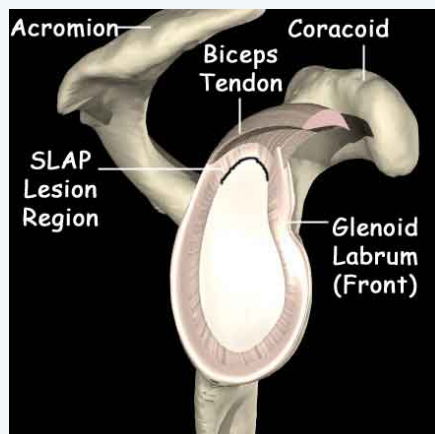


SLAP



- Superior Labrum Anterior Posterior
- Lesion is tear of glenoid labrum (rim of fibrocartilage in the glenoid fossa) at that area
- Long head of bicep convergences with the labrum

Causes

- Injury/repetitive microtrauma
- Superior compression/sudden inferior traction
- Fall, direct blow to the shoulder, FOOSH with shoulder abducted and flexed
- Overhead (biceps pulls labrum from underlying bony attachment)
- Bicep stabilises shoulder by generating compressive forces - limits translation
- Protects shoulder from anterior subluxation
- Depresses humeral head during arm elevation
- Chronic SLAP
- Rotator cuff dysfunction - unable to depress humeral head - superior migration of the humeral head happens
- Labrum lifts from its attachment
- Barkart, A/C arthrosis, instability, supraglenoid cysts

Classification

- **Type 1:** Fraying/degeneration of the margins of the glenoid labrum without detachment/biceps tendon avulsion
- **Type 2:** Detachment of the glenoid labrum from the bony rim - less stable biceps anchor - may be lifted during muscular contraction
- **Type 3:** Bucket handle displacement of the superior labrum into GH joint
- **Type 4:** Dysfunction + partial rupture of the long head of biceps tendon
- Most common = Type 1 and 2



Hx

- Young active male thrower, however it increases with age
- Hx of trauma
- Deep vague non-specific shoulder pain
- Provoked by overhead and cross body activity
- May have weakness and stiffness, popping, clicking, grinding, catching
- Pt complains of a "dead arm"
- Advanced will have S&S of instability

DASH

SPADI

PE

- Tenderness over long Head of Bicep
- Decrease/Pain in ROM in cross body adduction and flexion
- Increased translation of humeral head (more advanced)
- +ve Active Compression
- +ve Jobses
- +ve Passive Distraction
- There is not a specific test for a SLAP lesion

DDx

- AC joint sprain/pathology/degeneration
- Biceps Tendinopathy
- Cx radiculopathy
- Brachial plexus injury
- Fracture/dislocation
- Bankart Injury
- GH degeneration
- Instability
- Rotator cuff tendinopathy/tear

Imaging

- Can be used to rule out other pathologies
- US/ MRI (gadolinium)

- MRI Findings:

High signal intensity of Bicep tendon anchor on the labrum

Increased signal intensity at superior glenoid fossa

Displacement of superior glenoid from the labrum

Presence of glenoid labrum cyst

Thickening of the middle GH ligament is a normal variant



Management

- Conservative management often unsuccessful
- Improvement of symptoms mainly focused on restoring shoulder motion, rotator cuff balance, hip, core and scapula stability
- 6-12 week conservative care before surgery
- NSAIDs, stopping activities that aggravate pain
- Restore GH internal rotation (cross body adduction and sleep stretches) especially in throwing athletes
- Strengthening of SCapula and rotator cuff muscles - balance of anterior (pec, upper traps) and posterior (lower traps, SA, rhomboid) muscles
- STW of subscap, infraspinatus, anterior shoulder muscle and posterior capsule
- SMT of Cx and Tx
- IF suprascapular nerve compressed from paralabral cyst, surgical consultation is crucial
- Clear traumatic and cases of instability = surgery
- Surgical intervention is usually unsuccessful especially type 2
- 4-6 month rehab postoperative is recommended



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