# FOR THE PRIMARY CARE PROVIDER

Please know that it is my pleasure to help you in any way that I can. If you would like to talk with me personally, please call my assistant Tonya at 503-905-4130 and she can put you in touch with me or give you my cell phone number. You can always call our main line (503-656-0836), though I must admit that this will often be less expeditious.

While I am a shoulder and upper extremity specialist, I do treat patients for a wide variety of conditions. For example, I am the team physician for the Clackamas high school, and Clackamas Community College and treat their athletes for the whole spectrum of sports related injuries.

If you have a patient that you would like me to see urgently, please call me, and I will be happy to work them in on the very same or next day.

**Below are several of my suggestions that I thought you might find helpful when considering patient referral.**

## SHOULDER DISLOCATIONS:

If you see a patient within the first 2 weeks of a dislocation, I would suggest immobilization in a sling, and symptomatic treatment. Dislocation of the humeral head usually produces significant **labral/ligament tearing** which rarely heal naturally in anatomic position. This often leads to recurrent instability and pain. I would urge you to send all patients that sustain a shoulder dislocation for early orthopedic evaluation (within 2 weeks). If you are concerned that the shoulder may not be reduced, then they need to go to the ER or see me that SAME Day. Surgical treatment decisions regarding shoulder instability I find to be rather complex and complicated. In general, patients under the age of 35 are prone to experience repeated instability episodes and sustain worsening damage to the joint. I am usually more aggressive in recommending early surgery for these patients. Patients with dislocations after the age of 40 are less prone to have recurrent dislocations and I am much more likely to treat them without surgery. Dislocations after the age of 55 are associated with a high rate of concomitant rotator cuff tears and again often require surgical treatment.

## ROTATOR CUFF TEARS:

Rotator cuff tears occur quite frequently and often produce significant pain and disability. I am happy to assist you in the treatment of these patients at any point in their care. Fortunately many patients with rotator cuff tears can be treated without surgery. Small or partial tears are often effectively treated in a conservative fashion with injections and therapy. I will often recommend surgery for younger patients (less than 70) with acute, full thickness, rotator cuff tears. I prefer to see these patients within the first two weeks of their injury, as delay can allow for tendon retraction and ultimately a worse prognosis. I will seldom recommend surgery for patients over 75 years of age with degenerative appearing tears due to the poor rate of healing in this population.

## FROZEN SHOULDER:

Adhesive capsulitis (frozen shoulder) is one of the most painful and debilitating shoulder conditions one can experience. Intra-capsular inflammation leads to scarring/thickening of the joint lining. It is most commonly seen in females between age 40 and 60 and typically is idiopathic. Painful restricted range of motion is the hallmark of frozen shoulder. The diagnosis may be rather obvious in the more advanced stages of motion loss and yet very difficult when the motion loss is subtle. In my opinion, the most effective conservative treatment includes a steroid injection to the glenohumeral joint space (not the subacromial space) and formal physical therapy with instruction for manual passive and assisted stretching to regain full motion (strengthening exercises are not beneficial). I find that 80% of patients are treated effectively with conservative measures while roughly 20% require surgical release and manipulation. Regardless, the long term prognosis is good. I am happy to be involved early in the treatment course of these miserably painful patients though there is no real urgency.

## FRACTURES ABOUT THE SHOULDER:

Fractures of the proximal humerus and clavicle can be very painful. At initial presentation it is best to immobilize the shoulder with a sling and use Ice treatment. I would prefer to see these patients as soon as possible to give the maximum flexibility for treatment decisions. I may recommend surgery for more severe fractures, and ideally this occurs in the first two weeks from injury. I will make every effort to work these patients into my clinic on the same or next day from your referral.

## IMPINGEMENT SYNDROME:

This is a relatively common ailment of the shoulder that no doubt you will see frequently in your clinics. Impingement in the shoulder occurs when the rotator cuff tendons contact the undersurface of the anterior lateral acromion during shoulder height and above arm motion. Several factors can potentiate this disorder including: poor scapular posture and abnormal scapulothoracic motion patterns; tight inferior shoulder capsule as can be seen with frozen shoulder; bone spurs/hook shaped acromion morphology (genetic or developmental); and rotator cuff tendonitis and swelling. These patients will complain of anterior and lateral shoulder pain/ pinching and catching that occurs when lifting and using the arm in an outstretched or overhead position. Untreated, impingement will cause progressive wear and eventual tearing of the rotator cuff tendons. Fortunately most patients with this problem can be effectively managed without surgery. Most patients will benefit from formal physical therapy. I typically recommend scapular postural correction, periscapular and rotator cuff strengthening exercises, as well as active assisted and passive stretching to maximize shoulder motion and laxity. Steroid injections placed into the subacromial space can be very effective in treating impingement related symptoms. I use 60 mg of Depomedrol and 2 cc of 1/4% plain Marcaine and suggest you aim to place the medicine under the anterior-lateral corner of the acromion. If patients fail a course of physical therapy and have only temporary benefit from steroid injection, then I generally will obtain an MRI to rule out more significant rotator cuff pathology. Please feel free to refer these patients at any point in their treatment course.

## SHOULDER PAIN OF UNCLEAR ETIOLOGY:

The shoulder is a very complicated joint with many causes of pain and dysfunction. I will be the first to admit that occasionally I am not certain of the diagnosis. Please know that I am at your service and happy to lend assistance at any point in the care of your patients. Please don't hesitate to call with questions or for treatment advice. My assistant Tonya can usually connect us the most efficiently, and she can be reached at 503-905-4130.