Shoulder Surgery Usually Not Beneficial For Most - Frankly Speaking EP 86

Transcript Details

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Dr. Frank Domino:

Dan is a 52-year-old roofer. He owns his own business. And because we're here in New England, he's busy seven days a week, March through November, because that's when the weather permits him to work outside. He presents in mid-July with a nagging right shoulder pain. Initially, it just bothered him after a long day of work, and it got better with a few ibuprofen. Now it's keeping him up at night. It bothers him round the clock. He states, "Doc, don't tell me I need surgery, I just don't have the time to do it now." Hi, this is Frank Domino, professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School, and joining me is Susan Feeney, assistant professor and coordinator of the Family Nurse Practitioner Program at the University of Massachusetts Medical School's Graduate School of Nursing. Hi, Susan.

Susan Feeney:

Hi, Frank. So this patient, Mr. Dan, is very common. I mean, this is a real problem that we see in our patients. So can you remind us about the causes and the differential diagnosis for atraumatic shoulder pain?

Dr. Domino:

Sure. So as you said, this is very common. We're seeing lots of patients in our practice who say, "Gee, I didn't fall, I didn't do anything new, and all of a sudden, my shoulders bother me a little bit, and sooner or later, it's keeping me up at night." In this case, it's his right shoulder, it's his dominant hand, and so we have to think about what we used to call rotator cuff tendonitis, or what's currently called impingement syndrome, which is inflammation or even eventually tearing of one of the four tendons that go into maintaining the shoulder integrity. Another common cause is osteoarthritis of the shoulder, in particular, affecting the acromioclavicular joint. A third possibility is an infectious disease, where in New England, lyme disease could possibly cause atraumatic shoulder pain. One type of shoulder pain that can happen is derangement of the shoulder due to labral dysfunction, and that typically is associated with trauma, but the trauma may have happened 30, 40 years ago, and now the shoulder is popping in and out of the joint a little bit, causing him some discomfort.

So those are the common causes. If it was on the left side, I might add angina, as an anginal variant that you had to consider. But those are the common causes and the differential that you need to begin to think about when someone presents with these symptoms.

Susan Feeney:

And it could be that Dan has a couple of these processes going on...

Dr. Domino:

Sure

Susan Feeney:

Because of his age and the work he does. So how effective is imaging? And should we get an MRI for this gentleman? I mean, how would you proceed here?

Dr. Domino:

Okay. So with regards to imaging, there's a variety of bits of data of which we don't really know. So getting plain X-rays often identifies osteoarthritis. But as you said, he's a hardworking person in his mid-50, chances are, you're going to see osteoarthritic changes on an X-ray that may have nothing to do with his symptoms. So there was a very interesting study published in the radiology literature, that they took a group of healthy adults with no symptoms and they imaged them, and they found that over 90% had an abnormality on that imaging, that if it had been done in someone with complaints, might have led to intervention and surgery. So about 78 were found to have subacromial bursal thickening, which can imply bursitis, yet, they had no symptoms. Arthritis was found in 65% of the people in this study. So they found clinical radiologic findings of arthritis, they found tendinopathies is common in 40% of the people, and they had partial tears of the tendons in about one and five, and they found dysfunction of the glenoid process in about 15% of the patients. So aggressive imaging can only lead you down a path of, not only, but is likely to lead you down a path of a false positive in someone with atraumatic shoulder pain. So I guess my quick answer to your question is, no, I wouldn't image, this person right off the bat, unless I had a specific thing I was looking for.

Susan Feeney:

So that's really... It's fascinating and frustrating because, you're right, if we think he's got something, we send him, "A-ha, we found it," and you said it may have nothing to do with the symptoms he has. So how do we manage shoulder pain? What are our options?

Dr. Domino:

Well, if we think the person has an impingement syndrome, or a little bit of an arthritis, the two mainstays are getting some pain relief and then retraining the muscles of the shoulder to work properly. So if you feel comfortable, subacromial corticosteroid injection is very effective. You intervene, they're good for five to six weeks, and you get excellent control of both the inflammation and the symptoms. If you don't feel comfortable using a corticosteroid injection, just as efficacious is using oral antiinflammatories taken on a daily basis for probably five to six weeks. Either of those must be coupled with muscle retraining, and that normally involves physical therapy. It used to be, not that long ago, that most physical therapy was covered by managed care organizations, and that's changed in the last few years where people are using far more high co-pay or high deductible plans. Nonetheless, I refer everybody that I make a diagnosis of subacromial bursitis or tendonitis, I refer them to physical therapy, and I always put on my request to have the patient be given a home exercise program, so that instead of being able to afford six to eight visits to the physical therapist, they're may e getting three, they're paying half the co-pays and hopefully still getting the benefit.

Susan Feeney:

Yeah, because that is a big point, is it's expensive now, and people like Dan have to take time off of work because oftentimes it's not in the evening or weekends that these offices are open. So that's a really great point to come up with a sort of an alternative workaround. So what surgery for the shoulder?

Dr. Domino:

Well, there was a really interesting study published just recently in The Lancet that compared shoulder surgery to non-surgery. There're actually three arms; in one arm, they got standard arthroscopic surgery where they opened up the shoulder joint, they cleaned

out the arthritis, they fixed damaged tendons, they took the scope out; the second arm, they did almost the same thing; they went to the OR, they put a scope in, they took the scope out and they closed up, and then they compared those two interventions to just physical therapy, and they followed them forward for six months, and sure enough, all three arms had an equivalent outcome.

So they looked, in particular, at whether the shoulder surgery versus the sham surgery had different outcomes, and there were none, and they looked at the two interventions compared to just doing physical therapy, and those two even combined, still found no clinical benefit to the surgery compared to aggressive physical therapy.

Susan Feeney:

Wow, that's really stunning. And you think about shoulder surgery, people are out of work, they're immobile. I mean, Dan mentions this, that "I can't be away." He would be out of work for a substantial amount of time, and immobile. And you think, "If I refer patients to orthopods, what's the percentage that would have surgery, especially if they would get an MRI and finds something that might be wrong, that actually may not be causing the pain?"

Dr. Domino:

The problem.

Susan Feeney:

Yeah.

Dr. Domino:

Right. So I think the takeaway here is that we have to get very aggressive with managing shoulder pain, especially atraumatic shoulder pain. If someone falls on an outstretched arm

and their shoulder's dislocating, that's a different circumstance. But if someone's got atraumatic shoulder pain, we need to think about the differential, we need to get very aggressive with anti-inflammatory use, whether by injection or by pill, and then we need to integrate our physical therapists with us. And we also need to make it very clear to the patients that we're not just trying to fix the pain, we're trying to fix their shoulder, and that the physical therapy is probably the most important of the interventions that they need to do.

Susan Feeney:

And I agree in that sometimes being able to share with them is, even though there's time and money involved with physical therapy, it's less than surgery, and it's also going to teach them ways to prevent this in the future.

Dr. Domino:

And it hopefully will prevent them ultimately needing surgery.

Susan Feeney:

Correct.

Dr. Domino:

Well, thank you, thank you very much, Susan.

Susan Feeney:

Well, thank you, Frank, this was very interesting.

Dr. Domino:

Practice pointer: In the management of atraumatic shoulder pain, use of NSAID’s and most

importantly, aggressive physical therapy, is the key to having your patient do well and not need referral to surgery. Battling burnout practice pointer: Be open to change. You can refill anti-hypertensives and birth control pills for a year without worry about patients coming back for follow-up. This will save you two to three minutes per prescription, and may add 30 minutes to your day. Join us next time when we discuss the use of behavioral interventions to treat chronic non-cancer pain.