

Superior labrum anterior posterior (SLAP) tear refers to a specific injury of the superior portion of the glenoid labrum that extends from anterior to posterior in a curved fashion [5]. These tears are common in overhead throwing athletes and laborers involved in overhead activities [5,1,9]

Without proper examination in the early stages diagnosis may be missed. Early diagnosis and if appropriate early rehab is the best way to ensure successful outcomes for the patient with respect to, loss time of injury, financial and physical stress. The patient's demographic will have a large impact on their success, for example throwers tend to fail conservative rehab more regularly because of the physical demands placed upon their shoulders [1].

To successfully determine if orthopaedic review is appropriate and further imaging necessary it is essential to perform a combination of tests which have varying degrees of specificity and sensitivity. 2 sensitive tests and 1 specific test is more efficient to diagnose a SLAP lesion.

#### Sensitive tests

- Compression rotation test
- O'Brien test
- Anterior apprehension test

#### Specific Tests

- Speed's test
- Yergason's test
- Biceps load test II [1]

If one of the three tests are positive, this will result in a sensitivity of about 75%. But if all three tests are positive this will result in a specificity of about 90%. [1] [3] The O'Brien test is the most sensitive test (47%-78%) and the Speed's test the most specific (67%-99%). [6] [1]

Several studies have looked at the combined outcome of the tests and there is a fair amount of variability. [1] [6] [10] With this in mind, in the absence of instability, we recommend that a patient who is not responding appropriately within 4-6 weeks of Physiotherapy management pursue orthopaedic opinion.

If a conservative management pathway is indicated, the patient will be guided in avoiding aggravating activities, pain relief strategies and expected time frames for recovery. If necessary, NSAID's and intra-articular corticosteroid injections can be applied to help diminish complaints, however clinical opinion varies here [8] [7]. The pain control means Physiotherapy can be started sooner. Strength, stability and motion are the components of shoulder function that should be focused on during rehabilitation. [9] This course of treatment should focus on restoring strength of the rotator cuff, shoulder girdle, trunk, core and scapular musculature, restoring normal shoulder motion, and training to improve dynamic joint stability. [8]

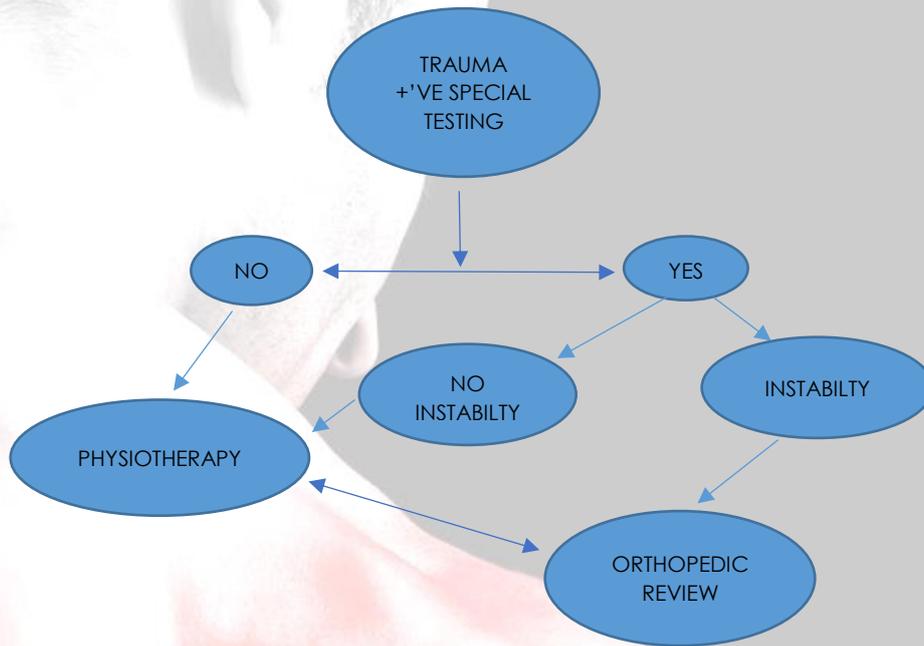
Regaining GIRD is a crucial aspect in the rehabilitation of SLAP lesions. [8] By the use of posterior capsule stretching exercises, such as sleeper stretch and cross body adduction stretches, and exercises for scapula stabilisation, redevelopment of the internal rotation can be accomplished. [7] [10]

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If surgical intervention is required, it is important to have rehab from an experienced physiotherapist with an understanding of shoulder mechanics. First and foremost, protecting the surgical repair in the short term is the most important factor. Following this, goals will include restoration of range as appropriate then progressing to restoration of humeral head control, scapular mechanics, gross strength and activity specific exercises are then integrated after the 12-week mark when it is safe to load.

In the acute setting it is important to consider if physiotherapy is appropriate and may help improve your patients long term outcomes whilst awaiting surgical review.



**Written by Dion Wallace**

Please contact [physio@sportsandspinalphysio.com.au](mailto:physio@sportsandspinalphysio.com.au) for a full reference list

**Sports & Spinal shoulder team:**



**Dion Wallace**  
Maroochydore



**Louise Meek**  
Coolum



**Simon Burley**  
Buderim



**Joakim Wisting**  
Kawana



**Ben Hones**  
Nambour



**Bethany Butler**  
Sippy Downs



**Alana Dinsdale**  
Chermside



**Adam Horwitz**  
Buderim

**SPORTS & SPINAL PHYSIOTHERAPY**