Functional Screening for a SICK Scapula in a Collegiate Softball Athlete  
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**Background:** An 18 year old, collegiate field hockey and softball athlete reported to the athletic trainer during softball season complaining of right biceps brachii pain. Objective findings included: antalgic shoulder position with the right shoulder held lower, pain over the proximal aspect of the biceps brachii, full active range of motion eliciting pain with forward flexion and abduction, and the O’briens, Speeds’, Neer, Hawkins-Kennedy, and Crossover tests were all positive. The athlete was removed from practice and treated conservatively for impingement with ice, electrical stimulation and rest. On the third day, her pain intensified while extending to the trapezius and paraspinal muscles bilaterally, she also complained of paresthesia from mid biceps brachii to the 3rd, 4th & 5th digits and was tender to palpation over the coracoid process. **Differential Diagnosis:** Signs and symptoms were consistent with biceps brachii strain, biceps brachii tendonitis, biceps brachii impingement, avulsion fracture, labral pathology, ulnar neuritis and cervical radiculitis. **Treatment:** Physician’s findings included: moderate limited range of motion with internal and external rotation, forward flexion, and abduction; laxity of glenohumeral joint; and tender to palpation over the coracoid process, middle third of the clavicle, and insertion of the pectoralis major. No imaging studies were conducted. The physician’s diagnosis was SICK scapula and multidirectional glenohumeral instability with neurological symptoms resulting from the instability. The athlete was treated with heat, massage and electric stimulation for pain control, while rehabilitation included strengthening of periscapular and rotator cuff muscles, oscillations and rhythmic stabilization. A Selective Functional Movement Assessment (SFMA) was performed on the athlete, which identified a decreased single leg stance on the left as compared to the right and positive left peroneal nerve tension. The neurological pain and shoulder dysfunction were attributed to left single leg stance dysfunction altering the kinetic chain of the athlete, changing the weight distribution on her contralateral lower extremity while throwing. She completed a series of stretches to decrease neural tension. Through the kinetic chain, improving single leg stance and abolishing neural tension in the left lower extremity improved her right shoulder symptoms and function. Although eliminating the neural tension improved her right shoulder condition, treatments of heat, massage, electric stimulation, stretching and strengthening continued through the season to further control her symptoms. **Uniqueness:** Use of the SFMA to identify a left lower extremity dysfunction as contributing to her right shoulder condition. **Conclusions:** This athlete presented with complaints of right biceps brachii pain that progressed bilaterally into the trapezius and paraspinal muscles, and began to complain of paresthesia from mid upper arm to digits. SFMA screening identified a left lower extremity dysfunction that seemed to be affecting her right shoulder through the kinetic chain while throwing. Understanding functional screening methods may help clinicians identify “regional interdependent” dysfunctions at remote anatomical regions that may contribute to a patient’s chief complaint. **Relevant Evidence:** SFMA is a system to identify “regional interdependent” dysfunctional movement patterns seemingly unrelated to the primary musculoskeletal complaint, which may contribute to the primary complaint. Non-painful dysfunctional movement patterns are further assessed to expose specific mobility or stability impairments causing the dysfunctional pattern. Intra-rater reliability for the SFMA score (kappa, % agreement) has been reported as “substantial” (.61-.8) or “almost perfect” (.81-1.0), while the most experienced raters had the highest intra-rater reliability (.83, .91) as compared to the least experienced rater (.72, .88). The most experienced raters had the highest inter-rater reliability (.76, .88), while the least experienced raters, had to lowest inter-rater reliability (.20, .82). To date, no evidence on the validity of SFMA has been identified. **Word Count:** 586 words.