Letters to the Editor

Finding the Etiology of Shoulder Pain

I commend Petchkrua and Harris’s on their recent clinical note. They illustrate very well the educational point that shoulder pain may actually represent referred pain from organ systems within the torso.

In my clinical practice, I have been consulted 3 times about patients who presented with left shoulder pain in the emergency department and subsequently were admitted to the cardiac unit to rule out myocardial infarction. In each case, after the electrocardiograms and cardiac enzymes came back normal, a physiatry consult was requested and my musculoskeletal physical exam revealed rotator cuff tendinitis. In each case, a diagnostic (and therapeutic) subacromial injection gave dramatic relief of the symptoms, such that these patients were promptly discharged from the hospital and started on outpatient rehabilitation.

These cases, as well as Petchkrua and Harris’s case study, demonstrate the need to consistently consider that shoulder pain can be caused by musculoskeletal pathology (eg, within the shoulder region) or by pathology of organ systems within the trunk. It is wise for clinicians to assess for all of these possibilities when a patient complains of shoulder pain.

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Reference

doi:10.1053/apmr.2000.18577

The authors reply

We gratefully appreciate Foye’s comments on our recent clinical note and respectfully respond as follows.

We believe that most physiatrists will come across a clinical scenario similar to geriatric hemiplegic shoulder pain (GHSP). We modified the table, causes of GHSP, from a number of references, mainly from Zuckerman and Sharpiro. This table is the key point of our note. We thank Foye and others for seeing its educational value, especially for residents.

Our patient required the extensive work-up before definite diagnosis of pneumonia was made. Without considering this unusual etiology of GHSP, the patient would have had a grave outcome. Foye shared with us his experiences of shoulder pain due to rotator cuff tendinitis, which was listed in our table as well. Again, we want to emphasize the need for thorough assessment and treatment of GHSP to help prevent impairment and disability.

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References

Teaching Complementary and Alternative Medicine in Residency Programs

We recently read Ko and Berbrayer’s article with great interest. As pointed out by Eisenberg et al, the number of individuals who use complementary and alternative medicine (CAM) has grown tremendously this past decade, as have expenditures on these alternative therapies. Ko and Berbrayer appear to have concluded that this growing popularity equals usefulness and therefore that CAM should be taught in physiatric residency.

We do not share this enthusiasm. Their meaning of “useful” was never quantified, making it susceptible to various interpretations. As medicine moves to a more evidence-based model, we should likewise move the specialty of physiatry in a similar direction.

Historically, many initially promising treatments with excellent outcomes have fallen by the wayside when more rigorously controlled studies followed. Early success may have been based on few studies that were poorly controlled, or may have suffered from selection bias either on the part of the author or subject. The response may have also been due to nonspecific effects that were not considered. Roberts and Kewman reported that nearly 70% of new treatments originally touted as being successful were later determined to be ineffective when better controlled studies were conducted 4 to 7 years later.

Rather than rushing to teach alternative approaches in our residency programs, we think it is far wiser to evaluate rigorously the efficacy, safety, cost, and value of these new interventions, remembering that most fail to live up to their original success.

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References


The authors reply

We appreciate the interest generated by our article and agree with Bates and LoRe that, before any full endorsement, a new