Misdiagnosis of Shoulder Pain

Primary Author: Gretchen Wienecke MD
OU Health Science Center

Co-Authors: Alexander Bautista, MD; Badie Mansour, MD; James Sweet, MD; Nathan Overbey, MD; Ryan Vincent, MD;

Misdiagnosis of Shoulder Pain

Introduction

Myofascial Pain Syndrome (MPS) is a common but often overlooked cause of acute and chronic pain. The hallmark of MPS is an active trigger point (ATP). ATPs can cause not only pain, but other symptoms as well, including numbness and paresthesias. MPS is often triggered by coexisting pain syndromes such as degenerative spine and joint disease, and can easily be missed while concentrating on the more obvious diagnosis.

Case Report

A 45-year-old female with chronic left shoulder pain status post four prior shoulder surgeries presented to the pain medicine clinic with complaints of a “new” left shoulder pain which she described as a constant sharp stabbing pain near the upper scapula, with radiation to the anterior chest wall. She reported the pain felt “like a knife that is going through from front to back” with associated intermittent numbness and paresthesias in the left upper extremity following no dermatomal distribution. This new pain began approximately two weeks prior to presentation with no initiating incident and was severe enough to bring her to tears at times. Her current medications including diclofenac, amitriptyline, hydrocodone, and fentanyl patch provided no relief. The patient had undergone physical therapy in the past for her chronic shoulder pain, but none since this acute injury. She underwent intra-articular shoulder injection as well as oral steroids with her orthopedic surgeon, which were unfortunately of no benefit.

On physical exam, her upper extremity neurologic exam was unremarkable. Range of motion in the left shoulder was relatively well preserved. She was tender to palpation around her acromioclavicular joint, which was not new for her. An active trigger point was found in the upper medial scapular border. This was injected with 3 cc of normal saline using a 25G 1.5” needle, with greater than 90% resolution of her symptoms immediately after injection. Upon follow-up three months after injection, the patient reported 100% resolution of her pain, numbness, and paresthesias. She was most recently seen eight months post injection without recrudescence of those symptoms.

Discussion

MPS has been called the “great mimicker” as it can often present as a variety of other syndromes ranging from bursitis, appendicitis, angina, and radiculopathy to intrinsic joint pain, as
well as many others. In our case there was a natural bias to assume the patient’s shoulder pain was a result of her multiple previous surgeries with MRI documented rotator cuff and arthritic issues. On presentation to our clinic, however, she had already failed oral and intra-articular steroids. She was also quite clear in her history that this was a “new” pain, different from her typical chronic shoulder pain. With her additional symptoms of upper extremity numbness and paresthesias, cervical radiculopathy was considered. However, her neurologic exam was unremarkable and ATP was found on exam. The diagnosis of MPS was confirmed with immediate resolution of her symptoms after trigger point injection.

References
