

# THE PAINFULL SHOULDER – WHAT I RECOMMEND IN PRIMARY CARE

Mr Rajeev Sharma  
Consultant Orthopaedic Surgeon  
Shoulder Elbow Wrist and Hand  
Hon Senior Lecturer Imperial College London  
National Examiner for Orthopaedic Surgeons  
Medical Director One Healthcare  
Responsible Officer GMC  
[rajeevsharma.co.uk](http://rajeevsharma.co.uk)

# test

- ▣ I am totally competent and comfortable with managing Shoulder pain in Primary care
- ▣
- ▣ Answers: tick one answer
- ▣ Yes
- ▣ No.

# The sections

- ▣ The presentation
- ▣ The initial management
- ▣ The final outcome

# The presentation - PAIN

- ▣ ACUTE and severe: calcific tendinosis, acute bursitis or impingement, infection
- ▣ Chronic severe: impingement, frozen shoulder, rotator cuff tear with history of trauma, arthritis
- ▣ Chronic mild to moderate: chronic rotator cuff tear, early arthritis, mild frozen shoulder or capsulitis, associated cervical spondylosis.

# THE 3 MINUTE SHOULDER EXAMINATION IN THE CLINIC

- ▣ Neck examination.
- ▣ Shoulder ROM.
- ▣ Rule out Frozen shoulder.
- ▣ One impingement test. (Neers or Hawkins)
- ▣ One rotator cuff test if necessary.

# SHOULDER PAIN MANAGEMENT BULLETS IN CLINIC

- ▣ Physiotherapy: Accupuncture etc.
- ▣ NSAIDS.
- ▣ Injections in subacromial space – maximum one.
- ▣ Ultrasound exam not essential.
- ▣ Refer if index of suspicion is high for surgical intervention – or no relief after above.

# FROZEN SHOULDER

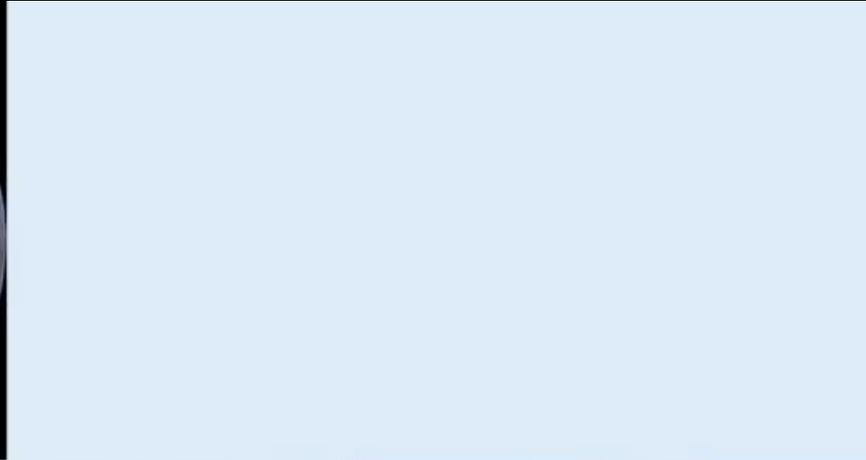
- ▣ Stiff, painful, night waking, refractory to medication.
- ▣ Natural progression – 6 months to 7 years
- ▣ Primary tmt: NSAIDS, injection anywhere in the shoulder, Physio
- ▣ Refer: the pt gets 1. Distension. 2. MUA 3. Arthroscopy with capsulotomy
- ▣ Surgical intervention high in diabetics.
- ▣ Expectation: 1 night, excellent initial recovery but recurs by 50% in 4 weeks, a bit disappointing to the patient. RTW in 2 weeks

# Rotator cuff tears

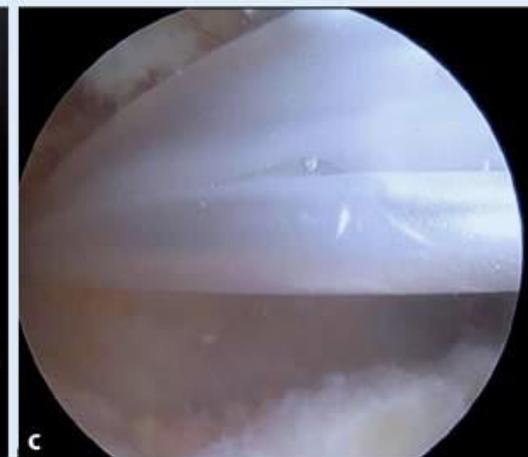
- ▣ The open repair
- ▣ The No repair and physiotherapy
- ▣ The arthroscopic repair – better access better visualisation.
- ▣ The muscle transfers for reconstruction.
- ▣ The bio – material reconstruction: the dermal patches/ graft jackets etc.
- ▣ The repair/ reconstruction in an older age group – 70- and above too.
- ▣ Balloon Inspace absorbable spacer – assists rotator cuff repairs



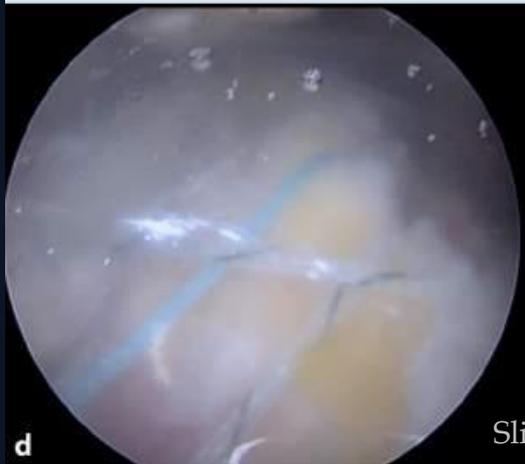
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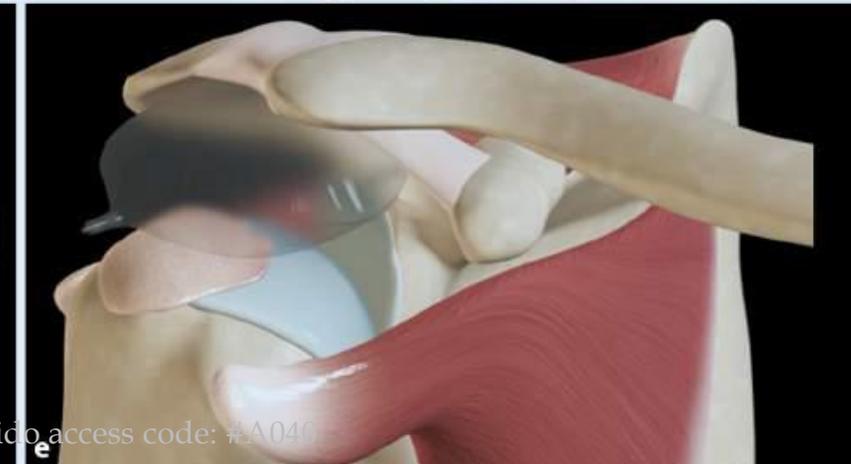
b



c



d



e

# ARTHRITIS

- ▣ Intact cuff
- ▣ Arthroscopic debridement
- ▣ Primary joint replacement
- ▣ With stem cement/no cement
- ▣ Without stem – minimalist/easy to revise in the future
- ▣ Torn ineffective cuff
- ▣ Change the mechanics to make it easy for the deltoid to do all the work
- ▣ The Reverse joint replacement



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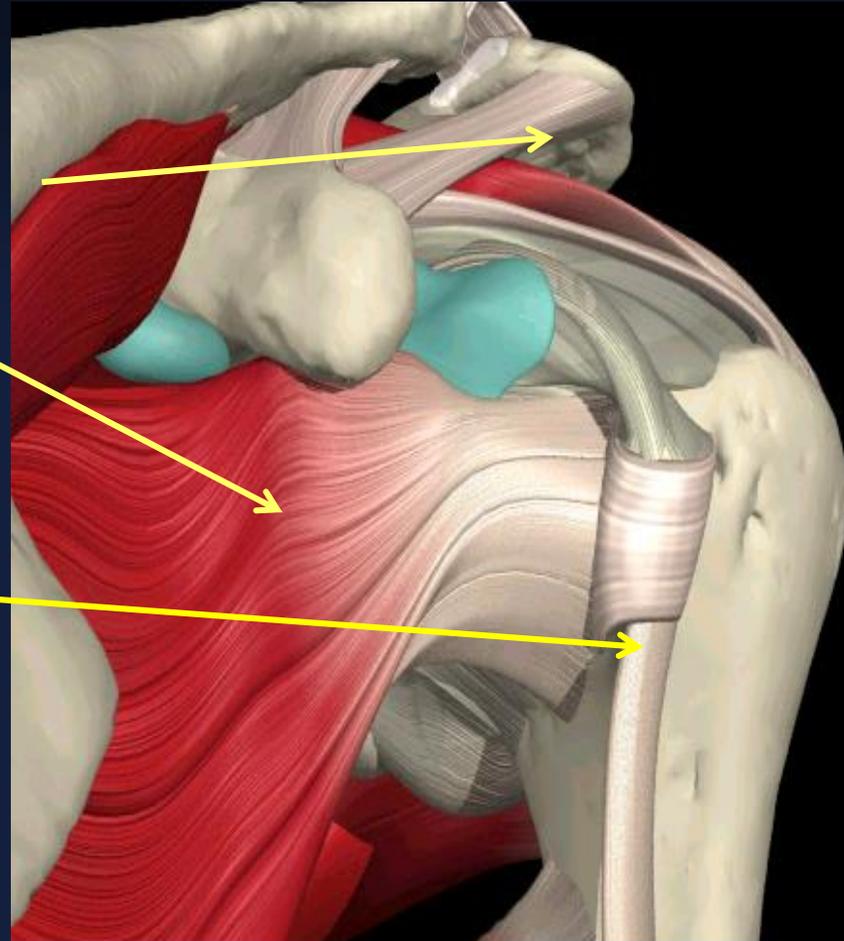


# The anterior view of the Shoulder

▣ Sub-acromial space

▣ Subscapularis

▣ LH Biceps

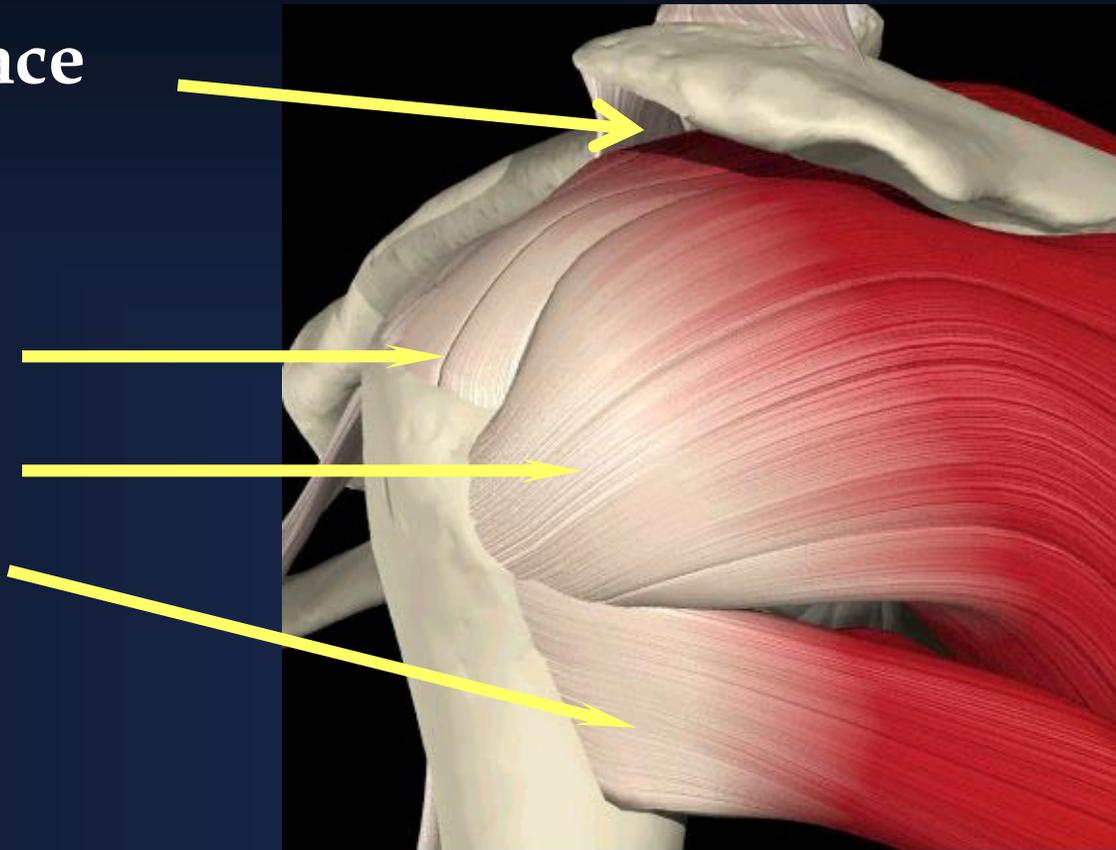


# Posterior view of the Shoulder

**Sub-acromial space**

**The rotator cuff-**

- ▣ **Supraspinatus**
- ▣ **Infraspinatus**
- ▣ **Teres Minor**



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# INVESTIGATIONS

- ▣ X-RAY – AP, AXILLARY +/- Y OUTLET
- ▣ ULTRASOUND – WHY?
- ▣ MRI – WHY ?

# Why Inject

- ▣ Quick
- ▣ Cheap
- ▣ Sometimes curative
- ▣ Short term pain relief- helps with recovery- physio etc
- ▣ Large access for the patient – both primary and secondary care
- ▣ Better and safer techniques, indications and drugs

# WHEN AND WHY SHOULD I REFER A PATIENT TO SECONDARY CARE

- ▣ Pt is a pain in the BS (NOT).
- ▣ You will know: failure of conservative management etc
- ▣ Please ensure patient is suitable and willing to have a surgical intervention!
- ▣ The controversial (why) triage service – can be used.
- ▣ Finally – what does the patient want.

# Further Information and Education

- ▣ Website: [rajeevsharma.co.uk](http://rajeevsharma.co.uk)
- ▣ Click on Home page
- ▣ Several tabs: latest posts at the bottom/ knowledge tab/ symptoms tabs.
- ▣ There is a dedicated password for GPs.
- ▣ Please email me if access is needed for a full presentation. My web manager will create a login for you.
- ▣ Secretary email: [pa2mrsharma@gmail.com](mailto:pa2mrsharma@gmail.com)

# THANK YOU

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