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STATION 23

Information given to candidates

Marcus Harrison is a 58-year-old patient who rarely comes to the surgery.

His records show that he had a duodenal ulcer when he was 33 years old, for which he required surgery. He has not had any related symptoms since then.

As Marcus enters the consultation room you can see that he is not moving his right arm but has it flexed at the elbow and held against his body.

The first words the patient says when he enters the room are, 'Sorry to bother you, doctor, but my right shoulder has been giving me so much trouble, I can't sleep and driving my taxi is getting a real problem. I know that I shouldn't be taking the Brufen but it's the only thing that helps the pain. It's really starting to get me down.'

- What do you think this station is testing?
- Make notes or discuss your thoughts with a colleague before you read on.

Plan your approach to this station:

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Information given to simulated patient

Basic details – You are Marcus Harrison, a 58-year-old taxi driver.

Appearance and behaviour – When you enter the consulting room you are holding your right arm against your body, with it bent at the elbow. If the doctor examines your shoulder there are no specific tender points but it feels generally sore. You find it painful to move your right arm at the shoulder in any direction, whether against resistance or not (i.e. forwards, backwards, outwards, or twisting the arm inwards or outwards), but you are able to do so by about 30 degrees in all directions (i.e. about a third of the way between having your arm by your side and having your elbow at the same height as your shoulder). The only exception to this is twisting or rotating the shoulder outwards – this is particularly painful and you cannot really manage it at all as the pain is so bad. You will not be able to put your right hand behind your head or place your right hand in the small of your back if asked to do so by the doctor. Your left shoulder is fine.

History

Freely divulged to doctor – You do not normally come to the doctor's but your right shoulder has been giving you problems for the last 4 weeks. It started off as a general ache with the joint feeling stiff. It has become increasingly painful, with restricted movement. You have been finding it hard to sleep as the pain wakes you up and is particularly bad if you lie on your right side. With the pain and not sleeping, things are really getting you down.

Divulged to doctor if specifically asked – You do not remember injuring or straining your shoulder. You feel the pain most in your upper outer arm, just below your shoulder joint. No other joints are affected. You have not noticed any swelling, heat or redness of your right shoulder. You have not had any neck pain. There is no tingling or numbness in your right arm or hand. You have been well in yourself otherwise and have not been feverish. You are right-handed, so the shoulder problem has been even more difficult to manage. You now brush your teeth and eat using your left hand. You have found it increasingly hard to work as your right shoulder has been so painful. You have been using your left arm to steer and try not to use your right arm, changing gears by taking your left hand off the steering wheel momentarily. Even getting dressed in the morning has become difficult, particularly if there are any front fastenings. You are not going to the toilet more frequently and you are not excessively thirsty.

Ideas, concerns and expectations – You think you may have strained your shoulder but you are not sure how you did this. You think it is best to rest your shoulder. You have heard from a friend that acupuncture can help shoulder pain and want to ask the doctor about this. A couple of your customers have commented on the way you take your hand off the steering wheel to change gears and you are worried that someone may report you. You know you should probably stop driving at the moment but you need the income. You are hoping the doctor will arrange an x-ray and may be able to offer you some treatment – some acupuncture or an injection.

First words spoken to doctor – 'Sorry to bother you, doctor, but my right shoulder has been giving me so much trouble, I can't sleep and driving my taxi is getting a real problem. I know that I shouldn't be taking the Brufen but it's the only thing that helps the pain. It's really starting to get me down.'

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Medical history – You had an ulcer just beyond your stomach in your small bowel when you were 33 years old which required surgery. You have not had any further problems with ulcers since then. You are otherwise fit and well.

Drug history – You have been taking ibuprofen, which you bought at the supermarket, for the last 4 weeks. To start with you took only one or two 200 mg tablets a day. But as the shoulder pain worsened you started to take more and you are now taking two 200 mg tablets four times a day (which you know is more than the maximum it says on the packet). You did try paracetamol at first, but this did not seem to give much relief.

Social history – You work as a self-employed taxi driver. You have not smoked since you were a teenager. You used to drink heavily but after your ulcer surgery you stopped completely. You live with your wife and grown-up son.

Family history – There is no family history of diabetes or joint problems in your immediate family.

- Having read the information given to the simulated patient, what do you now think this station is testing?
- Make notes or discuss your thoughts with a colleague before you turn the page.

Review your approach to this station:

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Tested at this station:

1. Generic communication skills.
2. History-taking skills.
3. Physical examination skills.
4. Reaching a shared management plan.

Domain 1 – Interpersonal skills

Generic communication skills

At each station in the Clinical Skills Assessment (CSA) you need to ensure that you demonstrate competence in all three domains (interpersonal skills; data gathering, technical and assessment skills; clinical management skills). At this station there is no specific communication issue, such as the patient being angry, talkative, or with a hearing or visual impairment. Indeed, the primary nature of this case is testing physical examination skills. However, you must still be able to demonstrate effective communication skills during the consultation, so the list below is a recap on some of these generic skills:

- Remember the importance of non-verbal communication, including body language and eye contact.
- Always start with open questions before moving on to more specific closed questions.
- Use paraphrasing, checking and summarizing to show that you are actively listening.
- Pick up on, and respond to, cues that the patient gives, such as his awareness that he should not be driving in his current condition.
- Always remember to ask about the patient's ideas, concerns and expectations. Does he have any thoughts about what is going on with his shoulder? Are there any particular concerns? What is he hoping will happen from coming to see you today?
- When giving information, such as explaining a diagnosis, avoid talking at length. Instead 'chunk and check', i.e. give information in manageable chunks, then check the patient's understanding before you move on.
- Avoid medical jargon and use lay terminology – appropriate to the patient – when explaining diagnosis and treatment options.
- Try to stay patient-centred during the consultation – in other words, identify the patient's agenda and address it.
- Give patients the opportunity to raise any other issues which they might not at first have mentioned – *'Is there anything else I can help you with today?'*
- Encourage patients to ask questions at the end of the consultation – *'What would you like to ask?'*
- Check understanding of the management plan, including follow-up. Can he say what the plan is that you have jointly agreed?

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Domain 2 – Data gathering, technical and assessment skills

History-taking skills

When a patient presents with a painful joint you need to feel confident that you have excluded conditions requiring immediate action (e.g. septic arthritis or dislocation). You should also rule out other red flags that might prompt referral to a specialist. Next, you need to identify the likely structural origin of the pain (e.g. in this case neck, shoulder or elsewhere). Finally, if you feel the problem is indeed originating from the shoulder, you should try to differentiate between the common shoulder injuries (see Knowledge base). A focused history, together with examination, will help you do all this:

- He says his right shoulder has been giving him trouble. Can he say more about this?
- Where precisely is the pain: neck, shoulder or arm? Can he show you?
- Any history of trauma? Does the patient do any heavy exercise involving his arms?
- Is he well in himself otherwise – any fevers or general malaise?
- Any weight loss or problems with his breathing? Does he have pain at rest? Is there any history of cancer?
- Has his shoulder ever been dislocated? Does it feel unstable as though it might become dislocated?
- Has his shoulder swollen up? Has the skin over the joint been red or hot?
- Are any other joints affected?
- Has he had problems with his joints in the past?
- Is the pain worse first thing in the morning or later on in the day, or is there no pattern?
- Do any of the patient's immediate family suffer from joint problems (such as rheumatoid arthritis)?
- Any eye problems or pain passing urine (Reiter's syndrome)?
- Is the patient left- or right-handed?
- What effect has the shoulder problem had on his day-to-day life? He says that driving his taxi has become a real problem. Can he say more about how it is affecting his work?
- During the history you should also try to exclude referred angina or diaphragmatic irritation as causes of his shoulder pain.
- This patient has a history of peptic ulcer disease and he has been taking regular non-steroidal anti-inflammatory drugs (NSAIDs). You need to make sure that he has not experienced any symptoms suggesting recurrence of an ulcer or gastrointestinal bleed:
  - Any heartburn or indigestion recently?
  - Any abdominal pain?
  - Does he feel nauseous or has he vomited?
  - Has he seen any blood in his stools or have his stools changed colour such that they are now dark and tarry?

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Physical examination skills

The GP curriculum lists examination of the shoulder as one of the psychomotor skills that you should be able competently to demonstrate. Indeed, physical examination is the 'nub' of this case. With any joint examination a rough guide is: look, feel, move (active, passive and against resistance):

- Explain the nature of the examination to the patient and gain consent.
- You can often pick up clues even before the start of the formal examination. This patient enters the room with his right arm immobile, flexed at the elbow and held against his body, which gives you an idea about his loss of function.
- Ask the patient to take his top off so you can examine the shoulder adequately. This also allows you to judge what gross movements he is able to perform.
- Inspection – both from in front and behind, look for signs of deformity, swelling, asymmetry, redness and muscle wasting.
- Palpation – palpate the sternoclavicular, acromioclavicular and glenohumeral joints, looking for signs of localized tenderness (see Knowledge base). The tendon of biceps is palpated anteriorly in the bicipital groove between the humeral greater and lesser tubercles.
- Assessing movement – as a quick screening test ask the patient to put his hands behind his head and then to place them in the small of his back. This is a gross test of a variety of movements at the shoulder joint, including flexion, extension, internal and external rotation.
- Assessing movement – active movement. In turn, ask the patient to flex, extend, abduct, adduct, externally and internally rotate the shoulder as far as he can. For abduction, you can fix the scapula to isolate glenohumeral joint function.
- Assessing movement – passive movement. If there are limitations of active movement, see whether you can passively move the joint beyond the limitations found on active movement. Frozen shoulder problems usually do not allow any further passive movement whereas rotator cuff injuries often do.
- Assessing movement – painful arc. Pain on abduction between 70° and 120° suggests rotator cuff injury, as does pain on abduction that is worse against resistance.
- Assess for crepitus during the examination.

There are no abnormalities on inspection apart from how the patient holds his right arm on entering the room. See Information given to simulated patient above for further positive findings.

Domain 3 – Clinical management skills

Reaching a shared management plan (overlap with domain 1)

This patient's history and examination findings suggest a glenohumeral joint disorder, namely frozen shoulder (adhesive capsulitis). However, mixed shoulder problems are common and the exact diagnostic category often does not change what is primarily conservative management in a general practice setting, namely

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analgesia, physiotherapy, and encouragement to return to normal activities as early as possible:

- Explain the probable diagnosis – how the capsule around the shoulder joint can become swollen and thickened and lead to pain and restricted movement.
- Give advice on prognosis – prepare the patient for a potentially protracted course, as symptoms can last for 2 or 3 years.
- Encourage self-management of his condition. Explain that keeping the shoulder mobile is a key goal. Gentle shoulder exercises several times a day will help. The exercises will involve some discomfort but are important to prevent muscle wasting.
- Pain management is a key element to facilitate mobilization and allow him to sleep better. You need to explain the risks associated with oral NSAIDs and negotiate their use. Has he thought about trying regular maximum-strength paracetamol, with a topical NSAID gel? He could then reserve oral ibuprofen for occasional use if the pain is particularly bad. You could also consider giving him a proton pump inhibitor – e.g. omeprazole 20 mg OD – for gastroprotection to cover his use of oral NSAIDs. Explain how he would need to discontinue NSAIDs if he started to suffer from indigestion.
- Offer the patient other treatment options, including steroid injections and physiotherapy. Physiotherapy will involve exercises and possibly heat treatment. Explain that the evidence for both treatments' long-term effectiveness is weak, but they may help with short-term relief. What does he think about these options?
- Explain that x-rays and blood tests are not indicated unless there are worrying (red flag) signs, and reassure him that he has none.
- Encourage early return to normal activities, if possible.
- However, at present it appears that his restricted movement renders him unsafe to drive. You should be explicit in your advice that he has a legal duty to inform the Driver and Vehicle Licensing Agency (DVLA) and must refrain from driving at this time. This advice has major implications for the patient and you need to explore his response sensitively and empathetically.
- He is reluctant to stop working due to financial pressures. You could offer to give him a 'Fit note' (Statement of Fitness for Work Med 3 form) as he may be entitled to Employment and Support Allowance (ESA) once he is off work through illness for 4 days or more.
- The patient wants to know about acupuncture treatment for his shoulder. You can advise him that there is little evidence to either confirm or refute the effectiveness of acupuncture for shoulder problems, but that it may improve pain and function for a few weeks.
- Frozen shoulder is five times more common in people with diabetes mellitus, but he has no symptoms and no family history so it is unlikely to need further investigation.

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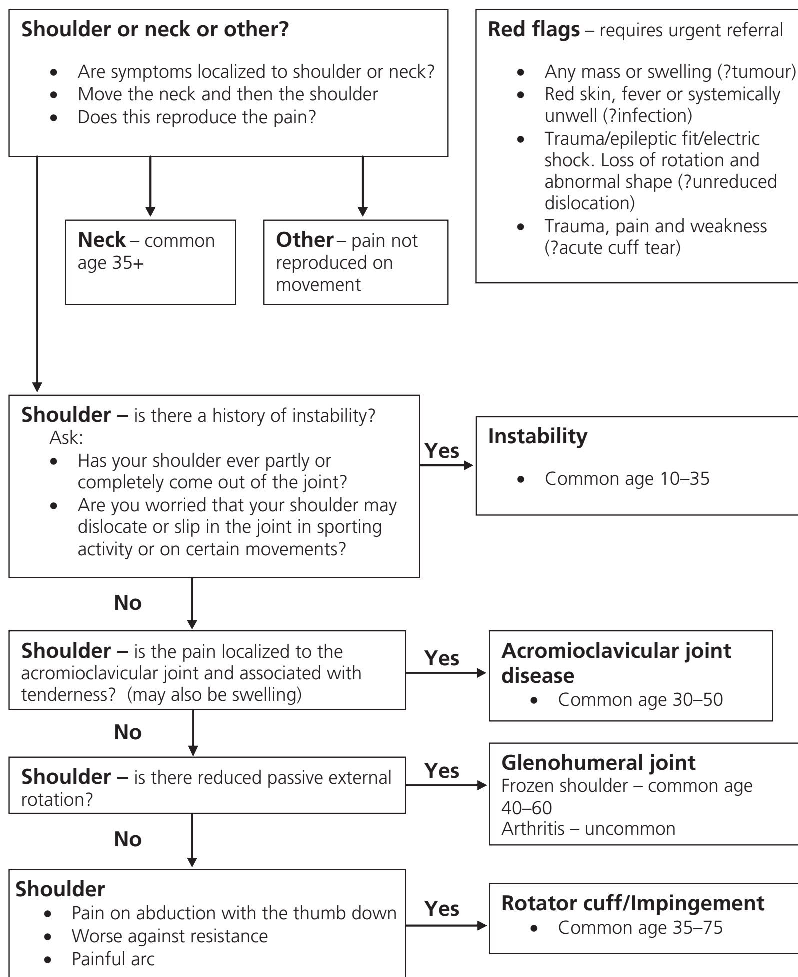
Knowledge base – Diagnosis of shoulder problems



Adapted with permission from Oxford Shoulder and Elbow Clinic shoulder diagnosis flowchart

Referral to a specialist is indicated if:

- red flags are present (see above)
- there is a history of joint instability
- there is significant disability and no improvement in pain over a 6-month period, despite conservative management
- there is diagnostic uncertainty.

Surgery may be considered if conservative treatment is unsuccessful.

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Take-home messages

- Shoulder problems are common, can be protracted and mainly involve conservative management in primary care.
- Always exclude red flags when patients present with joint pain.
- Remember that at each CSA station you need to score marks in all three domains.

Tasks

- Re-run the scenario with the examination findings revealing a painful arc syndrome. Would this change the management options?
- Re-run the scenario with the patient refusing to stop driving.
- Re-run the scenario with the patient complaining of pain and swelling of the small joints of his hands.

1-minute explanations for patients

- Explain what painful arc syndrome is.
- Explain what would be involved with a steroid injection of the shoulder.
- Explain what exercises would be good to keep the shoulder mobile.

Ideas for further revision

Examination of a joint lends itself to inclusion in the CSA. Be sure that you have a good framework for examining the shoulder, knee, hip and back, and can apply the principles to any joint examination.

Further reading

GMC guidance – Confidentiality. Supplementary guidance: Reporting concerns about patients to the DVLA or DVA www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

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Thomas J, Monaghan T. *Oxford Handbook of Clinical Examination and Practical Skills*. Oxford: Oxford University Press, 2007