






Shoulder pain

Shoulder pain is the third most common musculoskeletal reason for patients to attend their GP (after back and neck pain). It is particularly prevalent in certain occupational groups and is a common WorkCover presentation. Chronic shoulder pain can cause severe disability, particularly in the elderly. There is evidence that GPs are uncertain in the diagnosis and management of shoulder pain, leading to a high rate of unnecessary imaging – this is likely to be even more so in GP registrars. A careful and systematic approach to diagnosis and management is therefore important.

<p>TEACHING AND LEARNING AREAS</p> 	<ul style="list-style-type: none"> • Anatomy and function of the shoulder joint • Common causes of shoulder pain in general practice • Appropriate history-taking, including red flags for serious disease • Appropriate shoulder examination, including special tests • Approach to shoulder injuries • Differential diagnoses, including non-MSk causes • Indication for investigations • Management options and role of corticosteroid injection • Indications for referral and appropriate pathways 				
<p>PRE-SESSION ACTIVITIES</p> 	<ul style="list-style-type: none"> • Read the 2009 Medicine Today article - The Painful Shoulder 				
<p>TEACHING TIPS AND TRAPS</p> 	<ul style="list-style-type: none"> • Shoulder pain is commonly multifactorial in aetiology, especially in the elderly • Consider PMR in patients with bilateral shoulder pain • Referred pain from the neck can mimic shoulder pathology • Risk factors for adhesive capsulitis include diabetes, trauma and prolonged immobility • Global pain and restriction of both active and passive movements is highly suggestive of adhesive capsulitis • The most common isolated clinical finding in biceps tendinopathy is bicipital groove tenderness • Imaging for shoulder pain rarely adds to a careful history and examination, and is usually unnecessary – however, investigations are appropriate in patients with red flags • Over half of patients over 60 have asymptomatic rotator cuff tears and imaging can therefore be misleading • Subacromial injections of corticosteroids are effective for rotator cuff tendonitis 				
<p>RESOURCES</p> 	<table border="1"> <tbody> <tr> <td data-bbox="330 1827 430 1921">Read</td> <td data-bbox="430 1827 1505 1921"> <ul style="list-style-type: none"> • NHMRC Guidelines – Evidence Based Management of Acute Musculoskeletal Pain • AAFP articles 2008 – Chronic Shoulder Pain Part 1 and Part 2 </td> </tr> <tr> <td data-bbox="330 1921 430 1982">Watch</td> <td data-bbox="430 1921 1505 1982"> <ul style="list-style-type: none"> • Brief video on shoulder examination </td> </tr> </tbody> </table>	Read	<ul style="list-style-type: none"> • NHMRC Guidelines – Evidence Based Management of Acute Musculoskeletal Pain • AAFP articles 2008 – Chronic Shoulder Pain Part 1 and Part 2 	Watch	<ul style="list-style-type: none"> • Brief video on shoulder examination
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Watch	<ul style="list-style-type: none"> • Brief video on shoulder examination 				
<p>FOLLOW UP/ EXTENSION ACTIVITIES</p> 	<ul style="list-style-type: none"> • Registrar to undertake clinical reasoning challenge and discuss with supervisor 				

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Clinical Reasoning Challenge

Janice Frost is a 53 year old accountant who complains of a 6 week history of left shoulder pain, especially when doing up her bra and reaching up to high shelves.

QUESTION 1. What are the MOST IMPORTANT key features of history i.e. red flags, in helping to identify potentially serious causes of Janice's shoulder pain? List up to FIVE.

1 _____

2 _____

3 _____

4 _____

5 _____

QUESTION 2. There is no significant further history. What is the MOST LIKELY diagnosis at this point? List ONE diagnosis

QUESTION 3. On examination there is tenderness over the lateral aspect of the shoulder and a 'painful arc' on shoulder abduction, but otherwise normal range of movement.

What are the next actions in Janice's initial management? Select as many management actions as appropriate.

- | | | |
|---|---|---|
| <input type="checkbox"/> FBC | <input type="checkbox"/> MRI shoulder | <input type="checkbox"/> Paracetamol |
| <input type="checkbox"/> ESR | <input type="checkbox"/> Bone scan | <input type="checkbox"/> NSAIDs |
| <input type="checkbox"/> Calcium level | <input type="checkbox"/> Sling for 2 weeks | <input type="checkbox"/> Panadeine forte |
| <input type="checkbox"/> Plain x-ray shoulder | <input type="checkbox"/> Simple shoulder exercises | <input type="checkbox"/> Oxycodone |
| <input type="checkbox"/> Ultrasound shoulder | <input type="checkbox"/> Refer for physiotherapy | <input type="checkbox"/> Pregabalin |
| <input type="checkbox"/> CT scan shoulder | <input type="checkbox"/> Referral to orthopaedic specialist | <input type="checkbox"/> Corticosteroid injection to shoulder |

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ANSWERS

QUESTION 1

What are the MOST IMPORTANT key features of history i.e. red flags, in helping to identify potentially serious causes of Janice's shoulder pain? List up to FIVE.

- Trauma
- History of malignancy
- Fevers
- Weight loss
- Night pain
- Neurological deficit

QUESTION 2

There is no significant further history. What is the MOST LIKELY diagnosis at this point? List ONE diagnosis.

- Supraspinatus tendonitis/subacromial bursitis

QUESTION 3

On examination there is tenderness over the lateral aspect of the shoulder and a 'painful arc' on shoulder abduction, but otherwise normal range of movement.

What are the next actions in Janice's initial management? Select as many management actions as appropriate.

- | | | |
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There is no indication for imaging with a short duration of pain, absence of red flags and the patient yet to trial physiotherapy.