

# Quick guide to Shoulder Examination in Primary Care

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The diagnosis can be predicted fairly accurately according to age and sex of patient.

Age	Likely diagnosis
16-25	Instability/Bankart labral tear SLAP (Superior Labrum Anterior to Posterior) tear ACJ disruption
30-60	Frozen shoulder Calcifying tendonitis Rotator cuff tear Labral tear
65 and over	Rotator cuff tear Glenohumeral arthritis Cuff tear arthropathy ie both the above

## **5 key tests to establish diagnosis**

1. **External rotation (active and passive).** If there is limited or no external rotation, in a middle aged person, the most likely diagnosis is frozen shoulder. In an elderly person, consider glenohumeral arthritis. If there is increased passive external rotation, it implies a large rotator cuff tear involving subscapularis.
2. **Jobe's test or empty can test for supraspinatus** Resisted abduction with the arm in 30 abduction, 30 of forward elevation in the plane of the scapula and maximally internally rotated. A positive test occurs when there is pain with weakness.



**Jobe's empty can test  
for supraspinatus**

3. **Yocum's test for supraspinatus.** This is another supplementary test for supraspinatus function. Place the patient's hand on the contralateral shoulder, ask patient to flex the arm upwards against resistance. A positive test occurs when there is pain with weakness.



**Yocum's test for  
supraspinatus**

4. **ABER – Passive Abduction External Rotation.** This test is positive (ie painful) in SLAP tears, labral tears or any intra-articular pathology such as frozen shoulder or glenohumeral arthritis. Although not specific, it is the one of the most sensitive tests for intraarticular pathology.



**Passive ABER  
(Abduction  
external rotation)**

5. **Biceps** Check for the Popeye sign for rupture of long head of biceps. Proximal tear is likely to be associated with cuff tear and occurs usually in the elderly, nothing further needs to be done for biceps but consideration should be given to investigate the rotator cuff tear. Distal tear occurs in middle aged men, usually well built labourers and require urgent surgical repair.



**Popeye  
deformity**

## **Injections around the shoulder – Dos and Don'ts**

- Do not inject if there is no pain
- Do not inject if there is history of trauma
- Do not inject if diagnosis is not certain
- Do not inject the ACJ (generally difficult to do and often quite painful)
- Avoid injections in young patients < 25
- Avoid injecting again if 1<sup>st</sup> injection did not work
- I would recommend injecting through the posterior approach
- Do use at least a green needle when injecting especially from posterior approach (the others are far too short to reach the joint)
- If your needle is in the right place, 10ml of marcain should flow into the joint very easily without much pain reported by the patient. If not, take it out!

### **Injecting the glenohumeral joint using posterior approach**

- Indication**
1. Frozen shoulder
  2. Glenohumeral arthritis (very difficult as joint is tight already)

#### **Technique**

Palpate the posterolateral corner of the acromion with your thumb, use your middle finger to palpate the coracoid, insert the needle into the 'soft spot' approximately 1cm medial and 1 cm inferior to posterolateral corner of acromion, aiming towards the coracoid.

### **Injecting the subacromial space using posterior approach**

- Indication**
1. Subacromial impingement
  2. Calcifying tendonitis
  3. Rotator cuff tear not amenable to surgery

#### **Technique**

Entry point 1cm medial and 1 cm inferior to posterolateral corner of acromion, aim just below the acromion.