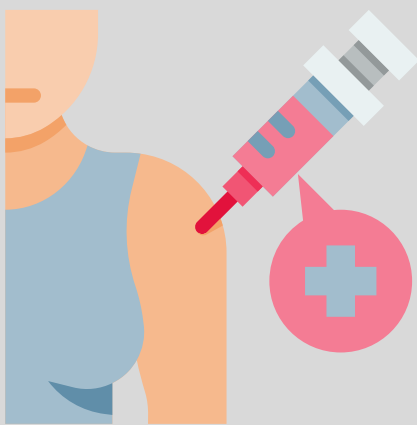


# SHOULDER PAIN : DIAGNOSIS & MANAGEMENT IN PRIMARY CARE



C.MITCHELL ET AL., BMJ 2005;331:1124-8

## COMMON TYPES OF SHOULDER PAIN IN PRIMARY CARE



### Top 4 causes

- 1) Rotator cuff disorders
- 2) Glenohumeral disorders
- 3) AC joint disease
- 4) Referred neck pain



Shoulder pain prevalence : 16 -26%

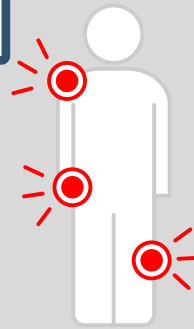
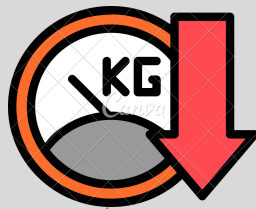
3rd most common Musculoskeletal consult in primary care

## STUDY DESIGN



Studies chosen: 7  
systematic reviews of  
shoulder interventions  
and diagnostic tests.

Studies had to be  
relevant to primary care  
Countries of studies not  
indicated



## RED FLAGS!



- Weight loss
- Generalized joint pain
- Hx of cancer
- Fever
- Lymphadenopathy
- Bony swelling/mass

\*Blood tests & imaging  
now required

## RESULTS

### Rotator cuff disorders

- O/E - non-dominant arm, non-mechanical workers.
- Positive drop arm test = large or complete tear
- Mx - analgesia & rehab, avoid steroid injection if positive drop arm test

### Glenohumeral disorders

- Adhesive capsulitis - no benefit in steroid injection or physiotherapy in early phases.
- Symptoms persist >3 yrs in Diabetics

### AC Joint

- Usually secondary to OA or trauma.
- Mx - rest & analgesia (non-traumatic),
- If symptoms persist - steroid injection

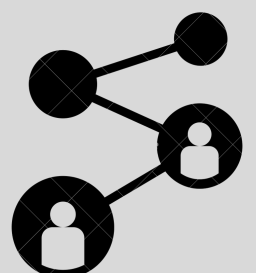
### Referred Neck Pain

- Pain is referred to shoulder & UL area
- UL paresthesia may exist
- Mx- rest + analgesia, physiotherapy



## WHEN DO I REFER MY PATIENT ?

- Pain & disability > 6months - despite appropriate mx efforts.
- Hx of instability - multiple spontaneous dislocations or constant feeling that shoulder will 'pop' out



## CONCLUSION:

MANAGEMENT SHOULD BE MULTIDISPLINARY AND INCLUDE SELF HELP ADVICE, ANALGESICS, RELATIVE REST & PHYSIOTHERAPY. STEROID INJECTIONS HAVE A MARGINAL SHORT TERM EFFECT ON PAIN



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