The Curbsiders: Internal Medicine Podcast
Episode 274: "MSK Triple Distilled"
Audio Transcription

Molly
Let's start out with a general case. And we'll start out with Christian he's a 55 year old healthy man with a BMI of 31. He's presenting complaining about joint pain that's been slowly getting worse over months, and he doesn't have any specific trauma. And so one thing that really struck me when I listened back to these episodes was that our orthopedist colleagues and our sports medicine colleagues really weren't as interested in getting a detailed history as we've been taught to generally in internal medicine, they were mostly focused on thinking about the patient's age, gender, and maybe comorbidities, and not so much about the quality of the pain or radiation of the pain or all those questions that were taught to ask. So I think we can really simplify things, save time on our history and just get to the point.

Matt 3:54
Yeah, and this, this is a guy, this Christian, he's 55. And he has more of like months of pain. So it's sub acute, at least probably more of a chronic pain. And I like what you referenced. So we talked with Dr. Neogi, in Episode 177, where we talked about osteo arthritis. And we were talking about some of the physiology, pathophysiology and about like your pain receptors, and she said, at some point, patients go from peripheral, like somatic pain to more of a centralized pain. And Molly, like how how do you look for that, in your practice, when you're trying to figure out is this like, a centralized pain condition or not?

Molly 4:35
Yeah, I think we in primary care and a perfect place to look for that because, you know, if you go to a knee orthopedist, they're really just thinking about your knee, they're not thinking about you as a whole person. Whereas in primary care, we see our patients for lots of different complaints. And so you know, if you saw that patient two months ago for migraines and three months ago for irritable bowel syndrome, and that they also have low back pain, and so you can really put it in a whole patient focused approach. And know that if patients do have a lot of these chronic overlapping pain conditions, they're likely to be a more challenging situation and have more centralized pain going on.

Matt 5:10
Yeah, and these are, these are some of the yellow flags that you think about. I mean, before we get on to talking about yellow flags, the the centralized pain thing, when we talked with Dr. Claw, which is way back on our Fibromyalgia episodes, he basically said, the reason why someone

with rheumatoid arthritis can also develop fibromyalgia, because once the pain has been there for years decades, they can start to develop a central component where they're not going to really respond to your typical peripheral treatments, which could even includes a surgery. So sometimes you want to make sure you're not trying to fix a centralized pain condition with a surgery. That's how you get unhappy customers in the long run and where it doesn't work. Because you're it's harder to fix that. And you have to do other things to fix a centralized pain component. So what are some of the yellow flags?

Paul 5:59
Though I think one recurring theme is I we'd like to think of at least joint pain is something easy because it's biomechanical. So it's just wear and tear on the cartilage gets bad. And then the patient has pain. But I think something that has come up with each episode is the fact that it's much more complicated than so we talked about the central versus peripheral pain, there's this idea of discordance between what we see on imaging, the patient's pain you're experiencing that we talked about with Dr. Neogie. And then there's this idea of the yellow flags that I think you're gonna get to in just a second. But even even things like the epicondylitis were Dr. Parks was like, actually, we don't know what's going on, there are jacking Neogie talks about it's not just cartilage, this is total joint failure, as opposed to like heart failure or something else. So it's not, unfortunately, like everything else in medicine, that nothing is easy or straightforward when we don't fully understand how 90% of this stuff works or how to fix it a lot of the time.

And we don't really talkabout the yellow flags very often in the in the clinic, but it's certainly something that we think about, and I don't know, I found that to be pretty helpful and useful to Molly did. Did you want to tell us what those are?

Molly 6:57
Yeah, sure. Um, so the the other files traditionally are applied to back pain, but I think they transfer very well to all painful conditions. And these would suggest that the patient may not follow as easy a course or may not respond as well to traditional treatments. And these would be a negative attitude, that the pain is harmful or potentially severely disabling. So kind of catastrophizing, fear avoidance behaviors, and reduce activity levels, an expectation that passive rather than active treatment will be beneficial, so that someone else needs to fix this problem for them, rather than them making changes to fix it. And a tendency towards depression, low morale and social withdrawal. I think we can all think of lots of pain patients who have those issues and make it more challenging.

Paul 7:42
Yeah, I think it's actually applies to a lot of medical conditions, not just MSK.

Matt 7:46
Yeah, with chronic pain. Whenever I talk about chronic pain to my patients, or just to trainees, I always talk about like, you really want to give like a buffet of options, and just try to help the patient feel empowered that they can try a whole bunch of things to see to see what works. And I that can hopefully short circuit some of these yellow flags. But I'm sure you can all think of

patients where they have like every yellow flag, and it's just like, so you're it's such an uphill battle. So let's move on to the next section. We'll keep this in mind as we're talking through these conditions, knowing that it's not just going to purely be a mechanical issue that we're going to have to treat.

Paul 11:01
And first up, just like a buffet, you got to pick something to start with. So we need to talk about the knee joint, which was gloriously recorded at ACP in 2018. With Dr. Ted parks, so Molly, where do we go from here?

I'm sorry, what? The buffet? I feel like I'm missing. I like,

Unknown Speaker 11:19
I thought that was good.

Paul 11:21
Because he used the word buffet, and it was so random. Alright, we're gonna use it again,

Molly 11:27
do buffets still exist in the pandemic? I don't know if that's, I mean,

Matt 11:30
maybe I encourage everybody in tech, though, get out to your local cafe.

Paul 11:36
Alright, sorry for your rolling, I thought there was a fire that I was missing. So please.

Molly 11:42
Well, the need we need to talk about money. Alright, so to clarify the case a little bit Christian is our 55 year old male with a BMI of 31. And he's actually complaining of knee pain. It's been going on for a couple months, he feels a little stiff. It's kind of diffused around his knee and it feels worse with exercise. an exam he has a bony enlargement, a slightly limited flexion extension range of motion, but no laxity and no focal joint line tenderness to palpation. So Dr. Parks kind of helped us think about the knee in four distinct buckets. Matt, do you want to jump into those?

Matt 12:20
Yeah, and I was just thinking we really need to by the time this is produced, I know we have some lag time between when we're recording when this comes out, we definitely need to get some make a graphic for this because I think this was before we were so heavy into infographics, I don't remember if we had one for the knee, but I think this really would lend itself to it. So Dr. Parks, he did say the first thing he always thinks about is if it's an emergency. So he said he's really looking to make sure that someone doesn't have a joint infection like a septic arthritis when he's thinking about the knee. And a lot of the times from the history, you can tell

that so somebody that has months of knee pain, it's non traumatic, you know, this, this guy, this case is not sounding like this is somebody that where it's an emergency where we really have to, like evaluate them in emergency department or something. So if it's not an emergency situation, you can think about these buckets as a ligament, a meniscus, it could be arthritis, patellofemoral complaint, or none of the above, which is kind of a catch all term. And Molly, why don't you I love the way that he talked about ligaments because it just like a such a surgeon's way of talking about it, you want to remind the audience that it definitely sticks in your head. Yeah, so

Molly 13:31
he was describing the ACL is about the thickness of your pinky finger. So it needs a lot of force to break. So I'm just someone with a little trip on the sidewalk or, you know, they, I don't know, jostled their knee a little bit. And that caused some pain that's not going to create an ACL tear. And so you don't need to be too concerned about that. It really is something more like a skiing accident or a sports accident.

Matt 13:54
Yeah. And he and he did say that somebody with we're not going to talk about the physical exam too much on this, but he did say that that's one that you can often pick up on exam, like if someone truly did fully tear a ligament you can, that's something you might be able to pick up on the exam.

Molly 14:09
Yeah, with the meniscal injury. And I sometimes find this challenging because we think of young people with a meniscal tear as something that needs to be treated right away, and that they do well with surgery and cleaning that up. But someone who's older, it's really just part of the osteoarthritis progression. And so it's not as valuable to really diagnose a meniscal tear specifically, but I can think of a few patients who are sort of in their 40s. And so they're not young, but they're not old and maybe they've had a meniscal tear in the past that was cleaned up. And now they're, you know, convinced they have a new one and I struggle with trying to convince them that this is really more of a chronic problem now and they maybe don't need surgery again, but I don't think there's a clear line as to where that age cutoff happens.

Matt 14:53
Molly I find I do find meniscal tears or meniscal injuries difficult as well. I do think it's helpful to think In the much older person that you're not really going to have to be as aggressive, especially about like, you could probably try conservative things that's ending in the surgery. But for the younger person, if you're trying to figure this out on the physical exam, he talked about the mcmurry test, which he said he had done wrong for years. And so people can watch the video of the knee exam, I would recommend it, he shows us a 30 second knee exam on how to do that. But it's a bit of a, it's one of the things that you can look for is if the person has pain on like, full flexion of the knee where they're really bending their knee as much as they can. And they, they get pain on one side or one location. And that that can be a sign of a meniscal tear. And then he said, if you have someone laying on their back, with their legs initially just like

straight out, and then they bring their knees, their heels towards their butt and kind of start to bend their knees, if they start to develop tenderness along the joint line. And that that's another sign that that could localize to a meniscal tear, but I think it's a, something the younger people will probably send to surgery and the older people try conservative things. Paul, do you have any tricks for this?

Paul 16:00
No, I was just thinking, I can't remember if this is the talk, he goes at ACP or when he was talking to us, but this is one right find the history actually is useful, at least for the acute care. Like I think he tells a story of the 50 year old divorced dad who's just starting yoga for the first time ever extends and feels a pop, and then the knee swells up like he just, I feel like mechanistically I hear that one a lot more often. And then I take that we don't we don't talk about this new episode and get this out, even though I actually prefer the thessaly if the patient can tolerate it, which is we actually have them bear weight on the affected knee and then lift up their opposite leg and and rotate on top of the need to actually kind of recreate that grinding and catch them in this ghost. If you recreate pain that way. It's it's a positive test. Mechanically, it's much easier, but it's also a cruel thing to do the patient. Yeah, that

Matt 16:39
seems just like a violin that's

Paul 16:42
coming to me.

Unknown Speaker 16:44
I see that when

Molly 16:46
most people tolerate it. I mean, the challenging thing is it is uncomfortable in patients with advanced osteoarthritis. And then so it doesn't really help you in that kind of situation. But

Matt 16:55
so what about the osteo arthritis?

Paul 16:57
What Can I just add something real quick. One thing that that so Dr. Parks is looking more for gross instability, significant knee injuries and pain. One of the things I find with my population that I take care of which half about half the population, I care for our younger, healthier individuals who come in for sprains and strains. One of the things that's very helpful, it's actually just directly palpating, the origin and insertion of the MC l tendon, which commonly is strained or sprained for these young individuals who are increasing their activity level when they weren't before. And we're seeing that a lot more with individuals who during the pandemic weren't as active, and now they're finding themselves more active, so more like the pivot injury, but without an actual tear. And I think that that's helpful, at least for our patient population, in identifying

what the potential etiology was, although the treatments can be the same for the most part when we get there.

Matt 18:02
We've talked about two buckets, the ligament injury, the meniscus injury, and the next two big buckets are osteoarthritis and patellofemoral joint issues. Molly for osteoarthritis, any specific things that you wanted to point out?

Molly 18:15
I think for that one, we'll go into a little bit more detail about sort of treatment options and further evaluation options after we sort of wrap up the buckets but tends to be chronic often bilateral. Dr. Parks did a nice job describing that it is a chronic disease, but sometimes it can be exacerbated by like a small injury and he kind of described it as someone with a healthy knee can have a little trip and fall and you know, walk it off be fine. But if you're, you know, have pretty advanced osteoarthritis, but you're managing, okay, a small fall can really push you over the edge so that those those more mild injuries can exacerbate things.

Matt 18:54
And then finally, the patellofemoral joint issue is the other big bucket. It's not a catch. Well, it's a little bit of a catch all, but

Stuart 19:02
not not as much. Not

Matt 19:03
that none of the above. Yeah,

Molly 19:05
yeah. I actually hadn't really thought about patellofemoral osteoarthritis before re listening to this episode. No. And I guess, you know, it makes sense. But it just wasn't on my radar.

Matt 19:15
Right. So this is where he said you you have the patient just sit on the table and put your hand on top of their kneecap and just have them flex and extend and if you feel that rice crispy stuff that can be and it's worse on this side that they have pain, then that can be a sign of the osteoarthritis.

Stuart 19:31
I can attest to that.

Matt 19:33
Steve Stewart as patellofemoral horribly, oh, no. And then for patellofemoral conditions in general. That's the one where it makes sense. He said biomechanically that pain is most pronounced walking down stairs. And I tend to see this in a lot of younger, younger people that

are still more active. They get the pain when they're walking down stairs, and it's anterior knee pain, right?

Paul 19:53
Yeah, I feel like I see a ton of this and it's poorly localized and the patients are gestures vaguely at the front of their knee, that that's where it hurts. And then he mentioned that theatregoers sign as well were worse if you sit for a period of time and then stand up. And that's when you really experienced the pain, which I feel like I just see a boatload of this in my own practice.

Matt 20:09
Yeah. And so then the final bucket is none of the above. Which, Molly, do you what do you think? Is any of these are high yield that are particularly high yield for the audience? Or do you want to just kind of blow by this one?

Molly 20:23
I think we can generally blow by it. I mean, you know, I sometimes see like a knee bursitis. If you have localized, sort of more external swelling, rather than a joint effusion, and pretty localized tenderness to palpation. There, it banned stuff we certainly see. Stewart was mentioning some of the, you know, more ligamentous strains.

Matt 20:44
So for the exam, I mean, at this point, you take the history, try to localize where the knee pain is coming from, figure out which bucket you think they're in, out of the ones we've talked about, definitely watch the video where Dr. Parks teaches you how to do a 32nd knee exam. And once you've decided on the exam, you may want to get some imaging to follow that up. And there's really only three views that he wanted to talk about. And Molly, since you just mentioned the patellofemoral stuff, there was one of the views that was particularly good for, like patellofemoral OEI, which,

Molly 21:17
that's the merchant when it's there. Yeah, that's the merchants or sunrise or the sub patellar views. And I think his discussion of the X rays was really helpful to me, because I just ordered the one with the most views. And I'm like, three or four, sounds good. And then I get the report back. And it's like exam limited by non weight bearing. And I think it's important to remember that most of those knees series are really made for the emergency room to rule out a fracture. And so they're really good at really no fracture, but they're not as good at giving us the information that we're looking for if

Matt 21:46
we're thinking about arthritis. So specifically asking for that merchants view, which is sort of that sub patellar view, and also getting standing AP views that are weight bearing, the other one was like a side view of a partially flexed knee. So the person's like kind of slightly knee slightly bent and their weight bearing. And that you can imagine, they can look at the posterior articular surface of the joint to see if there's cartilage loss there. Because he said, sometimes it's not as

common, but usually what we're used to seeing is like the knee from straight on, and you look at both sides to see if if there's that nice black space where the cartilage would be and see if it's a symmetrical, but if that looks okay, but then you get the partially flexed knee and look from the side, you might catch posterior, like osteoarthritis. So so just those three views. So make sure you probably got a free text it and this is actually another reason, Paul, I don't know about you, but I've taken to just if I'm sending someone to ortho, a lot, they almost all of them get their own x rays in the office. So I just don't even bother getting x rays, or I tried to talk the patient out of it. Because I know they're gonna get their own ones, and they're gonna get the right views. Because, like Molly said, like the default views often don't work. But

Paul 23:03
I it depends. I mean, obviously, like everything, it depends, but I kind of like to see myself before I even send them to ortho. So I oftentimes I will, or especially now that I think actually, this is one of the major practice changing things you have to this episode is exactly what views our orders, I just get so excited to actually look at the X ray. So maybe it's just selfishness. But I just, I also I want to see the standing films, I want to see the versions for you and see if I can figure it out myself before I send them off, but your waist probably nicer to the patient.

Matt 23:29
Let's get back to the buffet, Molly and talk about treatment here.

Molly 23:32
For that, can we jump back to the physical exam just for a second. And I just wanted to highlight this recent Jama review from February 2021 by cats, that was about osteoarthritis. And I thought it was very interesting that they highlighted bony enlargement as one of the most significant physical exam findings that was suggestive of osteoarthritis in the knee with a likelihood ratio of 11. So much better than capitas, which only had a likelihood ratio of two and osteophytes that had an annex rate that had an a likelihood ratio of 5.4.

Paul 24:06
I think those are pretty late finding though, right? So kind of surprising.

Matt 24:09
Yeah,

Molly 24:10
that makes sense. But the crap it is isn't really all that helpful. Yeah. Unfortunately now.

Matt 24:15
Now back to our buffet for Stuart. I know Stuart wanted me to talk more about buffets. What about the non pharmacologic treatments for knee?

Molly 24:26

I think the patient education is really important. And since most of our medical treatments really aren't that great. They're really helping people understand that this often is a slowly progressive disease, and many of them can do well for many, many years without really invasive treatments. And that self management things like exercise and weight loss are really the primary mainstays of treatment.

Matt 24:49
Paul, you want to shout out your your recent hotcakes

Paul 24:53
yeah, no, I should refer you to our almost certainly at this point award winning show. Our hotcakes episode was a 255 I believe I actually looked at write an article that looked at comparing physical therapy versus intra articular steroid injections. And both did well and actually decrease pain increased functionality. But actually physical therapy did better and lasted longer after one year. So PT, still kind of counter intuitively, to me, seems to actually really help with arthritis, pain and functionality. So it's, it's always it's always almost always the right answer for any of these musculoskeletal complaints.

Matt 25:24
Yeah, so just try to get your patients to explore a lot of these options and see what they, you know, see what kind of help they get. Because the pharmacologic options and the injections, which we'll talk about next, I still it's just so depressing how it's kind of like how poorly they are where it's kind of like placebo.

Paul 25:42
I mean, that's essentially what we're doing half the time seems.

Matt 25:47
Yeah, yeah.

Paul 25:49
So nihilistic about acetaminophen, like my residents, I'll be like, I think we'll try them on like, why don't you just spit on the patient. Like, let me just do that. Like whatever.

Matt 25:59
Molly, can you talk about the treatment options, topical versus oral?

Molly 26:06
Yeah, you know, if we spend as much time with our patients talking about the education stuff, and feel confident talking about it, it gives them gives the patients the sense that these self care things are as important as the medications. And so if you spend most of your time talking about medications, that patients will think those are the most important. And unfortunately, as we said, they don't work. So acetaminophen, you could certainly try it, but it doesn't work well. And the topical NSAIDs are probably a good choice. So like topical diclofenac, because they're so safe,

and they have pretty comparable effects to oral NSAIDs. And it's nice that topical diclofenac at least the gel is available over the counter now, so should be readily readily available to patients.

Matt 26:46
I was going to just point out, back to the non pharmacologic thing we went when we were talking about the pathophysiology that this is total joint failure. I think probably part of the reason that like weight loss works is not just the mechanical offloading, but it's like, there's a lot of metabolic benefits to the body from like improving diet and lifestyle. And that is probably overall making the joint more healthy. That's probably why these uh, Paul loves talking about pleiotropic effects. But I think that's why things that like, just like these, the simple things work, because they they have effects that we just can't measure or can't replicate with just like making a single drug. And that's probably why these don't work. We also talked about the yellow flags, Molly. So do you ever use duloxetine for people with like, joint complaints? And how do you how do you select those out?

Molly 27:37
Yeah I definitely offer it to patients, and it doesn't work for a lot of people. So you know, I offer it with that caveat, that it's not something that we need to continue if it's not helping them for patients that it works well for, you know, I think it's a pretty safe option for them to continue on.

Yeah, I mean, it is FDA approved for low back and knee osteoarthritis and chronic musculoskeletal pain.

Matt 28:01
Paul, you look like you're gonna say something

Paul 28:03
I like it. For first like patients, I think we know we talked about the yellow flag. So if there is comorbid mood disorder, I think it's sort of a go to choice for someone who also has chronic pain. And I've I've had Yeah, I agree with Molly. Absolutely. There's, it's not something I offer broadly. But I think there's a subset of patients for whom it actually is probably more effective than most of the stuff that we offer. So it just you have to, it's like everything else is not a shotgun approach. You have to sort of be thoughtful, to whom you offer what but there are some patients I think that actually really benefit from duloxetine.

Matt 28:31
And for for the steroid injections, we we challenged all our guests about this, the fact that the trial data is just so grim. Saline works as well, in some cases or lidocaine works as well. And we just don't really know how well these things work. Or I guess we do know how know how well they work like people I know that people get them. And I know that they don't seem to work that well. But it seems like almost people are so desperate that they just want to do something. And when we went back to our placebo episode like treatments that hurt more work better, so maybe that's part of it.

Paul 29:05
100%.

Matt 29:07
But Dr. Parks did say he pretty much both with knee and hip, tries to steroid injections, especially if someone's in a lot of acute pain. And with the hip, which we'll talk about. He says he's trying to buy himself time because he says the hip technology is constantly improving. And they might get a better hip if they can wait an extra five years or something like that, then they would have so I don't know Molly, Paul Stewart, you are you all using a lot of hip injection or knee injections rather,

Paul 29:35
I don't know, I still do knee injections, but first select patients realistically, you know, if they've if they report that they've received benefit from it before then I'm I'm willing to consider it. For those patients who haven't received the injection. The understanding is that the knee injection is just a temporizing measure to get them to physical therapy. It's not something that I tell them is going to treat their Pain, it just gonna is going to help temporize it. I've actually had a lot of steroid injections myself for shoulder and knee pain, I, at least for me, anecdotally, it helps to relieve the pain for about five to 10 days for me. And that helps me to get into physical therapy and do some of the mobility exercises that I need in order to prevent the pain from getting worse. And so that's kind of the way that I talked my patients about it to some patients have longer term pain or benefit, but realistically, if they're doing the same mechanical activity that caused the pain in the first place, it's just going to come back.

Matt 30:33
Yeah. Yeah, if the joints totally gone at some point, they may just benefit from a joint replacement. But

Stuart 30:39
all right, yeah, I think that's where I'm at if they if the patient, I'm trying to actually work this the other way around. So if if treatment fails, the patient, the conservative management, the physical therapy, the medications that we have to offer, probably the next step for me would be the referral to orthopedic surgery, which realistically means they're probably getting a steroid injection before there's consideration for replacement. And I think it's sort of management them at that point for but it's not something I offer, especially out the gate, right?

Matt 31:02
We talked about the hyaluronic acid, you know, hyaluronic acid agents and Dr. Dr. Parks really didn't didn't love those. And he said that he often will not recommend them. If a patient asks it's it's like a third or fourth line for him. But usually those patients are moving towards joint joint replacement surgery.

Molly, you want to tell us about our next one. Actually, Stuart you want to transition us to our next?

Stuart 33:35
That's right. And because Dr. Ted Parks and because Dr. Ted Parkes is truly too hip to be square a reference Paul, he might get actually. Next up we have Episode Number 149 or as I like to remember it Hip hip. Hooray.

Molly 34:08
will be significantly shorter than our need gave, since luckily they have is pretty straightforward for most conditions. So our next patient is Pele. He's a 60 year old man who has three months of hip pain. So Dr. Burks had a really nice sort of bucket analogy for us again, so really just three steps, three buckets and helped us put it in a very easy framework. So step one, if the patient has groin pain, you want to check for a limited range of motion of the hip. So like kind of the windshield wiper test, if they do have pain and limited range of motion that's consistent with hip osteoarthritis. And he would treat that pretty similarly to knee Okay, like we just went over. Step two would be if the patient has lateral hip pain, and you palpate over the greater toe canter and it's more tender than the other side. You can diagnose them with greater choke and hurt pain syndrome. And step three, you want to rule out back pain. Though that would be pain that's more in the buttock or more posterior. So on exam, Pele has limited internal rotation and pain with the windshield wiper tests, we diagnose him with oae talk about options like physical therapy for stretching and strengthening and pain relief medications. And if he fails, conservative treatments, patients do very well with hip replacements.

Matt 35:20
Can I make a couple comments about just the exam things first, I like how Dr. Parks and this I think this pretty much applies to all the MSK, he said he likes to do, he always the examines both sides, just to kind of compare because some of the maneuvers can be a little bit uncomfortable. So you want to make sure that it's more uncomfortable on the affected side. And with this windshield wiper test, that's one where they just are sitting on the table with their legs dangling, and you just kind of grab hold of their ankle and move side to side. And he said, you're basically like wringing the hip joint capsule, like a rag. And if that's like filled with fluid and inflamed, it's going to hurt the person. And part of the way that he thinks the stretching works is just kind of improving their their mobility in that joint capsule. So I thought that was all kind of very useful stuff that he had to say on this, which was, and you can use that when you're talking to patients about it as well. All right, Molly. So after my wild tangent there, where are we going next with the hip.

Molly 36:20
So Dr. Park has talked us through thinking about x rays for the hip. And it's really not required to get x rays to diagnose osteoarthritis, but it can be helpful just to give us a little bit more information and sometimes to rule out sort of unusual things like a vascular necrosis. And he recommends getting the AP pelvis which compares both hips, which I was not doing, I was getting that like hip for view by view. I will try to start ordering the hip baby pelvis. And I thought it tied back really nicely. What do you reference Dr. Yogi's as 2006 BMJ study earlier, where she talks about the osteoarthritis findings between different people on X ray is really not reliable. So

different people process pain differently or experience pain differently. And if you compare two hip x rays from two different people, one could look terrible on the patient may have no pain, and one could look perfect, and the patient does have quite a bit of pain. And so I think getting the AP pelvis is really helpful because you can compare both sides. And her study showed that within a single person arthritis findings at one joint as compared to the contralateral side are highly correlated with pain. So it can sort of give us that control like Matt was talking about for the physical exam.

Matt 37:38
Yeah, one of the great things about the AP film when he was talking about he said, I get the AV film, and then I just show the patient and I'm just like, this is the hip, you know, this, see this hip, it has this nice Crescent of black space there. That's healthy cartilage. This one is missing it. That's why you're painting this hip. And he mentioned, we I already alluded to the hip surgery a little bit, but he mentioned that the hip surgery has great outcomes. And it's it's a good surgery for if someone over 60 has worn out hip, that's a good candidate for surgery. Under 50 years old, he said that that hips not going to last their lifetime, the technology is just not there yet. And that person is going to need another surgery and they they really try not to put a hip in to somebody under 50 years old. So that he goes into a lot of detail about the the surgical management if people want to go back and listen to that episode. It was it was pretty interesting. Paul Stewart anything else with the hip?

Paul 38:37
I just wanted to say that it drives me a little bonkers that every single patient comes into the office and says they have hip pain and 99% of them

Matt 38:49
have buttock have bursitis Yeah,

Paul 38:51
buttock or bursitis. Yeah, it's like it hurts on the outside of my head. That's not your hip.

Matt 38:58
Well, they're not any greater trochanter pain syndrome.

Paul 39:02
What a dream. Yeah,

but but everyone thinks their head

Unknown Speaker 39:04
is

Molly 39:06
a little anything else with my head? I'm like, No, what's your back? Yeah,

Matt 39:10
no, they just don't want their chief complaint to say I have a pain in my butt. Right? That's what they don't want to say. So it's a whole different differential.

Alright, Stuart, any fancy transitions for us?

Paul 39:21
Yeah. So if you'd like to know more about how Dr. Ted Parkes approaches joint pain, check out practical office orthopedics. It's presently available on Amazon. So last up to round out our joints. Let us help a tick. Let us help pick up your shoulders

with episode we have elbow what after after shoulder right.

Matt 39:43
Oh, yeah, shoulders now what we just did hip so we're on shoulder, right? Yeah, I've

Paul 39:48
got shoulder Yeah. All right. You guys are okay brewing

Matt 39:53
started again. Take it from practical

Paul 39:58
if you'd like to know more about how Dr. Ted parks approach is joint pain. Check out practical office orthopedics on Amazon and last up to round out our joints. Let us help take a weight off your shoulders with Episode Number 124 affectionately titled.

Matt 40:14
Well, you're gonna get a bonus one because we are going to do elbow as well. But let's do shoulder first, Molly. All right.

Molly 40:20
All right, so we got Danny, she's a 50 year old woman with type two diabetes who's presenting with six months of shoulder pain, it's acutely worse than the past week after overdoing it with some weight lifting at the gym. And so Dr. Center talked us through sort of thinking about breaking down shoulder pain in terms of the patient's age and comorbidities. And so she highlights that a younger person under 40 is most likely to have tendinitis. Whereas a middle aged person is more likely to have rotator cuff disease or frozen shoulder. And frozen shoulder is especially common in diabetics and women. And then patients over 50 years old atraumatic tears are quite common, especially in those with a remote history of shoulder dislocation. And people in their 80s and 90s are most likely to have glenohumeral. arthritis.

Matt 41:04

I wanted to just point out a couple other historical clues that I really thought was great. So she said, if somebody has pain reaching overhead, that's that's like your pretty standard for shoulder pain, it hurts when you reach over your head. But if it's actually relieved by reaching overhead, or if they put their hand on top of their head, and it's relieved, then that suggests it's more of a cervical issue. Because as I was saying to her on the episode, that's something that I've struggled with, like is a cervical or is this coming from the shoulder. So as the patient, if it gets better reaching overhead, it could be coming from their neck. And then the other one she asked about is nocturnal pain. And it's not because that really helps her with the differential, it just helps her know how well the patient is doing. Because a lot of the times, if someone's really sharp suffering with anything going on with their shoulder, they have trouble sleeping. And she's more likely to get that person and injection quickly, and be more aggressive about treatment, trying to get their pain under control, because of that reason. So those are just two other pearls that I thought were really helpful. Molly, what about the buckets with shoulder pain? or How did she break this down? Because there's so many diagnoses, but she did make it a lot easier for us. Yeah, she

Molly 42:13
has a very easy branch point. And so she focuses on the passive range of motion. And so if someone has a limited passive range of motion versus normal, that puts you in two different buckets. So to go back to our case, we find out that Danny has a limited passive range of motion on abduction and external rotation. And so that kind of puts us in the adhesive capsulitis versus glenohumeral arthritis bucket, the patients with a limited range of motion. And in those patients and X ray can be helpful to evaluate, is there signs of osteoarthritis? If the X ray looks pretty normal that would be most consistent with adhesive? capsulitis?

Matt 42:50
Yeah, in the passive range of motion test that she said, She's like, if I was seeing, like 100 shoulders in a day, you know, which test would I do? She said she would have do the one where they just do external rotation where they have kind of had their elbows hugged in against their, their side with their, their elbows bent at 90 degrees, and you just rotate their their arm, you externally rotate their arm. And if they have limited range of motion there, that that kind of brings you into this bucket here. But this is a I mean, oh a and I had the misperception that people would have an abnormal X ray with frozen shoulder and she said it should be pretty normal with frozen shoulder, which is something that I just did not know. Do you want to talk about the natural history of that, Molly? Yeah, frozen shoulder as well.

Molly 43:35
Yeah, the good news is that it gets better on its own. And our treatments really are mostly aimed at pain relief. They don't impact the natural course of the illness. The bad news is that it can take up to a year or two before it really resolves. So classically, the patient will have about six to nine months of pain, and then about six to nine months of painless stiffness. And then about six to nine months of improvement back to full normal baseline. And Dr. Center gave us this pearl that it's very unlikely that adhesive capsulitis will occur again in the same joint, but they may develop it in the other shoulder.

Matt 44:11
Yeah, I think that was her morbid joke to patients. She's like, Well, the good news is it probably won't happen on the same side again. Which would not be that reassuring if you're in the middle of like an 18 month sentence. Right there. But yeah, so pain greater than stiffness early, then stiffness greater than pain, and then and then it's the thawing phase where it slowly goes back to normal. Alright, so if they're X ray, so they have apt to abnormal passive range of motion, then and an abnormal X ray, it's probably osteoarthritis. But if they have abnormal passive range of motion, and normal X ray, we think about frozen shoulder, especially if they've diabetes, or they're an older woman. And what about our patient here?

Molly 44:54
Yeah, and just one other comment on the frozen shoulder. I think it's pretty interesting that we really don't know what causes that are What even it is, which I'm always amazed in this day and age, but there are still medical conditions that we have names for. And we can describe, but we actually pathophysiological, we don't understand them at all, which makes sense that we don't really have a treatment that works. Yeah, so the other kind of branch point or bucket is that the passive range of motion is normal. And then you're dealing more with rotator cuff disease. And your main goal is to make sure that the patient doesn't have a full thickness rotator cuff tear, which would cause weakness. So if we re examined Danny, and this time, she actually has full range of motion, then we're putting her in this other bucket of rotator cuff pathology, and we want to check for weakness. There are certain things I think,

Matt 45:42
Yeah, I was gonna say that the the case that she Dr. Center said, sometimes it's not quite as easy to figure out if their range of motion is limited because of pain, or because of actual issues with range of motion. Paul, have you ever seen this happen? Like where you're just not sure in it, they something changes

Paul 46:00
all the time. Yeah, I think even with adhesive capsulitis much in the case that we're explaining here, where someone's just very limited by pain, and they're even fighting your passive range of motion, because it just hurts them to have the arm higher. And it's not that it's even the range of motion, it's just you're causing that much discomfort. So I think just by a lot of the time, the exam, you're just kinda limited by the patient's pain. And for me, at least, I have a hard time differentiating between pain and weakness and a range of motion issues, because they're all kind of impact each other.

Matt 46:25
So what she said is that if you give somebody a steroid injection and bring them back in a couple weeks, and now suddenly they have normal range of motion, then you realize this wasn't frozen shoulder because it wouldn't get better that quickly. So that means you're probably dealing with something like the rotator cuff rotator cuff pathology. And those, these are the other

buckets. How did how do you break this down? Molly, based on our conversation with Dr. Center? Yeah, so

Molly 46:51
if if I don't find any weakness on exam, and they have normal range of motion, then it's consistent with impingement or partial tear of rotator cuff or tendinitis. But I think for our practices can be pretty interchangeable, although possibly there is some mechanical difference. We were kind of talking about this in pre recording, and Paul was still on the fence about it if there was a difference, or

Paul 47:18
Oh, I'm sure there's a difference. I just don't think I understand what it is. I think that's probably the bigger issue or if it matters, right, yeah,

Matt 47:24
yeah. Yeah, I mean, her point was, I like the way she mentioned, it was like, your job in primary care if you're, if you're dealing with this bucket of rotator cuff is to seek and destroy full thickness tears. And we talked about the internal and external rotation lag tests, which are the ones that were from the the JAMA rational exam series. Yeah. Which they're very easy to do. So I highly recommend people try those. We have video showing you how to do these, or you can look them up, but they are, you know, really, you should do those tests on all your patients with rotator cuff pathology, to see if there's weakness. If there's not weakness, then those patients they're probably going to be fine. with physical therapy, you can try topical oral and Said's. These patient, most of these patients are going to get better without anything. But if it's a full thickness tear, then you want to, you want to repair it as soon as possible because it gets harder and harder to repair. The older the tear gets and the ligament starts to retract back away from where the tendon starts to retract back away from where it's supposed to be. It makes it a harder surgery. Anything else about the shoulder that you wanted to point out, Molly?

Molly 48:35
Now I think those buckets make it pretty easy and really end up helping us differentiate most of what will come into the office.

Matt 48:44
Yeah, so what was Danny's case just since we we gave a little more play to this case than the others as sir so

Molly 48:50
on exam, she had weakness on the dose test and on the internal rotation lag test and so we promptly diagnosed her with a full thickness tear and referred her to orthopedic surgery.

Stuart 49:03
Okay. Anything else guys?

Matt 49:06
Stuart, we're ready for a transition. Okay,

Paul 49:10
so not to be outdone by the shoulder. We have yet another joint elbowing its way in with episode number 240. elbow pain, straighten it out with Dr. Ted marks.

Molly 49:23
All right are fine. Okay, here is Sue. She's a 42 year old librarian who's complaining of elbow pain. On exam she has tenderness over her lateral epicon dial and reproduce lateral elbow pain on resisted wrist dorsiflexion with her elbows extended. So we diagnosed her with lateral epicondylitis

Matt 49:40
So Paul, I was I was bragging and pre recording that since the elbow pain episode. This is something that I had almost no differential before I was just like, get an X ray. Maybe there's a fracture, which didn't even make sense like sure traumatic elbow pain,

Paul 49:53
probably musculoskeletal. Yeah, yeah.

Matt 49:55
I mean, Dr. Parks, he makes everything so simple. And then and then he does is a really great job of explaining it. But he basically said, there's like three things we talked about, which was olecranon, bursitis, the epicondylitis, either medial lateral, and then this Radiohead fracture. And if the person didn't have like a fall on an outstretched arm, then you're probably not going to be that worried about a Radiohead fracture. So it's probably either going to be epicondylitis, or electron on bursitis, one of which you can diagnose like from the door. So I was I was bragging and pre recording that now when someone has elbow pain, I like kick the door open to the exam room, I'm like, let me see that thing. And I look at their elbow. And if there's no swollen electron on Bursa, then like, it's better the electron is better be epicondylitis. Right? I have no idea what's going on. So, Molly, how do you did this change your practice? And like, which examine Hoover are you doing for the epicondylitis? And tell us how you talk to patients about that?

Molly 50:56
Yeah, it definitely changed my practice in that before the recording, I felt like I didn't know how to treat it. And after the recording, I felt better that no one knows how to treat it. So I feel much better counseling patients that have similar to the adhesive capsulitis. None of our treatments really affect the long term recovery. And this will get better just on its own. And the treatments are really focused on pain relief. And so if a patient wants something for pain relief, it's very reasonable to try the all the things that we do for osteoarthritis, like topicals and Said's physical therapy. There's also for this one, specifically, some things like bracing, but none of these are going to affect the long term outcome.

Matt 51:36
What about you, Paul had any any change the way you think about this one?

Paul 51:39
Why I think like you, he just really simplified the exam, because otherwise my differential is both nothing and everything. And it was one of those things where like, now that I had three main diagnoses to parse through, it made it much easier. As Molly mentioned, you mentioned bracing actually one of the things that blew my mind, not that it's all that helpful. But he talked about how counterforce bracing works for epicondylitis, and how it actually works like a guitar kebo to prevent transmission of sounds, or vibrations, up to the affected area, which just because mechanistically, they were made a lot of sense to me is one of those things that just you did for the illusion of motion. But I actually have a reason for how it might actually work I thought was really cool. Yeah,

Matt 52:13
and the way that the way that he recommended diagnosing this, other than they just have pain on the medial or lateral epicon dial is they they hold their arms out, kind of like Frankenstein in full extension, and you press down either you either press their hand into extension, or you press from the top of their hand and press their hand down into their wrist down into flexion. So basically, you either flex or extend the wrist against resistance with their with their elbow straight. And if it the pain should map tested on both sides, but the pain should map to the affected location. And then the treatment is basically just stretching, basically trying anything you can ice heat, topical and says just don't really injections. He said, be real careful with those. But in general, ice heat stretching, and this should get better on its own.

Pascal 53:06
How's yours coming? After it? Yeah, Stuart,

Matt 53:09
I believe

Paul 53:12
I was checking it see if it still hurts. No, I think we're good.

Matt 53:16
Okay, students been cured. I think that means the show is probably probably coming to an end here.

Paul 53:22
Unless you know, you have Yeah, I just I wanted to touch on and I want you to correct me also, if I'm mistaken. But I think the other physical examination point that I thought was really neat was differentiating bursitis from a septic joint. He said, that's the console, he often gets, which I and the way you sort of can quickly differentiated I guess this is not 100% sensor specific, but actually, the septic joint is going to be extraordinarily inflamed and painful. And so it's not going

to be so the way that you would actually elicit pain with that is actually by testing pronation supination near the patient's arm either side and have them pronate and supinate. And if that causes pain, it's almost certainly not a upper site is that is more likely to be a septic joint. That's sort of one of the Quicken differentiating examination University did, which I also thought was a really neat point, too.

Matt 54:03
Yeah, absolutely. Thank you. I think that's very important. And it's like, it's it's such a quick exam like the knee, like the hip, he really didn't give us much. So for knee for knee, he gives you a 32nd exam, you can watch the video on that for hip, it's like the windshield wiper test. And and when you press on their toe canter, and then for the elbow, you just resist, resist a wrist extension wrist flexion and, and then do the supination pronation. That's it. So it's very quick. boils it down for us. All right. Any anything else before we let the audience go Molly, take home points. Will you lead very nicely into that that

Molly 54:45
common things are common and the top few diagnoses if you're confident about them and comfortable with them, and if you sort of have a differential and that's kind of a bucket in your head for each joint. It's pretty easy to take care of most musculoskeletal complaints in Primary Care. But I think also really important to have a follow up plan. So this covers like 80 90% of what we're going to see for common complaints, but there are those patients that fall through the cracks. And if someone's not responding in the way that we would expect with conservative treatments, it's always appropriate to have them referred on to a specialist and get further evaluation.

Matt 55:19
Oh, the outro...