



Body System: Musculoskeletal		
Session Topic: Upper Extremity Musculoskeletal Exam Techniques		
Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. <u>Please describe your interest and plan for teaching a PBL on your proposal form.</u>
Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
<ul style="list-style-type: none"> Inadequacies in musculoskeletal education have previously been documented among medical students, residents, and attending physicians in a number of specialties. Physicians often have knowledge gaps with regard to appropriate application of Ottawa rules; proper examination skills; understanding which diagnostic imaging tests to order, and when to order them; establishing a standardized process for coordinating referrals; being aware of new, more effective tests; and improving surveillance of pathological findings. 	<ol style="list-style-type: none"> Distinguish musculoskeletal conditions that result from overuse/repetitive motion injuries in the upper extremities, with particular attention to those that occur in pediatric patients. Assess an injured patient's range of motion, stability, bone alignment, soft tissue swelling, palpable warmth or mass(es), pain or tenderness and crepitation in the upper extremities. Apply appropriate treatment strategies for patients with musculoskeletal injuries of the upper extremities that include pain management, application of the RICE strategy, casting, splinting, joint injection/ aspiration, dislocation reduction and/or emergency stabilization. Identify red flags from the physical examination of upper extremity injuries that warrant referral to a sub-specialist (e.g. surgery, physical therapy) or for diagnostic imaging. 	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.
ACGME Core Competencies Addressed (select all that apply)		
X	Medical Knowledge	Patient Care



Interpersonal and Communication Skills	Practice-Based Learning and Improvement
Professionalism	Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
 - Visit <http://www.aafp.org/journals> for additional resources
 - Visit <http://familydoctor.org> for patient education and resources
- Provide recommendations for utilizing evidence-based guidelines to determine the need for radiography of patients presenting with acute sprain in an upper extremity.
- Provide strategies for distinguishing musculoskeletal conditions that result from overuse/repetitive motion injuries to upper extremities, with particular attention to those that occur in pediatric patients.
- Provide recommendations for assessing a patient presenting with an upper extremity injury for range of motion, stability, bone alignment, soft tissue swelling, palpable warmth or mass (es), pain or tenderness and crepitation.
- Provide recommendations for prescribing rotator cuff strengthening exercises for 3-6 months for subacromial shoulder pain
- Provide evidence-based recommendations regarding the use of steroid injections for lateral epicondylitis
- Provide evidence-based recommendations for using steroid injections as a first line treatment and often cure DeQuervain’s tenosynovitis.
- Provide strategies and resources for developing collaborative care plans for patients with sprains, strains or dislocations of an upper extremity, emphasizing current evidence-based recommendations for pharmacologic and non-pharmacologic therapy.
- Provide recommendations regarding guidelines for Medicare reimbursement.
- Provide recommendations to maximize office efficiency and guideline adherence to the diagnosis and management of musculoskeletal injuries.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.

Needs Assessment



Most musculoskeletal injuries occur in the home, as a result of an accident or during a sports activity; however, the latter is a significant source of hospitalizations, rehabilitation and lost productivity. Additionally, sprains, strains and dislocations together account for nearly 50% of all musculoskeletal-related injuries, incurring significant economic costs due to ambulatory visits and hospitalizations. Sprains and strains accounted for nearly 18.4 million musculoskeletal injury treatment episodes in 2006-2007 (the last year for which such estimates were available); most commonly among patients aged 18-44. Dislocations occur most frequently in the 45-64 year age range, and although they're less common, they are more likely to be treated in physician offices.¹

Consider the following statistics from the CDC:

- The 2009 *Health of the U.S.* publication reported that arthritis and other musculoskeletal conditions were the leading causes of activity limitation among working-age adults 18–64 years of age in 2006–2007.²
- The 2009 *National Health Interview Survey* reported 5.9 million injuries occurred playing sports (3.8 million, or 26%, among men and 1.7 million, or 12%, among women – particularly teenagers).³
- The most recent *National Ambulatory Medical Care Survey* reported that family physicians provide patient education on “injury prevention” in over 4.4 million office visits.⁴

Family physicians must be prepared to evaluate a variety of musculoskeletal injuries, including sprains, cartilage and ligament tears, fractures and other traumas. However, family physician residents are frequently inadequately trained to manage musculoskeletal injuries effectively. Over 25% of office visits to U.S. & Canadian physicians are for musculoskeletal pain, and 77% of these musculoskeletal visits are to primary care providers (Caudill, Pain, 2005 & Power, J Rheumatol, 2006)^{5,6}. However, only 8% of primary care resources and 2% of medical school curricula are dedicated to meeting these musculoskeletal needs. Additionally, most referrals to orthopedic and sports medicine clinics are for common musculoskeletal conditions that could easily be managed by family physicians.^{7,8}

When patients present with acute or chronic musculoskeletal injuries, family physicians can employ a number of examination techniques to assess such factors as range of motion, stability, bone alignment and soft tissue swelling or masses. Although the type of exam depends on the injury and area affected, some of the typical clinical indications in upper and lower extremities include: joint effusion, locking, popping or cracking; pain or stiffness upon movement; crepitation; localized tenderness; and a palpable enlarged mass and/or warmth.^{9,10} The increasing burden of musculoskeletal diseases indicates a need for enhanced training in a number of areas for family physicians, such as proficiency in casting, splinting and joint injections, in order to help patients regain functioning for “everyday activities” or returning to vigorous physical activity.

Additionally, when patients present with acute or chronic musculoskeletal injuries, family physicians can employ a number of examination techniques to assess such factors as range of motion, stability, bone alignment and soft tissue swelling or masses. In the event that injured bones or soft tissue require immobilization to reduce pain, swelling and/or muscle spasms, casting or splinting is often the most appropriate form of treatment.^{11,12} In some cases, patients



may benefit from wrapping and taping as a form of stabilization or a prophylactic mechanism for injury prevention.¹³ However, a physician should first thoroughly assess the injured area – including skin, bony structures and neurovascular status – as well as the stage and severity of the injury, potential for instability and functionality, and risk of complications. These steps should be followed to diagnose the injury before determining which mechanism is more suitable, as each has its own advantages and disadvantages.^{11,13}

The AAFP Recommended Curriculum Guidelines for Family Medicine Residents indicates that family medicine residents should possess the following competencies related to musculoskeletal and sports medicine:¹⁴

- Perform an appropriate musculoskeletal history and physical examination, and formulate an appropriate diagnosis and recommend treatment, including requisite subspecialty referrals (Patient Care, Medical Knowledge, Systems-Based Practice)

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have statistically significant and meaningful gaps in the medical skill necessary to employ efficacious musculoskeletal exam techniques, including the appropriate use of diagnostic imaging.¹⁵ More specifically, CME outcomes data from 2012-2016 AAFP FMX (formerly Assembly): *Musculoskeletal Exam Technique* sessions suggest that physicians have knowledge and practice gaps with regard to appropriate application of Ottawa rules; proper examination skills; understanding which diagnostic imaging tests to order, and when to order them; when to order physical therapy; efficacious use of injections, especially for treatment of deQuervains; establishing a standardized process for coordinating referrals; being aware of new, more effective tests; and improving surveillance of pathological findings.¹⁶⁻¹⁹ A review of the literature indicates that inadequacies in musculoskeletal education have previously been documented among medical students, residents, and attending physicians in a number of specialties.²⁰⁻²⁴

As many family physicians are encouraged to serve as a sports medicine physician in their community (and some may choose to be a team physician), they must be prepared to evaluate acute injuries, including sprains, cartilage and ligament tears, fractures and other traumas.^{25,26} When patients present with acute or chronic musculoskeletal injuries, family physicians can employ a number of examination techniques to assess such factors as range of motion, stability, bone alignment and soft tissue swelling or masses. Although the type of exam depends on the injury and area affected, some of the typical clinical indications in upper and lower extremities include: acute inflammation (indicating tendonitis/bursitis); joint effusion, locking, popping or cracking; pain or stiffness upon movement; crepitation; localized tenderness; and a palpable enlarged mass and/or warmth.^{9,10,27}

In its recommended residency curriculum guidelines, the American Academy of Family Physicians advises that family physicians have the skills and competence to prepare them for treatment and management of patients who require casting or splinting, joint injections or aspirations, dislocation reduction and emergency recognition and stabilization.¹⁴ However, family physicians should also be aware of the differences in treating injuries in pediatric and adult patients. As part of a musculoskeletal exam, family physicians should be prepared to stabilize and mitigate a patient's pain in the event of a traumatic injury and offer appropriate



treatment recommendations, such as NSAIDs, pain medication, the “RICE” (rest, ice, compression, elevation) strategy, and new examination techniques.²⁸ Nonsteroidal anti-inflammatory drugs (NSAIDs) can effectively treat painful conditions, but have been associated with adverse cardiovascular, gastrointestinal, and renal effects; however, topical formulations may provide adequate local pain relief without reaching systemic concentrations high enough to cause adverse events.²⁹ They should also recognize when imaging studies are needed or referral to a sub-specialist is required, in which case they should still coordinate patient care to ensure compliance with treatment and any follow-up protocols.

The increasing burden of musculoskeletal diseases indicates a need for enhanced training in a number of areas for family physicians, such as proficiency in casting, splinting and joint injections, in order to help patients regain functioning for “everyday activities” or returning to vigorous physical activity. Although some patients may require referral to sub-specialists for enhanced treatment, having the family physician coordinate care for the patient is the optimal approach to ensure compliance with treatment, oversee medications, help patients and their families cope with a given condition and offer ongoing exams to ensure healthy behavior.

Physicians may improve their ability to apply appropriate musculoskeletal exam techniques by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:^{13,30-38}

- Wrist
 - Anatomic snuffbox swelling, scaphoid tubercle tenderness and pain with axial pressure on the first metacarpal bone are sensitive but not specific tests for diagnosing scaphoid fractures.
 - If plain radiography results are negative in a suspected scaphoid fracture, then the wrist should be protected in a thumb spica cast with repeat plain radiography in 10 to 14 days or a bone scan one to two days after injury.
 - The Finkelstein test has good sensitivity and specificity for diagnosing de Quervain tenosynovitis.
- Finger
 - Finger fractures involving greater than 30 percent of the intra-articular surface should be referred to an orthopedic or hand surgeon.
 - Displaced, oblique, or spiral finger fractures should be referred to a hand surgeon.
 - Assessment of stability is necessary for appropriate management of dislocated joints.
 - Radiographic evaluation with a minimum of three views (commonly anteroposterior, true lateral, and oblique) is required if any fracture or dislocation is suspected
- Elbow
 - If an ulnar collateral ligament injury is suspected, the medial joint space of the symptomatic elbow should be compared with the asymptomatic side for the amount of opening, the subjective quality of the end point while a valgus force is applied across the joint, and pain.



- In patients with signs of compressive ulnar neuropathy at the cubital tunnel, a physical examination of the upper extremities and cervical spine is essential to rule out other compressive neuropathies.
- To avoid introducing infection, aspiration of olecranon bursitis should be performed only when the diagnosis is uncertain or to relieve symptoms in refractory cases.
- Magnetic resonance imaging is the preferred imaging modality for chronic elbow pain.
- Shoulder
 - Neurovascular and lung examinations should be performed to screen for these complications.
- Overhead Athlete
 - Scapular motion and position should be evaluated in overhead athletes with shoulder pain, and physical therapy should be initiated if dyskinesia is present.
 - Physical examination maneuvers and magnetic resonance arthrography accurately identify intra-articular shoulder injuries, but their diagnostic effectiveness is limited for partial-thickness rotator cuff tears.
 - The Jobe relocation and O'Brien tests are the most reliable for identifying labral pathology.

Physicians may improve their musculoskeletal exam techniques by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:^{13,31-33,39-41}

- American Academy of Physical Medicine and Rehabilitation
- Do not order an imaging study for back pain without performing a thorough physical examination.
- Low back pain should be classified as nonspecific low back pain, low back pain with potential radicular symptoms, or secondary low back pain associated with a specific spinal cause.
- Do not order imaging studies unless there is concern for infection, fracture, or cauda equina syndrome, or unless required before invasive interventions.
- NSAIDs, opioids, and topiramate (Topamax) are more effective than placebo in the short-term treatment of nonspecific chronic low back pain.
- Acetaminophen, antidepressants (except duloxetine [Cymbalta]), skeletal muscle relaxants, lidocaine patches, and transcutaneous electrical nerve stimulation are not more effective than placebo in the treatment of chronic low back pain.
- Epidural steroid injections are not more effective than placebo for long-term relief of chronic back pain from various causes.
- Spinal manipulation therapy results in small improvements in pain and function in chronic low back pain for up to six months.
- If reconstructive surgery is indicated, it should be performed within the five months following injury.



- Anatomic snuffbox swelling, scaphoid tubercle tenderness, and pain with axial pressure on the first metacarpal bone are sensitive but not specific tests for diagnosing scaphoid fractures.
- If plain radiography results are negative in a suspected scaphoid fracture, then the wrist should be protected in a thumb spica cast with repeat plain radiography in 10 to 14 days or a bone scan one to two days after injury.
- The Finkelstein test has good sensitivity and specificity for diagnosing de Quervain tenosynovitis.
- Corticosteroid injections in the shoulder have only short-term benefits in adhesive capsulitis and subacromial impingement syndrome.
- Corticosteroid injections for lateral and medial epicondylitis lead to short-term improvement but have a high rate of recurrence and are no better than other options in the long term.
- Corticosteroid injections can be considered for patients with carpal tunnel syndrome who wish to avoid or delay surgical treatment.
- Corticosteroid injections for de Quervain tenosynovitis and trigger finger are effective early in therapy.

Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.^{42,43}

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Common finger fractures and dislocations³⁴
- Stress fractures: diagnosis, treatment, and prevention⁴⁴
- Common forearm fractures in adults⁴⁵
- Diagnosis and management of metatarsal fractures⁴⁶
- Diagnosis and treatment of acute low back pain³⁰
- Acute lumbar disk pain: navigating evaluation and treatment choices⁴⁷
- Diagnosis and treatment of biceps tendinitis and tendinosis⁴⁸
- Evaluation and diagnosis of wrist pain: a case-based approach³²
- Acute finger injuries: part II. Fractures, dislocations, and thumb injuries⁴⁹
- Acute finger injuries: part I. Tendons and ligaments⁵⁰
- Management of head and neck injuries by the sideline physician⁵¹



- Manual medicine guidelines for musculoskeletal injuries⁵²
- AIUM practice guideline for the performance of a musculoskeletal ultrasound examination⁵³
- Exam documentation: charting within the guidelines⁵⁴
- FamilyDoctor.org. Dealing With Sports Injuries (patient education)⁵⁵

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