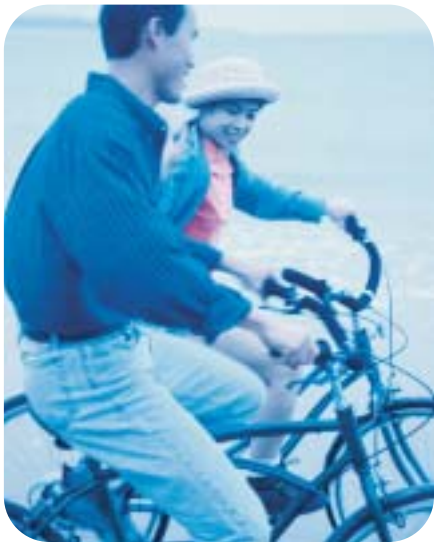

Shouldering Shoulder Pain

Howard A. Winston, MD, CCFP, FCFP, Dip. Sport Med. (CASM)

Moe, 42, presents to his family doctor with right shoulder pain following a bicycle accident the previous day. He landed on his right side with his right arm tucked under him. Moe immediately experienced pain, which has since gotten progressively worse.

Moe's family doctor takes the appropriate history and performs a focused physical examination of his shoulders. Moe indicates he had difficulty sleeping the previous night, as pain woke him every couple of hours. Night pain is always significant, usually meaning significant pathology is present. Pain relievers are of no benefit.

An X-ray is ordered at the time of Moe's initial visit. His physical examination shows:

- a very contracted range of motion of his right arm compared to his left,
- positive impingement signs and
- significant weakness of the abductors/flexors/rotators of his right shoulder.

Moe is instructed to ice his shoulder for a couple of days, take the prescribed anti-inflammatory for 10 days and avoid any activity involving his right shoulder.

Moe returns for his followup appointment three weeks later. His shoulder has improved by 50%, but he is still having night pain, which is interfering with his sleep and causing weakness. His range of motion is nearly 100%, but he still has some limitations. Moe has had no adverse effects from the anti-inflammatories.

Moe is referred for physical therapy. He attends a public community clinic, where he receives 18 treatments over six weeks. Moe then returns to his family doctor.

Upon examination, the patient still has a lot of pain during the early stage of lifting his arm. He is asked what the therapist does during a typical session. Moe explains the therapist ices the shoulder for 15 minutes, rubs jelly on his shoulder and connects him to electrical things. The patient, losing sleep and patience, demands a cortisone injection for the pain, but his doctor doesn't feel comfortable with the decision, so he defers to a specialist.

Moe is booked to see the orthopedist in three months, but is in too much pain to wait. Instead, he takes an appointment with a primary care sports medicine physician, who is concerned about a possible tear of his right rotator cuff muscle. A soft tissue ultrasound is booked.

Moe returns 10 days later to review the results of the soft tissue ultrasound. The report indicates a partial tear of his right supraspinatus muscle tendon. It is not a full thickness tear, and there is evidence of subacromial bursal thickening.

The sports medicine phsyician decides to continue with conservative management with a stepwise plan for physical therapy, including a graduated strengthening program for the rotator cuff and many of the supporting shoulder girdle muscles.

Moe returns for further followup with a smile on his face. His right shoulder is in much less pain, there is a greater range of motion and even improved strength. He still requires further therapy, but the decision of a cortisone injection has been put to rest for now. Moe is told the exercises he is learning must be done as "homework for life," otherwise, he will always be vulnerable to relapse.

Are any further radiologic investigations required at this time?

The short answer is, no. Remember, we always treat the patient, not a radiology report. If the patient is pleased with his/her pain level, is functional for his job/activities and is living a very acceptable quality of life, then you have done your job well. If not, you owe it to the patient to pursue further investigations.

Dr. Winston is an assistant professor, department of family & community medicine, University of Toronto, and medical director, Centre for Health and Sports Medicine, North York, Ontario.

There may be the need to seek a surgical/orthopedic opinion. For rotator cuff pathology though, recalcitrant pain is the main reason to pursue rotator cuff surgery, not loss of strength. Surgery is always a last resort.

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