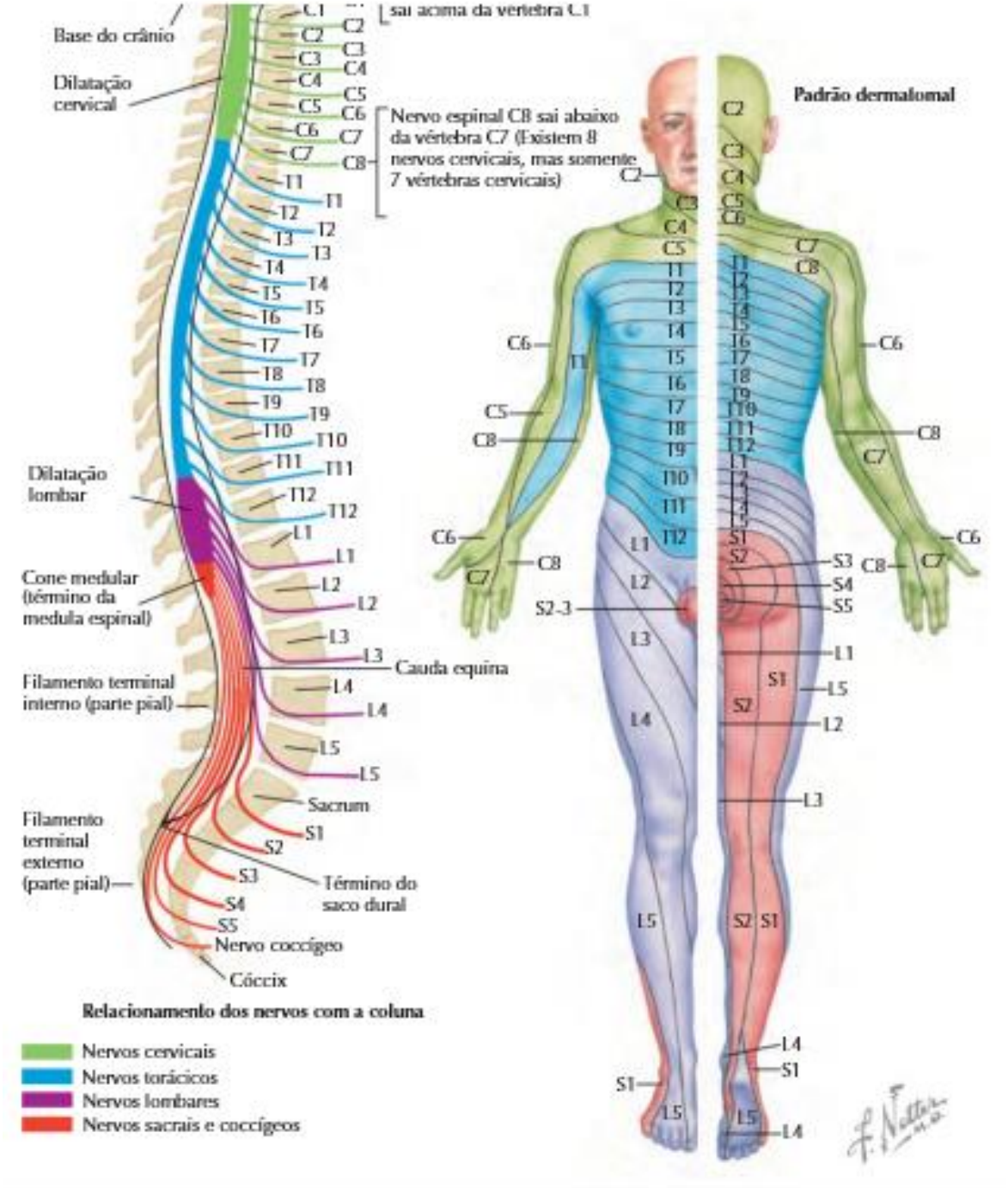
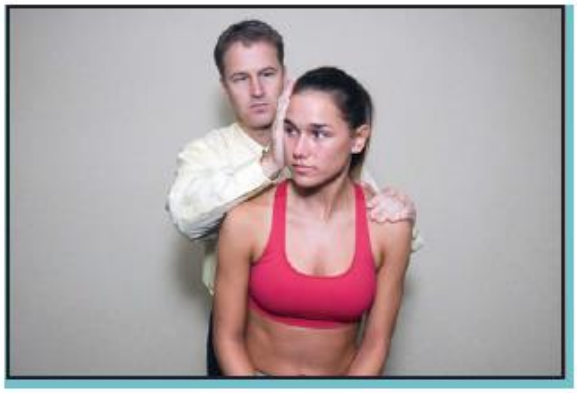
DERMÁTOMOS


Base do crânio
Dilatação cervical
Dilatação lombar
Cone medular (término da medula espinal)
Filamento terminal interno (parte pial)
Filamento terminal externo (parte pial)
Nervo espinal C8 sai abaixo da vértebra C7 (Existem 8 nervos cervicais, mas somente 7 vértebras cervicais)
Cauda equina
Sacrum
Término do saco dural
Nervo coccígeo
Cóccix
Relacionamento dos nervos com a coluna
Nervos cervicais
Nervos torácicos
Nervos lombares
Nervos sacrais e coccígeos
Padrão dermatomal

MIÓTOMOS DO MEMBRO SUPERIOR



1. The patient is placed in sitting.
2. To test C1–3, cervical rotation is resisted.

3. The patient is placed in sitting.
4. To test C4, shoulder shrug is resisted.

TESTS FOR CERVICAL RADICULOPATHY

5. The patient is placed in sitting.
6. To test C5, shoulder abduction is resisted.

7. The patient is placed in sitting.
8. To test C6, the biceps are resisted.

9. The patient is placed in sitting.
10. To test C7, wrist flexion is resisted.

11. The patient is placed in sitting.
12. To test C8, thumb extension is resisted.

13. The patient is placed in sitting.
14. To test T1, finger abduction is resisted.
15. With all areas, a positive test is noticeable weakness when compared to the opposite side or versus expectations if bilateral symptoms are present.

UTILITY SCORE 2

Study	Reliability	Sensitivity	Specificity	LR+	LR−	QUADAS Score (0–14)
Wainner et al.[54] (Deltoid)	.62 kappa	24	89	2.18	0.85	10
Wainner et al.[54] (Biceps)	.69 kappa	24	94	4	0.8	10
Wainner et al.[54] (Extensor Carpi Radialis)	.63 kappa	12	90	1.2	0.97	10
Wainner et al.[54] (Triceps Brachii)	.29 kappa	12	94	2	0.93	10
Wainner et al.[54] (Flexor Carpi Radialis)	.23 kappa	6	89	0.54	1.05	10
Wainner et al.[54] (Abductor Pollicis Brevis)	.39 kappa	6	84	0.37	1.12	10
Wainner et al.[54] (First Dorsal Interosseus)	.37 kappa	3	93	0.42	1.04	10
Matsumoto et al.[33] (C4–5) (Deltoid Weakness)	NT	35	98	17.5	0.66	6
Matsumoto et al.[33] (C7 or below) (Wrist Extensor Weakness)	NT	28	74	1.07	0.97	6

Comments: Note that the test tends to exhibit strong specificity and low sensitivity, suggesting it may lack practicality as a screen. The test is frequently performed as a component of the upper quarter screen.

MIÓTOMOS DO MEMBRO INFERIOR

Muscle Power Testing (Lumbar Radiculopathy Secondary to Disk Herniation or Protrusion)

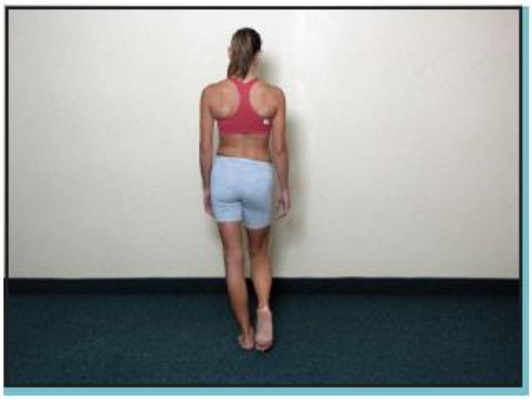
1. The patient is placed in sitting.
2. To test L1–L2, hip flexion is resisted.

TESTS FOR LUMBAR RADICULOPATHY

3. The patient is placed in sitting.
4. To test L3–L4, knee extension is resisted.

5. The patient is placed in sitting.
6. To test L5, great toe extension is resisted.

7. The patient is placed in standing.
8. To test L4–L5 (dorsiflexion), the patient is requested to walk on his or her heels.



9. The patient is placed in standing.
10. To test L5–S1, the patient is requested to unilaterally stand.
11. The examiner observes pelvic drop on the opposite side for weakness in the hip abductors.

12. The patient is placed in standing.
13. To test S1, the patient is requested to walk on his or her toes.
14. With all areas, a positive test is noticeable weakness when compared to the opposite side or versus expectations if bilateral symptoms are present.

UTILITY SCORE 3

Study	Reliability	Sensitivity	Specificity	LR+	LR−	QUADAS Score (0–14)
Knuttson[28] (L5–S1) (Great Toe Weakness)	NT	48	50	0.95	1.1	3
Knuttson[28] (L4–L5) (Great Toe Weakness)	NT	74	50	1.5	0.52	3
Knuttson[28] (L3–L4) (Great Toe Weakness)	NT	100	50	NA	NA	3
Knuttson[28] (L4–L5) (Great Toe Weakness)	NT	36	50	0.72	1.3	3

(*continued*)

TESTS FOR LUMBAR RADICULOPATHY

Study	Reliability	Sensitivity	Specificity	LR+	LR−	QUADAS Score (0–14)
Gurdjian et al.[19] (Great Toe Weakness)	NT	16	50	0.32	1.7	4
Gurdjian et al.[19] (Foot Drop-Dorsiflexion)	NT	1	50	0.02	1.98	4
Kerr et al.[26] (L4–L5) (Hip Extension Weakness)	NT	12	96	3	0.92	7
Kerr et al.[26] (L5–S1) (Hip Extension Weakness)	NT	9	89	0.77	1.03	7
Kerr et al.[26] (L3–L4) (Ankle Dorsiflexion)	NT	33	89	3.03	0.75	7
Kerr et al.[26] (L4–L5) (Ankle Dorsiflexion)	NT	60	89	5.45	0.45	7
Kerr et al.[26] (L5–S1) (Ankle Dorsiflexion)	NT	49	89	4.45	0.6	7
Kerr et al.[26] (L3–L4) (Ankle Plantarflexion)	NT	0	100	NA	NA	7
Kerr et al.[26] (L4–L5) (Ankle Plantarflexion)	NT	0	100	NA	NA	7
Kerr et al.[26] (L5–S1) (Ankle Plantarflexion)	NT	28	100	NA	NA	7
Hakelius & Hindmarsh[20] (Great Toe Extension, All Levels)	NT	79	NT	NA	NA	3
Hakelius & Hindmarsh[20] (Dorsiflexion, All Levels)	NT	75	NT	NA	NA	3
Hakelius & Hindmarsh[20] (Quadriceps, All Levels)	NT	79	NT	NA	NA	3

Comments: Note that the study results are highly variable and depend on the population examined. In addition, positive findings are affected by the prevalence of conditions represented in the study. Most patients in the studies demonstrated L4–L5 or L5–S1 disorders, thus it's expected to see better diagnostic value with muscle groups that reflect this innervation pattern. The test is frequently performed as a component of the lower quarter screen.

Referência Bibliográfica

Dermátomos: Atlas de Anatomia no Netter

Miótomos