ASSESSMENT OF COMMON SHOULDER PROBLEMS AND SOME GENERAL SHOULDER RULES

Thin HONG 2013
GP CME
Braemar
# SHOULDER PAIN

<table>
<thead>
<tr>
<th></th>
<th>SUB-ACROMIAL PAIN</th>
<th>ACJ PAIN</th>
<th>GHJ PAIN-frozen shoulder/OA</th>
<th>GHJ CHRONNIC INSTABILITY</th>
<th>ACUTE &quot;HOT&quot; SHOULDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HISTORY</strong></td>
<td>Deltoid → arm</td>
<td>ACJ → neck</td>
<td>diffuse or posterior deltoid pain</td>
<td>apprehension</td>
<td>Trauma</td>
</tr>
<tr>
<td></td>
<td>Painful abduct &amp; IR</td>
<td>Overreach pain</td>
<td>overreach pain</td>
<td>History of instability</td>
<td>Severe Pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>may clicks</td>
<td></td>
<td></td>
<td>Beware of Bruises</td>
</tr>
<tr>
<td><strong>EXAM</strong></td>
<td>No to slight limitation of passive motion exc. Pain inh.</td>
<td>Loss about 30 % terminal elevation</td>
<td>Gross limitation of passive motion</td>
<td>Normal motion</td>
<td>No motion due to pain</td>
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# SHOULDER PAIN

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<tr>
<td>Impingment +/- weakness</td>
<td>ACJ provocation</td>
<td>Stiff shoulder with end range pain</td>
<td>Aprehension test</td>
<td>Exam impossible</td>
<td></td>
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<tr>
<th>XR</th>
<th>Impingement series:</th>
<th>-ACJ view (Zanca)</th>
<th>-GHJ AP -Ssp outlet -Axil lateral</th>
<th>Instablity series:</th>
<th>Trauma series:</th>
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<tr>
<td>-GHJ AP</td>
<td>-Ssp outlet</td>
<td>-Axil lateral</td>
<td>- GHJ AP</td>
<td>-Ssp outlet</td>
<td>-Scapular lateral</td>
</tr>
<tr>
<td>-Stryker notch view</td>
<td>-West point view</td>
<td>-Velpeau axil lateral</td>
<td>OR Apical oblique</td>
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| Impingement lesion | Calc. tendonitis | ACJ OA Osteolysis Dislocation | GHJ OA Normal for frozen shoulder | Hill sach lesion, bony bankhart | # dislocations etc.. |

- Impingement:
- ACJ OA:
- GHJ OA Normal for frozen shoulder
- Calc. tendonitis
- Sub-acromial
- Dislocation
- Osteolysis
- GHJ AP
- Scapular lateral
- Stryker notch view
- West point view
- Velpeau axil lateral
- Apical oblique
- Impingement series:
- GHJ AP
- Ssp outlet
- Axil lateral
- Trauma series:
- GHJ AP
- Ssp outlet
- Stryker notch view
- West point view
- Velpeau axil lateral
- Apical oblique

- Hillsach lesion
- Bony Bankhart
- # dislocations etc..
# SHOULDER PAIN

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<tr>
<td><strong>US</strong></td>
<td>Good screening for RCT, beware of frozen shoulder, overdiag Ca++</td>
<td>No role</td>
<td>No role</td>
<td>No role</td>
<td>Screen for RCT</td>
</tr>
<tr>
<td><strong>PHYSIO</strong></td>
<td>Jackins program</td>
<td>Not much role</td>
<td>Stiff phase of frozen shoulder</td>
<td>In selected cases</td>
<td>In selected cases</td>
</tr>
<tr>
<td><strong>STEROIDS</strong></td>
<td>In selected cases</td>
<td>Yes, except sepsis</td>
<td>Painful phase of frozen shoulder</td>
<td>No role</td>
<td>In selected cases</td>
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XR

• Trauma series - Acute painful shoulder

• Impingement series +/\ ACJ view

• Instability series
AP SHOULDER
- do not order this!
AP GLENOHUMERAL JOINT / SCAPULAR VIEW

ext rotation
TRAUMA SERIES

- GHJ /Scapular AP
- Scapular Lat.
- Velpeau axil. Lat.
APICAL OBLIQUE
– for very sore shoulder
AP projection: dislocation
LATERAL - Dislocations

ANTERIOR

POSTERIOR
IMPINGEMENT SERIES

AP GHJ

AXIL. LATERAL

SSP OUTLET
ACJ VIEW ( ZANCA)
ANTERIOR SHOULDER DISLOCATION

LIGAMENTOUS BANKHART

BONY BANKHART

HILL SACH LESION

HILL SACH LESION
U/S

• Good screening test for RC

• Good for guided injection into GHJ.

• Should always accompany with an XR

• Beware of frozen shoulder & “calcific “ tendonitis
STEROID INJECTIONS

• SUBACROMIAL
  max of one in young patient with normal cuff or tear < 1cm.
  Max of two in older patient with good strength
  refer if injection have no benefit

• ACJ – can have 2-3 injection, patient may faint!

• GHJ – for frozen shoulder only.
  Should be US guided
• IMPINGEMENT
  - JACKINS PROGRAM

• POSTOP
  – guided by surgeon

• POST SHOULDER DISLOCATION
  – only in specific cases →
    MDI, nerve palsy, postop..

• FROZEN SHOULDER
  – when pain settled, physio for stiffness

• OA & ACJ DISLOCATION
  – not much role
WHO SHOULD BE REFER TO THE ORTHOPOD??
Rotator cuff lesion – refer

- ALL acute Subscapularis tear
- Full Thickness Tear on US < 45 yo
- Rotator cuff tear post dislocation
- All cuff lesion without weakness but not improved with conservative treatment for 3mths
- Tear with clinical weakness
ACJ OA OR osteolysis:

- Pain not response to steroid injection
- Pain keep recurring after 2 steroids injection

GHJ OA:

- Pain not improve with NSAIDs, analgesia, activity modifications
FROZEN SHOULDER

• >50% loss of passive motion with normal XR & CBC and at most slightly raised ESR & CRP

• Self limiting  
  – pain, freeze, thaw, 6-8 mths each phase

• Steroids during painful phase,  
  beware of IDDM

• Physio/hydrosilatation/MUA during stiffness phase

• Refer if stiffness not improve at all after 6 mths  
  OR if not sure of diagnosis.
INSTABILITY - REFER

- Acutely unstable shoulder, ie, re-dislocation within a week – need to exclude glenoid #
- If symptom persist > 3 wks, need US to exclude RCT – refer
- >2 dislocation within 2 yrs.
- Dislocation > 12 hours
- # dislocation.
- Incongruous reduction
SHOULDER RED FLAG
RULE 1..

• BEWARE OF VISIBLE BRUISES
  THAT IS **NOT** DUE TO BICEPS RUPTURE:

• GET US AND XR, REFER IF UNSURE....
RULE 2..

• Most shoulder pathology gets night pain

BUT

FOR SEVERE RELENTLESS NIGHT PAIN:

RESOLVING CALCIFIC TENDONITIS
SEPTIC SHOULDER
NEURALGIA AMYOTROPHY
RULE 3..

• BEWARE OF THE ACUTELY UNSTABLE SHOULDER

- need to exclude glenoid #
RULE 4..

• BEWARE OF THE INCONGRUOUS REDUCTION

usually patient have painful stiff shoulder that he/she can’t move

URGENT REFERRAL TO RULE OUT MASSIVE CUFF TEAR WITH INTERPOSITION.
RULE 5..

• All shoulder dislocation (especially > 40yo) who are symptomatic at 2-3 wks should have an US to check for RC tear.

• REFER if US showed RCT or if patient have lack of active motion.
RULE 6..

• FROZEN SHOULDERS
  = Diagnosis of exclusion.

• Always XR

• CBC, ESR, CRP, GLUCOSE

• SEPTIC SHOULDERS IS DIFFICULT TO DIAGNOSE
  – steroids, immunocompromise
RULE 7..

• POSTERIOR SCJ DISLOCATION:

NEED IMMEDIATE REFERRAL TO WPH FOR..

RELOCATION WITH PRESENCE OF

VASCULAR SURGEON.
RULE 8..

• NEUROLOGY IN HAND:

Consider Neck and Apical lung pathology
RULE 9..

• ULTRASOUND:

• Good screening, not accurate.
• Always correlate with result with clinical picture. If discrepancy between clinical exam & US, refer for further investigation.

• Do not diagnose calcific tendonitis on US.

• Beware of US impingement, could be Frozen shoulder
GENERAL SHOULDER RULES..

• Beware of visible bruises that is NOT long head of Biceps rupture.
• Severe relentless night pain: septic shoulder resolving calcific tendonitis neuralgia amyotrophy/ brachial neuritis tumor
GENERAL SHOULDER RULES..

• Acutely unstable shoulder = glenoid #
• Incongruous GHJ XR post reduction = massive RCT interpostion
• Patient still having symptom 2-3 weeks after dislocation need RC investigation, esp >40 yo.
• Frozen shoulder is a diagnosis of exclusion: Gross reduction of passive ROM with Normal XR and CBC, and no gross elevation of ESR, CRP.
GENERAL RULES..

• Posterior sternoclavicular dislocation need immediate referral to WPH
• Numbness & tingling in hand, consider neck & lung apex (pancoast)
• US is a screening test, must correlate with clinical assessment
• If you order US, Always have XR as well.
• Beware of exertional shoulder pain, could be cardiac.
THANK YOU