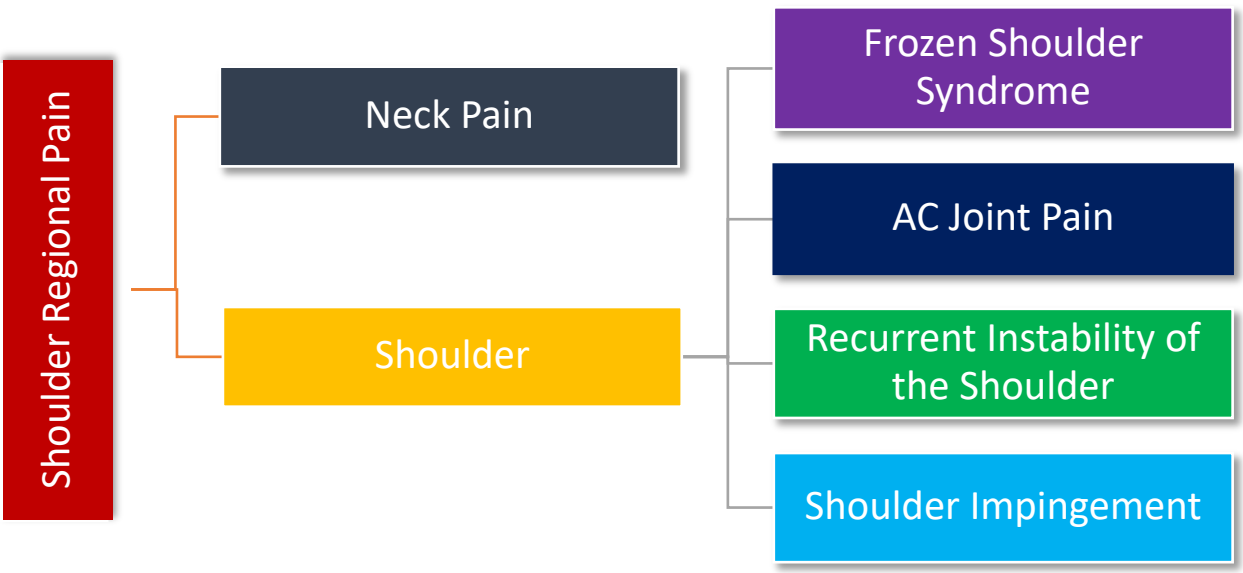
GPECS Neck & Shoulder Guidelines



GPECS MSK treatment guidelines

Shoulder Pain and neck pain

Pain in the shoulder region is a common presentation in primary care.

Clinical resource Shoulder Examination Versus Arthritis

https://www.youtube.com/watch?v=l1rlHmbwJj8

Red Flags for possible serious conditions

Urgent referral to A&E +/- Orthopaedic ICATs / Radiology

• Shoulder pain with red skin, fever or systemically unwell – A&E to exclude septic joint

• History of acute significant trauma or epileptic fit leading to loss of rotation and abnormal shape – A&E to exclude unreduced dislocation

• Any mass or swelling >5cm – Red Flag referral to exclude tumour

• Trauma, pain and reduced power on resisted testing – urgent shoulder ultrasound to exclude acute rotator cuff tear after dw radiology / urgent icats referral

Could the pain be referred from the neck?

• Ask the patient to move the neck and then the shoulder to see what reproduces the pain.
• Perform Neurological examination (see neck pain folder)

Is the pain coming from the acromioclavicular joint?

• Is the AC joint tender to palpate?
• Is the pain reproduced by the cross-arm test?
• Is there high arc pain?

Is it coming from the glenohumeral joint?

Is there reduced passive external rotation?
Frozen shoulder/Shoulder Capsulitis – common age 35-65 years
Osteoarthritis – common age >60 years

Is pain arising from Rotator cuff tendinopathy/shoulder impingement?

• Is there a painful arc of abduction?
• Is there pain on abduction with the thumb down, worse against resistance?
• Rotator cuff tendinopathy – common age 35-75 years old

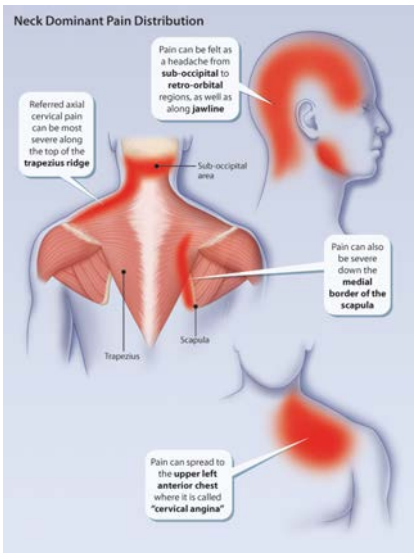
GPECS Neck Pain

Red flags / Urgent referral for neck pain:

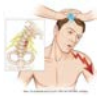
trauma, high risk of osteoporosis, myelopathy, history of cancer, unexplained weight loss, fever, infections and any of the following signs and symptoms:

• constant, progressive, non-mechanical pain
• cauda equina syndrome/widespread neurological symptoms, *gait disturbance,* ***clumsy or weak hands****, loss of sexual, bladder or bowel function*
• Lhermitte's sign (flexion of the neck producing an electric shock sensation down the spine and into the limbs)
• Dizziness, drop attacks, blackouts
• **Progressive myotonal weakness**

Signs and symptoms



• Pain reproduced by neck movements
• Any deformity, e.g. torticollis
• Any neurological symptoms – numbness, paresthesia, weakness in the arm , poor grip , impaired fine motor skills eg. Doing up buttons , holding pen etc ?
• Any tenderness of the bony cervical spine and surrounding musculature?
• Spurling's sign - the examiner turns the patient's head to the affected side while extending and applying downward pressure to the top of the patient's head. A positive Spurling's sign is when the pain arising in the neck radiates in the direction of the corresponding dermatome ipsilaterally.



• Consider upper and lower limb focal neurological examination eg reduced power , loss reflex UL , brisk reflex LL , ankle clonus

Diagnosis to consider include:

• Non-specific mechanical neck pain, Whiplash, Cervical spondylosis (osteoarthritis), Acute torticollis.

•Neck pain may be accompanied by pain radiating down the arm (radiculopathy) or headaches (cervicogenic headaches)

Investigations

• Cervical Spine X-rays are generally not recommended.
• Consider Chest X-ray if clinically indicated
• If evidence of persisting focal neurology not settling with conservative management, consider referral for MRI of cervical spine / Orthopaedic ICATS .

Primary care management

• Rest from aggravating activity, NSAID, Analgesia 95% + neck pain will improve with time
• Refer Community Physiotherapy if not improving after 6 weeks
• If evidence of persisting focal neurology not settling with conservative management consider referral to ICATS

Patient Information Neck Pain- Versus Arthritis

https://www.versusarthritis.org/about-arthritis/conditions/neck-pain/

Neck pain exercise sheet

https://www.versusarthritis.org/media/21788/neckpain-exercise-sheet.pdf

Link to Web based neck exercises page VA
https://www.versusarthritis.org/about-arthritis/exercising-with-arthritis/exercises-for-healthy-joints/exercises-for-the-neck/

Frozen Shoulder Syndrome (Adhesive Capsulitis):

A common cause of pain and stiffness.
There is a global reduction in the range of motion of the shoulder (stiffness). Most idiopathic or may follow an injury or surgery to the shoulder. It is more common in women and diabetics (when it is often bilateral and resistant to treatment).

Initially the shoulder becomes painful. The pain is severe and can waken the patient at night. The pain is deep and usually cannot be localised any more precisely. The shoulder is painful to move, particularly rotation. Likely to develop a bursitis pattern due to the capsular contraction (hence reason why do SA Bursa injection)

Pain subsides (this may take 6 months) but the stiffness will increase and may be so severe that the shoulder has virtually no movement. This may them improve for up to 2 years, but some patients may be left with a residual loss of motion.

Stage I – If early prior to much capsular restriction
Management: Urgent CSI & rehab

Stage II – Restricted ROM with pain
Management: Hydrodilation then rehab

Stage III – Improving ROM
Management : Rehab +/- CSI

Primary care management
• Consider X-Ray before injection but do not delay treatment awaiting xray unless there is an atypical or clinically concerning presented
• Intra-articular steroid injection. If not available in surgery refer to GPECS MSK clinic for injection . If suspect early Capsulitis refer 'urgently' to GPECS MSK
• Consider up to 2 injections 6 weeks apart – refer if ineffective
• Refer for physiotherapy with request to start rehab to start 48 hours to 2 weeks after injection

•Non Acute (> 3mths) not resolving with Physio and steroid injection x2 - Refer radiology for Hydrodilation / refer ICATS to facilitate

Referral to orthopaedic consultant for surgical opinion

When stiffness and pain fail to respond to physio / injection / hydrodilation and patient would consider surgery refer to ICATS

Patient Information booklet & exercises . Frozen Shoulder Versus Arthritis

https://www.versusarthritis.org/media/23100/shoulder-pain-information-booklet.pdf

AC Joint

• Pain from OA or traumatic dislocation are the most common problem.
• Pain usually well-localised to AC joint area and the joint itself is typically tender to palpate.
• Sharp pain when reaching overhead. Symptoms of rotator cuff impingement may also occur.
• AC joint OA is frequently associated with subacromial impingement and rotator cuff

• Traumatic dislocation / subluxation of the joint usually occur following a fall onto the hand

• **Scarf test** – ask the patient to put their hand on the opposite shoulder. Then place the patient into further horizontal abduction (like throwing a scarf over the shoulder). A positive test is indicated by pain around the AC joint.

Investigations

• Acute AC joint injury should be assessed at A&E
• Consider X-ray if no improvement with conservative management options – AP and lateral
•Consider inflammatory markers if suggestions of inflammatory cause

Primary care management

• Offer rest (sling), NSAIDs (topical/oral) +/- analgesics.
• If not available in surgery Refer to MSK clinic for AC joint steroid/LA injection + exercise advice.
• Consider physiotherapy referral to address underlying biomechanical issues.

Secondary care referral:
If pain severe and disabling
Consider if patient is fit for and willing for surgery before referral

Recurrent Instability of the Shoulder

Atraumatic
Usually female – in those with *hypermobility*. *No surgical option*. Management is always physiotherapy rehab .
Investigation not normally required unless concern wrt other pathology such as AC joint, SA pain etc

Traumatic
Commonly young males (teens and twenties). Significant trauma initially thereafter the shoulder may dislocate or feel unstable with relatively minor provocation.

Traumatic Instability
SLAP tear
Anterior dislocation
Posterior dislocation

Catching pain in activity
+ve apprehension
Increased laxity on testing

Management of Traumatic – subluxation / dislocation

Acute -check for decreased sensation deltoid – injury to axillary nerve . Refer ED
After first episode of dislocation physiotherapy rehabilitation is always the management.

Recurrent dislocation – post traumatic.

•Management may depend on patient's job / hobbies .
•If patient has completed rehabilitation physiotherapy and continues with an appropriate home exercise programme then referral to orthopaedic ICATS would be appropriate if patient wants surgery .

Patient resources
https://www.sheffieldachesandpains.com/assets/info%20leaflets/shoulderinstability.pdf

Subacromial Pain Syndrome

Which encompasses:
Bursitis
Tendinopathy
Calcific tendonitis – can be primary but more usually mechanically caused
RC tear
Degenerate AC Joint

Tissues in the subacromial space become inflamed, causing pain.It is often difficult to distinguish between bursitis, tendinitis and small rotator cuff tears in the initial stages. The treatment is the same.

Presentation:
Continuous dull ache, often worse at night, located over the lateral aspect of the shoulder and may extend to the elbow.

Pain on lifting the arm felt just below the acromion and radiating to elbow. May have a painful arc.

Acute traumatic tear with 'true' weakness (due to disruption of the integrity of the muscle) & dramatic loss of ROM should be scanned urgently .

Refer urgent US shoulder / Urgent ICATS

Non Acute presentation
• Pain - Continuous dull ache, often worse at night, located over the lateral aspect of the shoulder and may extend to the elbow.
• With acute intense onset pain consider acute calcific tendonitis.
• Pain on lifting the arm particularly in abduction often starting at 30 – 40 degrees abduction, and may ease if the arm can be brought to vertical: the "painful arc"
• Exclude referred pain from cervical spine
• In rotator cuff tendinopathy, pain generally reproduced with &resisted abduction with thumb pointing down.
• Test for rotator cuff weakness
• To exclude large or complete rotator cuff tears (largely of the supraspinatus muscle), do the 'drop arm test' – can the patient bring their arm down smoothly and in a controlled fashion from 90-100 degrees of abduction to their waist? If the arm just drops, suspect a complete rotator cuff tear.

Investigations
• Consider X-Ray of the shoulder.

• If weakness in rotator cuff is detected an USS of shoulder may be considered particularly if acute onset of weakness. Rotator cuff tears are part of ageing process and asymptomatic in the majority of patients . Rotator cuff repair has reducing success rate over the age of 60 .

Primary care management of non traumatic acute pain

• Avoid aggravating activities, NSAIDs +/-
• Consider subacromial steroid injection - if not available in practice refer to GPECS MSK clinic for injection
• Refer to physiotherapy for rehabilitation ideally soon after injection if offered.

Consider further investigation e.g. USS/referral if anatomically guided injection not successful.

In older patients who are not suitable for surgery ongoing rotator cuff exercises and Intermittent sub acromial injections may help with symptom management and maximise function .

Rotator Cuff Tear of the Shoulder

The presence of a RC tear on imaging does not mean that patient should automatically be referred for surgery - The majority of tears seen will be degenerate tears and with rehab the rest of the RC is likely to compensate

Management
•Like any subacromial pain
•NSAIDS. Refer physiotherapy rehab
•Consider subacromial injection for pain control and improve ability to engage with rehab .

Full thickness tears

Acute tear : sudden onset of weakness especially in younger patients or associated with trauma . Refer urgent USS or ICATS

Chronic Tears / Acute on Chronic

As we get older tendon quality diminishes and repair less successful - from 60-65 cons start outweighing pros

75% will improve with conservative management

Refer physiotherapy as key is to get rest of RC to compensate for tear

Patient resources
Rotator Cuff Exercises Versus Arthritis
https://www.versusarthritis.org/media/1923/shoulder-pain-exercise-pamphlet.pdf

Five ways to help your shoulder pain
https://www.versusarthritis.org/news/2021/june/five-ways-to-help-shoulder-pain/

Clinical resource - Shoulder Examination

https://www.versusarthritis.org/about-arthritis/healthcare-professionals/training-and-education-resources/clinical-assessment-of-patients-with-musculoskeletal-conditions/the-musculoskeletal-examination-rems/examination-of-the-shoulder/

Consider Referral to orthopaedics

Weakness on resisted testing of rotator cuff strength (urgent if recent onset) Injection and physiotherapy fail to improve symptoms Consider if patient is fit for and willing for surgery before referral.