is possible but posterior translation is not possible. Less than 25% of the hh moving anteriorly is normal 

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<p>Apprehension / Relocation (aka- "crank test") (p. 279)</p>	<p>Anterior GH capsule</p>	<p>- Pt supine; examiner abducts shoulder of pt to 90 degrees and laterally rotates the patients shoulder slowly</p>	<p>- Examiner ER pt shoulder to end range watching for pt's expression of apprehension with movement - Examiner may apply an anterior-posterior pressure to pt's anterior humeral head</p>	<p>(+) test = pt shows apprehension at end range of ER due to anterior instability</p>  <p>(+) test = pt has relief of pain and apprehension due to relocation of hh into glenoid</p> 
<p>Push-Pull test (p. 287)</p>	<p>Posterior capsule</p>	<p>- Pt supine - Examiner holds pt's arm at wrist, abducts shld to 90 and flexes 30 degrees - Examiner places other hand on pt's hh</p>	<p>- Examiner pulls up on the pt's wrist while pushing down on the hh</p>	<p>(+) test= greater than 50% of hh translates posteriorly or if the pt becomes apprehensive and/or pain could indicate posterior instability</p> 
<p>Jerk test</p>	<p>Posterior capsule, posterior labrum</p>	<p>- Sitting, IR arm and flex to 90 deg</p>	<p>- Axially load the arm proximally (posteriorly) then horizontally adduct the shld.</p>	<p>(+) test = Jerk occurs as the humeral head slides off the posterior rim and jerks again as the arm is brought back to the start and the head relocates</p> 

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Thoracic Outlet Syndrome				
Adson's test (p. 322 Magee)	Scalene involvement	- Pt sitting - Find pt's radial pulse	- Pt's head is extended and rotated toward test shoulder - Therapist extends and ER pt shoulder - Pt instructed to hold breath	(+) test = reproduce sx and/or loss of pulse 
Costoclavicular test (p. 322)	Clavicular compression	- Pt sitting - Find pt's radial pulse	- Therapist draws pt shoulder down and back (depressing shoulder slightly) (common in pts who wear heavy backpack or coat)	(+) test = reproduce sx and/or loss of pulse 
Hyperabduction test (P. 321)	Pectoralis minor	- Pt sitting - Find pt's radial pulse	- Therapist brings hand over pt's head with elbow in coronal plane and shld laterally rotated - Have pt take a deep breath and hold	(+) test = reproduce sx and/or loss of pulse 
Allen's test	Pectoralis minor	- Pt sitting - Find pt's radial pulse - Flex pt's elbow to 90 deg, abduct shoulder to 90 deg and externally rot to 90 deg	- Pt rotates head away from test arm	(+) test = reproduce sx and/or loss of pulse 

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Roo's test	General test for TOS	<ul style="list-style-type: none"> - Pt seated or standing - Pt elevates bilateral arms to "90/90" position 	<ul style="list-style-type: none"> - Pt opens and closes the hands slowly for 3-minutes <p>(+) test = inability to keep arms in starting position for 3 minutes or ischemic pain, heaviness or profound weakness of the arm, numbness/tingling of the hand</p> <p>Minor fatigue and distress are normal</p>	