

The Supination-Pronation Test for Distal Biceps Tendon Rupture

Louis S. Metzman, MD, and Kristin A. Tivener, MET, ATC/L

Abstract

Prompt diagnosis of a distal biceps tendon complete rupture increases the ability to perform a primary repair and to restore motion and strength. When examining an acute injury, it is important to isolate the biceps brachii tendon from the lacertus fibrosus and the brachialis because the examiner may mistakenly miss a distal tendon rupture by not isolating supination and pronation. The supination-pronation test can be performed easily in the acute setting and confirms attachment of the biceps tendon distally to the bicipital tuberosity of the radius. If the distal biceps tendon is intact, there is substantial change in the shape of the biceps as the arm is supinated (the biceps moves proximally), then pronated (the biceps moves distally). Clinically, the supination-pronation test has been found to be a reliable, pain-free test that should be incorporated in the physical examination to evaluate patients for distal biceps injury.

Distal biceps tendon ruptures have been reported with increasing frequency, occurring 1.2 times per 100,000 patients per year, representing 3% of tendinous avulsions involving this muscle.^{1,2} This injury occurs most commonly in men between the ages of 40 and 60 years, and more often in the dominant extremity after an unexpected or violent eccentric contraction.^{2,3} Generally, the patient is performing a task that is more strenuous than usual and only performed occasionally; usually, it is a flexion task. The biceps muscle is the most superficial muscle in the anterior compartment of the arm with the distal tendon passing deep in the antecubital fossa to insert at the radial tuberosity (Figure 1). Pronation of the forearm rotates the radial tuberosity medially and posteriorly, drawing the biceps tendon distally with it (Figures 1-3). The biceps muscle is primarily responsible for supination of the forearm, although it is also important in elbow flexion.^{4,5} The bicipital aponeurosis (lacertus fibrosus) arises from the medial aspect of the muscle belly at the junction of the musculotendinous unit and the distal biceps tendon. This passes distally and medially across the antecubital fossa, blending with the fascia overlying the proximal flexor mass of the forearm, and

Figure 1. Radial tuberosity, with biceps insertion in red. Anterior view of forearm positioned in full supination.



Figure 2. Forearm positioned in neutral; note movement of radial tuberosity, with biceps insertion in red.



Figure 3. Posterior-lateral view of forearm in full pronation; note posterior position of biceps insertion in red.



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inserts on the subcutaneous border of the ulna.³ A complete rupture of the distal biceps insertion can produce a 40% loss of supination strength, a 47% loss of supination endurance, and a 21% to 30% loss of flexion strength at the elbow when compared with the contralateral intact extremity.^{1,2,4}

Background

Prompt diagnosis of a distal biceps tendon complete rupture increases the ability to perform a primary repair, and to restore motion and strength.³ Patients with acute ruptures of the

distal biceps typically present with a history of experiencing a painful “pop” after a violent eccentric load force at the time of injury. Clinical examination of a patient with a distal biceps tendon rupture shows a loss of the normal upper arm contour, pain with flexion and supination of the forearm, ecchymosis, and an inability to palpate the distal biceps tendon in the antecubital fossa.⁵ It is important to note that a false-negative test can be elicited when examining the integrity of the muscle contour if the lacertus fibrosus remains intact when there is a complete rupture of the distal biceps tendon.⁶ This false negative also can occur with examination of the upper arm contour as the elbow flexes. Radiographic studies to evaluate the distal biceps tendon can aid in the diagnosis of ruptures but are not a substitute for a thorough history taking and physical examination.³ Plain radiographs may show hypertrophic bone formation at the radial tuberosity, although they are generally unrevealing.^{3,6} After a complete clinical examination of the distal biceps tendon, magnetic resonance imaging (MRI) can be an important tool for evaluation of the distal biceps tendon.³ This article introduces a special test used as a diagnostic tool during the physical examination to isolate the distal biceps tendon from the lacertus fibrosus and to evaluate the integrity of the distal biceps brachii tendon.

Test Description

To perform the supination-pronation test, the patient is positioned with both shoulders abducted to 90° and the elbows flexed to approximately 60° to 70° (Figures 4, 5). The examiner stands in front of the patient and observes the contour of the biceps muscle; the unaffected arm is used as a comparison. The examiner may either visually observe the contour of the muscle or may place a hand on the muscle belly throughout the test to feel for movement. The patient is asked to actively supinate and pronate the forearms by turning the hands. Through trial and error, we have found that the change in contour is most pronounced when placing the elbow in 60° to 70° of flexion. Additionally, through clinical experience, we have found testing the patient with both shoulders abducted to 90° provides the examiner with a reproducible examination that is easy to demonstrate to the patient; however, this shoulder position is not mandatory and can be modified if the patient struggles to get into testing position. Forearm position will maximize the size of the biceps, so the result is visually easier to appreciate. If the distal biceps tendon is intact, there is a substantial change in the shape of the biceps as the arm is supinated (the biceps moves proximally), then pronated (the biceps moves distally). Lack of migration of the biceps muscle during supination and pronation is considered a positive test, indicating rupture of the distal biceps tendon from its insertion on the radial tuberosity (Figure 6). We have found the anatomic correlations to a distal biceps injury may be clearly observed through the maneuver of the supination-pronation test and, therefore, provide a reliable clinical method to diagnose a complete distal biceps tendon rupture.

We have been using the supination-pronation test in our clinical practice for 2.5 years. In our experience, opportuni-



Figure 4. Patient positioned for test with hand in full supination; note biceps mass more proximally located in arm.



Figure 5. Patient moves to position arm in full pronation; note distal change in biceps position.

ties to use the supination-pronation test are very limited and specific. This type of tendon avulsion is rare, and the number of patients who warrant clinical examination using the supination-pronation test is small. We have had 5 positive supination-pronation tests in patients with suspected distal biceps tendon ruptures. To confirm if the supination-pronation test correctly demonstrated a full biceps tendon rupture in these 5 patients, we followed their clinical examination with MRI of the involved arm. Only 4 of the 5 patients were able to obtain MRI. Of these 4, all studies showed complete tearing of the distal biceps tendon from its attachment on the radial tuberosity. All 5 patients were taken into the operating room to confirm the clinical diagnosis and then repair it surgically. Through surgical exploration, we observed a full and complete tear of the distal biceps tendon in all patients, and the tears were repaired successfully. Postoperatively, all patients showed a full recovery with no complications, and all were able to regain full range of motion and strength in the involved arm. All 5 patients were discharged with no complaints.

Although we have not encountered false positive and false negatives using the supination-pronation test in clinical practice, we speculate that there would be a low rate of incidence for these outcomes. There is a possibility of a false-positive test in obese patients in whom the contours of the biceps are difficult to appreciate (although we have not observed this clinically). In these patients, the examiner may not see the migration of the biceps that is occurring. In practice, we have found that, if the contours of the bicep are difficult to appreciate, the test can be performed with the examiner placing his/her hand on the muscle belly during the test to actively feel for movement. This could decrease the risk of a false-positive supination-pronation test. A false negative may occur if the

distal biceps tendon is almost completely torn. In this case, enough of the tendon fibers may remain intact to pull the biceps muscle belly distally as the hand is pronated. In our experience, this was not observed but should be noted as a potential risk for a false-negative test.

If the lacertus fibrosus is intact, and the distal biceps tendon is ruptured, the biceps will still change shape as the elbow is flexed and extended but will not change shape with supination and pronation. The biceps brachii muscle attaches distally to the radial tuberosity of the radius; contraction of the muscle pulls the tuberosity anteriorly, rotating the forearm into supination. When the forearm rotates into pronation, the tendon is pulled distally and the muscle lengthens, which causes the contour to be more elongated. Since the lacertus fibrosus attaches to the proximal ulna, it is not involved in forearm supination and pronation. It does, however, assist with elbow flexion.

It is very important to isolate the biceps brachii tendon from the lacertus fibrosus and the brachialis because the examiner may miss a distal tendon rupture by not isolating supination and pronation. The supination-pronation test is a novel clinical test that allows the examiner to isolate the biceps brachii tendon in supination and pronation to evaluate for distal biceps tendon rupture. It has been well established that early anatomic repair of distal biceps tendon rupture is advocated for optimal results in returning flexion and supination strength.^{3,4,6} Although some patients may choose nonoperative management of complete ruptures, prompt diagnosis of the injury is vital so that the option of surgical management at the time of presentation is not compromised by delay in diagnosis. Clinically, we have found that a delayed diagnosis results in more difficulty performing the surgery, and it may not be possible to obtain enough excursion for the biceps to be reattached with the passage of time. The literature suggests that patients with chronic ruptures (more than 4 weeks) often present with proximal retraction of the biceps muscles and scarring to the brachialis, which can make anatomic repair a difficult challenge.^{3,7}

It is important to note the differences in treatment of proximal versus distal bicep tendon ruptures. Proximally, there are 2 tendon attachments. The tendon of the short head attaches to the coracoid process of the scapula. The tendon of the long head runs into the shoulder joint, attaching intra-articularly to the superior aspect of the glenoid. This tendon is often involved in degeneration concurrently with the adjacent rotator cuff and is vulnerable to rupture. Rupture of this tendon is usually treated nonoperatively. Because proximal rupture nearly always affects only the tendon to the long head, the muscle preserves 1 proximal attachment and continues to function, both as a supinator and as a flexor. Also, this type of rupture tends to occur in more elderly and less active patients who are less adversely affected by the modest loss of function associated with proximal ruptures.

Conclusion

The supination-pronation test properly isolates the distal biceps tendon and does not cause significant discomfort, which can be a problem with other physical examination tests for

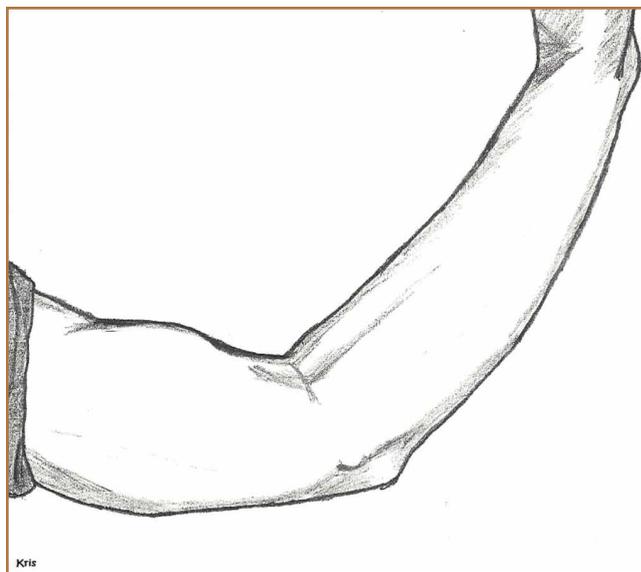


Figure 6. Patient moves to position arm in full pronation; note there is no distal change in biceps position. Lack of migration of the biceps muscle during pronation and supination is considered a positive supination-pronation test.

acute distal biceps ruptures. The squeeze test involves placing the patient in 60° to 80° of elbow flexion with the forearm pronated. The examiner places 1 hand at the distal myotendinous junction, and the other around the belly of the muscle and squeezes, looking for forearm supination.⁵ We have not found the squeeze test to be optimal because the amount of forearm supination obtained by performing this test can be subtle. Additionally, the patient commonly has significant ecchymosis and pain associated with this rupture, and it may be too painful to squeeze the muscle belly hard enough to have a reliable test. Another test is the hook test, which is performed by the examiner “hooking” an index finger under the intact biceps tendon from the lateral side.⁸ Clinically, we have found this test difficult to administer because it requires palpation of the tendon, which is often painful for the patient with an acute injury.

The supination-pronation test can easily be performed in the acute setting, and confirms attachment of the biceps tendon distally to the bicipital tuberosity of the radius. It will not show an incomplete tear, but in that case, the muscle retains its normal length, alleviating the urgency of surgical management. We have found the supination-pronation test to be a reliable and pain-free test that should be incorporated in the physical examination to evaluate patients for distal biceps injury.

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