

**An Integrated Care Pathway
for the Management of
Hemiplegic Shoulder Pain**

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This pack contains the following documents:

	Pages
Suggested Guidelines for the management of Hemiplegic Shoulder Pain (HSP) in rehabilitation settings incorporating:	
• Guidelines for clinical management of HSP	2
• Service guidelines for the management of HSP	3
Flow chart summarising the care pathway over its designated timescale.	4
‘Handling, Support and Pain management protocol’ incorporating:	
• Protocol A for management of the hypotonic (flaccid) shoulder	5
• Protocol B for management of the hypertonic (spastic) shoulder	7
Screening and evaluation questionnaires:	
• Northwick Park Ability to Complete a Questionnaire	9
• Northwick Park Shoulder Pain Questionnaire	10

Northwick Park Hemiplegic Shoulder Pain Protocol incorporating:	
• Proforma for recording process of care	Appendix
• Preliminary assessment and management form	
• Multi-disciplinary assessment and management form	
• Summary of management form	

Guidelines for the management (prevention and treatment) of Hemiplegic Shoulder Pain (HSP) in rehabilitation settings.

These guidelines for best practice in the management of HSP are based on assimilation of the evidence available at the time of preparation and on current clinical opinion.

Guidelines for clinical management of HSP

1. Hemiplegic shoulder pain (HSP) requires co-ordinated multi-disciplinary management to minimise interference with rehabilitation and optimise outcome.
2. Prevention of HSP is as important as treatment, so all patients should be assessed as soon as possible following admission to identify the presence of HSP or the risk of developing it.
3. Education of all staff and relatives involved in handling the patient is vital to prevent damage that may prolong hospital stay and increase disability.
4. HSP broadly divides into hypotonic (flaccid) and hypertonic (spastic) presentations – each requiring different approaches to positioning, handling and support. Management should vary accordingly.
5. All patients with HSP should have a clearly documented treatment plan with dated goals.
6. The analgesic regimen should be carefully adjusted to the timing and severity of pain.
7. The analgesia and support regimens should be reviewed and documented frequently (recommended at fortnightly intervals) and adjusted to changing need.
8. Physiotherapy targeted on restoring alignment and normal tone, range and movement patterns should be provided regularly (recommended at least three times a week) by a neurologically trained physiotherapist.
9. Passive range of exercises should only be undertaken by clinicians trained to handle the shoulder. **Overhead pulleys can cause damage and should be avoided.**
10. Medical assessment and investigation should be undertaken to exclude or treat associated conditions such as:
 - a) Soft tissue inflammation and damage (e.g. capsulitis, rotator cuff tears)
 - b) Reflex Sympathetic Dystrophy
 - c) Osteopenia/occult fracture
 - d) Neurogenic pain
 - e) Depression

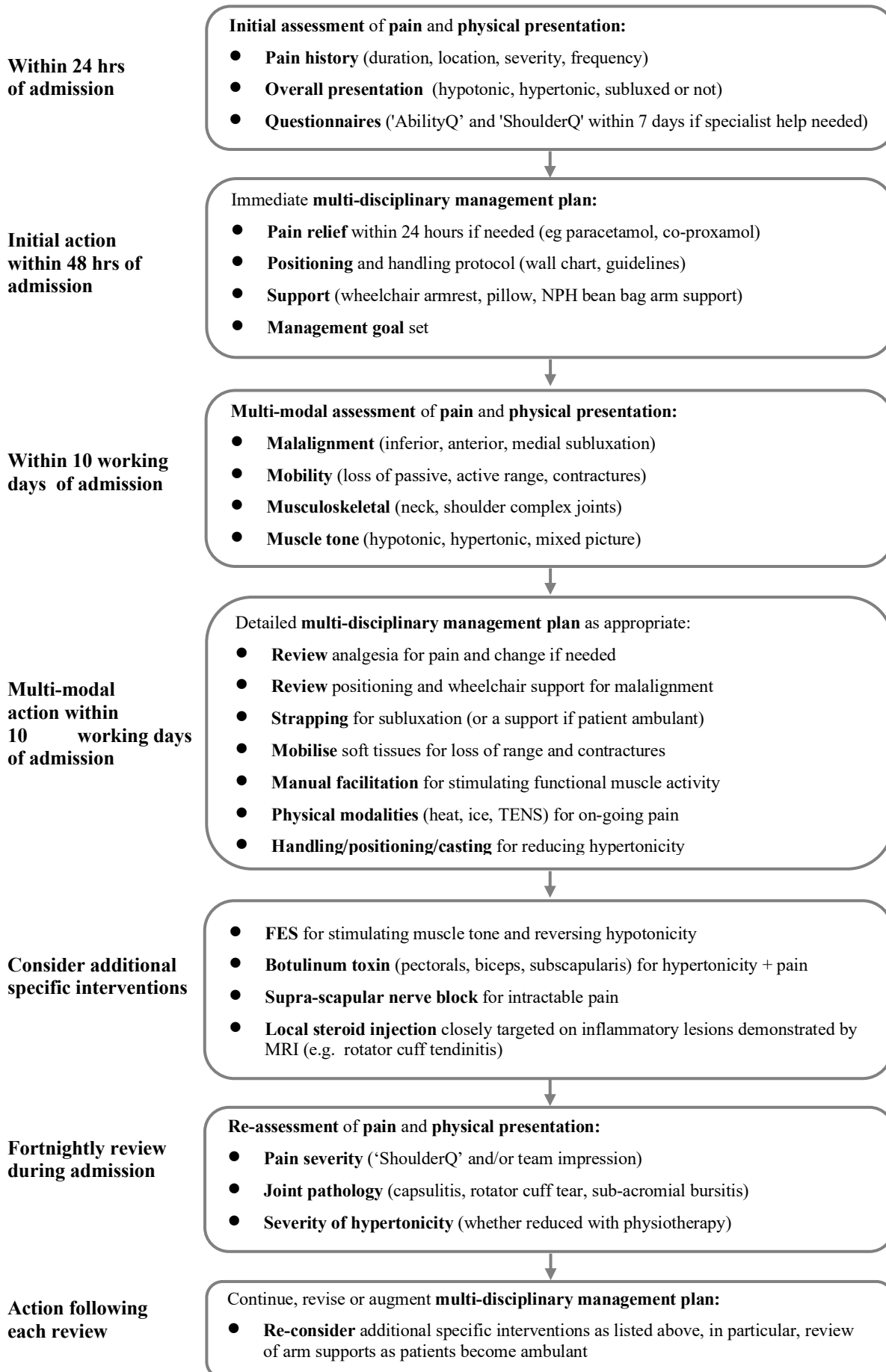
11. Local injection with corticosteroid offers little proven benefit and can produce tissue atrophy which will further weaken the rotator cuff and periarticular soft tissues in the longer term. It should only be used in the presence of active inflammation (e.g. as demonstrated on T2-weighted MRI image or ultrasound).
12. Nerve blockade (e.g. supra-scapular nerve block) is non-specific but anecdotally successful in reducing HSP. It may be tried where severe pain interferes with sleep or with the rehabilitation programme, but may need repeating at 6-12 week intervals.
13. A number of specific interventions show promise for the management of HSP. These include:
 - Functional electrical stimulation (FES) for the hypotonic (flaccid) shoulder to build up tone and muscle bulk in the supraspinatus and posterior deltoid muscles.
 - Botulinum toxin to reduce painful hypertonia (spasticity) in shoulder girdle muscles (e.g. pectorals, rhomboids, subscapularis).

Service guidelines for the management of HSP

1. All rehabilitation centres should have an agreed written protocol for the prevention and treatment of HSP. This may take the form of an integrated care pathway (ICP).
2. An educational programme should be in place to raise awareness of HSP among all staff involved in handling patients and to teach them how to avoid further damage in the hemiplegic shoulder.
3. Rehabilitation services should have a range of equipment available for supporting the hemiplegic shoulder and trained staff with the relevant experience to select the most appropriate support for the individual patient's shoulder problem.
4. All centres should have access to the appropriate medical facilities to support investigation and management of HSP in line with the recommended guidelines. These include:
 - ***Radiology services:*** X-ray, Ultrasound MRI and isotope scanning (dexa- and 3-phase bone-scans)
 - ***Pharmacy:*** Ability to prescribe the recommended agents.
 - ***Specialist services:*** For Botulinum toxin injection and FES
 - ***Surgical services:*** E.g. for soft tissue release

Timescale

Summary of Intervention



Protocols for basic management of Hemiplegic Shoulder Pain (HSP)

In the hemiplegic arm, shoulder pain may present in one of two basic patterns representing either end of a spectrum with a range of variations in between. While some of the basic principles of management are similar for hypotonic (flaccid) and hypertonic (spastic) shoulders, there are some important differences which require specific attention to detail.

Protocol A: Hypotonic (flaccid) shoulder

Floppy muscles around the shoulder girdle cause the shoulder to droop downwards on that side, and the head of the humerus literally to fall out of the shoulder socket (subluxation). Pain arises from stretching of the capsule and ligaments. The protocol focuses on supporting the arm from underneath the elbow at all times, to reverse subluxation.

Handling

Transfers and position changing

- Handle affected arm carefully
- Support upper arm and forearm when changing position
- *Never pull on the arm*, but guide from behind the shoulder.

Elevation of the arm e.g. for dressing

In the normal arm, elevation is accompanied by automatic rotation of the humerus to avoid impingement of the humeral head on the acromion and damage to the rotator cuff.

In the *hypotonic (flaccid)* shoulder, paralysis of the rotator cuff muscles prevents this rotation from occurring automatically. Unless it is provided by the person moving the arm, impingement and tearing of the rotator cuff may ensue.

- Abduction requires 45⁰ external rotation
- Forward flexion requires 30⁰ internal rotation

Subluxation must be reversed by re-location of the humeral head in the glenoid fossa prior to passive elevation of the arm.

- *Never forcibly elevate the arm* without the appropriate rotation
- *If you have not been trained to do this, do NOT attempt to elevate the arm*
- *Never use overhead pulleys* or other passive elevation devices

When dressing the upper body – always put the hemiplegic arm into garments first.

Support

The *hypotonic (flaccid)* arm should be supported in both lying and sitting to achieve the following:

- Elbow supported from beneath – to bring the shoulders level and reverse subluxation
- The upper arm should be in about 30⁰ abduction and 30⁰ forward flexion, with as near to neutral rotation as possible
- Forearm in mid-position between pronation and supination (thumb uppermost)

In lying the *hypotonic (flaccid)* arm should be supported on pillows or a bean bag.

In the wheelchair the *hypotonic (flaccid)* arm is best supported by a tray or trough arm-rest, such as the 'Otto Bock' positioned at the correct height to support the elbow from below and bring the shoulders up level. The Otto Bock armrest has two alternative hand pieces – a *paddle*, to stretch out finger flexion contractures and a *pommel* to encourage supination. If this type is used, the correct hand piece should be selected by the physiotherapist or occupational therapist

If the patient is on their feet, the *hypotonic (flaccid)* shoulder should be supported using a brace or strapping.

Pain relief (Protocol A)

Pain control is actively monitored using the Shoulder Pain Questionnaire and Pain Chart.

Principles: **Target analgesia based on timing and severity of pain:**

1. First-line management

- Paracetamol/ co-codamol prn – but this is rarely effective by itself

2. If there is evidence of inflammation:

- Use regular NSAIDs (eg Naproxen or Diclofenac Slow Release) with PPI cover if not contra-indicated
 - Contraindications: GI bleeding, renal failure anticoagulation

3. Timing of pain symptoms

- Pain at rest during the day: give long-acting analgesics in the morning
- Pain during movement only: Target analgesia on active periods (eg physiotherapy sessions, washing/ dressing)
- Pain at night: give long-acting analgesics at bedtime.
 - Consider co-codamol or stronger opioids at night
 - (Sedative effects are best avoided during the day, but can be advantageous at night)
 - Watch out for constipation on opioids

4. Further medical intervention is undertaken in collaboration with the treating physiotherapist, having ensured that the basic Handling and Support techniques are in place. Consider:

- Supra-clavicular nerve block for pain relief – if successful may need to be repeated
- TENS

5. Intra-articular steroid should only be given if there real evidence for local inflammation (as demonstrated on Ultrasound or MRI) as repeated steroid injections can weaken the rotator cuff and may it more susceptible to damage. All steroid injections should be targeted using appropriate imaging techniques (usually ultrasound)

- For tendinitis or a partial tear of the rotator cuff with secondary sub-acromial bursitis. Steroid (triamcinolone 40 mg) to the subacromial burse may be indicated

6. For subluxation

- Functional electrical stimulation (FES) to stimulate muscle tone around shoulder girdle
- Strapping of shoulder

Protocol B: Hypertonic (spastic) shoulder

Tight muscles around the shoulder girdle hunch the shoulder upwards, typically pulling the arm into adduction and internal rotation, and often with flexion at the elbow. Pain arises from hypertonicity (spasticity) and traction on the muscle/ tendon insertion sites. The protocol focuses on maintaining a degree of abduction and external rotation in order to retain muscle length and reduce deformity and pain.

Handling

Transfers and position changing

- Handle affected arm carefully
- Support upper arm and forearm when changing position
- *Never pull on the arm*, but guide from behind the shoulder.

Elevation of the arm e.g. for dressing

In the normal arm, elevation is accompanied by automatic rotation of the humerus to avoid impingement of the humeral head on the acromion and damage to the rotator cuff.

In the *hypertonic (spastic)* shoulder, tight muscles pull the arm into internal rotation and prevent the external rotation which is needed for abduction. Unless it is provided by the person moving the arm, impingement and tearing of the rotator cuff may ensue.

Special care must therefore be taken when abducting the arm

- *Never forcibly elevate the arm* without the appropriate rotation.
- *Always move the arm slowly allowing time for **hypertonic (spastic)** muscles to release their pull*
- *If you have not been trained to do this, do NOT attempt to elevate the arm*
- *Never use overhead pulleys* or other passive elevation devices.

When dressing the upper body – always put the hemiplegic arm into garments first.

Support

The *hypertonic (spastic)* arm should be supported in both lying and sitting to achieve the following:

- The upper arm should be in about 30⁰ abduction and 30⁰ forward flexion, with as near to neutral rotation as possible.
- Forearm in mid-position between pronation and supination (thumb uppermost)

In lying the *hypertonic (spastic)* arm should be supported on pillows or a bean bag.

In the wheelchair, the *hypertonic (spastic)* shoulder cannot usually be externally rotated enough to use a tray or trough arm-support. Instead, a pillow or bean-bag is placed between the arm and the torso to encourage abduction and external rotation. A Bexhill arm support may be used to help keep the pillow in place.

Pain relief (Protocol B)

Pain control is actively monitored using the Shoulder Pain Questionnaire and Pain Chart.

1. **First-line and second line management Steps 1-4** as for Protocol A
2. **Intra-articular steroid** should only be given if there real evidence for local inflammation (as demonstrated on Ultrasound or MRI) as repeated steroid injections can weaken the rotator cuff and may it more susceptible to damage. All steroid injections should be targeted using appropriate imaging techniques (usually ultrasound)
 - For adhesive capsulitis – consider intra-articular (GHJ) hydro-distension with bupivacaine and steroid (triamcinolone 40 mg)
3. **For spasticity**
 - Consider botulinum toxin to subscapularis / pectorals and other spastic shoulder girdle muscles.

AbilityQ

Name:

Date:

Please mark the "Yes" box.

Yes

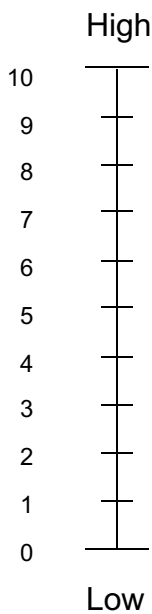
No

Please mark the "No" box.

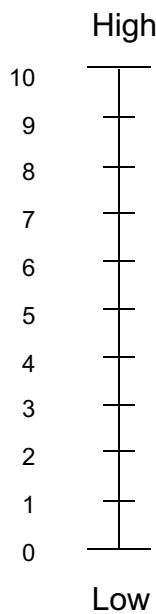
Yes

No

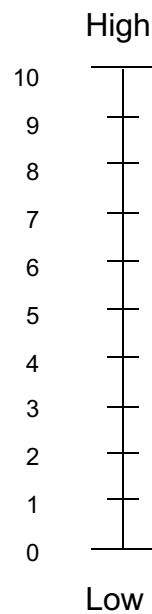
Please place a mark at the
MID POINT
Of the line below



Please place a mark at the
HIGHEST SCORE
On the line below



Please place a mark at the
LOWEST SCORE
On the line below



Please indicate "Mild" below:

- None
- Mild
- Moderate
- Severe

Please indicate "Much worse" below:

- Much worse
- A bit worse
- The same
- A bit better
- Much Better

How was the questionnaire completed?

- By the patient alone
- With help from friend /family
- With help from staff

If help was given, describe type of help:

- Just acting as scribe
- Reading questions out to them
- Presenting each question, one at a time
- Presenting questions enlarged on cards
- Bringing them back on track
- Other:

Administered by:

Print Name:

ShoulderQ

Name:

Date:

1. Do you have pain in your shoulder? Yes No

If Yes:

1a: When do you have pain?

- All of the time
- Most of the time
- Some of the time
- Only when my arm is moved

1b: How severe is your shoulder pain overall?

- Extremely severe
- Severe
- Moderate
- Mild

1c: How severe is your pain in comparison to last week?

- Much Better
- A little better
- The same
- A little worse
- Much worse

2. Does your pain wake you from sleep at night?

- Most nights
- Some nights
- Not at all

2a: If it wakes you from sleep, how many times a night?

- More than twice a night
- Once or twice a night
- Only occasionally

3. Does your pain interfere with therapy sessions?

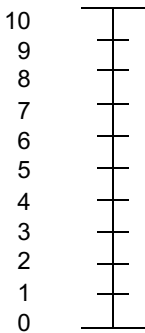
- Most sessions
- Some sessions
- Not at all

3a: If it interferes with therapy sessions, how much?

- Very much
- Quite a lot
- Only occasionally

4a: Mark on the line how severe your shoulder pain is AT REST

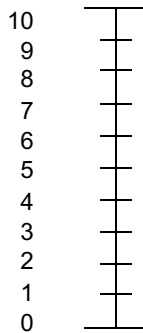
Pain as bad as it could be



No pain at all

4b: Mark on the line how severe your shoulder pain is ON MOVEMENT (eg in Physio)

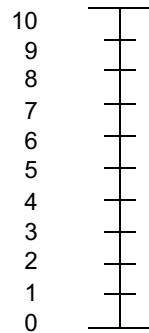
Pain as bad as it could be



No pain at all

4c: Mark on the line how severe your shoulder pain is AT NIGHT

Pain as bad as it could be



No pain at all

5. During which tasks do you have more pain

- Transfers
- Washing and dressing
- Physiotherapy sessions
- Turning in bed at night
- None of the above
- Something else: (give details)

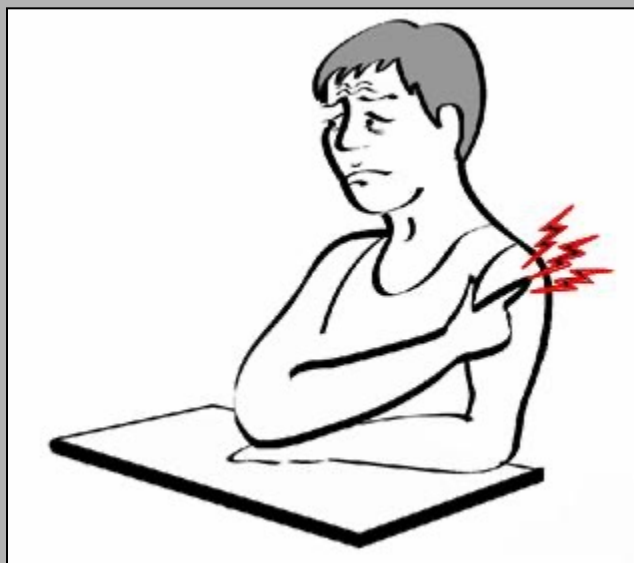
6. Which of the following helps to relieve your pain?

- Positioning - such as support on pillow / arm rest
- Pain-killing tablets
- Strapping / brace
- Functional Electrical Stimulation
- None of the above
- Something else: (give details)

SPIN version of shoulderQ

For patients with communication
difficulties

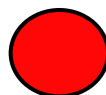
Do you have pain in your shoulder?



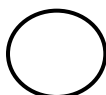
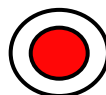
Yes

No

How bad is the pain when sitting still?



Pain as bad as it could be



No pain

How **bad** is the **pain**
when your arm is **moved**?



Pain as bad as it could be

No pain

How **bad** is the **pain** at **night**?



Pain as bad as it could be

No pain

Appendices

1. Proforma Documentation for recording process of care

2. Database assessment forms

- **Preliminary assessment and management form**
- **Multi-disciplinary assessment and management form**
- **Summary of management form**

Hemiplegic Shoulder Pain Protocol

Name: Admission date:...../...../.....

Day 1 – Within 24 hours

Doctor's Assessment: Completing Doctor: Date

Tick if done

HSP Assessment Form (Preliminary Assessment Page 1)

Ability to Complete Questionnaire Independent Able with help Unable

Shoulder Pain Questionnaire Administer with same type of help as AbilityQ

Variance (reasons) i.e. if not done, say why and when

Initial Management:

Severity of shoulder pain None Mild Moderate Severe

Type of shoulder syndrome: Hypotonic (Flaccid) Hypertonic (Spastic)

Initial Analgesia: Current medication for

HSP:.....

Simple analgesia p.r.n:.....

Other modalities: Heat / ice/.....

Other comments:

Liaison: Nurse:.....Physio.....O/T.....

Investigations:

Tick if done

Full Blood Count Normal: Yes / No

U+E, LFTs Normal: Yes / No

Erect AP shoulder x-ray (if able to sit unsupported)

Measurement of subluxation on x-ray	Normal	Affected
Vertical distance: Inferior Acromial point – mid Humeral head:mmmm
Horizontal distance: Mid-Glenoid – mid Humeral head:mmmm

Northwick Park Hemiplegic Shoulder Pain Protocol

Day 2: Within 48 hours

Nurse's Protocol: Completing Nurse: Date

Tick if done

Positioning chart above bed

HSP protocol Hypotonic (flaccid) shoulder (A) Hypertonic (spastic) shoulder (B)

Other comments:

If protocol not initiated, give reason:

Support system: Completing O/T: Date

Recommended support system: (None needed)

Arm-support on wheelchair: Bexhill Ottobock Other.....

Cushion in chair/wheelchair Beanbag Pillow Other.....

Personal Strapping Sling Type:.....

Was recommended system provided? **No** **Yes**

(If not, given details in variance box below)

Other comments:

If not, reason for variance (eg recommended system not available, say what was done instead)

Documentation: Completing O/T / P/T: Date

Goal for management of HSP to be documented in notes

Tick if done

Goal:

If not, reason for variance

Northwick Park Hemiplegic Shoulder Pain Protocol

Medication review: Completing Doctor: Date

Pain severity at rest	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Pain severity on movement	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Interference with daily function	<input type="checkbox"/> None	<input type="checkbox"/> Nursing tasks	<input type="checkbox"/> Therapy sessions	
Night-time disturbance by pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Requests for prn analgesia/24 hrs	<input type="checkbox"/> 0	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> >4
Pain Control	<input type="checkbox"/> Satisfactory		<input type="checkbox"/> Not satisfactory	
Contra-indications to NSAIDs impairment	<input type="checkbox"/> Gastric history	<input type="checkbox"/> Anticoagulation	<input type="checkbox"/> Renal	
NSAID use permissible	<input type="checkbox"/> Yes	<input type="checkbox"/> With care	<input type="checkbox"/> NO – absolute contra-indication	

Suggested analgesic regimens (for information only)

Agent	Persistent daytime pain	If Pain disturbs sleep Add:	If Pain interferes with therapy: Give 1 hour before
NSAIDs (1st choice unless contra-indicated) <i>Precautions: Consider Misoprostol protection</i>	Voltarol Retard 75mg morning Alternatives Naprosyn 250 mg tds Ibuprofen Retard 800mg od	Voltarol Retard 75mg evening Naprosyn 250mg nocte Ibuprofen Retard 800mg	Voltarol (normal) 25-50 mg NB Total daily dose must not exceed 150mg Naprosyn 250mg Ibuprofen 400mg
Regular simple analgesics	Paracetamol 1g tds	Paracetamol 1g nocte ± Temazepam 10mg	Co-proxamol ii 1hr before NB: Total dose of paracetamol not to exceed 4g per day
Stronger analgesics <i>Precautions: consider Lactulose / Senna</i>	Co-proxamol ii tds Alternatives Co-dydramol ii tds	Co-proxamol ii nocte ± Temazepam 10 mg Co-dydramol ii nocte	Ditto

Chosen medication regimen

Regular medication:

P.r.n medication:

Monitoring required: Yes No (on NSAIDs: recommend monthly FBC / Biochem)

Details:.....

Other: eg Nerve Block /Botulinum Toxin

Details:

Other Associated features.

Soft tissue damage:

- *Soft tissue shoulder syndromes are common in themselves and may pre-date the stroke*
- *Rotator cuff tears may result from poor handling or falls, especially in the subluxed shoulder*
- *Adhesive capsulitis is probably less common than textbooks suggest*

Pre-existing shoulder problems: No Yes Details:

History of falls: No Yes

Suspected soft tissue damage: No Yes Type:

If yes, MRI Requested: No Yes Result:

Local steroid injection given: No Yes
(only if demonstrable inflammation on MRI)

Details of injection: (Agent, dose, site(s)):

Osteopenia / occult fracture

- *Osteopenia is common in women in stroke age-group – especially with petite form or Hx of steroid therapy*
- *Occult fracture may follow trauma / falls / poor handling*

Known osteopenia: No Yes

Risks for osteopenia: No Yes Details:

Women: Post-menopause: No Yes Year of menopause:.....

On HRT: No Yes Details:

Suspected osteopenia No Yes Details:

If yes, Dexa scan requested: No Yes Results:

Suspected occult fracture No Yes Details:

If yes, Bone scan requested: No Yes Results:

Prescription:
 Bisphosphonates Other:
 HRT

Northwick Park Hemiplegic Shoulder Pain Protocol

Reflex sympathetic dystrophy

- Oedema, wasting and flexural contracture are common in the hemiplegic hand anyway
- Look for vasomotor change – skin colour, temperature, sweating – and MCP/wrist tenderness

Features of RSD: No Yes Possible Details:

Suspected RSD No Yes

If yes, Bone scan requested: No Yes Result:

Prescription:

Steroids

Other:

Ganglion blockade

Neurogenic pain

Constant, unremitting pain with burning, highly unpleasant character – unaffected by movement

- Central (so-called 'thalamic type') pain
- Traction on peripheral nerves eg brachial plexus, axillary nerve – look for neuro signs

Neurogenic type pain: No Yes Details:

Peripheral neurological signs: No Yes Details:

Suspected neurogenic pain: No Yes

If yes, EMGs requested: No Yes Result:

Prescription:

Amitriptyline

Other:

Carbamazepine

Neck: cervical spondylosis

- Musculoskeletal pain and stiffness in neck
- With or without cervical root entrapment – pain radiating down arm ± neurological root signs

Neck stiffness: No Yes

Signs of root entrapment No Yes Details:

Suspected neck pain: No Yes

If yes, Cx Spine xrays requested: No Yes Result:

Prescription:

Soft collar

Other

MACP Physio assessment

Progress notes:

Northwick Park Hemiplegic Shoulder Pain Protocol

First Multi-disciplinary Review: (Approx Day (10-14)) **Date** .../.../....

P/T Assessment: Completing P/T: **Date**

Tick if done

HSP Assessment form: M-D Assessment Page 2

If not, reason for variance (eg not done to timescale)

Treatment Plan / Goals:

Review of handling / support:

What is current support system?
Is it appropriate / best available?
If not, what is recommended

Medication review: Completing Doctor: **Date**

Tick if done

Shoulder Pain Questionnaire **Better** **Same** **Worse** **Resolved**

Pain control **Satisfactory** **Not satisfactory**

Current medication for HSP:

Change of medication to:

Monitoring: **FBC** **U+E** **LFTs**

Other.....

Other intervention: eg Nerve Block /Botulinum Toxin

Details

Progress notes:

Copy and repeat as necessary

Subsequent Multi-disciplinary Review: Date..../.../....

Individual Review: P/TO/T.....Date

Update Treatment Plan:

Hypotonic (Flaccid) shoulder - Have you considered FES?
Hypertonic (Spastic) shoulder – Have you considered Botox?

Update handling / support

What is current support system?
Is it appropriate / best available?
If not, what is recommended

NB: When pt gets on feet will need alternative support system

Medication review: Completing Doctor: Date

Tick if done

Shoulder Pain Questionnaire Better Same Worse Resolved

Pain control Satisfactory Not satisfactory

Current medication for HSP:

Change of medication to:

Monitoring: FBC U+E LFTs
Other.....

Other intervention: eg Nerve Block /Botulinum Toxin

Details

Copy and repeat as necessary

Northwick Park Hemiplegic Shoulder Pain Protocol

Final Assessment: Date .../.../....

Discharge **Pain resolved**

Final Assessment: Doctor..... Date.....

Tick if done

- Shoulder Pain Questionnaire Better Same Worse Resolved
 HSP Assessment form (Page 3: Summary of management) complete

Follow-up plans:

Final assessment: P/T Date.....

Tick if done

- HSP Assessment form (Page 3: Summary of management) complete

Follow-up Plans:

Review of Protocol and reasons for variance

Further Comments

Signed

SHOULDER PAIN HSP ASSESSMENT AND MANAGEMENT FORM

PAGE 1: PRELIMINARY ASSESSMENT

Surname **Age** **Hospital number**
First name **Sex** Male Female **Date of admission**

MAIN DIAGNOSIS

Diagnostic category **Physical deficit** L hemi Other...
 R hemi
 Tetraparesis
Date of onset

DESCRIPTION OF SHOULDER PAIN

Duration of shoulder pain (weeks)

Brief History of shoulder pain

Pain severity

None Moderate
 Mild Severe

Main category of HSP

Hypotonic (flaccid)
 Hypertonic (spastic)

History of Trauma

Yes (describe)
 No

Previous Shoulder problems

Yes (describe)
 No

Main examination findings

Sleep disturbance

Yes No

Pain at rest

Yes No

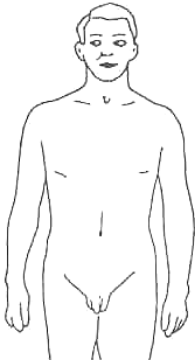
Pain on movement

Yes No

Neurogenic type pain

Yes No

Localisation of pain



Investigations

U+E Dexa scan
 FBC/platelets EMGs
 Plain AP xR Cx Spine Xray
 MRI Shoulder Cx Spine MRI
 Bone Scan Other...

Date of initial management plan

See proforma page 1 for details of management plan

Print name.....**Signed**.....**Date**.../.../.....

HSP ASSESSMENT AND MANAGEMENT FORM

PAGE 2: M-D ASSESSMENT

Date of M-D Assessment

Functional Neglect of arm Yes No

Assessors Dr - name:
 P/T - name:

Learned disuse Yes No

MUSCULOSKELETAL ASSESSMENT

Neck movement

- Normal
- Neck pain at rest
- Neck pain on movement
- Painless restricted range
- Suspected root entrapment

GlenoHumeral joint

- Normal
- Degenerative change: Non-tender enlargement
- Inflammation: Warm / swelling / redness
- Effusion

AcromioClavicular joint

- Normal
- Degenerative change: Non-tender enlargement
- Inflammation: Warm / swelling / redness
- Effusion

SternoClavicular joint

- Normal
- Degenerative change: Non-tender enlargement
- Inflammation: Warm / swelling / redness
- Effusion

Sensation in arm

- Intact
- Somatic loss
- Proprioceptive loss
- Not assessable

Reflex sympathetic features

- None
- Red/purple skin discoloration
- Temperature change
- Loss of sweating
- MCP tenderness
- Thin shiny skin

Severity of GHJ subluxation

- None Marked
- Mild

GHJ Subluxation

- Flaccid Other...
- Spastic

Direction of GHJ subluxation

- Inferior Medially rotated
- Anterior
- Superior

Scapular malalignment

- None Protracted
- Elevated Retracted
- Depressed Winged

RANGE OF NON-PAINFUL MOVEMENT

Measured with shoulder aligned as far as possible, but before physiotherapy

Abduction

Flexion

External rotation

Internal rotation

Elbow flexion

Elbow extension

Suspected RC tear Yes No

Osteopenia Yes No

Suspected Occult fracture Yes No

Position assessed in Sitting Standing
 Lying

Tone around shoulder Predominantly Low
 Predominantly High
 Other...

Overactive muscle groups None Subscapularis
 Pectorals Biceps
 Lat dorsi Triceps
 Trapezius Other...
 Rhomboids

Restriction of range None Elbow flexors
 Medial rotators Other...
 Adductors

Distal tone Predominantly Low
 Predominantly High
 Other...

Muscle activity at shoulder None Selective
 Flickers Functional
 Gross

Return of activity in arm None Distal
 Proximal Throughout

HSP ASSESSMENT AND MANAGEMENT FORM

PAGE 3: SUMMARY OF MANAGEMENT

Help for positioning

- Full assistance
- Occasional assistance
- Not needed

Protocol initiated

- Standard protocol A (Flaccid)
- Standard protocol B (Spastic)
- Individual

Main method of locomotion

- Manual Wheelchair
- Electric wheelchair
- Walking

Support in bed

- Pillows
- Bean cushion
- Other...

Support in wheelchair

- Bexhill Arm support
- Ottobock support
- Bean cushion
- Pillow
- Other...

Support on feet

- Strapping
- Brace
- Sling (Type)
- Other...

Physiotherapy management

- Positioning
- Reduction of tone
- Mobilisation of soft tissues
- Splinting / casting
- Manual facilitation of activity
- Pain relieving modalities (ice / TENS)
- Advice to pt / carers
- Functional re-education
- Sensory stimulation
- Other...

Botulinum toxin given

- Yes
- No

Botulinum toxin response

- Good
- Partial
- None

Botulinum toxin sites

- Subcapularis
- Biceps
- Pecs
- Retractors

FES used

- Yes
- No

FES response

- Good
- Partial
- None

FES muscle groups

Details of medical management

Summary of Analgesia

Suprascapular block response

- Good
- Partial
- None

Suprascapular block given

- Yes
- No

RESULT

Pain resolved

- Completely
- Partially
- No

Date of resolution

Signed

Date