Clinical Reasoning for the Management of the Shoulder Complex Pain

WPTA Spring Conference – 2019
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Who are these people?

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• Dr. Hanni Cowley PT, DPT
  – Board Certified Clinical Specialist in Sports Physical Therapy
  – Owner- Movement Solution LLC
  – Faculty-Specialized Physical Therapy Education
Objectives

• Integrate an evidence-informed clinical decision making framework into a PATIENT CENTERED assessment and management plan for patients with different upper quarter dysfunction/pain.
• Understand common movement impairments associated with upper quarter dysfunction and appropriately match interventions to address these impairments.
• Demonstrate clinical decision making ability to integrate a multi-model treatment plan including patient education, manual therapy, motor control/strengthening for patients with upper quarter dysfunction.

Why this course?

• Upper extremity injuries are a common diagnoses seen in healthcare.
• Shoulder pain is the 2nd most common diagnosis seen by primary care physicians

Physician Visits for MSK Sprains and Strains

National Center of Health Statistics, National Ambulatory Medical Care Survey 2006
Full Disclaimer

We don’t have all the answers...then again, who does???

"Outdated" Patient Management Model

Traditional "Medical" Model
(Nagi / Disablement)

But Where’s the Patient???
Paradigm Shift

• Pitfalls of the “Medical Model”
  – Care is based around a pathology AND NOT the individual
  – Disregards other contextual factors associated with condition
  – Poor Diagnostic Accuracy of special tests to determine “active pathology”
  – Over-utilization of diagnostic imaging and tests and possibly surgery to address the “active pathology”
  – Increased costs of care with no improvement in patient outcomes
• Need for a change in the Patient Management Model

Consider the following

• 47-year-old with superior lateral shoulder pain
• 6 month history. Started after throwing the baseball with his son (reliving the “glory days”!)
• In PT, motion is limited and aggravated with motions out to the side and behind back. Cuff weakness is noted.
• What health care practitioner should he see???? His future will depend on it!
47 year old with shoulder pain scenarios

- Mentions it to his primary care MD:
  - X-rays taken show a “hooked acromion”
  - Dx: Shoulder Impingement
- Goes directly to an ortho MD:
  - X rays show a “hooked acromion” and MRI shows a partial RC tear
  - DX: Shoulder impingement and RC tear
- Goes to a chiropractor:
  - X rays taken
  - DX: “Subluxation” in mid thoracic spine and shoulder bursitis
- Sees a PT
  - Notes increased prominence of inferior angle during sitting and RC weakness during a MMT at 90° elevation
  - DX: Scapular dyskinesia and RC syndrome

What happens if he sees all FOUR health care providers?

Ok. A few things that make you go hmmm...

**DIAGNOSTIC IMAGING - FILMS**

- In 1972, Neer proposed that IMPINGEMENT leads to attrition of SS tendon and bursa. In 1983 identified that 95% of tears “are caused by impingement”.
- Attention to the **acromion morphology** was heightened as a potential contributor to impingement (Bigliani, 1986)
- Leading to rationale for **Subacromial Decompression** (SAD) surgery
Subacromial morphology

• **Large variation of acromion and scapular morphology in asymptomatic population** (Chopp-Hurley J. Sur Rad Anat. 2016)

• More tears occur on the articular side of the joint than on the bursal side (Payne, 1997. Ellman, 1990)

• Poor correlation between acromion shape and symptoms (Snow, 2009)

• Let’s think: What does the term “hooked acromion” instill in the patient?

Other things to consider re: DIAGNOSTIC IMAGING – MRI’s...

• MRI of **ASYMPTOMATIC ADULTS** show 20% have partial and 15% have **full thickness tears**. Those >60 y/o, 50% have some type of rotator cuff tear (Siber J. 1995, Sher. 1995)

• 40-80% of asymptomatic professional baseball players/pitchers presented with **R/C tears on MRI**. In 5 year F/U after retirement, most remained asymptomatic (Conner, 2003. Miniaci, 2003)

• NO correlation between severity of tear and pain in patients with **RC tears**. There WAS a correlation with comorbidities, lower educational level and race to pain (Dunn. 2014)
Is surgery the answer?


• Recent CPG in BMJ reported NO BENEFIT TO SAD but there are harms and it is burdensome and SAD SHOULD NOT BE OFFERED TO PATIENTS (Vandvik, 2019)

• Non-operative tx of chronic RC tears was effective in 75% of patients (Kuhn, 2013. Boorman, 2018)

• Neither labral repair or biceps tenodesis surgery had any benefit when compared to SHAM surgery (Shroder, 2017)

Paradigm shift
ICF Model of Patient Management

Patient Centered!!
Clinical Reasoning

Knowledge & Theory

- Knowledge and Evidence from the Literature
- Understanding of Anatomy; Physiology; Biomechanics; Pathologies
- Hypothesis

What the patient is telling you

Clinical Information

- History, Signs & Symptoms
- Hypothesis

Informed Diagnosis

For PT: Development of ICF - Based Clinical Practice Guidelines

• Goals:
  – Provide a **scientific basis** for consequences of health conditions.
  – Establish a **common language** to improve communication
  – Provide a **systematic process** for uniform care across patients
  – Establish a template to assist in **Clinical Reasoning**

*Godges et al 2008 JOSPT*
Shoulder Clinical Practice Guidelines

Classification Based System

– Shoulder Pain with associated Mobility Deficits (2014)
– Shoulder Pain with associated Muscle Power Deficits/Rotator Cuff Syndrome
– Shoulder Pain with Movement Coordination Impairments/Instability (2019)

Goals of the Assessment

• Exclude serious pathology
• Consider pain mechanisms (nociceptive neurogenic, central sensitization)
• Determine influence of contextual factors and other co-morbidities
• Understand how other psychosocial factors are influencing the condition (emotions, beliefs, etc.)
• Identify the nature of the symptoms (joint specific, soft tissue, motor, etc.)
Components to the Patient Centered Examination/Evaluation

- **Component 1:** Medical Screening - Subjective and Objective red flags and yellow flag assessment
- **Component 2:** Differentiation of *impairments, activity and participation restrictions* associated with health condition - "pattern recognition"
- **Component 3:** Diagnosis of severity, irritability, stage and stability of condition
- **Component 4:** Match intervention strategies based on findings

### Component 1: SCREENING

**Upper Quarter Tools**

- Past Medical History
- Medical Screening - Subjective and Objective information (Ex: neurological screen, specific tests for fracture, cardiopulmonary screen, etc.)
- Ransford Pain Diagram / Visual Analog Pain Scale / Body Chart
- Functional Outcome Measures (Ex: Shoulder Pain and Disability Index, Quick Dash, etc.)
- Psychological Risk Factors (Ex: FABQ-W, FABQ-PA, Tampa Scale of Kinesiophobia, Pain Catastrophizing Scale, etc.)
Component 2: Differentiation of Subjective and Examination Findings

1. ID Source of pain
2. Differentiation of Patient Subgroups!
   – “Pattern Recognition”
   – Standardized Elements vs. Differentiating Elements
3. Patient Centered Examination
   – Why is your patient here- THEIR primary limitations
   – ***Functional Asterisks / Comparable Sign ***
4. Vary exam vigor of exam based on irritability?

1. Sources of pain
   (Smart KM. Man Ther. 2012, Hodges P. 2019)

1. Nociceptive Pain
   • Proportionate pain
   • Aggravating and alleviating factors
   • Intermittent sharp or dull ache
   • No dysesthesia, burning or shooting
2. Peripheral Neurogenic
   • Pain in dermatomal or cutaneous distribution
   • ULTT and sensitivity to nerve palpation
   • Hx of nerve injury
3. Central Sensitization
   • Disproportionate pain
   • Disproportionate aggravating and alleviating factors
   • DIFFUSE tenderness
   • Psychosocial issue
2. Differentiation of Patient Subgroups:

Primary Impairments of Physical Function

- Cognition/Beliefs
  - Understanding of condition
  - Pattern of Pain
  - Fear avoidance beliefs/kinesiophobia
- Mobility/flexibility
  - Joint mobility
  - Soft tissue mobility/flexibility/tone
  - Neurodynamic mobility
- Motor function
  - Motor control/coordination
  - Proprioception/Kinesthetic Awareness
  - Muscle strength
  - Muscle endurance

What’s the Pattern?

What tools do we need to differentiate these dysfunctions?

- Motion assessment
- Joint specific AROM/PROM/ and ROM with Overpressure
- Joint Mobility Assessment
- Muscle Flexibility Assessment
- Specific Palpation
- General Neurodynamic Mobility
- Motor Control assessment
- Strength/Endurance Assessment
Elements of the upper quarter examination

**Standard Elements**

- Cervico-Thoracic Screening
- Functional Assessment - Combined planes of movement
- Shoulder AROM/PROM/Overpressures - Single plane movement

**Differentiating Elements**

- Joint Mobility Assessment
  - CT junction and Thoracic spine
  - Scapular/Sternoclavicular/Acromioclavicular joint
  - Glenohumeral Joint
- Soft Tissue Mobility/Tone Assessment
- Motor Testing – Coordination, strength, endurance
- Specific Testing as needed

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3. Patient Centered

**Identify a Asterisk signs**

*(Comparable signs, Concordant signs)*

Use the Asterisk signs to determine effectiveness of intervention and refine your clinical reasoning

**Commonly...**

- Specific MOTIONS which provoke symptoms?
- Specific EXAM FINDINGS which provoke symptoms?
- Specific FUNCTIONS which provoke symptoms?
  (choose what is important to the patient)

- Quantitative and Qualitative changes
- Within or between session changes

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Component 3:
Assessment of Tissue Irritability

“Ability to aggravate and ease sx’s”

Based on 3 components
1. Amount needed to 
   cause/provoke the sx
2. Severity of sx provoked
3. Activity and time to ease sx

Why?: Guides vigor of 
the exam & intervention

Exam Vigor = Tissue Irritability
Motion assessment based on Irritability

• Examine Functional Motion?
  – Assess PATIENT CONTROLLED combined movement patterns?
• Examine AROM?
  – Assess PATIENT CONTROLLED straight plane ACTIVE MOVEMENT
• Examine Repeated movements?
  – Assess PATIENT CONTROLLED response to multiple reps
• Examine PROM and overpressure?
  – PT APPLIED PHYSIOLOGICAL movement and end feel with overpressure
• Examine PROM combined movements with overpressure (a lot of “special tests”)?
  – PT APPLIED overpressure into multi-plane motion and or sustained holds
Treatment Vigor = Tissue Irritability

Will you limit the VIGOR of treatment?

- Moving to a limit of **Pain** - Stopping at the limit where pain commences - Severe /irritable patients
- Moving to the limit of **Motion** - Moving to end-range and appreciating end-feels - Less severe /irritable patients

Component 4: Best Interventions
Example from CPG for Adhesive Capsulitis
Component 1 and 2

Example from CPG for Adhesive Capsulitis
Component 3 and 4
1. Altered Cognition/Beliefs

- Cognition:
  - Lack of understanding of their condition
  - Patient doesn’t know what is going on
  - “Has heard or read many different things”

- Beliefs
  - FEAR of condition: Fear avoidance beliefs
  - Kinesiophobia: Fear of movement
  - “CATASTROPHIZE”: Believe that it is far worse than it actually is
  - AVOID ACTIVITY leading to further functional limitations

- May lead to central processing issues: IE: Central Sensitization: Non-specific pain
Fear Avoidance Beliefs Model

Common **SUBJECTIVE** findings associated with:

**Altered Cognition/Beliefs**

- MULTIPLE DIAGNOSES and DIAGNOSTIC TESTING – “Don’t know what’s going on”
- Associated with more CHRONIC/PERSISTANT PAIN
- Disproportionate pain to the mechanism or nature of their injury
- Feel as if they have lost control of condition
- Negative contextual factors in their life (job, home life, stress, high level of anxiety)
- No pattern to the pain, multi regional
- Difficulty describing aggravating or alleviating factors (“everything hurts” and/or “nothing helps”)
- Lower threshold to activity prior to onset of pain
- Associated with other psychosocial issues (depression or anxiety) and personal beliefs (fear avoidance beliefs or catastrophization)
Common **OBJECTIVE** findings associated with: **Altered Cognition/Beliefs**

- **Pain Diagram:** Multiple body regions
- **Fear Avoidance Belief Questionnaire (FABQ)**
- **Pain Catastrophizing Questionnaire**
- **PROM/overpressure:** Empty end feels
- **Palpation:** sensitivity to light touch (Allodynia)
- **Strength:** weak and painful in multiple joints
- **Patient verbalizes:** “I can’t do that” or “if I do that, I know I will hurt myself”

Anyone ever see something like this and wonder...?
2. Mobility Dysfunction

Common findings associated with: **JOINT Mobility Deficits**

- **Subjective**: reports tightness and/or referred pain in familiar pattern associated with joint. Pain with movement usually.
- **AROM**: loss of specific motion with feeling of tightness or pinching in joint
- **PROM**: Loss of AROM = loss of PROM
- **End range overpressure**: Early CAPSULAR end feel with or without pain
- **Joint mobility**: Hypomobility
- **Motor**: MAY have weakness of muscles that cross the joint
### Irritability

<table>
<thead>
<tr>
<th>HIGH</th>
<th>LOW</th>
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<tbody>
<tr>
<td><strong>AROM/PROM:</strong></td>
<td></td>
</tr>
<tr>
<td>Pain prior to end range</td>
<td>Pain at end range or with multiple repetitions</td>
</tr>
<tr>
<td>Limitations with single plane motion</td>
<td>Limitations with multi-plane motions</td>
</tr>
<tr>
<td><strong>End Range Overpressure:</strong></td>
<td></td>
</tr>
<tr>
<td>Empty End feel due to pain</td>
<td>Pain only with overpressure to end range</td>
</tr>
<tr>
<td><strong>Joint mobility:</strong></td>
<td></td>
</tr>
<tr>
<td>Pain with assessment</td>
<td>No pain with only stiffness</td>
</tr>
</tbody>
</table>

### Common findings associated with: **Soft Tissue Stiffness/Tone**

- **Subjective:** reports tightness and/or referred pain in familiar pattern associated with muscle. Pain with static postures
- **AROM:** loss of motion with feeling of tightness on opposite side of direction of motion (antagonist mm).
- **Specific Flexibility tests:** Increase muscle guarding/Elastic end feel. REPRODUCE pain (“their pain”)
- **Palpation:** tenderness areas of muscle with or without pain referral that REPRODUCES patients pain OR increase muscle tone to palpation
- **Motor:** Poor motor control of agonist mm
**Irritability**

**HIGH**  
AROM/PROM:  
Pain at end range AROM  
Flexibility:  
Limited motion  
Palpation:  
Tender with light palpation  
Referral with palpation:  
Latent (none)

**LOW**  
AROM/PROM:  
Pain with overpressure  
Flexibility:  
No motion limitation, only feeling of “tightness”  
Palpation:  
Tender with deep palpation  
Referral with palpation:  
Active (common referral pattern)

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**Pattern Recognition of**  
**NEURODYNAMIC MOBILITY DEFICITS**

- **Subjective:** Chronic and deep pain with prolonged posture that tension nerve structures
- **Cervical ROM:** Restricted motion and/or pain esp. with motion away. Varies with arm position
- **Peripheral joint ROM:** Variable dependent on tension of the nerve
- **Palpation:** pain and/or muscle tone along path of nerve
- **Special tests:** Positive neurodynamic testing
Irritability

HIGH    LOW

Posture:
Pain after short period

AROM/PROM:
Noticeable motion deficit

Palpation:
Tender with light palpation
(Tinel)

Neurodynamic tests
Pain before overpressure

Pain after long period
Minimal motion deficits
Tender with deep palpation
(sustained pressure)
Pain with overpressure

In General:
Assessing Irritability from Motion Assessment

- Joint motion/mobility
- Soft Tissue Flexibility Testing
- Neurodynamic Testing

Applies to:

HIGH
MEDIUM
LOW
3. MOTOR DYSFUNCTION

Common findings associated with: **Motor Control/Coordination Deficits**

- **Subjective:** Feels weak, poor coordination, poor balance
- **Functional movement assessment:** Aberrant motion, clumsy, poor body awareness, lacks dissociation of movement (ex: shrug sign)
- **AROM:** Painful arc, Scapular dyskinesia
- **Scapular tests affect symptoms:** Scapular assist test, scapular repositioning test
Scapular Test affect symptoms?

• Scapular assist test
  – Assist scapular upward rotation and assess SYMPTOMS (pain) (Rabin A. 2006)

• Scapular reposition test
  – Assist scapular ER and posterior tilt and assess STRENGTH (Tate A. 2008, Smith J. 2002)

(McClure P. 2012)

Common findings associated with:

**Force Production and Endurance Deficits**

• Subjective: Feels weak and inability to carry out functions for long time
• Functional movement assessment: fatigues with multiple repetitions
• AROM: Painful arc and less prevalent with shortened lever arm
• Strength assessment: Weak and painful with MMT and or other standardized strength assessment (ex: Hand held dynamometer or 1RM)
• Endurance assessment: Diminished force production with multiple repetitions
Where do special tests fit in here?

Questions to ask:
1. Have you already done most of the special tests during your exam?
2. Are special tests good enough to definitively RULE IN OR RULE OUT PATHOLOGY?
3. How do these special tests DRIVE YOUR TREATMENT?
4. How do the special tests affect your PROGNOSIS?

Which physical examination tests provide clinicians with the most value when examining the shoulder? Update of a systematic review with meta-analysis of individual tests

Conclusion: Based on data from the original 2008 review and this update, the use of any single ShPE test to make a pathognomonic diagnosis cannot be unequivocally recommended. There exist some in more than one study. Combinations of ShPE tests provide better accuracy, but marginally so. These findings seem to provide support for stressing a comprehensive clinical examination including history and physical examination. However, there is a great Hegedus EJ, Goode AP, Cook CE, et al. Br J Sports Med (2012).
Utilization of Special Tests

Organized based on your working hypothesis and understanding of tissue irritability

• **Highly Irritable:** Minimal if any special testing. Tests used to **Rule Out** Sinister Diagnoses

• **Moderately Irritable:** Some testing to **Rule Out** competing diagnoses and move to treatment

• **Minimally Irritable:** Some tests to **Rule Out** diagnoses followed by provocative tests to **Rule In** primary tissue

  Special tests become “Asterisks” to retest following treatment

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**Component 4**

**Matching Best Interventions With Clinical Findings**

• [https://www.youtube.com/watch?v=SX1RfdSgsMs](https://www.youtube.com/watch?v=SX1RfdSgsMs)
Best Interventions – PATIENT CENTERED

Based on a collection of information

• Patient
  – Interpretation of the problem
  – Expectations of care/Beliefs
  – Motivation and compliance
  – Contextual factors (personal and environmental)

• Therapist: Clinical Hypothesis
  – Hypothesis of patient subgroup
  – Tissue Irritability
  – Clinician Experience

• Therapist: Sound Clinical Reasoning Skills

1. Primary focus for Altered Cognition/ Beliefs

1. Primary Focus - EDUCATION
   – Pain Neuroscience Education
     • Nerves become sensitized – Next slide
     • Hurt ≠ Harm – pain is not associated with tissue damage
     • Motion is lotion” – MOVEMENT IS GOOD
   – Educate about imaging
   – Address patients preconceived beliefs
   – Graded Exposure/Exercises – SET GOALS

2. Others
   – Manual therapy to “diminish the sensitivity of the nervous system”
   – Exercise for movement – less focus on QUALITY and more on GRADING AMOUNT OF MOVEMENT (TOLERANCE)
2. Primary focus for **JOINT Mobility Deficits**

1. Patient education
2. Joint mobilization techniques
   - Mid to end range
   - Loading vs. unloading
   - Arthrokinematic vs. osteokinematic
3. Mobilization with movement techniques
4. Self mobilizations and self stretching

2. Primary focus for **Soft Tissue Stiffness/Tone**

1. Patient education
2. Soft tissue mobilization techniques:
   - Manual or instrumented STM
   - Self Mobilization
   - OTHERS (ex: dry needling, cupping, etc)
3. Stretching (Dynamic and/or Static):
   - PT assisted stretching
   - Pt self-stretching
2. Primary focus for **Neurodynamic Mobility Deficits**

1. Patient education
2. Joint mobilization techniques of joints in proximity to the nerve (CT region)
3. Soft tissue mobilization of muscles along nerve pathway
4. **Self Neurodynamic mobilization techniques**
   – GLIDING/SLIDING Techniques (aka: flossing)
   – TENSIONING Techniques

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**Use of Manual Therapy for Mobility Deficits**

- No longer thought of an isolated mechanism or an ISOLATED TREATMENT
- Addresses multiple different systems/impairments
  - Cognitive/“biopsychosocial”?  
    • Change in patient beliefs/attitudes  
    • Reduce the threat of movement
  - Neurophysiologic response?
    • External stimulus produces peripheral and central changes
    • CNS processing
  - Biomechanical response?
    • Soft tissue and joint restrictions, etc.
  - Placebo?

Bialosky. JOSPT. 2017, 2018
3. **Primary focus for Motor Control/Coordination Deficits**

1. Patient education
2. Motor coordination
   a. Dissociation movement patterns
3. Scapulo-thoracic muscle activation
   a. Lower trap and serratus activities
4. Movement reeducation during functional activities

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**Intervention options for Force Production and Endurance Deficits**

1. Joint and/or muscle specific strengthening activities
   - Single plane movements with progressive resistance
   - Multiple plane with progressive resistance
2. Joint and/or muscle specific endurance activities
   - Multiple repetitions
   - Extended hold times
CONTINUAL ASSESSMENT during TX

As mentioned, prior to intervention...determine an ASTERISK SIGN

REASSESS Asterisk sign to determine effectiveness of treatment and refine your clinical reasoning

• Quantitative and Qualitative changes
• within or between session changes

Are you on the right track?

Summary:

• Primary nature of the functional restriction: PATTERN RECOGNITION (cognition, joint, soft tissue, motor, etc.)
• Consider severity and irritability of symptoms
• Focus of intervention should align with Impairment based pattern of movement dysfunction
• Utilize Asterisk signs to assess both within and between session improvements and change over time.
• Use this information to GUIDE INTERVENTIONS!
Monday morning schedule

1. Kristine: 65 y/o shoulder and arm pain with confirmed R shoulder R/C tear from MRI
2. Nikki: 45 y/o with Right scapular and shoulder pain. Direct access
3. Mike: 48 y/o with diagnosed “Impingement syndrome”
4. Maria: 18 y/o with shoulder pain and potential labral tear
Clarifying Questions?:

Thinking in action after Subjective…

<table>
<thead>
<tr>
<th>Working Diagnosis</th>
<th>Irritability</th>
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<tbody>
<tr>
<td>1.</td>
<td>• Min / Mod / Severe</td>
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<tr>
<td></td>
<td>• WHY:</td>
</tr>
<tr>
<td>2.</td>
<td>Asterisks:</td>
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<td>3.</td>
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</tbody>
</table>
Plan Exam: What variables would you consider based on subjective?

- Cognition/Beliefs
  - Questionnaires to fill out?

- Body region to assess?
  - Cervical screen? Yes/no
  - Shoulder screen? Vigor?

- Motion
  - Active or passive motion assessment? Yes/no?
  - Single plane motion vs. tri planar motion? Yes/no?
  - Overpressures? Yes/no?

- Mobility assessment (vigor)
  - Joint mobility assessment?
  - Soft tissue assessment?
  - Neurodynamic assessment?

- Motor testing?
  - Motor coordination?
  - Manual muscle testing?
  - Endurance?

- Special tests/pain provocation tests?

Thinking in action after Objective...

Working Diagnosis

1. 

2. 

3. 

Irritability

- Min / Mod / Severe
- WHY:

Asterisks:

Prognosis:
Impairment Distribution

Cognition/Beleifs
Motor control
Mobility(Soft tissue)

Treatment
Day 1

• Education
• Manual techniques
  – Joint motion/mobilization
• Soft tissue techniques
• Motor
  – Motor Control/coordination
  – Strength
• HEP

Primary focus??
Subsequent Sessions
Primary focus??

• Education
• Manual techniques
  • Joint motion/mobilization
• Soft tissue techniques
• Motor
  • Motor Control/coordination
  • Strength
• HEP

Primary focus??