# Upper Limb Soft Tissue Conditions



## Shoulder

### Rotator Cuff Tears/Tendinopathy

*Anat:* supraspinatus, subscapularis, infraspinatus, teres minor
*Path:* Chronic impingement between acromion & coracoacromial lig ± superimposed acute injury. Tears also in acute shoulder dislocation.
*Features:* Recent fall/heavy lifting. Pain & loss of strength on flexion, abduction & external rotation. Positive drop test (passive abduct to 180°, ask pat to adduct: below 90° arm may drop as rotator cuff used instead of deltoid). Painful arc 70-120°.
*Inv:* USS inv of choice. MRI an alternative. Xray may show calcification in tendons & rule out #.
*Mx:* Rest, NSAID, physio. Sx if severe rupture.

### Subacromial Bursitis

*Anat:* Cushions coracoacromial lig from supraspinatus.
*Assocs:* Repetitive throwing, lifting, spupraspinatus tendinitis, RA, gout.
*Features:* Tender over greater tuberosity of humerus, painful abduction arc 70-120°.
*Inv:* USS may show bursa fluid or tendon/bursa impingement on acromion.
*Mx:* Rest, sling only for few days, NSAID, physio. Steroid/LA if persistent.

### Biceps tendon rupture

- Long head running in sub acromial bursa on sudden elbow flexion.
- Conservative Mx unless at insertion.

## Elbow

### Olecranon Bursitis

May be septic or non-infective mostly from acute trauma or chronic leaning on elbow.
*Features:* Focal swelling over posterior tip of the elbow ± pain, redness, warmth (more common with infection). May have signs of local minor trauma. ROM usually normal. Pain on movement → ?septic arthritis or #. Systemic signs in advanced infection. Examine other jts for gout or RA.
*Investigations:* Bursa aspiration (use Z approach to ↓risk of fistula) for WCC, micro, crystals, Gram stain & culture. ±Bloods: WCC, urate, RF, ESR/CRP. Xray if sig.trauma/painful movement.
*Management:* RICE, Physio, ABx if septic bursitis (IV/PO **flucloxacillin**) otherwise NSAID or steroid injection, compression bandage. Occ excision of bursa.

### Epicondylitis (Tendonitis)

*Tennis Elbow:* Lateral epicondylitis where ext. carpi radialis brevis inserts. Worse on resisted wrist extension, passive wrist flexion, and gripping/twisting. (Probably degenerative not inflam.)
*Golfer's Elbow:* CFO (medial) epicondylitis of CFO. Worse on resisted wrist flexion.
*Inv:* USS
*Mx:* Acutely RICE, counterforce brace (discontinue if ulnar n. symptoms) ± wrist splint. Can try 0.5ml 1% lignocaine+20mg methylprednisolone, but no difference to NSAID or placebo at 1y. Surgery may be used in severe persistent cases.