

❖ Practice Lab

Scapular Mobilization: Upward Rotation and Downward Rotation

Starting Position

Position the patient in supine. Elevate the bed for body mechanics.

Handling

1. Stand facing your patient, on the involved side.
2. Place your patient's involved arm between your humerus and your trunk.
3. Support the weight of the arm at the elbow.
4. Place your other hand under the scapula.
5. With a flat, open hand, move the scapula into elevation and protraction, in a circular motion. Your hand along the scapula does all of the work.
6. The hand along the scapula slides along the humerus and hooks on the epicondyles. Use a lumbrical grip.
7. Maintain traction of the scapula in protraction from the epicondyles.



8. Slide your hand (the one that had supported the arm at the elbow) up to your patient's hand as if shaking hands. Support the hand along the base of the metacarpalphalangeal (MCP) joints. Do not hang on the fingers. Make sure the arm is in external rotation.
9. Watch your patient's facial expression carefully as you slowly bring the arm over 90° of flexion. Note any expression of discomfort or anticipation of pain.



10. Bring the arm in forward flexion, maintaining traction at the hand and epicondyles.



11. Go only to the point of resistance or discomfort. DO NOT force ROM or any structures.
12. Gently and slowly lower the arm. Lowering the arm too quickly can cause pain.



Variations

If your patient has a heavy arm, reposition your patient in sidelying on the less involved side. The involved side is more accessible and easier to mobilize.

Factors to Consider

If your patient does not have full ROM in scapular excursion, check the less involved shoulder. If the limitation is bilateral, most likely the loss of ROM was prior to the stroke.



Factors which may contribute to loss of range:

- soft-tissue tightness
- increased muscle tone of those muscles acting on the scapula
- premorbid conditions