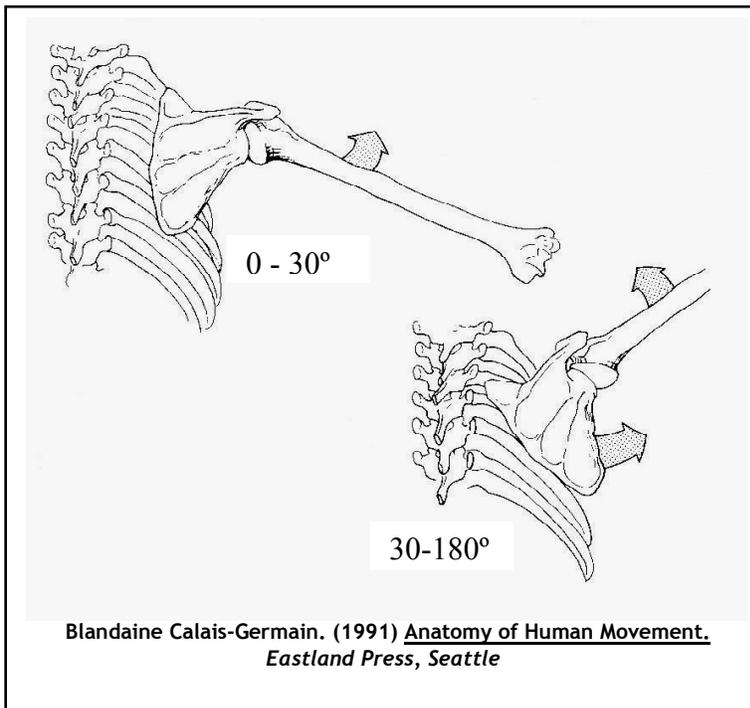


SCAPULO-HUMERAL MOVEMENT / RHYTHM



It is ideal to view scapulohumeral rhythm from the back. The client should have their t-shirt off for clear viewing.

Scapulohumeral rhythm should be smooth, co-ordinated and symmetrical. Watching a person lift their arms into abduction can relay a lot of information about which muscles they are recruiting to perform arm movements during their day to day activities.

The first 30° of abduction should be humeral movement only (**rotator cuff & deltoid**). The scapula should stay stabilized against the rib cage whilst the ball of the humerus moves within

the socket. From 30-180° of abduction, there should be close to a 1:1.5 ratio of movement observed between the scapula upwardly rotating and the humerus abducting respectively. It looks about even when observing the movement.

Overall - throughout the whole range of abduction, the humerus should move on a 2:1 ratio in comparison to the scapula rotation. The muscles controlling scapular upward rotation are the trapezius (all three portions - upper, middle & lower) and serratus anterior. The muscle abducting the humerus is the deltoid.

Abnormal scapulohumeral rhythm will predispose your client to the development of a shoulder injury. Disturbed scapulohumeral rhythm may be detected by seeing altered, jerky patterns of scapulohumeral movement. This could be:

1. Excessive scapula movement may be due to decreased stability of the glenohumeral joint (rotator cuff control), so the client has to move the scapula to allow abduction of the arm.
2. Excessive upper trapezius activations causing a hitch in the scapula
3. Weak serratus anterior muscles causing “winging” of the scapula
4. Overactive pec minor muscles (anterior stabilisers) causing a forward tilting of the scapula.

This may indicate an injury (Past or present) to the shoulder girdle or to the rotator cuff musculature.