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AAP BRS podcast: Shoulder Part 1

Impingement Syndrome:

Likely the most common cause of shoulder pain. Due to decreased subacromial space placing pressure on subacromial bursa, rotator cuff, and biceps tendon.

- **Presentation:** Typically affects patients >40 y/o. Common in athletes using an overhead throwing motion (eg, baseball/football). Anterolateral shoulder pain with overhead activities and abduction. Pain while lying on side.
- **Evaluation:** Neer's, Hawkins, and painful arc tests provoke pain. Pain upon palpation of rotator cuff tendons.
- **Imaging:** Radiography to evaluate morphology of acromion, presence of AC joint arthrosis/calcific tendinopathy. MSK ultrasound for real-time anatomic information. MRI for patients who do not adequately progress with conservative measures to evaluate for surgery.
- **Management:** Rehabilitation with pain reduction and mobilization. Retraining proper biomechanics and improving the strength and endurance of the rotator cuff and scapular stabilizers. Exercises that emphasize progressive, resisted, eccentric internal rotation. Steroid or biologic injections are included by some physicians.

Rotator Cuff tears:

The muscles of the rotator cuff are susceptible to various levels of injury. Tear subclassifications include partial or full thickness, and incomplete or complete tears.

- **Presentation:** Some patients are asymptomatic. Common presentations are dull ache deep within shoulder, sleep disturbance.
- **Evaluation:** Inspect for focal muscular atrophy, bruising, or bony deformities. Active and passive ROM, strength, isolation of RC muscles (empty can, external rotation, belly/lift-off), neurovascular testing. Examination of opposite shoulder for comparison. External rotation lag sign (PPV 1.0) positive as tears progress. Drop test (PPV 1.0) to distinguish infraspinatus vs. supraspinatus tears.
- **Imaging:** Radiography to rule out fracture. High riding humerus (supraspinatus tear). Ultrasound for functional assessment prior to MRI arthrography for suspicion of full thickness tear.
- **Management:** Early surgical management for traumatic cases. Anti-inflammatory medication and PT program to restore pain-free ROM for mild-moderate injury. Subacromial corticosteroid injection for pain control in patients who fail to progress after several weeks.

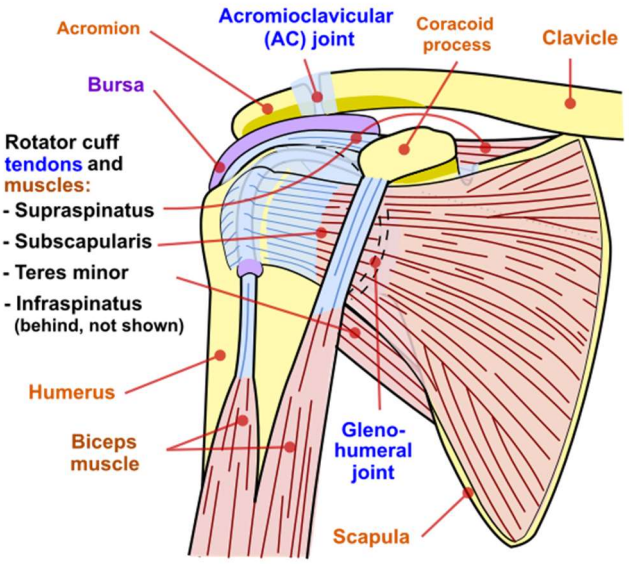
Glenohumeral instability:

Traumatic instability (TUBS)	Atraumatic instability (AMBRI)
Traumatic shoulder instability Unidirectional Bankart lesion Surgical management	Atraumatic shoulder instability Multidirectional instability Bilateral lesions Rehabilitation management as focus Inferior capsular shift (surgical management indicated).

AC Joint separation:

- **Presentation:** Acute pain, limited range of motion, trauma history. Inciting trauma is usually blunt force from above the level of the shoulder.
- **Evaluation/Imaging:** Radiograph showing separation of the acromioclavicular joint.
- **Management:** Acute reduction in emergent situations.

Classification	Description	CC Distance	Management
Type I	CC ligament is normal, AC ligament sprain	Normal	Non-operative
Type II	CC ligament sprain, AC ligament tear	< 25% of normal side	Non-operative
Type III	CC and AC ligament tears	25-100% of normal side	*Non-operative
Type IV	CC and AC ligament tears	Posterior dislocation	Surgery
Type V	CC and AC ligament tears	>100% of normal side	Surgery
Type VI	CC and AC ligament tears	Inferior dislocation	Surgery



https://commons.wikimedia.org/wiki/File:Shoulder_joint.svg

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