Differences in the management of shoulder pain between primary and secondary care in Europe: time for a consensus

We read with great interest the articles of Van der Windt and Bouter1 and Hay et al.2 There is no doubt that the study of Hay et al is well designed and has practical implications. They showed that physiotherapy or subacromial joint injection are equally effective for shoulder pain. This is new evidence as, so far, there has been little evidence to support the effectiveness of any common intervention for shoulder pain.3 However, the definition of “shoulder pain” illustrates the practical problem in diagnosis that general practitioners and hospital specialists face in routine clinical practice. We agree that the positive outcome for physiotherapy may reflect the increased contact time between physiotherapists and patient or the better understanding of the anatomical problem by the physiotherapist. The differences in management and in the effectiveness of physiotherapy by the British compared with the Dutch may also represent a cultural difference between the two countries. It is likely that physiotherapy departments could be overloaded with referrals from primary care doctors if they are always the first step in the pathway of managing shoulder problems. Hay et al did not carry out a cost-benefit analysis of the different treatments for shoulder pain (that is, injection versus physiotherapy). A course of physiotherapy would cost around £200–320 (€284–454), whereas an injection would cost around £60 (€85).

There is a lack of consensus in the UK about the exact role of the general practitioners in the treatment of shoulder disease.4 A survey among rheumatologists and physiotherapists practising in the Southeast Thames Region of London (47 rheumatologists and 9 physiotherapists) showed that the management of adhesive capsulitis in secondary care varied widely. Nearly all the rheumatologists (98%) used intra-articular steroid injection, but the time, site, and frequency of injections were variable, with 72% believing that early injections are a priority. One of five rheumatologists (22%) believed that physiotherapy and mobilisation offered no benefit. Only a small number of rheumatologists (14%) believed physiotherapy to be the only means of treatment.5 Interestingly, 90% of physiotherapists working in secondary care wanted to see patients with a frozen shoulder as early as possible before or immediately after steroid injections. However their waiting time varied considerably (range of 3 days–3 months).

Similarly, across Europe treatment of shoulder pain varies considerably between primary and secondary care.6 Therefore we propose that European consensus guidelines on the management of the painful shoulder should be developed.7 This consensus may be weakened by the lack of an adequate evidence base. In addition, we would suggest a third and fourth arm to future studies—steroid injection with physiotherapy and a no intervention control group.

D G Kassimos
Rheumatology Department, Dudley Group of Hospitals, Dudley, West Midlands, UK

G Panayi
Rheumatology Department, Division of Medicine, GKT School of Medicine, Guy’s Hospital, London UK

Correspondence to: Dr D G Kassimos; kassimos.d@dudleygh-tr.wmids.nhs.uk

Dr D G Kassimos is on study leave from the Ministry of Defence of Greece.

References


Author’s reply

Kassimos and Panayi deal with several important issues about the management of shoulder pain in their comments on the article by Hay et al and our leader.8 We agree that differences in the effect of treatment between the Netherlands and England may, at least partly, reflect differences in the organisation of care, as well as differences in expectations and beliefs between the two countries. We are also aware of the lack of consensus among general practitioners, physiotherapists, and rheumatologists about the management of shoulder pain. Between primary and secondary care, especially, the differences are large. This can partly be explained by the fact that the primary care doctor is confronted with an entirely different spectrum of disease than the specialist.9 Many patients in primary care present with vague symptoms that may and cause worry, but are relatively benign and have a favourable prognosis. Patients referred to secondary care have been pre-selected by the nature and severity of symptoms, and have another prognosis, resulting in different treatment requirements.

The lack of consensus among health professionals, indeed, emphasises the need for multidisciplinary guidelines for the management of shoulder pain. Regardless of the quality of the evidence base, multidisciplinary guidelines will facilitate communication among health professionals and may optimise diagnosis and treatment of patients with shoulder pain. We suggest that the AGREE Instrument (Appraisal of Guidelines for Research and Evaluation)5 is used in the development of any guideline for shoulder pain. This instrument includes recommendations for the description of the scope and purpose of a guideline, stakeholder involvement, rigour of development, clarity and presentation, applicability, and editorial independence.

The development of a European guideline for shoulder pain will be quite an undertaking. The authors of the EULAR guideline for the management of knee osteoarthritids indicated that there was often discordance between research evidence and the opinion of experts.10 In this international guideline, variation across countries in healthcare delivery systems, access to health professionals, ways of funding, and attitudes towards the disease, all contributed to this discordance. The use of a Delphi system permitted consensus agreement on difficult issues, but still the applicability in individual countries may be limited. In the case of shoulder pain, it may be wise to start out with the development of national (multidisciplinary) guidelines. As yet, only a few European countries or professional organisations have developed such guidelines.

Finally, regarding the closing point by Kassimos and Panayi, we agree that there is a need for additional research comparing physiotherapy or corticosteroid treatments with no treatment control. It might be difficult or undesirable to carry out such a
trial in patients with severe pain and limitations in daily activities, but controlled trials will certainly help to establish the effectiveness and cost-effectiveness of physiotherapy and injections in patients with mild to moderate shoulder pain. Future trials may also evaluate the effectiveness of combined treatment (injections plus physiotherapy).

References


Exercise in juvenile idiopathic arthritis: promise or passé

We were interested in the recently published article in the Annals by Takken et al. Notwithstanding their substantial work, we have a few comments pertaining to the exercise regimens in children with juvenile idiopathic arthritis (JIA).

Firstly, we did not see any information about whether the patients had ever been following an exercise protocol before they were included in the study and also whether they were prescribed a protocol afterwards. Information about these two points is important for an interpretation of the patients’ results and for providing evidence about the practical implications of the study.

Secondly, when mentioning the diminished loadbearing capacity of these subjects owing to their inflammatory disease and the immune suppressive drugs, they drew attention to a study in which weightbearing exercises were shown to improve the aerobic endurance of such patients.1 At this point, it is noteworthy to add that the myopathic effects of JIA should also be remembered when exercise is prescribed. It is known that eccentric muscle contractions in normal subjects are responsible for a much greater efflux of muscle enzymes into the circulation than is caused by concentric contractions, and are associated with ultrastructural indications of damage to the muscle.1,2 Thus in patients with JIA—where steroidal use is prevalent—concentric types of exercises should preferably be prescribed. These may include simply walking, cycling, or running. However, the list of sports which can be played is endless and there is an excess of activities these—otherwise sedentary—children can be encouraged to take part in to obtain exercise.3 In this way not only will there be an increase in their aerobic capacities but also they will encounter fewer disabilities related to muscle anaerobiosis—much more common in children who use much more energy than adults during daily activities.

L Özçakar
Hacettepe University Medical School, Department of Physical Medicine and Rehabilitation, Ankara, Turkey

Z B Özçakar
Ankara University Medical School, Department of Pediatric Nephrology, Ankara, Turkey

Correspondence to: Dr L Özçakar, Yeni Ankara sokak 27/1, Cebeći, Ankara, Turkey. lозçakar@yahoo.com

References


Authors’ reply

We would sincerely like to thank Özçakar and Özçakar for their response.

Firstly, the patients studied did not actively participate in endurance sports activities at the time of measurement. However, some of the patients had taken part in some sports activities in the period before the disease onset, but not in the six months before our study was performed. It is known from the literature that there is a rapid diminution in fitness once JIA is diagnosed.

We did not prescribe exercises based on the current findings. The Caltrac is a portable electronic activity monitor that measures physical activity and health related physical fitness. It sums the absolute value of the electronic activity in the vertical plane. It allows the user to observe the mechanical capacity of his/her body and to compare it with other people. It is also used in research efforts. The Caltrac is a portable device that measures the total mechanical capacity of the body in a vertical plane. It allows the user to observe the mechanical capacity of his/her body and to compare it with other people. It is also used in research efforts. The Caltrac is a portable device that measures the total mechanical capacity of the body in a vertical plane. It allows the user to observe the mechanical capacity of his/her body and to compare it with other people. It is also used in research efforts.
metabolic profile, and coagulation assays, including anticardiolipin antibodies and lupus anticoagulant. An echocardiogram and carotid Doppler ultrasound were normal. Intensive physical and occupational therapy were prescribed. Over the next 12 days, the left sided weakness progressed. The patient also developed decreased sensation, hyperreflexia, and extensor plantar response on the left. Further evaluation was started. Cerebrospinal fluid showed 1 white blood cell/high powered field (hpf), 0 red blood cells/hpf, protein 0.43 g/L, glucose 2.9 mmol/L. A repeat MRI of the brain showed progressive changes of white matter affecting the right cerebral hemisphere, again with sparing of the cortex. Extensive involvement of the pons was present as well as minimal involvement of the right middle cerebellar peduncle. Additional cerebrospinal fluid studies included negative viral and bacterial cultures, negative paraneoplastic autoantibodies, and negative viral and bacterial cultures. Interpretation of the second MRI was that stroke was unlikely owing to the rapid progression, distribution, and cortical sparing, and PML was likely in this immunocompromised patient (fig 1B). PML is well reported in HIV/AIDS publications, but there are fewer than 30 cases described in rheumatology patients, resulting in a low degree of awareness. This case emphasises the importance of informing radiologists about the immune status of patients being studied so that appropriate consideration for infection may be entertained. Otherwise, this algorithm may not be used, resulting in missed or delayed diagnosis.

Several features of our patient's presentation are rare in PML and caused early diagnostic confusion with delay in the diagnosis. These included the acute nature of the neurological event as well as cranial nerve involvement. Ménière's disease was initially suspected owing to the sudden onset of dizziness and left sided hearing loss, and probably reflects CN VIII involvement, as MRI did not have findings to suggest a central lesion at the cerebellopontine angle. Stroke, being considerably more common than PML in immunocompromised patients, was a further consideration in this patient owing to the acute onset of symptoms and was suggested on the initial request for imaging studies. This influenced the interpretation of the MRI changes towards infarction despite predominance of white matter involvement. The more ominous diagnosis of PML was suspected after neurological symptoms worsened (12 days after hospital presentation and 19 days after the initial event).

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The Antiphospholipid Syndrome II

The Antiphospholipid Syndrome II, subtitled Autoimmune Thrombosis, aims to give an overview, in four parts, of this intriguing syndrome. First is a brief overview of the history and epidemiology, a second part deals with immunology and pathophysiology, a third deals with clinical features, and, finally, several chapters discuss management and prognosis of the syndrome. Each part consists of a series of topics written by authorities in the field. The separate chapters can be considered as in-depth reviews of the item discussed.

As suggested by the title, all aspects of the syndrome are highlighted. Most chapters have a structured format, are illustrated, and well referenced. References are updated to 2001. The subject index is useful and directs the reader adequately to the items searched for. The book is especially suited for such an approach because the introduction to each chapter supplies the reader with similar, general information about the APS. Moreover, various chapters overlap. The reason probably is that the chapters are somewhat heterogeneous in selecting studies and topics to be discussed, and are not always restricted to didactic overviews. For use in clinical practice the book would have gained by including diagnostic flow diagrams and discussion on differential diagnostic dilemmas. The ultimate answers of how to deal with certain clinical situations are lacking, simply because these answers are not available yet. APS is studied extensively and further insights are developing continuously, making parts of a book like this quickly outdated.

Nevertheless, The Antiphospholipid Syndrome II is a very valuable source for those who want to have an overview of the great progress which has been made in fundamental research, the increasing pathophysiological insights and the current treatment modalities in APS. It is particularly useful for researchers and of value for clinicians dealing with patients with APS and the various disease manifestations these patients can develop.

M Bijl, C G M Kallenberg

CORRECTION


One of the authors names was incorrectly spelt. It should have been Kavanaugh A F.

International Society for the Study of the Lumbar Spine
31 May–5 June 2004; Porto, Portugal
Contact: International Society for the Study of the Lumbar Spine, 2075 Bayview Avenue, Room MG 323, Toronto, Ontario, Canada M4N 3M5
Tel: 00 1 416 480 4833
Fax: 00 1 416 480 6055
Email: shirley.fitzgerald@sw.ca

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Tel: +90 (0212) 258 6020
Fax: +90 (0212) 258 6078
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Fax: +44 (0) 161 275 3043
Email: Lisa.mcclain@man.ac.uk

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