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The anatomy of the shoulder girdle allows for great mobility in the upper limb. As a result of this mobility, it is possible to place your hand almost anywhere within a sphere of movement, which is initially limited by the arm length and space taken from the body. The mechanics of the Glenohumeral joint are that it allows these movements to be carried out without much difficulty. The shoulder joint is the most mobile of the human body, but all this mobility results in great instability, which means that this region has a greater predisposition to developing lesions. The lack of stability occurs due to the low depth of the glenoid cavity relative to the humerus. The stability of this joint is performed by ligaments and muscles surrounding the shoulder, more specifically rotator cuff muscles. Shoulder joint is of paramount importance in activities in daily life such as eating, dressing, personal hygiene, work activities, sports and various other functions. Since it is so necessary to perform activities in daily and professional life, it is common to use excessive and repetitive activities, which generate constant trauma and can result in several pathologies. The most common pathologies in the shoulder region are: Impact Syndrome Bicipital Tendinitis Tendinitis Calcific Adhesive Capsulitis Bursitis Subacromial Shoulder Pathologies cause pain and functional restriction, drastically reducing the quality of life of the affected individual. Shoulder anatomy of the bone structure The bones of the upper extremities are divided into four segments: Scapular Waist – formed by the clavicle and scapula; Arm - formed by humerus; Forearm - formed by radio and elbow; Hand – formed by the bones of carpal, metacarpals and phalanx. The shoulder complex is formed by the legs: scapula, clavicle and humerus, but the costal arches and sternum are also part of shoulder mobility. The scapula is a triangular and flat bone, which divides into body, acromiatic and glenoid. It consists of three edges (medial, lateral and upper), three angles (top, lateral and bottom) and two faces (dorsal and costal). On the back of the shoulder blade we find the joint spine, where its upper extremity is known as achroma. Above this spine is the supraspinatus fossa and below, infraspinatus fossa. On the costal face of the scapular lies the subscapular fossa. The scapula has a projection forward, under the clavicle and in the direction of the humerus head, called the coracoid process. The coracoid process is articulated with the glenoid fossa of the scapula. The Glenohumer alleda is the place where the upper arm head articulates with the scapula in glenoidfossa. The proximal part of the humerus is formed by the humerus head, tubercle tubercle major, bicipital sulcus, anatomical neck, surgical neck, and proximal humerus diasis. The clavicle is a curved bone formed from the bone, the only bone in the upper part that allows bone fixation of the upper part of the chest. The clavicle is formed by one body and two extremities, sternal and acromial, with its convexity forward medially and concavity forward in general. Its function is to act as a support ray for the shoulder blade and humerus, which increases glenohumeral mobility to allow activities with height of the upper limb. Shoulder joints clavicular sternum joint The sternoclavicular joint is of the synovial type, which involves the scapula, clavicle, and manubrium of the sternum. This joint connects the shoulder to the thorax, through the proximal end of the clavicle with the manubrium of the sternum medially and the cartilage of the first rib, which forms the floor of the joint. Achromioclavicular joint triaxial joint, consisting of the union of lateral articular facet of the clavicle and the concave area of the anterior part of the medial edge of the achroma. This joint has a capsule, which is enhanced by capsuloligaments, acromioclavicular stabilizers and conoid and trapezoidal coracoclavicular ligaments. Scapularthoracic joint Its structure is not considered a true joint ynovial. This joint is a functional structure, extremely important for the integrity of shoulder mobility, its lack of ligament support delegates the function of stability to the muscles that attach to the chest. The Glenohumer alleda is synovial, sphyallid and triaxial. It is formed by the head of the humerus and glenoid cavity. The glenoid cavity is rase and has a common surface much smaller than the upper arm head. To increase this depth, there is a fibrocartillafena edge called glenoid lip, which attaches to the contour of the cavity. The Glenohumeralleden is the most mobile of the human body, but all this mobility also makes it less stable. This joint consists of ligaments, tendons, joint capsule and muscles, mainly of the rotator cuff, which acts on stability and joint mobility of the shoulder. Ligaments ligaments are structures that stabilize joints, connecting bones to bones. The ligaments found in the shoulder joint are: 1) Coracoracromial ligament: it originates in the coracoid process and is part of the large and lower tuberosity of the humerus, forming a kind of tunnel through which the tendon of the long head of the biceps passes. 2) Glenohumeral ligament: there are three (upper, middle and lower) and originated in the labro of the glenoid cavity, forming capsular thickenings that attach to the cervix and tuberosity of the humerus. These ligaments are those that support the weight of the suspended arm, in addition to limiting the movement of external rotation. 3) Coracoacromial ligament: originated in the coracoid process and is part of acromion; 4) Superior Transverse Ligament of Scapula: originated on the medial side of the scapula notch, sits down at the base of the coracoid process. There is also the joint capsule, a kind of elastic bag that involves a joint joint. It is formed by the group of ligaments that bind the humerus to the glenoid cavity. Ligaments are the main stabilizers of the shoulder, along with the four sensor of the rotator cuff muscle group. Muscles The main muscles of the shoulder joint are rotator cuff muscles: supraspinatus, infraspinatus, less round and subscapular. These muscles involve the joint in the form of a cuff and place the upper arm head in the glenoid cavity, to stabilize it and hold it firmly in an anatomical position. Nerves It is through the nerves is that the signals from the central nervous system are transported to the muscles. They also return to the central nervous system feelings of touch, pain and temperature. The nerves in the upper extremities pass through the armpit region and under the shoulder joint. There are three main nerves passing through this place: Radial nerve Ulnar Nerve Median Nerve Bursas Bursas bursas are bag-shaped structures, located on two moving surfaces. Inside the bursa contains a small amount of lubricating liquid, which serves to reduce friction between the two structures that move in contact with each other. In the rotator cuff, in the outer layer of the shaft there are some bursas. Subacromial and subdeltoid bursa separate senan of the supraspinatus muscle and head of the acromion humerus, coracoid process, coracoacromial ligament, and deltoid muscle. Bursa's function is to avoid the influence between these structures and avoid damage. What is shoulder bursitis? Shoulder bursitis (also known as subacromial bursitis) is inflammation of the subacromial bursa, which is characterized by pain when performing shoulder movements. It can be divided into: 1) Acute bursitis: extremely uncomfortable condition, because when lifting the shoulder the response is an intense and very limited pain, accompanied by a painful arch. Bursitis pain is usually reproduced with passive abduction at 180°, passive internal rotation, and passive horizontal adduction. 2) Primary Chronic Bursitis: this type of bursitis is defined in two types: I – Caused by degenerative changes, especially by the supraspinatus muscle and acromioclavicular joint, which can generate a reduced space for the bag resulting in an inflammatory reaction. II - Caused by diseases such as rheumatoid arthritis. The pain of this type of bursitis develops gradually, usually located in the shoulder area and lateral deltoid, and can radiate out to the upper arm. 3) Secondary Chronic Bursitis: it is more common than the primary, resulting from other shoulder pathologies such as rupture of the medial coracoracromial ligament. It is similar to secondary chronic bursitis, with pain gradually developing in the shoulder and can radiate out to the upper arm. It is important to know that chronic bursitis is not a continuation or sequela of acute bursitis. Acute bursitis is a disease completely apart. Causes The shoulder joint is a dirt area at repeated pressures during movement. As mentioned earlier, the subacromial bursa function has to reduce friction caused by friction of the muscles of the rotator cuff, especially the supraspinatus tendon. Subacromial bursitis is an inflammatory condition that causes direct microtrauma scans due to contusion, indirect falls with palmar support, repetitive movements and associated diseases such as rheumatoid arthritis. The main causes of subacromial bursitis are: Excessive activity of shoulder Shoulder In Motion By Prolonged Hyperabduction Supraspinatus Rupture, Infraspinatus or Long Part of biceps Acromioclavicular Dislocation Trochanter Fracture Irritation in the Bursa region through the presence of Osteophytes Chronic Patient Adherence in bed Changes and inflammations of general symptoms Subacromial bursitis manifested by an image of acute pain , characterized by severe pain at shoulder level. Depending on the type of bursitis (secondary primary or chronic chronic), pain can radiate to the cervical region, to the arm, forearm and even fingers. In acute bursitis the individual refers to progressive intensely pains, which begin in the shoulder and then radiate to the arm to the wrist. Pains are very intense during the first ten days, usually leading to spontaneous healing for about six weeks. The clinical picture may also be confused with cervico-brachial neuralgia or septic arthritis, since at the site can occur redness and heat, typical signs of inflammation. Physiotherapeutic treatment Treatment of subacromial bursitis is different by type: Acute phase During the acute phase, it is necessary to conduct the rest of the affected axis, using susoia to avoid continuous irritation of the subacromial sum. However, complete immobilization can lead to tissue adhesion, so it is important to perform controlled movement exercises during this phase to maintain normal range of motion and reduce pain. Passive mobilisation and mobilisation techniques in the glenohumere oath shall be carried out with this and commuting exercises. The patient's pain limits should always be respected. To control pain in the acute phase, physical resources such as cryotherapy, electrotherapy (TENS and Interferential Current), laser and etc. are indicated. Subacute phase At this stage the goal is to regain function without irritation of the bursa. Active exercises can be started and progression should be done carefully, always avoiding pain. If the activity is kept within the safe dosage and frequency, symptoms and pain and edema will gradually decrease. The patient is the best guide to how the progression of therapy should be done. Usually pain leaves the individual with impaired function, and along with immobilization of the acute phase, can cause muscle weakening. When entering into a strengthening work, it is important to start with isometric exercises, kept within tolerance of the patient. Progression should be performed according to the patient's pain lining back, increase resistance gradually and develop into isotonic exercises with resistance, provided well tolerated by the patient. Types of treatment Physical resources Physical resources can be used as a supplement to physical therapy treatment to aid in the control of pain and inflammation: Cryotherapy: helps reduce edema, pain and muscle contractures Ultrasound: using thermal effect helps reduce pain, reduces joint stiffness and increases blood flow. It is not indicated in the acute phase. TENS: simple, inexpensive and effective analgesia technique, and can be used in virtually any case by orthopedic pathologies. Laser: has anti-inflammatory, analgesic action, reduces edema and stimulates tissue healing. Kinesiotherapy Kinesiotherapy is the use of physical exercises for rehabilitation. Strengthening exercises are performed to establish neuromuscular control of the humerus and scapula. For shoulder rehabilitation exercises should focus on strengthening dynamic stabilizers and rotator cuff muscles These exercises should begin with painless isometric contractions and progress to isotonic contractions with total range of motion without pain. Bandage Functional Bandage has as its basic functions: Promoting Prolonged and Constant Sensory and Mechanical Stimuli on the Skin Maintains Communication with the Deepest Tissues By Mechano Receptors Found in Epidermis and Dermis To Improve Contraction E Muscle Fatigue Reduce Pain Improve Blood and Lymphatic Circulation Proper Proprioception Rescan Subluxation of Aid Joints in Various Orthopaedic Pathologies Fighting Muscle Injuries Weakness Or Muscle Tension SprainsSprains Sprains Sprains Stretches StretcheEs e Corrects joints For subacromial bursitis, the following techniques are used: Lymphatic technique from the acromion of the upper arm In the form of octopus Width of 5 centimeters, with 4 strips of 1.25 centimeters Measure in stretched position of the acromion to where you want to apply the band In neutral position place the base of the band in the acromion without straining Strain the skin put the arm in external rotation / abduction or internal rotation / aduction. Place the strap one by one in a circular shape on the humerus in a neutral position, fixing the 4 different anchors. Technique of the painful points and trigger points in bursitis Four bands Width of 5cm Measure so that anchors are secured well outside the painful area, taking into account the necessary distance From the center and with maximum stretch, the first strap applies. Both anchors are stuck without noose. The second band applies perpendicular to the first, where the bands form a cross. The third band, applies diagonally. The fourth band is applied diagonally to the previous one. The four bands form a star. The centerpiece of this star must be a little above the pain. Functional bandage scares in subacromial bursitis significantly improves pain, improves blood and lymph circulation, improves joint stability of shoulder complexes, inhibits and activates muscles responsible for shoulder complexes, improving signs and symptoms of bursitis. Hydrotherapy The therapeutic procedures performed in the aquatic environment are recommended for the treatment of bursitis, as they offer good results due to the antigravitational effect and the resistance that water imposes on the joints, especially the axis, significantly assist its strengthening. Physical exercises in water reduce joint overload, resulting in reduced sensitivity to pain, reduced compression in sore joints, and offering better freedom of movement. The main goals are to reduce pain, relieve muscle spasm in the region, get relaxation of the shoulder muscles, improve muscle strength and improve range of motion. Benefits Physiotherapy plays an important role in the rehabilitation of shoulder bursitis, as it reduces pain and stimulates the individual's independence and functionality. Physical therapy rehabilitation has several resources and techniques that relieve pain, inflammation, improve range of motion, strengthen muscles and give body awareness. The physiotherapist analyses the techniques most appropriate for the patient's current condition, respecting the variables of the rehabilitation process and developing an exercise program that can correct deficits and recover the individual's ideal movements, in addition to educating him/her in relation to their posture and preventive practices, promote health, functionality and quality of life. Conclusion Shoulder bursitis, also known as subacromial bursitis, is characterized by the presence of shoulder pain, especially in certain movements. Abduction, external rotation and height of the upper part are the movements that most trigger pain. Subacromial bursitis is an inflammation of the subacromial bursa, a structure that serves to reduce friction between the sians of the shoulder joint. The disease can be acute, chronic primary and secondary chronic. Treatment is usually conservative, with the use of anti-inflammatory drugs and physiotherapy. Physical therapy in subacromial bursitis is aimed at reducing pain, inflammation and restoring movements so that the patient can again have functional shoulder movements without pain. Bibliographic References