

Table 11-1		
Special Tests for Posterior Instability		
Combination Clinical Test	Confirm (Rule In)	Screen (Rule Out)
Apprehension, relocation, and surprise	√	√
Kim and jerk		√

Table 11-2					
Special Tests and Diagnostic Values for Anterior Instability					
Clinical Test	Confirm (Rule In)	Screen (Rule Out)	Specificity	Sensitivity	Likelihood Ratio
Apprehension	√				17.2 (strongest positive)
Relocation	√		90%		
Surprise		√		82%	0.25 (negative)
Posterior apprehension	√		95%		
Jerk	√		98%	73%	

when used in combination, have the best clinical utility to rule in or out anterior instability (Table 11-1). Specifically apprehension and relocation offer the best specificity (98%) and sensitivity (81%). Apprehension alone has the strongest positive likelihood ratio (17.2), making it a good test to rule in anterior instability. The surprise test presented with the strongest sensitivity (82%) and negative likelihood ratio (0.25), making it a good test for ruling out anterior instability (Table 11-2).⁴

Common tests for clinically assessing posterior instability are the load and shift, jerk, Kim, and posterior apprehension tests (see Table 11-2). Posterior apprehension has a strong specificity (95%) and a sensitivity of only 58%, meaning a positive test will rule in posterior instability.⁴ The Kim and jerk tests, when used together, have a good diagnostic accuracy in ruling out instability and a negative test sensitivity (97%).² The jerk test alone has a 98% specificity and a 73% sensitivity.⁵

The sulcus sign and hyperabduction tests are the most commonly used tests in the clinical setting to assess multidirectional instability. Both of these tests will primarily assess inferior instability by putting the inferior GH ligament on stress. There is currently no diagnostic accuracy reported for these tests, but they stress the inferior GH ligament.⁵ This ligament is a primary static stabilizer in the GH