Sheffield Shoulder Pain

Sheffield NHS Primary Care Trust

MASSIVE CUFF TEAR: CASE STUDY ONE

A 76-year-old right-handed gentleman presented to his GP with a history of insidious onset right lateral shoulder pain and loss of movement.

He reports some aching at rest and pain when attempting to move the shoulder. He experiences some crepitus on movement. He was unable to lie on this side at night and his sleep was disturbed when turning over in bed.

The pain eased with paracetamol PRN and avoidance of provocative activities e.g. lifting the kettle (he was advised not to lift hot items with his right hand).

He denies experiencing pins and needles/numbness in his arm and hand. He has known degenerative changes in his neck but the symptoms have not altered recently.

Patient is having difficulty with personal hygiene, dressing, reaching activities and driving.

PAST MEDICAL HISTORY

Hypertensive
Diabetes type 2 (diet controlled)
He describes a previous episode of shoulder problems when working as an electrician 20-25 years ago which improved with steroid injections.
He has had little pain since he has retired apart from when he did DIY or heavy gardening e.g. hedge trimming.

ON EXAMINATION

Observations
No swelling, heat or redness
Wasting of the infra and supraspinatous fossa

ACTIVE MOVEMENT

- Elevation = 30degrees of glenohumeral movement and shoulder shrugging to achieve 60 degrees of elevation
- External rotation = nil

PASSIVE MOVEMENT

- 150 degrees of assisted/passive movement limited by pain at the end of range
- Crepitus mid to late range
- External rotation = 60 degrees

LAG TESTS

- External rotation = positive
- Lift-off test = positive

INVESTIGATIONS

- X-ray = “humeral head superiorly migrated, moderate AC joint degeneration with inferior osteophyte formation. Sclerotic changes seen in the greater tubercle. No degenerative joint disease noted in the glenohumeral joint”.

- Ultrasound scan not requested as clinically this gentleman has a massive cuff tear which are not operable in the elderly unless associated with OA GH joint requiring an arthroplasty.

MANAGEMENT

- Pain management
- Advice re:
    - posture at night
    - altering home to allow self care e.g. bringing crockery down to the work bench from the higher cupboards
- Physiotherapy
    - the deltoid programme
    - maintenance of passive range of movement with auto-assisted exercises
    - Functional rehab

OUTCOME

- Active elevation = 90 degrees
- Less pain on functional activity (pain only with prolonged use)
- Regained independence e.g. washing and dressing, cooking a meal etc
- Sleep less disturbed (occasional waking when turning over in bed)
- Satisfied patient