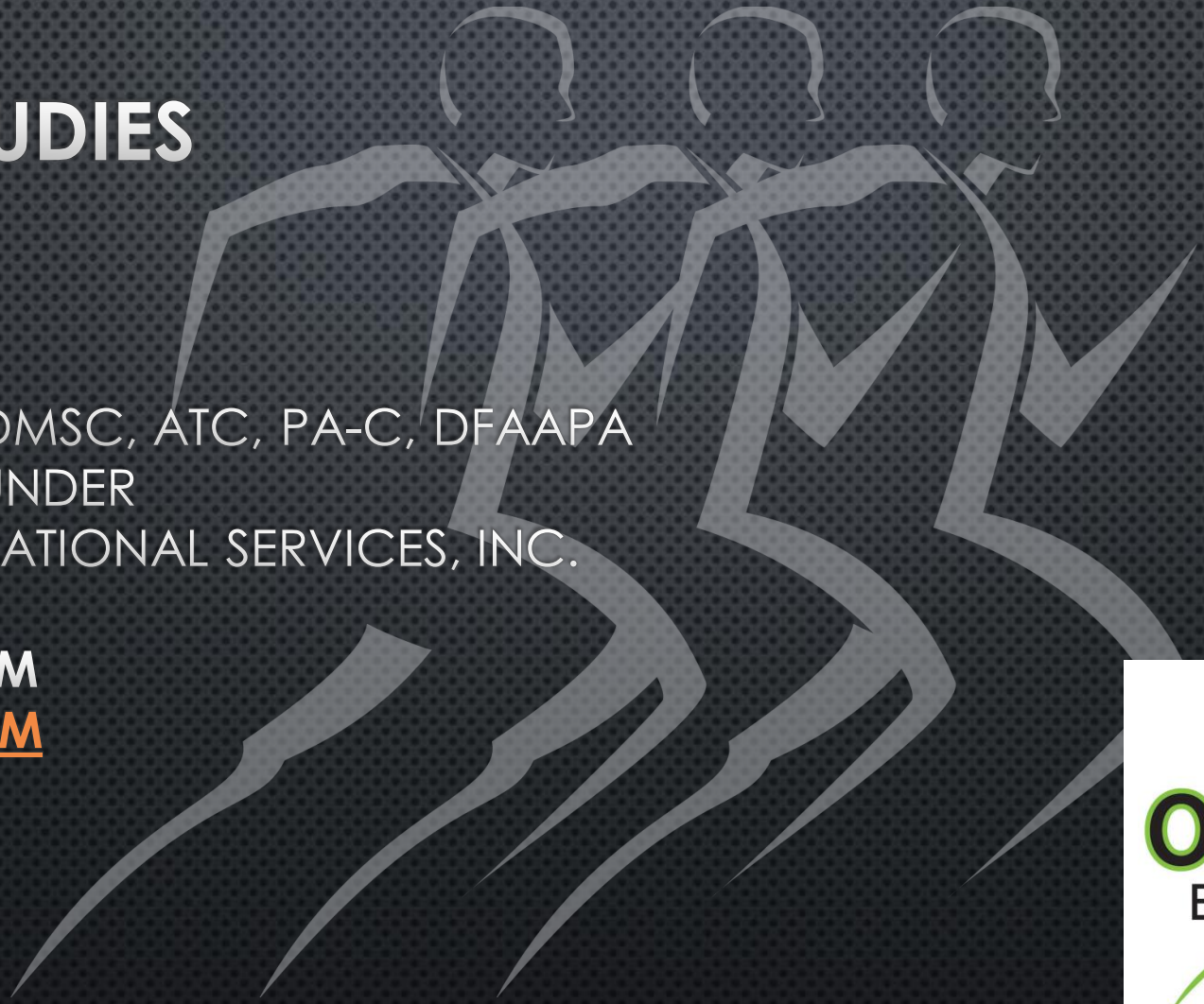
MSK CASE STUDIES

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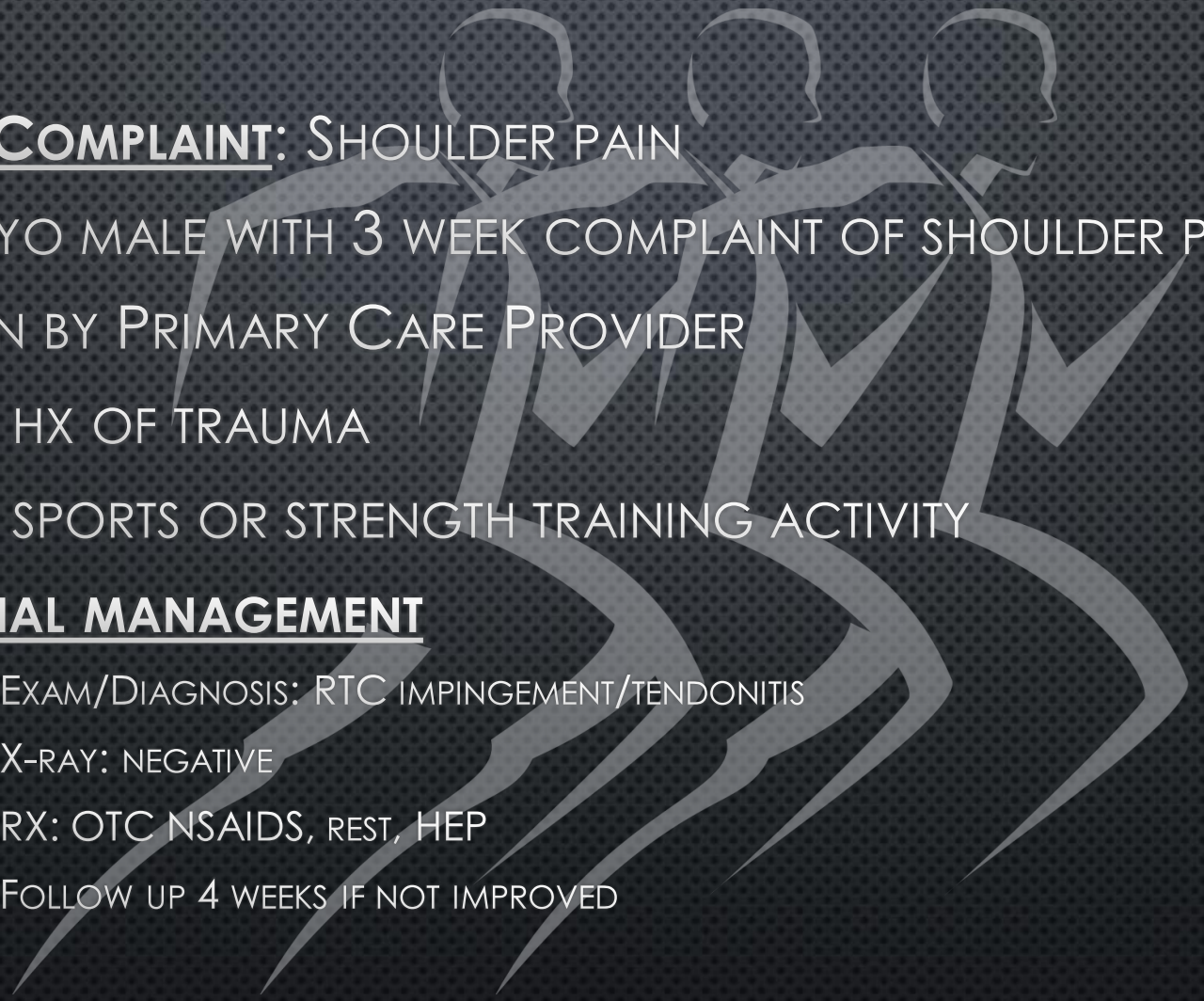
  American Academy of Physician Assistants
  - Financial
  - Splinting/Casting Workshop Director, Guide to the MSK Galaxy Course
- ***JBJS- JOPA*** *Journal of Orthopaedics for Physician Assistants- Associate Editor*
- ***American Academy of Surgical Physician Assistants*** *– Editorial Review Board*

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SHOULDER PAIN



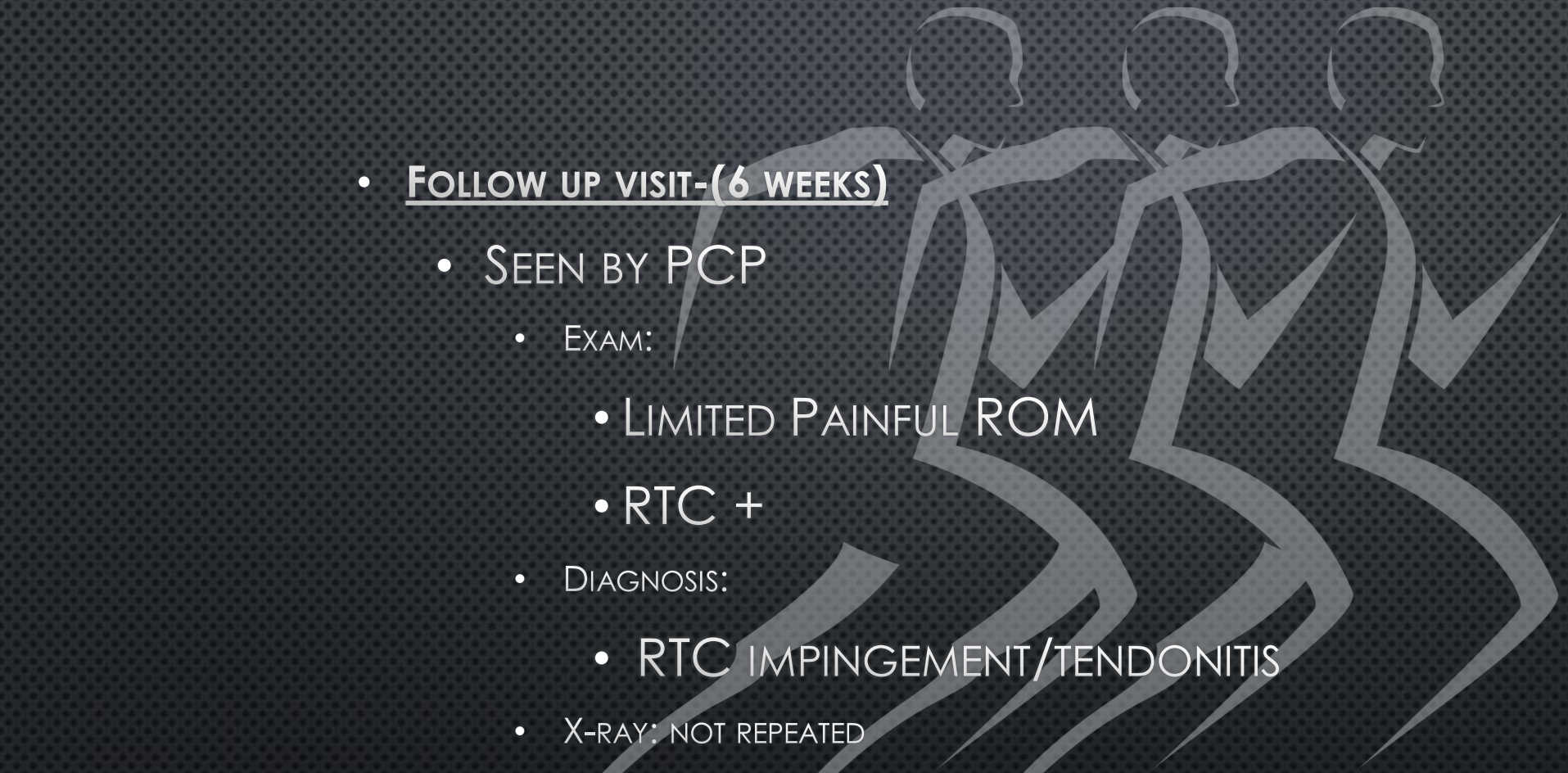
SHOULDER PAIN



- **CHIEF COMPLAINT**: SHOULDER PAIN
  - 56 YO MALE WITH 3 WEEK COMPLAINT OF SHOULDER PAIN
  - SEEN BY PRIMARY CARE PROVIDER
  - NO HX OF TRAUMA
  - NO SPORTS OR STRENGTH TRAINING ACTIVITY
  - **INITIAL MANAGEMENT**
    - EXAM/DIAGNOSIS: RTC IMPINGEMENT/TENDONITIS
    - X-RAY: NEGATIVE
    - RX: OTC NSAIDS, REST, HEP
    - FOLLOW UP 4 WEEKS IF NOT IMPROVED

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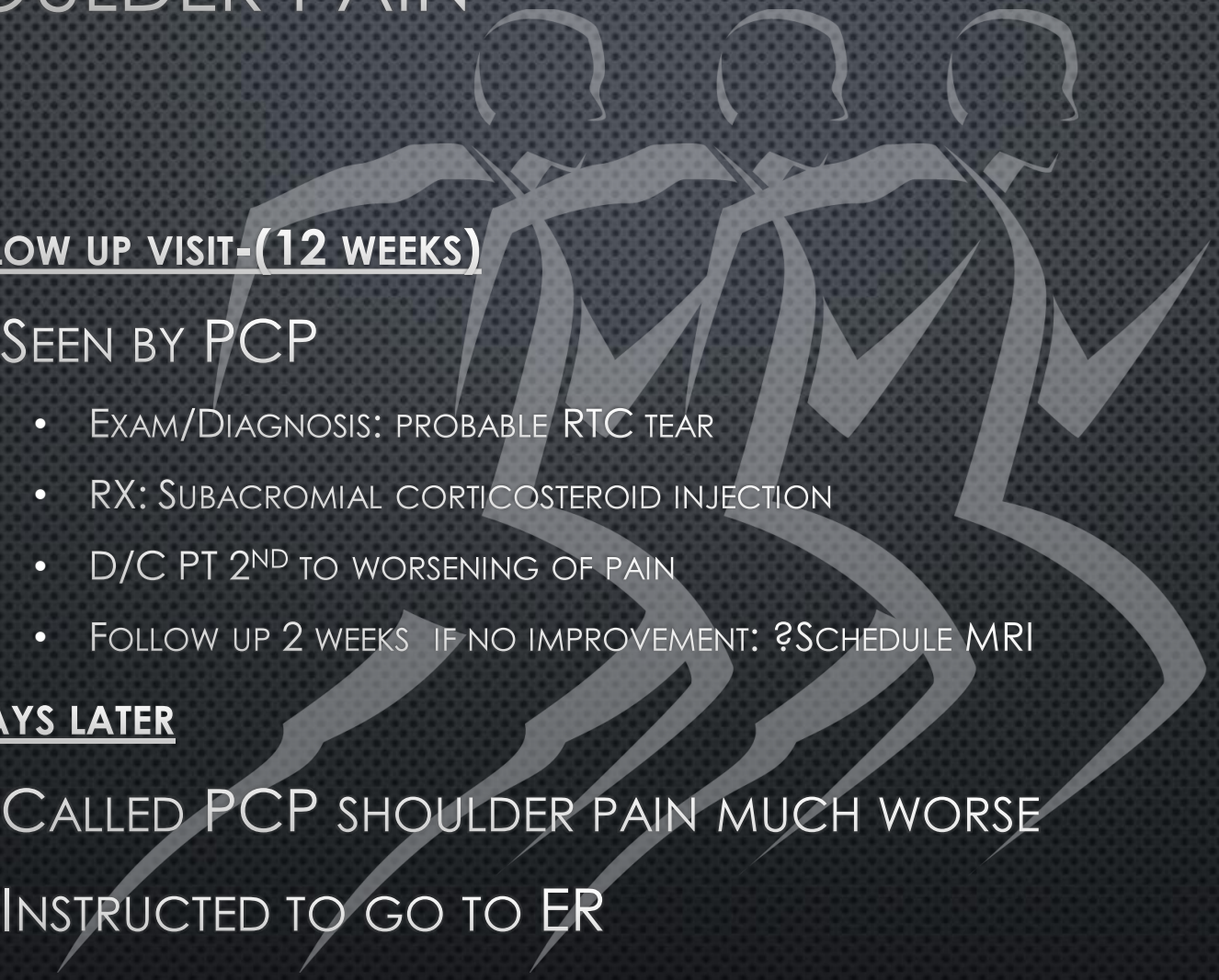
SHOULDER PAIN



- **FOLLOW UP VISIT-(6 WEEKS)**
  - SEEN BY PCP
    - EXAM:
      - LIMITED PAINFUL ROM
      - RTC +
    - DIAGNOSIS:
      - RTC IMPINGEMENT/TENDONITIS
    - X-RAY: NOT REPEATED
    - RX: RX-NSAIDS, FORMAL PT 6 WEEKS
    - FOLLOW UP 6 WEEKS IF NOT IMPROVED

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SHOULDER PAIN



- **FOLLOW UP VISIT-(12 WEEKS)**
  - SEEN BY PCP
    - EXAM/DIAGNOSIS: PROBABLE RTC TEAR
    - RX: SUBACROMIAL CORTICOSTEROID INJECTION
    - D/C PT 2ND TO WORSENING OF PAIN
    - FOLLOW UP 2 WEEKS IF NO IMPROVEMENT: ?SCHEDULE MRI
- **4 DAYS LATER**
  - CALLED PCP SHOULDER PAIN MUCH WORSE
  - INSTRUCTED TO GO TO ER

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Shoulder Pain

- **Chief Complaint**: Intractable RTC/Shoulder pain
- **History:**
  - 56 yo male with 3+month hx worsening shoulder pain
  - Progressively getting worse - constant
  - Now unable to lift arm without assistance
  - No hx of trauma
  - No sports or strength training activity
  - No moving/yard work/home improvements/child care/automotive/factory
- **Presenting Symptoms:**
  - Severe, constant pain
  - Deltoid pain
  - Sleep pain
  - Nite pain
  - Limited ROM

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SHOULDER PAIN

- **ALLERGIES**: NONE (DRUGS-FOOD-LATEX)
- **MEDICATIONS**: OTC NSAIDS, VERAPAMIL, ATORVASTATIN
- **PMH**: HTN, HYPERCHOLESTEROLEMIA
- **SOCIALHX**: OCCASIONAL CIGAR & ETOH, NEGATIVE DRUGS
- **FMH**: THROAT/LUNG CA
- **PHYSICAL EXAM:**
  - GENERAL: AAO, NORMAL APPEARANCE, NO ACUTE DISTRESS
  - SKIN-NO ABNORMALITIES
  - PALPATE: TENDER AC JT, CORACOID, DELTOID/PROXIMAL HUMERUS
  - ROM: LIMITED SHOULDER/PAINFUL, NORMAL CERVICAL ROM
  - NEURO/SENSORY INTACT
  - ORTHO TESTS: UNABLE TO PERFORM 2ND TO PAIN

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Radiographs
PCP office 3+ moths ago



What is your Diagnosis

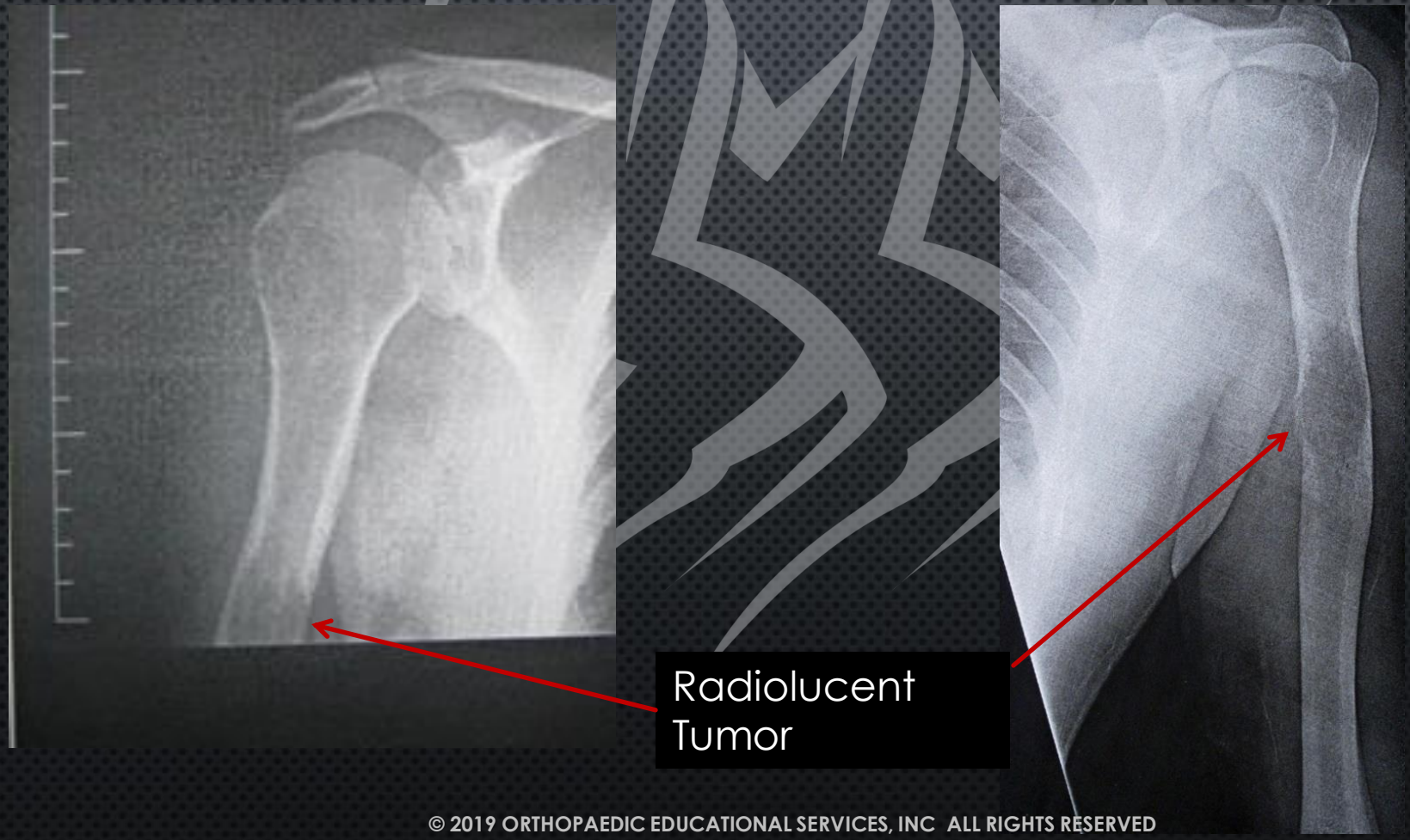
- RTC Impingement
- Rupture RTC Tendon
- Shoulder Arthritis
- Proximal Humerus fx
- Cervical Radiculopathy

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DIAGNOSIS: PATHOLOGIC HUMERUS FX

PCP OFFICE 3+ MONTHS AGO

ER VISIT



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TREATMENT

- **Diagnosed with Renal Cell Carcinoma**
  - Originates lining proximal convoluted tubules kidney
  - Most common kidney cancer in adults (80%)
  - Frequently presents: back/groin pain, Abd mass, weight loss, hematuria
  - Metastasis to bone (pelvis most common)
  - Responds poorly to Radiation and Chemotherapies
  - Favorable response to Immunotherapy
  - 5 year survival for patients with metastatic renal cell carcinoma is between 5 and 15%

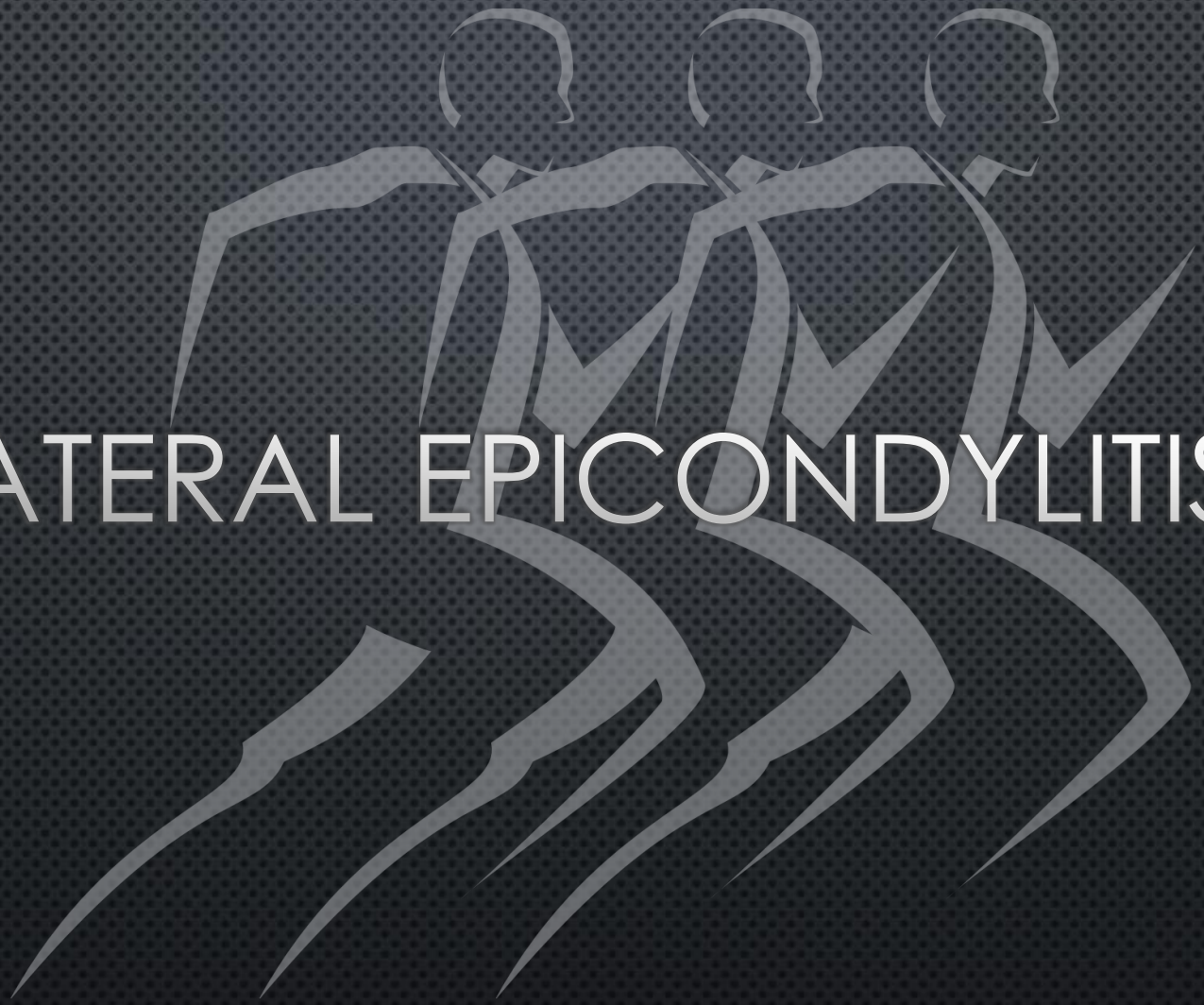
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TREATMENT

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LATERAL EPICONDYLITIS

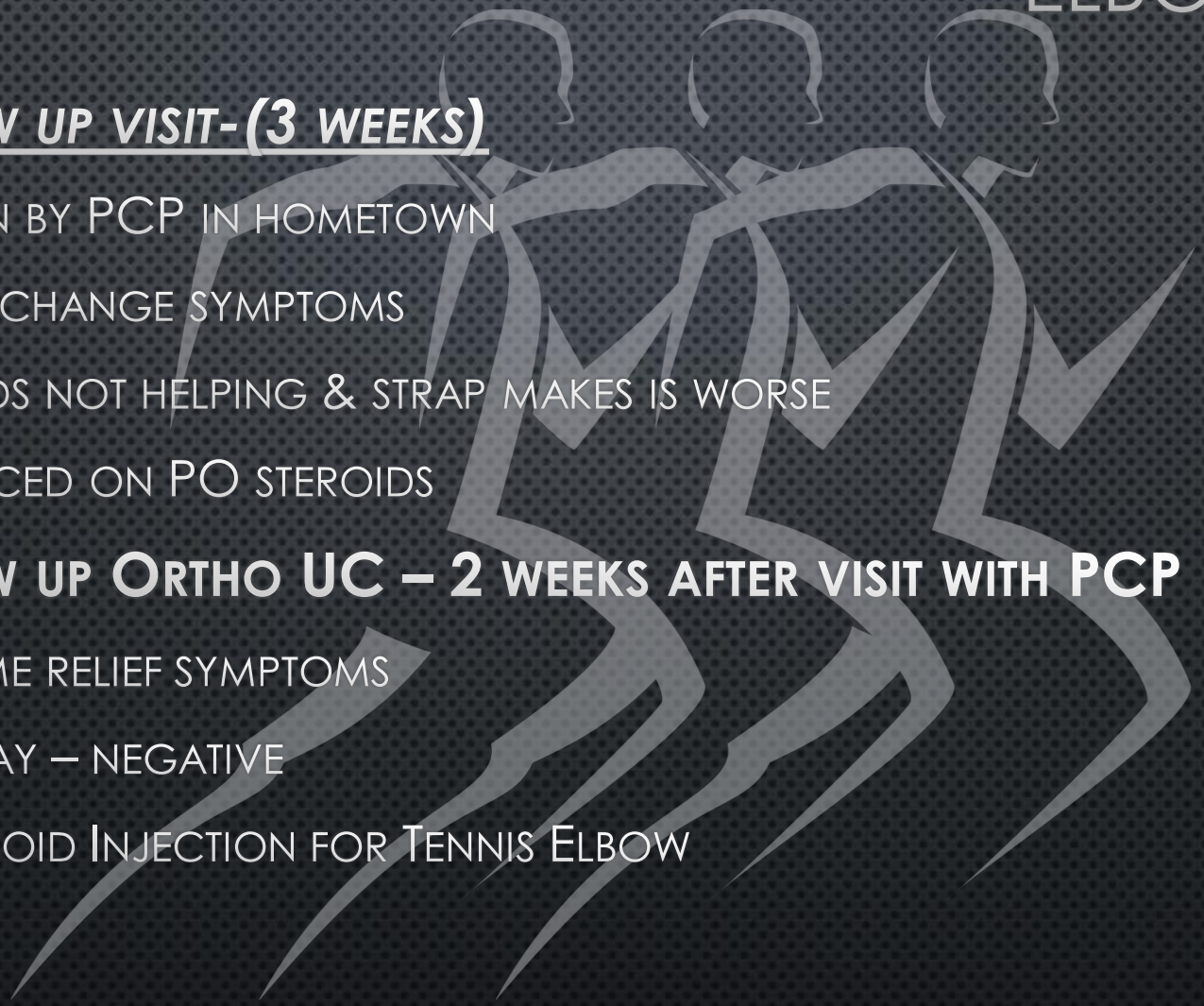


Elbow Pain

- **Chief Complaint**: Elbow pain
  - 44 yo female 4-week complaint of Elbow pain
  - Small animal Veterinarian
  - Elbow pain inhibiting surgical care
  - Trouble lifting/grasping/using surgical instruments
  - **Initial management**
    - Seen Ortho Urgent Care in NJ
    - Exam/Diagnosis: Lateral Epicondylitis
    - XR/O for Carpal Tunnel Syndrome
    - RX: Meloxicam and Tennis elbow strap
    - Follow up 4 weeks if not improved

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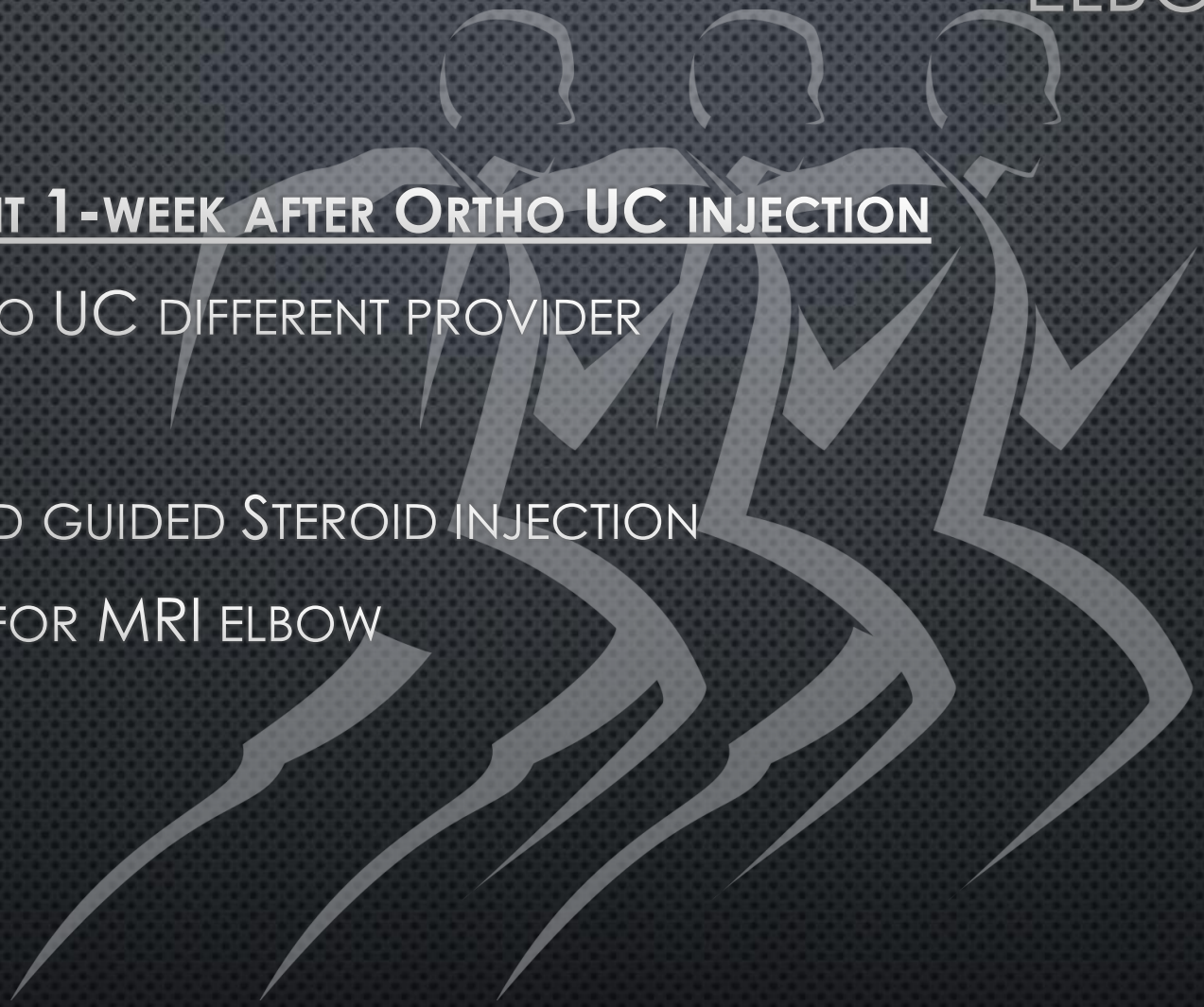
ELBOW PAIN



- ***Follow up visit- (3 weeks)***
  - Seen by PCP in hometown
  - No change symptoms
  - Meds not helping & strap makes is worse
  - Placed on PO steroids
- **Follow up Ortho UC – 2 weeks after visit with PCP**
  - Some relief symptoms
  - X-ray – negative
  - Steroid Injection for Tennis Elbow

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ELBOW PAIN

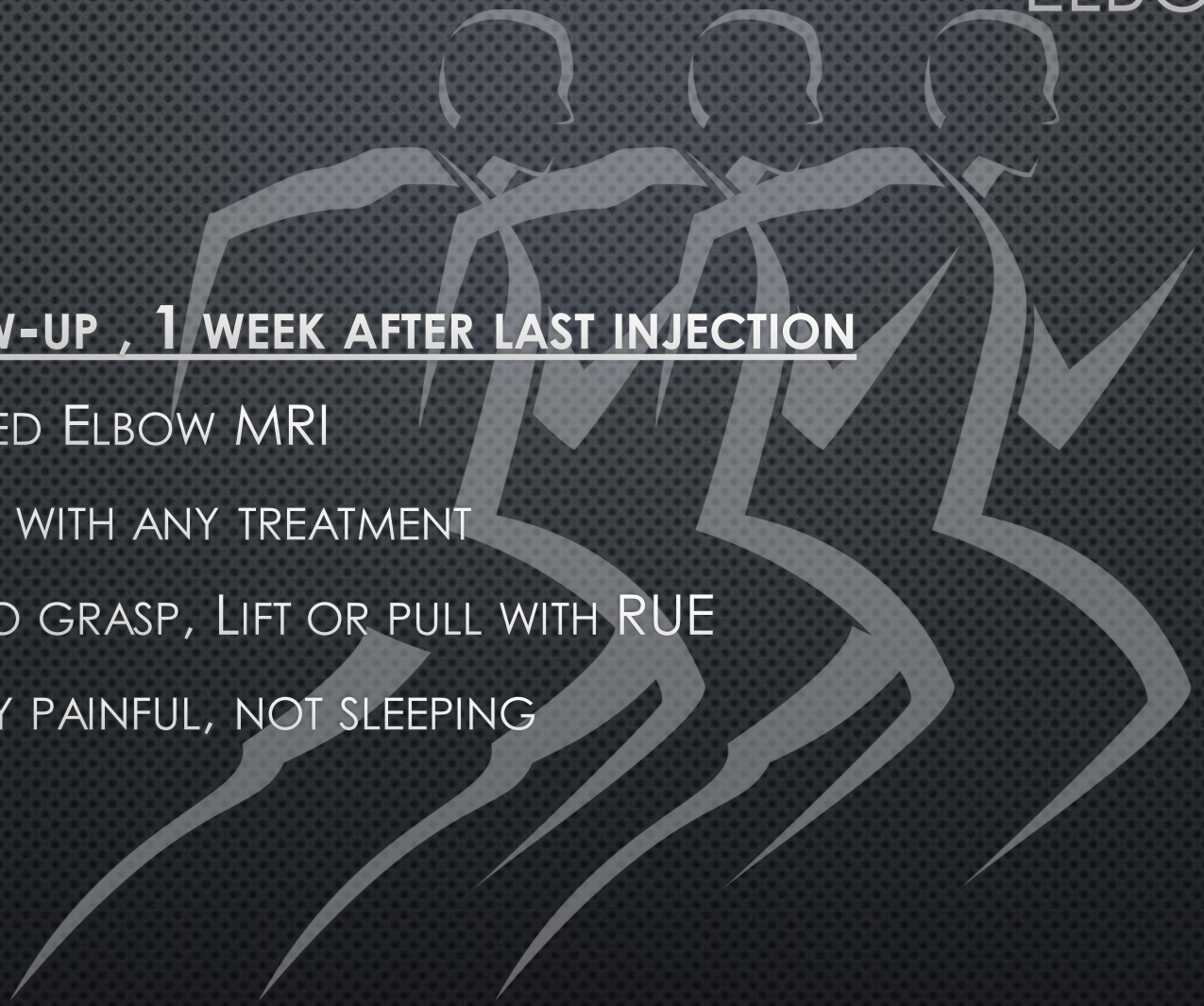


Follow up visit 1-week after Ortho UC injection

- Same Ortho UC different provider
- NO exam
- Ultra-sound guided Steroid injection
- Scheduled for MRI elbow

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ELBOW PAIN



ORTHO FOLLOW-UP , 1 WEEK AFTER LAST INJECTION

- CANCELLED ELBOW MRI
- NO RELIEF WITH ANY TREATMENT
- UNABLE TO GRASP, LIFT OR PULL WITH RUE
- EXTREMELY PAINFUL, NOT SLEEPING

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ELBOW PAIN

- **ALLERGIES**: NONE (DRUGS-FOOD-LATEX)
- **MEDICATIONS**: MELOXICAM, PREDNISONE, ACETAMINOPHEN
- **PMH**: NEG
- **SOCIALHX**: NEG
- **FMH**: NEG
- **PHYSICAL EXAM:**
  - GENERAL: AAO, NORMAL APPEARANCE, NO ACUTE DISTRESS
  - SKIN-NO ABNORMALITIES
  - PALPATE: NON-TENDER LATERAL EPICONDYLE/ECRB/CET
  - ROM: NO LIMITS WRIST/ELBOW ROM
  - STRENGTH: GRIP DIMINISHED
  - NEURO/SENSORY NUMBNESS TIP RING AND LONG FINGER
  - ORTHO TESTS: NEGATIVE FINGER EXTENSION TEST

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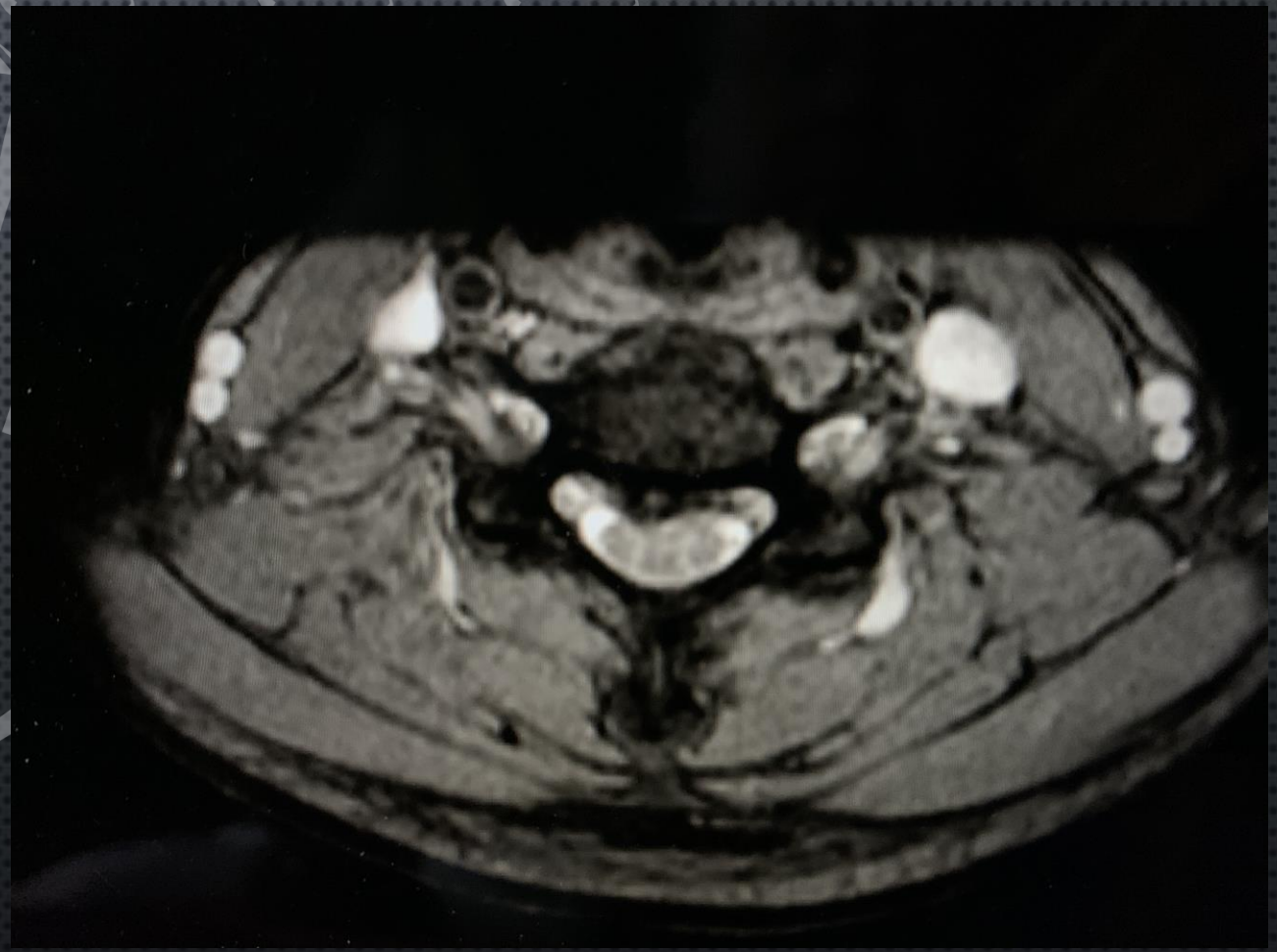


WHAT IS YOUR DIAGNOSIS?

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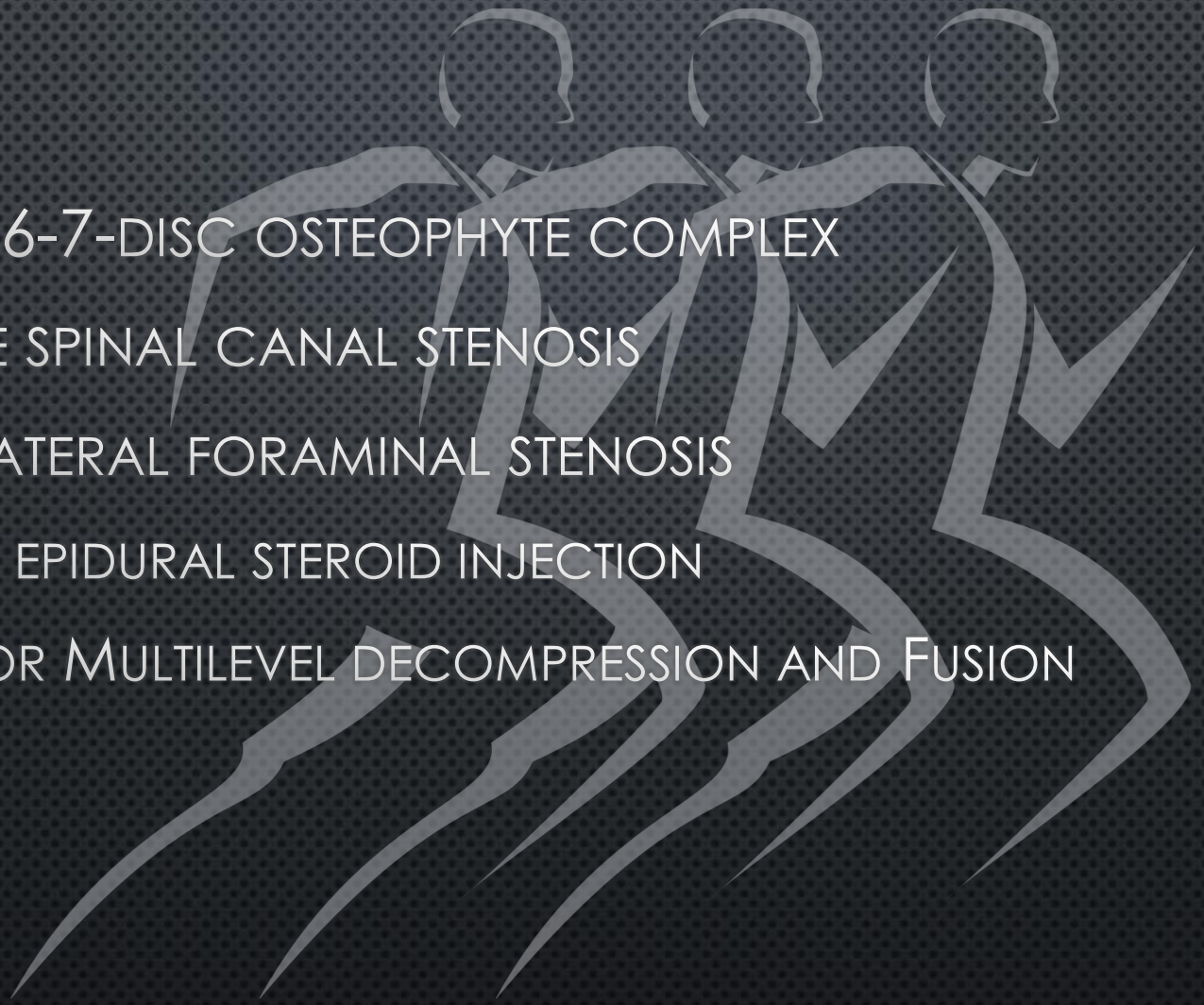
CERVICAL STENOSIS & RADICULOPATHY





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TREATMENT

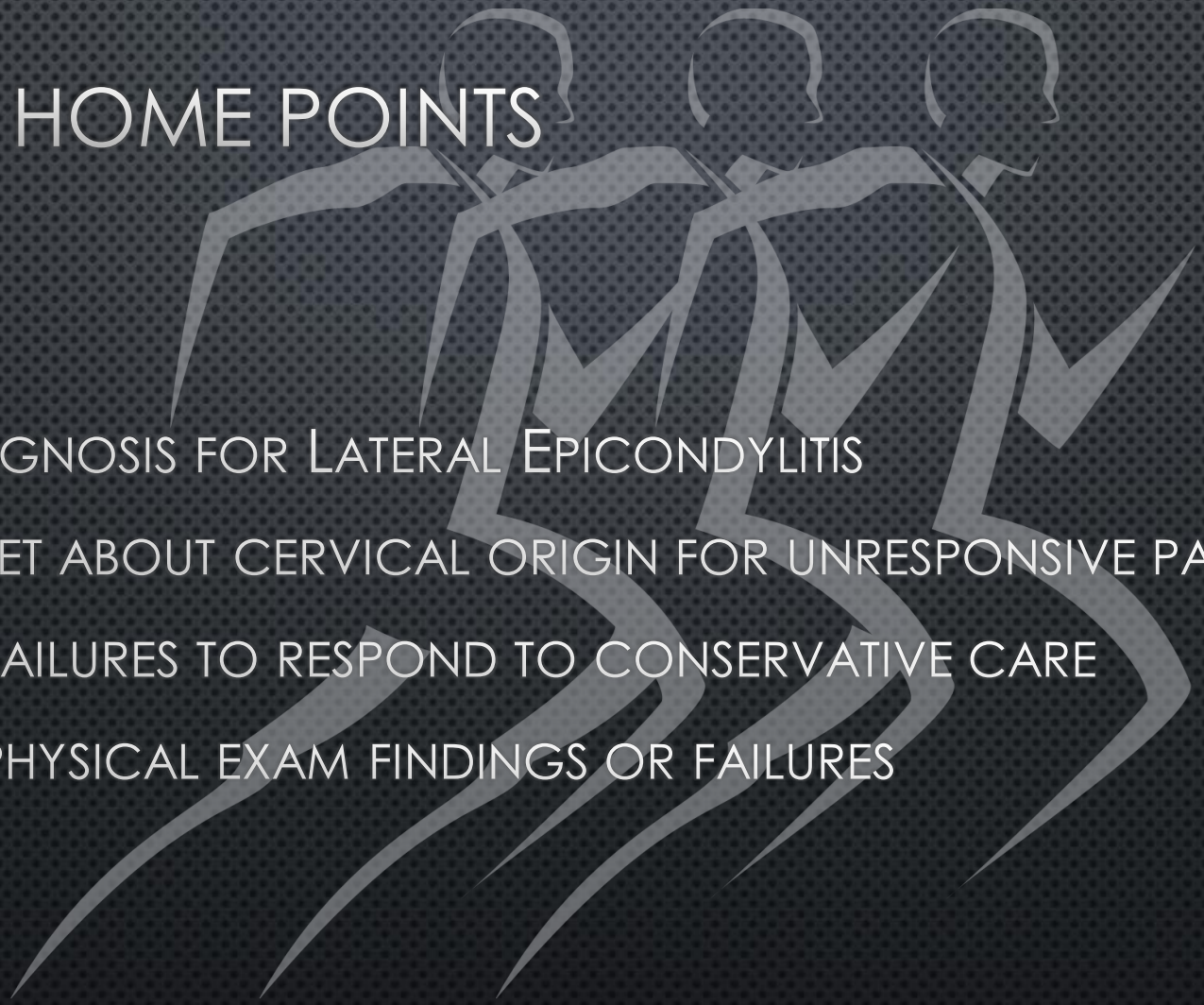


Diagnosis-

- C5-6 & C6-7-disc osteophyte complex
- Moderate spinal canal stenosis
- Severe bilateral foraminal stenosis
  - Urgent epidural steroid injection
  - Plan for Multilevel decompression and Fusion

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TAKE HOME POINTS



- Unusual diagnosis for Lateral Epicondylitis
- Don't forget about cervical origin for unresponsive pain symptoms
- Recognize failures to respond to conservative care
- Recognize physical exam findings or failures

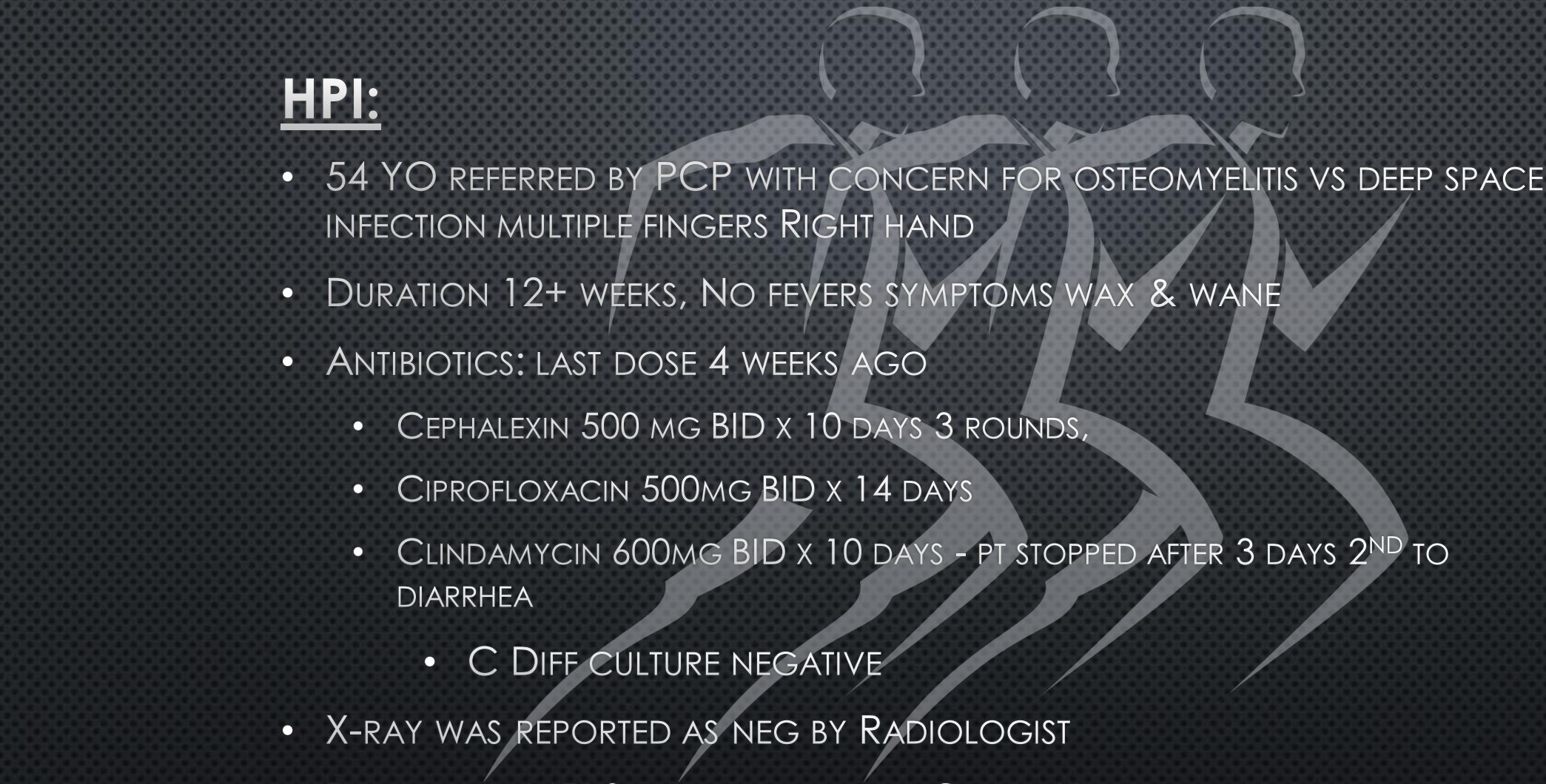
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FINGER INFECTION



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FINGER INFECTION

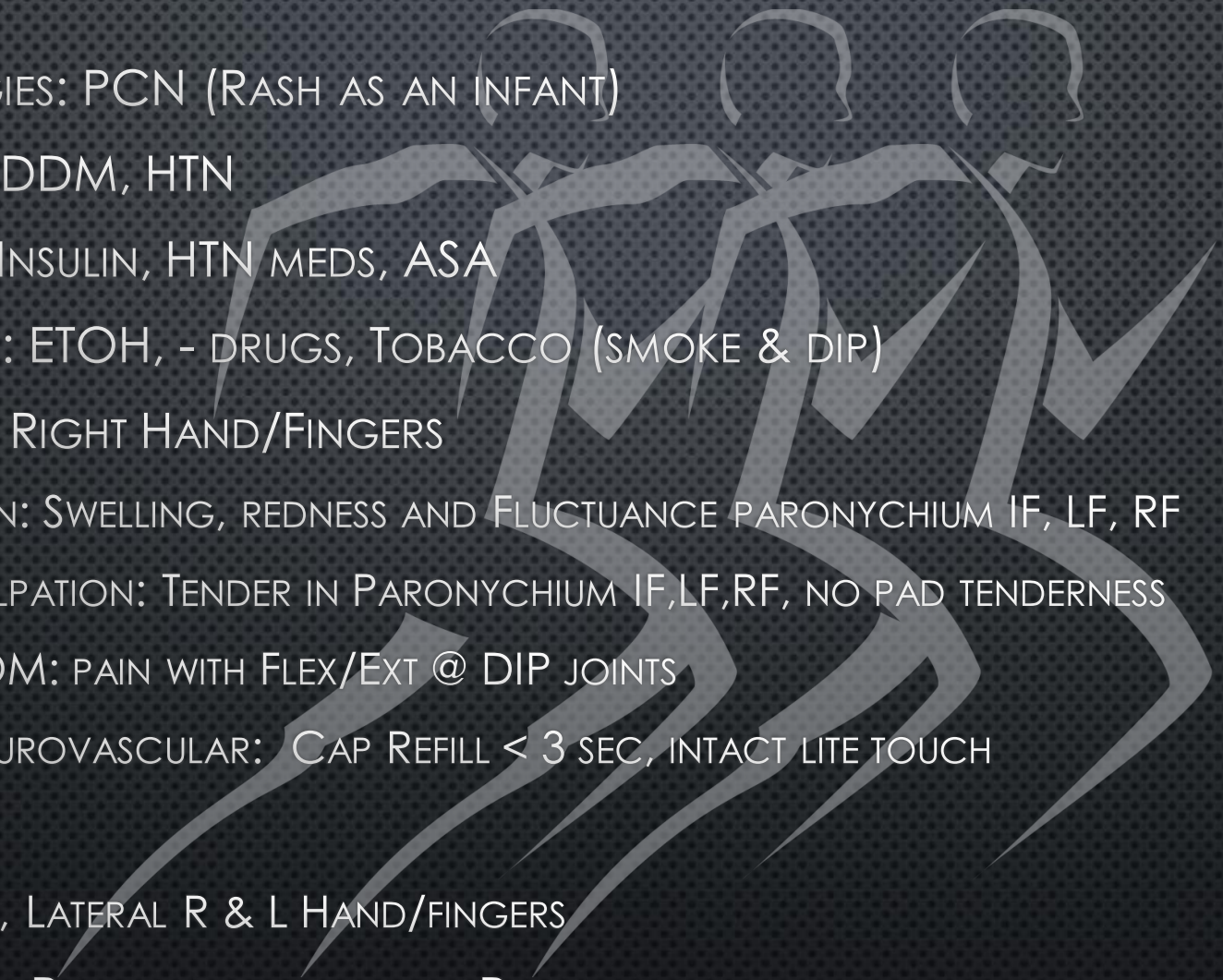


HPI:

- 54 YO referred by PCP with concern for osteomyelitis vs deep space infection multiple fingers Right hand
- Duration 12+ weeks, No fevers symptoms wax & wane
- Antibiotics: last dose 4 weeks ago
  - Cephalexin 500 mg BID x 10 days 3 rounds,
  - Ciprofloxacin 500mg BID x 14 days
  - Clindamycin 600mg BID x 10 days - pt stopped after 3 days 2ND to diarrhea
    - C Diff culture negative
- X-ray was reported as neg by Radiologist
- Pt. refused MRI Scan until seen by Ortho Hand consult

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FINGER INFECTION



- Allergies: PCN (Rash as an infant)
- PMH: IDDM, HTN
- Meds: Insulin, HTN meds, ASA
- SocHx: ETOH, - drugs, Tobacco (smoke & dip)
- Exam: Right Hand/Fingers
  - Skin: Swelling, redness and Fluctuance paronychium IF, LF, RF
  - Palpation: Tender in Paronychium IF,LF,RF, no pad tenderness
  - ROM: pain with Flex/Ext @ DIP joints
  - Neurovascular: Cap Refill < 3 sec, intact lite touch
- X-rays
  - PA, Lateral R & L Hand/fingers
    - Read as negative by Radiologist
- Labs: WBC, ESR, CRP - Normal BS:278, hA1C: 10

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FINGER INFECTION

What is your Diagnosis?

- Herpetic Whitlow
- Paronychia
- Felon
- Chronic Osteomyelitis



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Antibiotics choices: Human Bites: Adults/Children - **PO**

PARONYCHIA

- **Primary Drug of choice**
  - Amoxicillin/Clavulanate 875/125mg PO BID or 500/125mg PO TID x 7-10 days
  - Eikenella/Pasteurella – susceptible to PEN/ Ampicillin
  - Staph/Anaerobes – produce Beta-lactamase = Beta-lactam inhibitor (Clavulanate) makes more effective
- **Penicillin Allergy**
  - **Clindamycin or Metronidazole plus:**
    - Cefuroxime (Ceftin) 500mg PO BID
    - Doxycycline 100mg PO BID
    - Moxifloxacin (Avelox) 400mg PO Daily
    - TMP-SMX 800/160 PO BID

http://www.globalrph.com/antibiotic/bites.htm

Human and Other Mammalian Bite Injuries of the Hand: Evaluation and Management; JAAOS January 2015

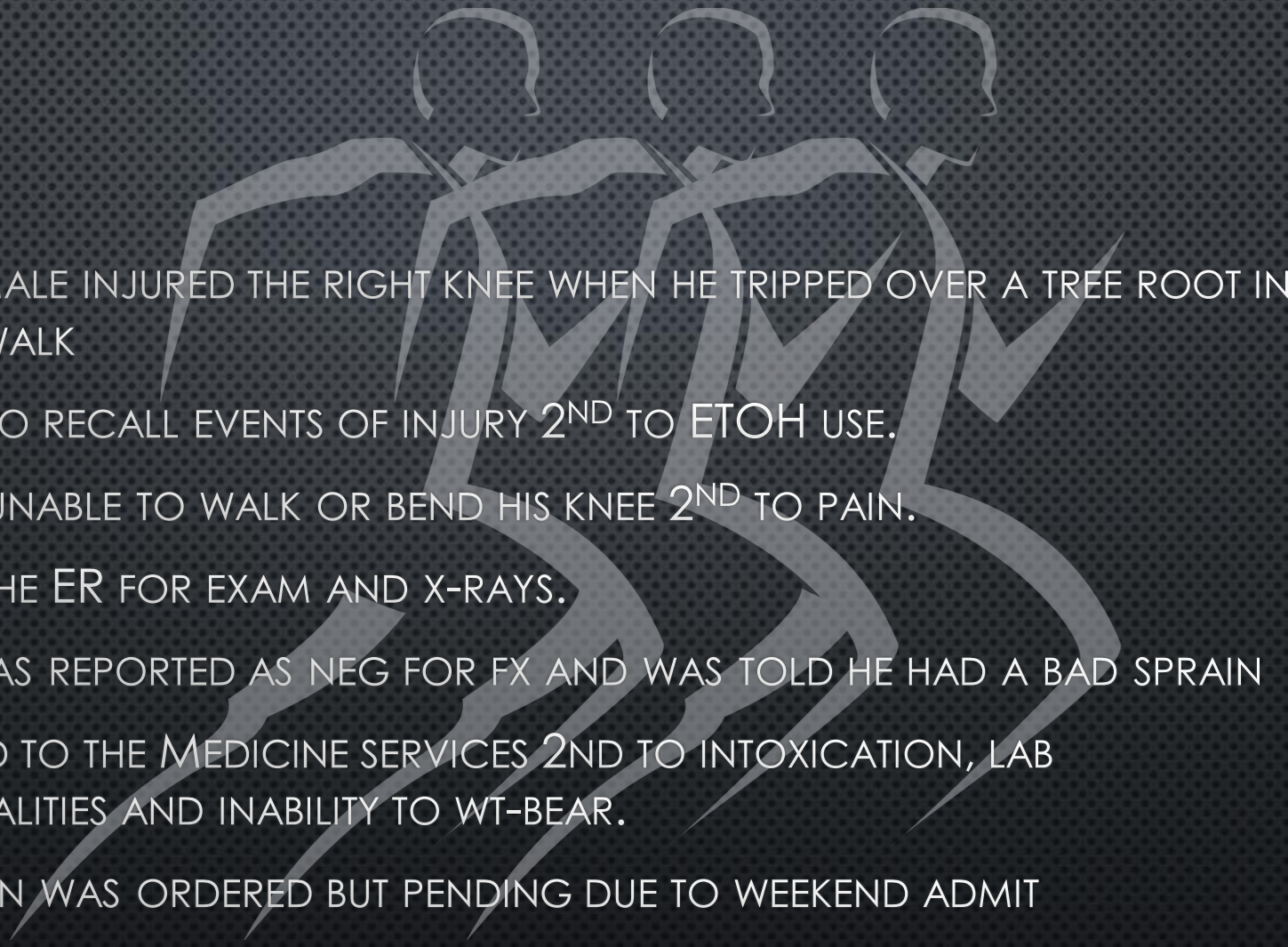
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KNEE PAIN



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SPRAINED KNEE



HPI:

- 34 YO male injured the right knee when he tripped over a tree root in the sidewalk
- Unable to recall events of injury 2ND to ETOH use.
- He was unable to walk or bend his knee 2ND to pain.
- Seen in the ER for exam and x-rays.
- X-ray was reported as neg for fx and was told he had a bad sprain
- Admitted to the Medicine services 2nd to intoxication, lab abnormalities and inability to wt-bear.
- MRI Scan was ordered but pending due to weekend admit

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SPRAINED KNEE



- Allergies: NKDA
- PMH: IDDM, HTN
- Meds: Insulin, HTN meds,
- SocHx: ETOH, - drugs
- Exam: Right Knee
  - 400 + lbs
  - 3+ effusion R knees
  - Skin: no lesions
  - ROM: 0 to 10 degrees, pain with any knee motion
  - Neurovascular: faint pulses, drop foot, L5 sensory changes
  - Ortho: Poor exam 2ND to body size, pain with any motion
- X-rays
  - AP, & Cross-table Lateral

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RADIOGRAPHS

AP VIEW



Photo courtesy TGocke, PA-C

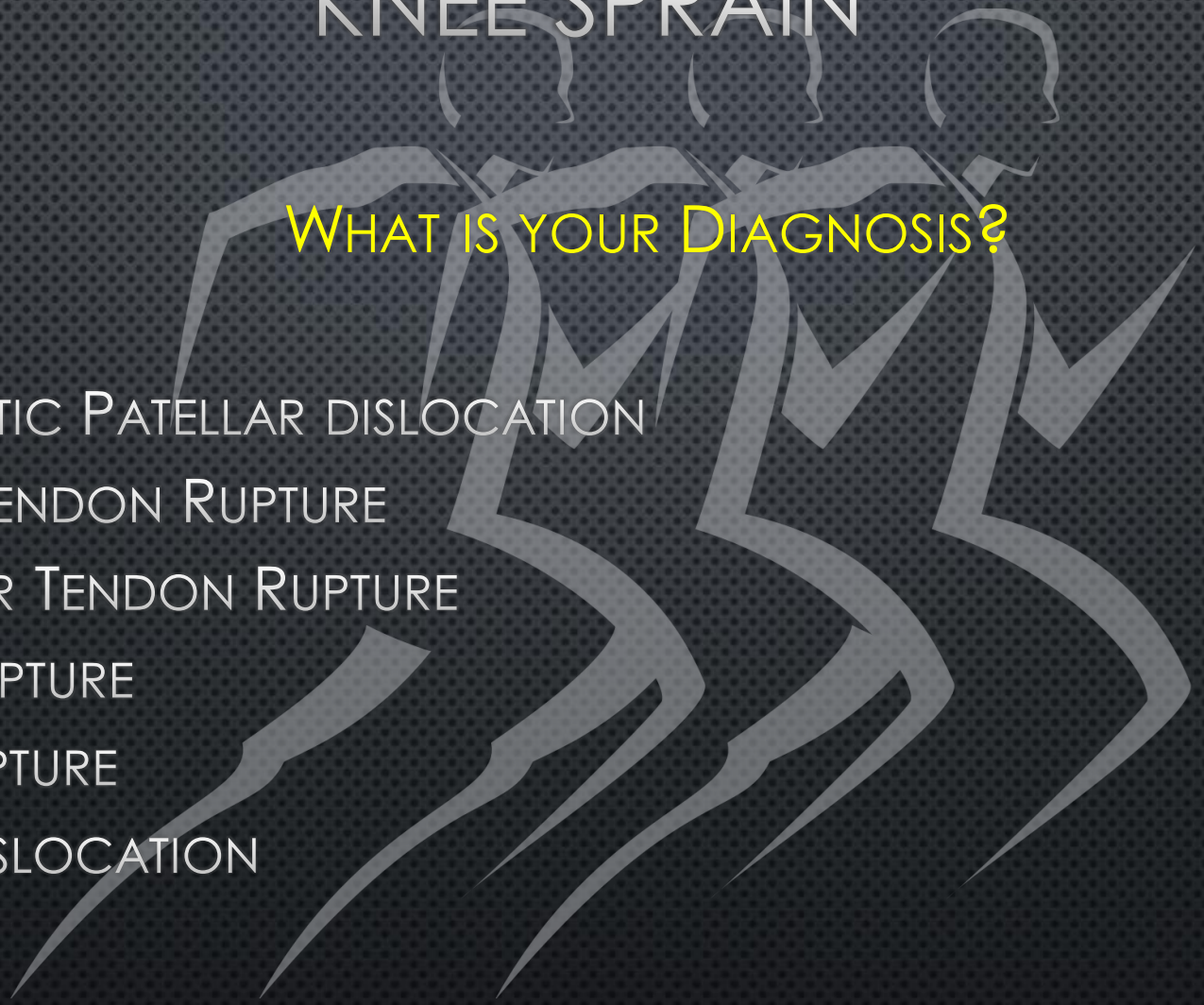
CROSS TABLE LATERAL VIEW



Photo courtesy TGocke, PA-C

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KNEE SPRAIN



WHAT IS YOUR DIAGNOSIS?

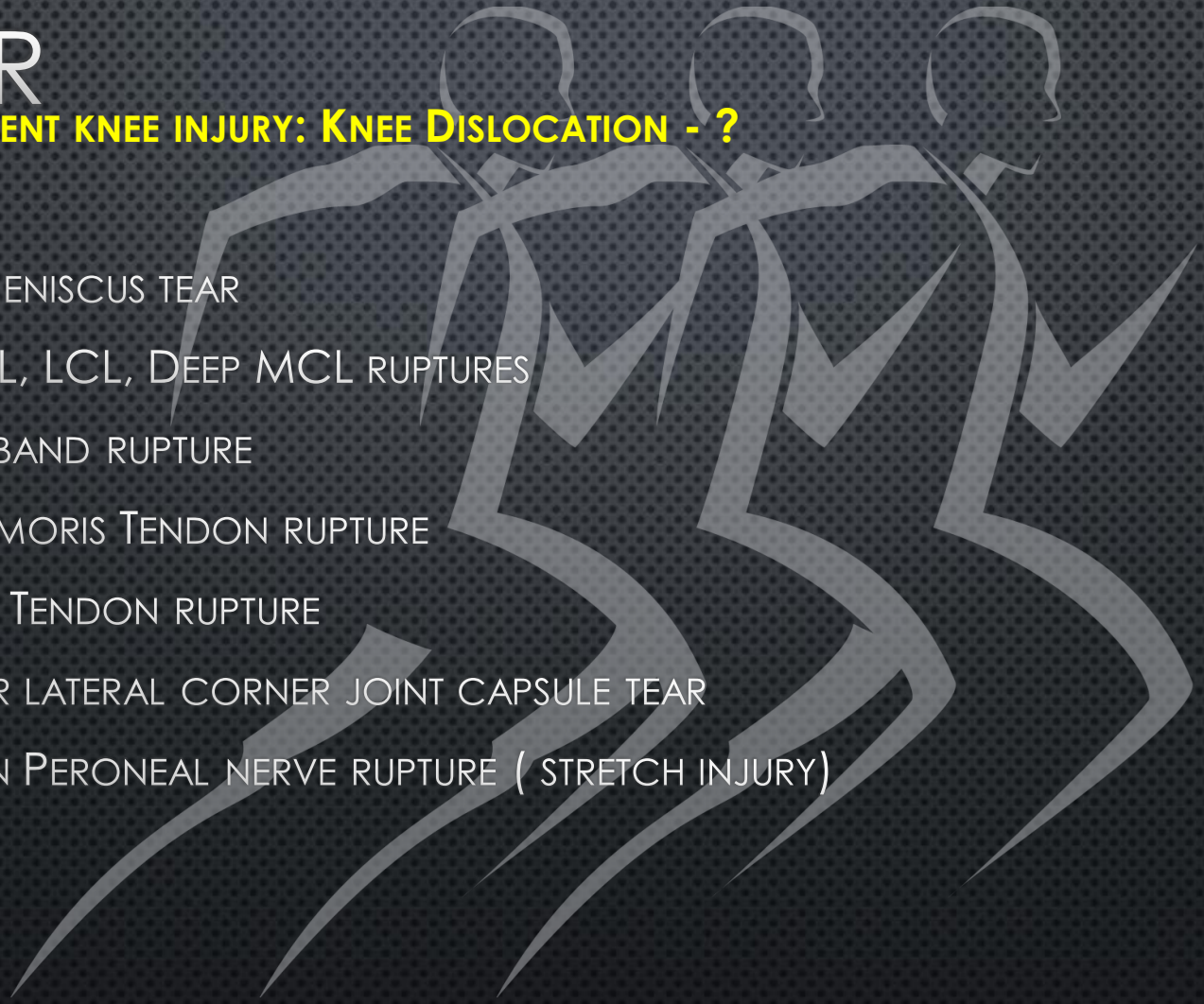
- TRAUMATIC PATELLAR DISLOCATION
- QUAD TENDON RUPTURE
- PATELLAR TENDON RUPTURE
- ACL RUPTURE
- LCL RUPTURE
- KNEE DISLOCATION

ANSWER

Multi-ligament knee injury: Knee Dislocation - ?

MRI results:

- Medial meniscus tear
- ACL, PCL, LCL, Deep MCL ruptures
- Iliotibial band rupture
- Biceps Femoris Tendon rupture
- Popliteus Tendon rupture
- Posterior lateral corner joint capsule tear
- Common Peroneal nerve rupture (stretch injury)



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TAKE HOME POINTS

- Mechanism of injury –Vague hx
- Physical Exam changes:
  - Unable to move knee
  - Multiple Ligament injury - **SKIN IS NOT A STABILIZER**
  - Drop Foot
  - Dorsal foot sensory changes
  - Asymmetric pulse assessments
- PMH: ETOH
- Reports x-ray was neg for fx
    - Joint effusion
    - Lateral joint swelling
    - Avulsion fx Fibular head
    - Varus knee alignment

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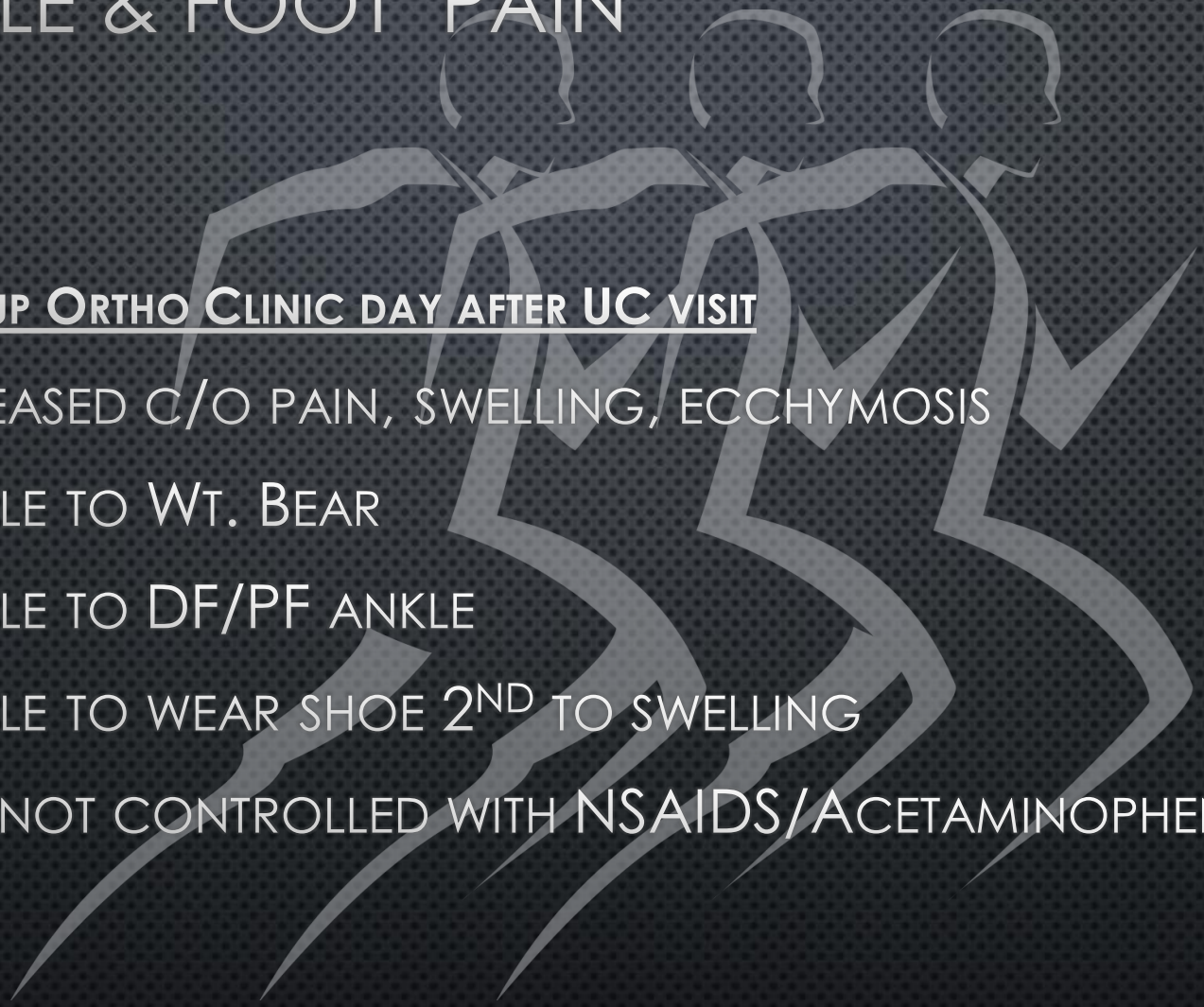
ANKLE & FOOT PAIN

ANKLE & FOOT PAIN

- **CHIEF COMPLAINT**: ANKLE & FOOT PAIN
  - 22 YO FEMALE WITH 4-DAY COMPLAINT OF LEFT ANKLE AND FOOT PAIN
  - COLLEGE VB COACH
  - TRIPPED OVER BAG ON FLOOR AND TWISTED ANKLE AND FOOT
  - DIFFICULTY WITH WT-BEARING
  - PREVIOUS HX LISFRANC JOINT INJURY W/ SURGERY
  - **INITIAL MANAGEMENT**
    - SEEN @ UC THE MORNING FOLLOWING HER INJURY
    - X-RAY: NEGATIVE PER UC PROVIDER
    - RX: OTC NSAIDS, REST, ACE WRAP AND CRUTCHES
    - FOLLOW UP W/ ORTHO IF NOT IMPROVED

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ANKLE & FOOT PAIN



Follow up Ortho Clinic day after UC visit

- Increased c/o pain, swelling, ecchymosis
- Unable to Wt. Bear
- Unable to DF/PF ankle
- Unable to wear shoe 2nd to swelling
- Pain not controlled with NSAIDS/Acetaminophen

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ANKLE & FOOT PAIN

- **Allergies**: none (Drugs-Food-Latex)
- **Medications**: OTC NSAIDS, Acetaminophen
- **PMH**: Asthma, D&C, Lisfranc injury
- **SocialHx**: Neg ETOH, Tobacco, Drugs
- **FMH**: DM, HTN, CA [Breast, ovarian, colon]
- **Physical Exam:**
  - General: AAO, normal appearance, no acute distress
  - Skin- deformity Tarsometatarsal jt.
  - Palpate: Tender Talonavicular jt, Neg Lisfranc, ankle jt
  - ROM: limited Ankle DF/PF, Inv/Eve
  - Neuro/sensory intact
  - Ortho Tests: Stable Anterior Drawer

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WHAT IS YOUR DIAGNOSIS?

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ANSWER

Talonavicular joint dislocation

- Ankle X-ray normal
- Foot X-ray dislocation Talonavicular joint
- Previous hx Lisfranc joint injury with surgical correction
- Referred to Teaching Hospital for follow up care same day
- Underwent conscious sedation & Closed reduction

Take Home Points

- **Knowledge foot/ankle anatomy**
- **Enhance skills Interpreting foot & Ankle radiographs**



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ANKLE PAIN

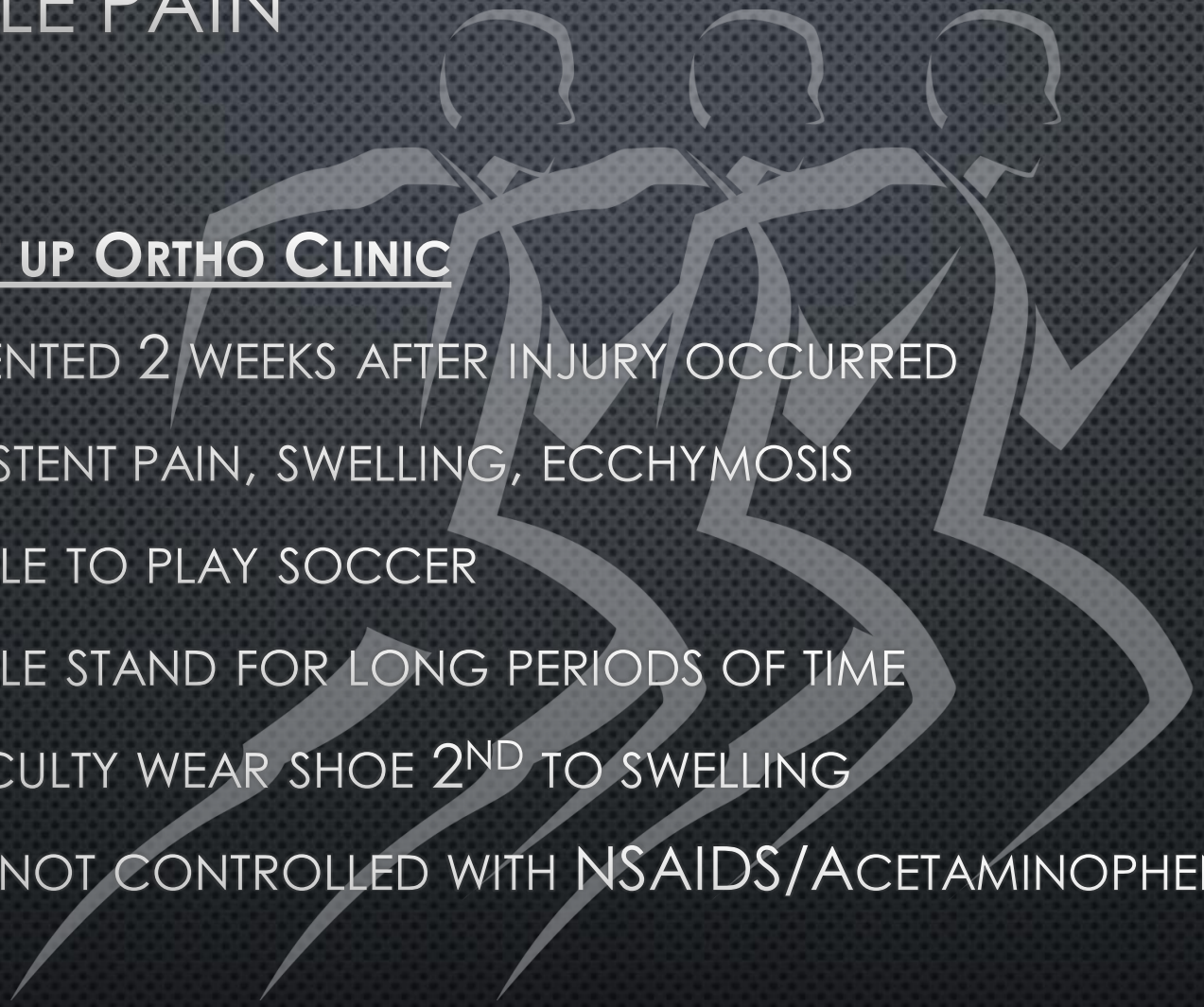
ANKLE PAIN



- **CHIEF COMPLAINT**: ANKLE & FOOT PAIN
  - 31 YO FEMALE WITH ANKLE INJURY AFTER PLAYING SOCCER
  - INITIALLY UNABLE TO WT BEAR AFTER INJURY WITH PAIN
  - PERSISTENT SWELLING AND ECCHYMOSIS
  - MANAGED WITH HOME TREATMENT & LIMITED ACTIVITY

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ANKLE PAIN



Follow up Ortho Clinic

- Presented 2 weeks after injury occurred
- Persistent pain, swelling, ecchymosis
- Unable to play soccer
- Unable stand for long periods of time
- Difficulty wear shoe 2ND to swelling
- Pain not controlled with NSAIDS/Acetaminophen

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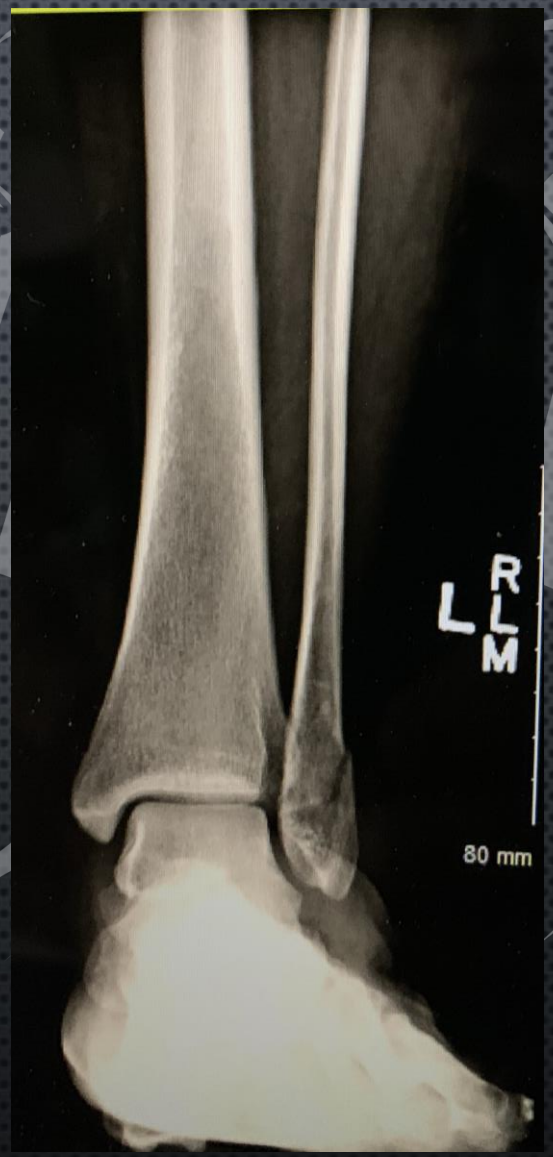
ANKLE PAIN

- **ALLERGIES**: NONE (DRUGS-FOOD-LATEX)
- **MEDICATIONS**: OTC NSAIDS, ACETAMINOPHEN, LOESTRIN
- **PMH**: TONSILLECTOMY
- **SOCIALHX**: NEG ETOH, TOBACCO, DRUGS
- **FMH**: DM, HTN,
- **PHYSICAL EXAM:**
  - GENERAL: AAO, NORMAL APPEARANCE, NO ACUTE DISTRESS
  - SKIN- SWELLING & ECCHYMOSIS
  - PALPATE: TENDER LATERAL/MEDICAL MALLEOLUS, SYNDESMOSIS
  - ROM: LIMITED ANKLE DF/PF, INV/EVE
  - NEURO/SENSORY INTACT
  - ORTHO TESTS: ANTERIOR DRAWER LAXITY

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RADIOLOGY

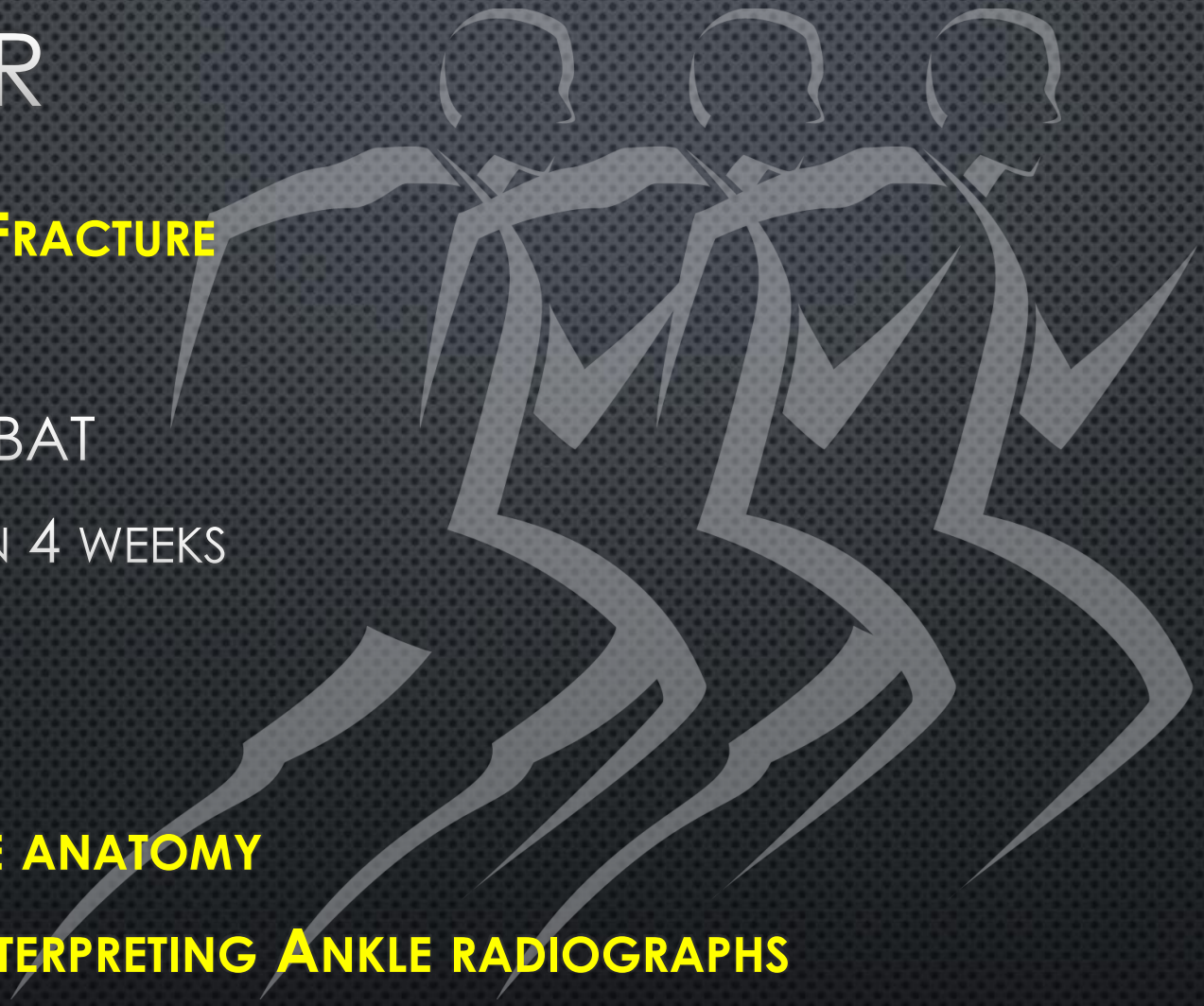
WHAT IS YOUR DIAGNOSIS?





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ANSWER



Lateral Malleolus Fracture

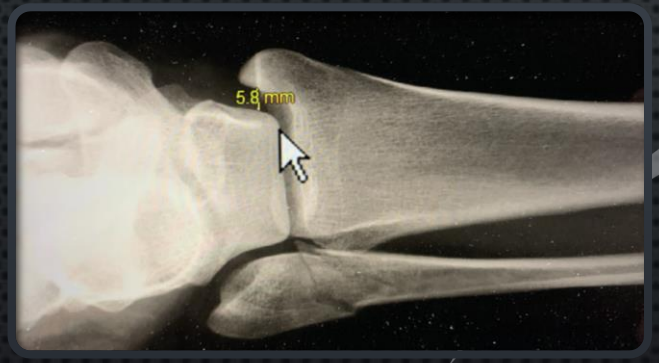
- Ankle X-ray
- Ankle Fx boot WBAT
- Follow up appt in 4 weeks

Take Home Points

- **Knowledge ankle anatomy**
- **Enhance skills Interpreting Ankle radiographs**

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ANSWER – DID YOU REALLY PAY ATTENTION

- **Lateral Malleolus Fracture**
- Ankle fracture at the level ankle Mortise
- Medial & lateral Malleolus tenderness
- Gravity stress view positive

- **Take Home Points**
- **Knowledge ankle anatomy**
- **Enhance skills Interpreting Ankle radiographs**

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KNEE PAIN AFTER A FALL



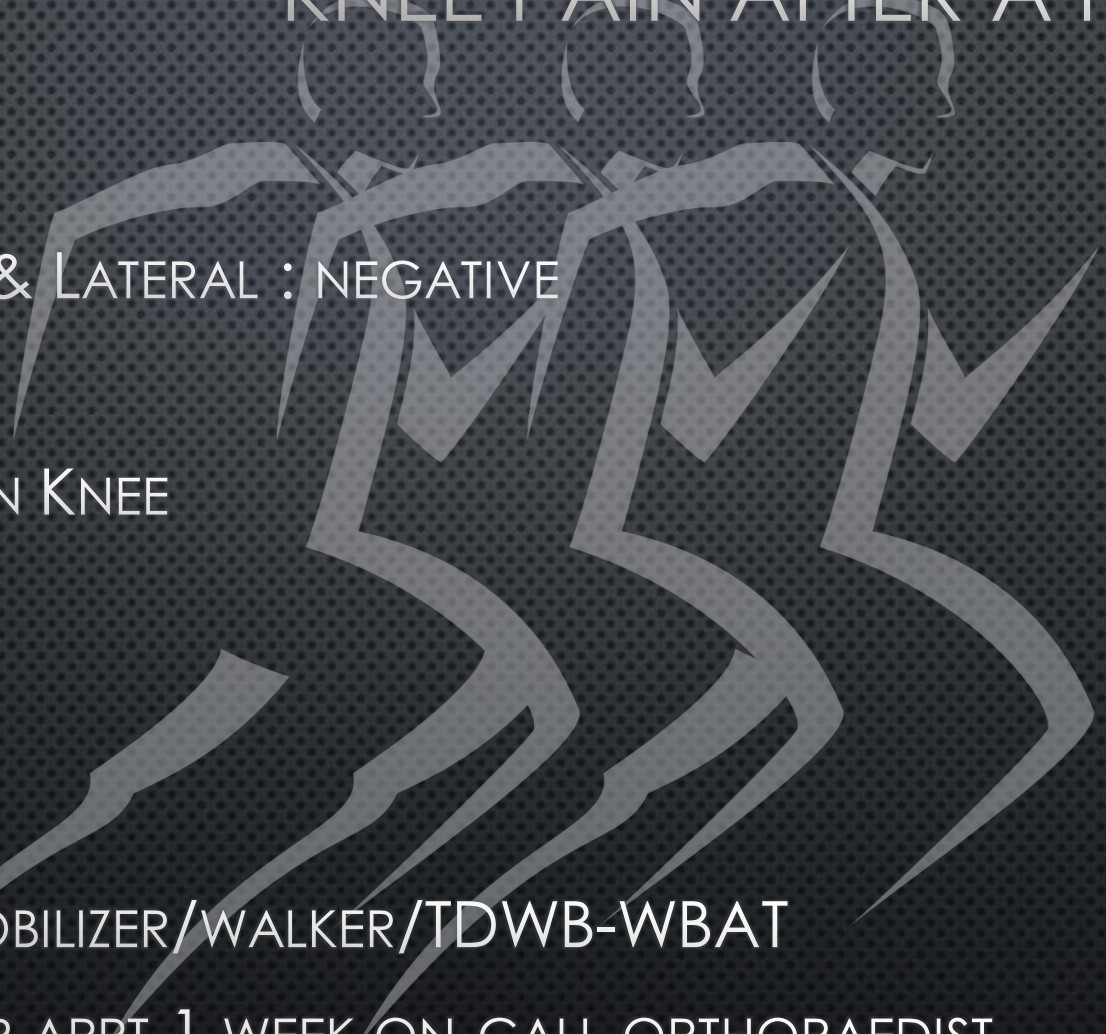
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KNEE PAIN AFTER A FALL

- **CC: KNEE PAIN**
- **HPI:**
  - 78 YO FEMALE TRIPPED AND FELL ON A FLEXED KNEE
  - ACUTE ONSET OF PAIN AND UNABLE TO WALK
  - PT TAKEN TO LOCAL ER BY EMS 2ND TO PAIN & UNABLE TO WALK
- **PE: (ED)**
  - VITAL SIGNS STABLE
  - DIFFICULTY WITH WEIGHT BEARING – IMPROVED AFTER PAIN MANAGEMENT

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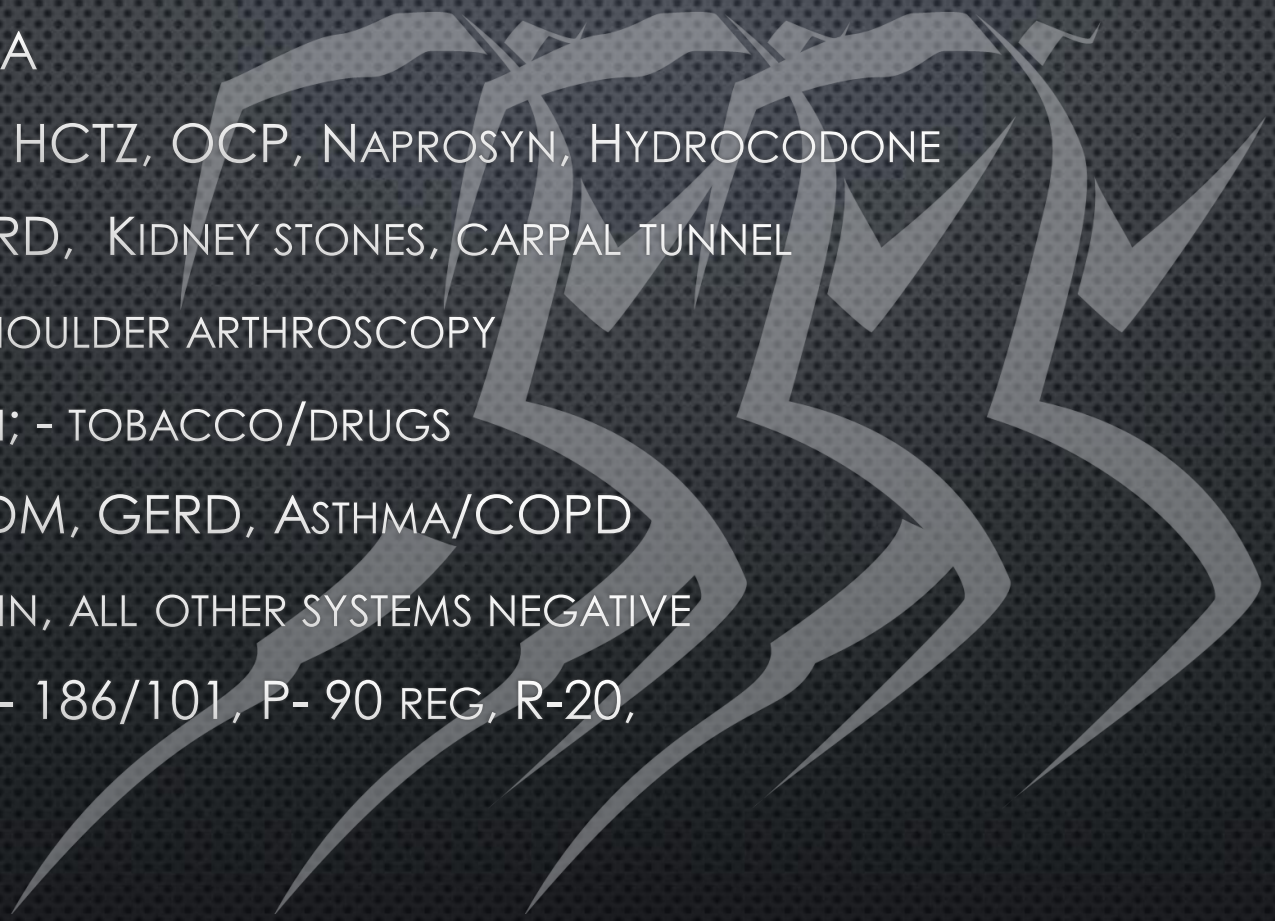
KNEE PAIN AFTER A FALL



- **PE: (ED) cont.**
  - Radiographs
    - KNEE AP & Lateral : negative
  - Diagnosis:
    - Contusion Knee
  - Treatment:
    - NSAIDS
    - Ice
    - Knee immobilizer/walker/TDWB-WBAT
    - Follow-up appt 1 week on-call orthopaedist

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KNEE PAIN AFTER A FALL

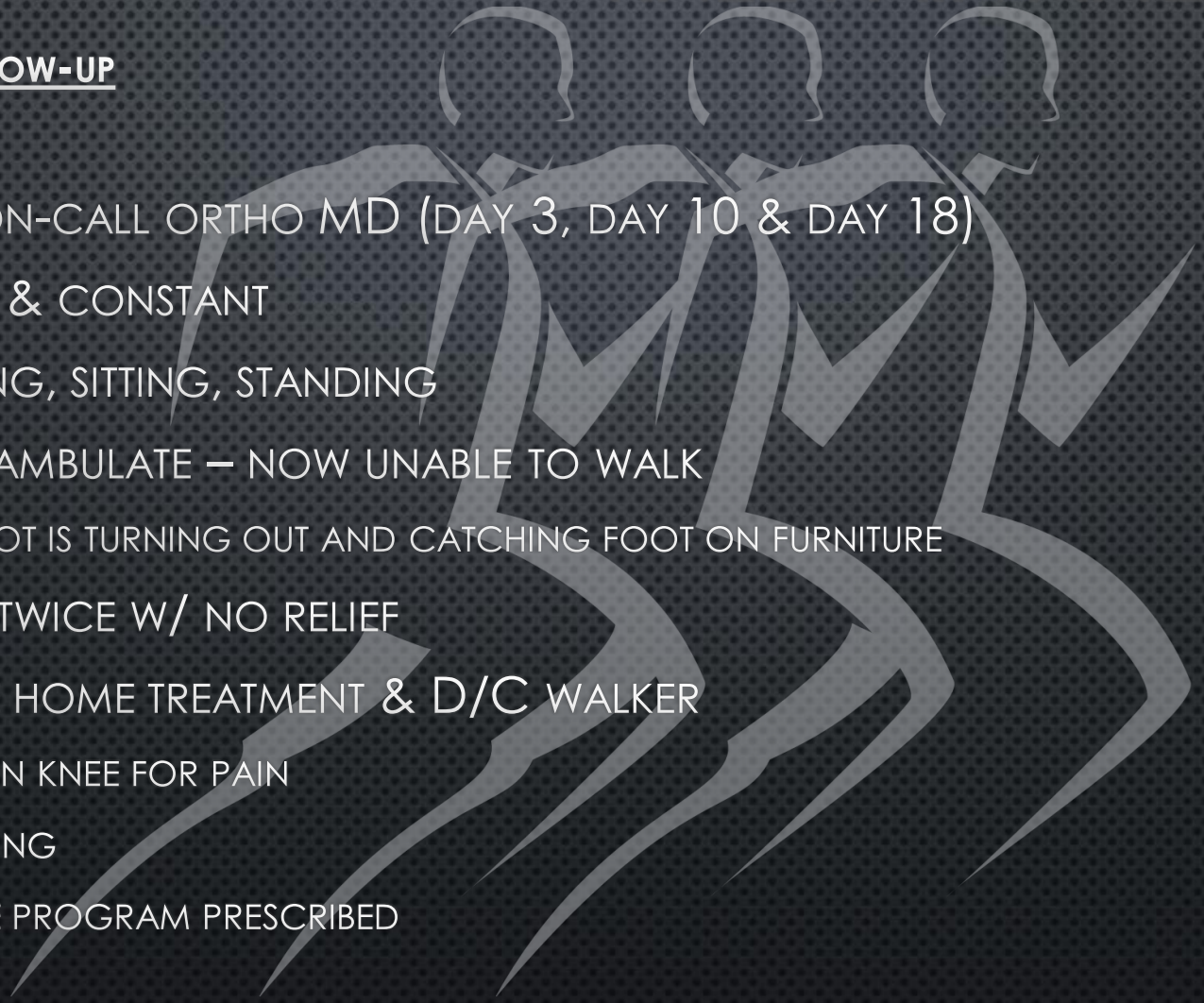


2ND OPINION ORTHOPAEDIC FOLLOW-UP

- **ALLERGIES**: NKDA
- **MEDS:** LISINIPRIL, HCTZ, OCP, NAPROSYN, HYDROCODONE
- **PMH**: HTN, GERD, KIDNEY STONES, CARPAL TUNNEL
- **SURGICALHX:** SHOULDER ARTHROSCOPY
- **SOCHX**: + ETOH; - TOBACCO/DRUGS
- **FAMHX**: HTN, DM, GERD, ASTHMA/COPD
- **ROS**: + KNEE PAIN, ALL OTHER SYSTEMS NEGATIVE
- **VITAL SIGNS**: BP- 186/101, P- 90 REG, R-20,

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KNEE PAIN AFTER A FALL



ON-CALL ORTHOPAEDIC FOLLOW-UP

- **HPI**
  - SEEN 3 TIMES BY ON-CALL ORTHO MD (DAY 3, DAY 10 & DAY 18)
  - PAIN ESCALATING & CONSTANT
  - DIFFICULTY SLEEPING, SITTING, STANDING
  - INITIALLY ABLE TO AMBULATE – NOW UNABLE TO WALK
    - COMPLAINS FOOT IS TURNING OUT AND CATCHING FOOT ON FURNITURE
  - REFILL PAIN MEDS TWICE W/ NO RELIEF
  - TOLD TO IMPROVE HOME TREATMENT & D/C WALKER
    - HEATING PAD ON KNEE FOR PAIN
    - INCREASE WALKING
    - HOME EXERCISE PROGRAM PRESCRIBED

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KNEE PAIN AFTER A FALL



ORTHOPAEDIC FOLLOW-UP

- PHYSICAL EXAMINATION: R KNEE
  - GEN: WNWD, NAD
  - MSK:
    - NO KNEE EFFUSION, NO SKIN LESION OR BURSING, NO DEFORMITIES
    - UNABLE TO WT BEAR
    - ROM- -5 -0-90 DEGREES (PAINFUL)
    - NO TENDERNESS KNEE OR THIGH
    - NO LIGAMENT LAXITY
    - NOTICEABLE LEG LENGTH DIFFERENCE
    - EXTERNAL ROTATED RIGHT FOOT
    - NV, NS INTACT

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KNEE PAIN AFTER A FALL



2ND OPINION ORTHOPAEDIC FOLLOW-UP

- **HPI**
  - PRESENTED 3 WEEKS AFTER INITIAL INJURY OCCURRED TO OUR CLINIC
  - PAIN UNCONTROLLABLE WITH NARCOTIC ANALGESICS
  - DIFFICULTY SLEEPING, SITTING, STANDING
  - WHEELCHAIR OR BED BOUND
  - PT STATES ON-CALL ORTHO X-RAYED KNEE TWICE WITH NEG.
  - HOME TREATMENT MAKING PAIN WORSE

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KNEE PAIN AFTER A FALL

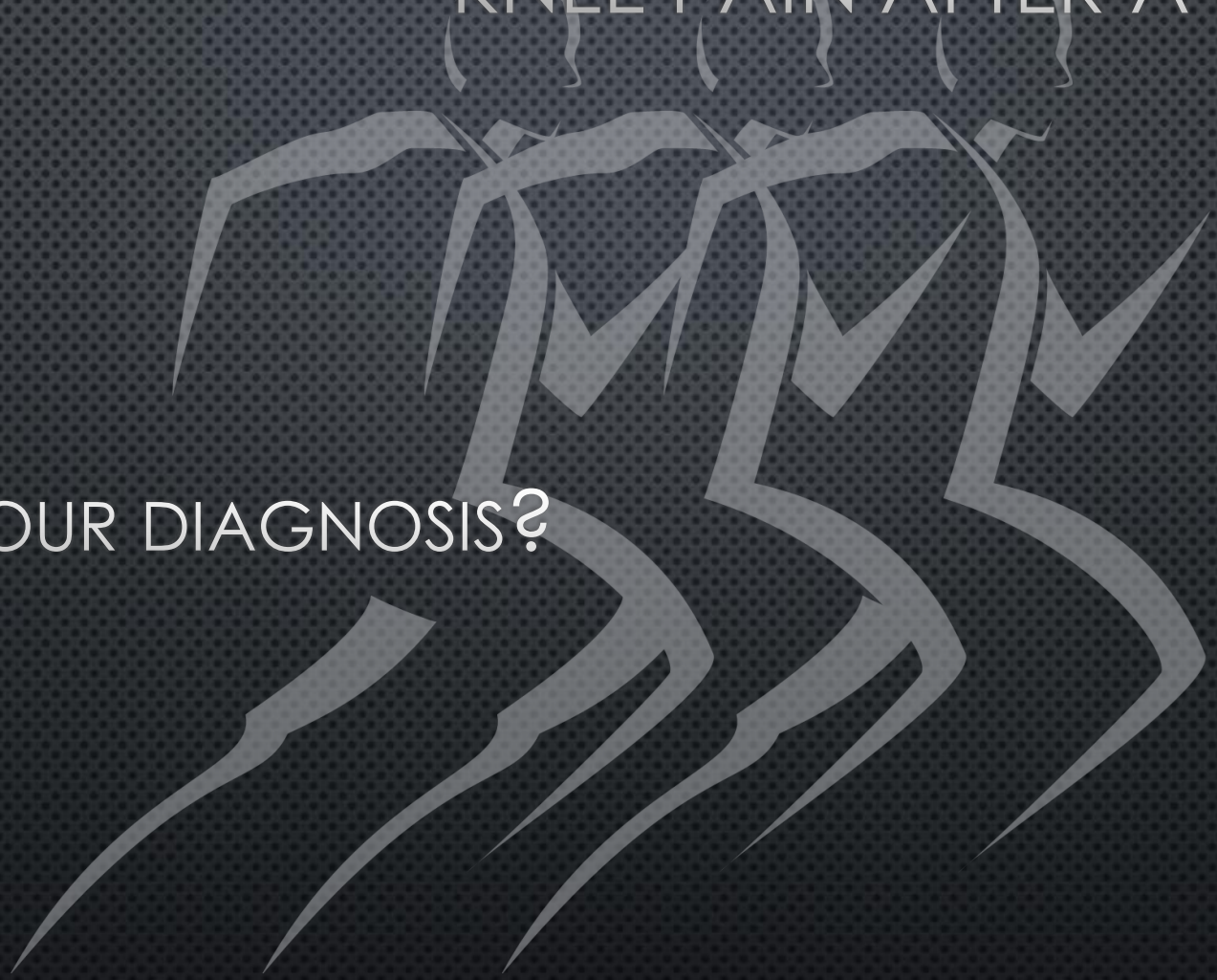
ORTHOPAEDIC FOLLOW-UP

- X-RAY EXAMINATION
  - AP, LAT & SKYLINE



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KNEE PAIN AFTER A FALL



WHAT IS YOUR DIAGNOSIS?

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Diagnosis: Femoral Neck Fx

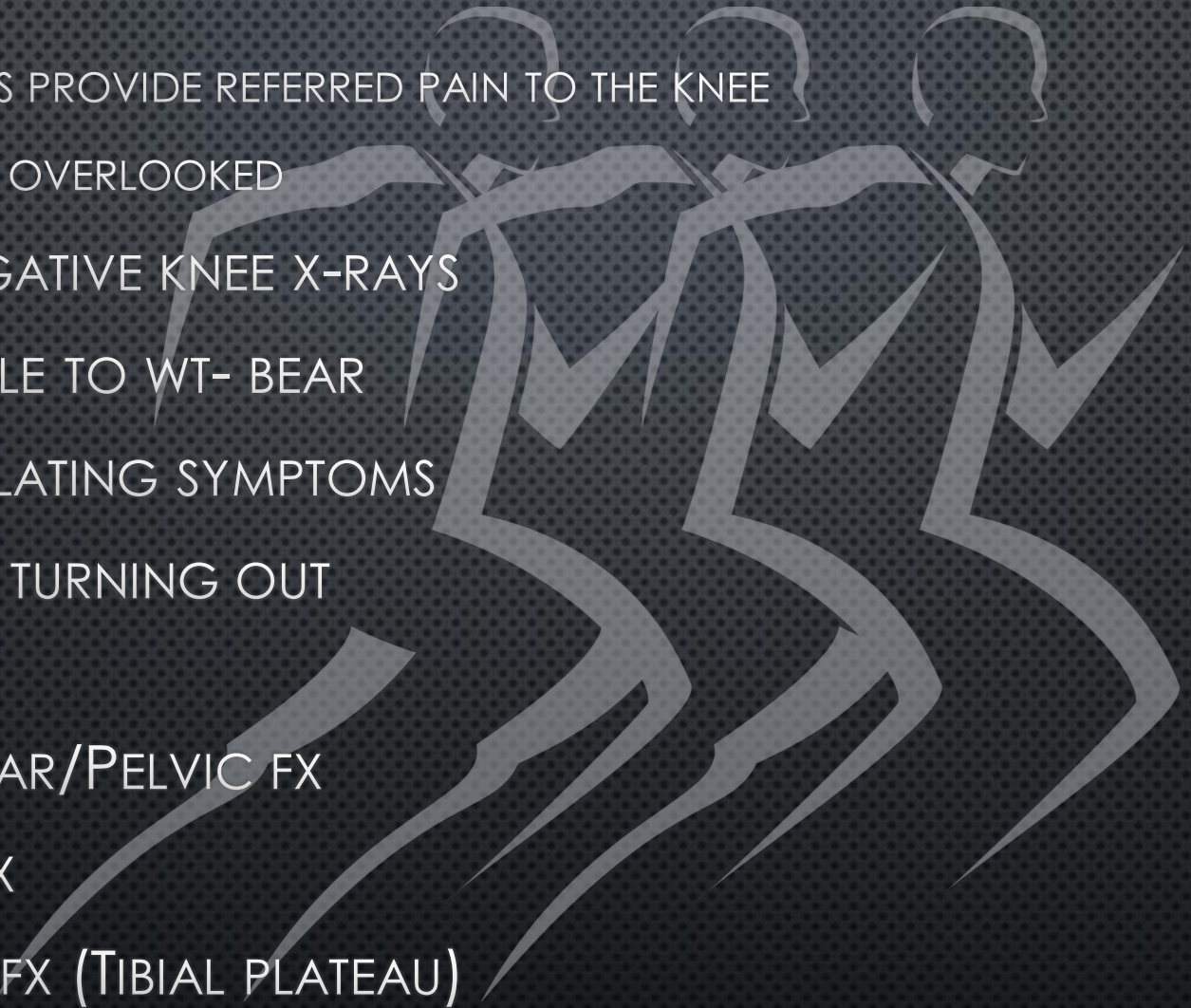
- Cause
  - 2nd falls or trauma
  - Osteoporosis
  - Tumor
- Symptoms
  - Age
  - Fall
  - Pain
  - Inability to wt-bear
  - Leg length inequality
  - Rotation deformities



Photo courtesy TGocke, PA-C

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TAKE HOME POINTS



- Hip Injuries provide referred pain to the knee
- Key points overlooked
  - 2 negative knee x-rays
  - Unable to wt- bear
  - Escalating symptoms
  - Foot turning out
- Consider
  - Lumbar/Pelvic fx
  - Hip Fx
  - Knee fx (Tibial plateau)

Proficient Physical Exam & Skeletal x-ray review

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HIP PAIN

- **HPI:**
  - 73 yo female had Total hip surgery and has been relatively sedentary for the past 3 months
  - She has trouble getting in/out chairs, sitting, buttocks pain
  - She is a large body habitus, general body deconditioning
  - Trouble sleeping on her sides
  - Changes position frequently and has trouble with stairs

NKDA

PMHx: DM, HTN, Anxiety

SocHx, FamHx: Negative

Meds: Atenolol, Metformin, Lasix, Wellbutrin

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HIP PAIN



PHYSICAL EXAM:

INSPECTION: HIGH BODY MASS INDEX 48 BMI

PALPATION: TENDER SCIATIC NOTCH, TROCHANTERIC & GROIN

ROM:

- LIMITED TRUNK, HAMSTRINGS, QUAD, GASTROC
- PAIN ALL OVER

STRENGTH: WEAK BODY

NEURO/VASCULAR: DECREASED SENSORY BILATERAL DORSAL FEET

ORTHO:

- PAIN W/ SLR TEST
- PAIN W/OBER TEST

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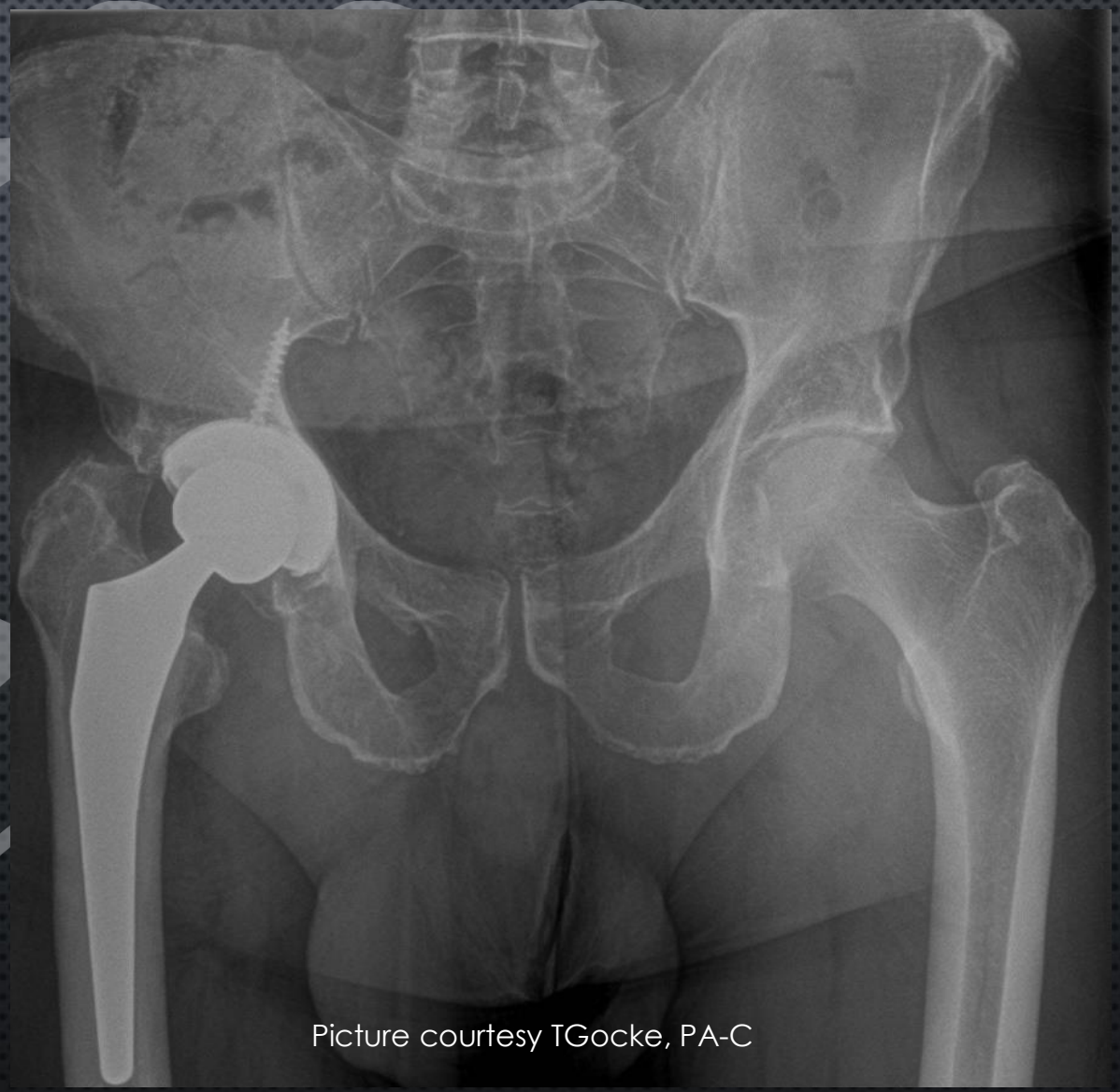
HIP PAIN

X-RAY:

- WHAT DO YOU SEE?

DIAGNOSIS

- AVN
- HIP OA
- TROCHANTERIC BURSITIS
- HERNIATED LUMBAR DISC
- SACROIILITIS



Picture courtesy TGocke, PA-C

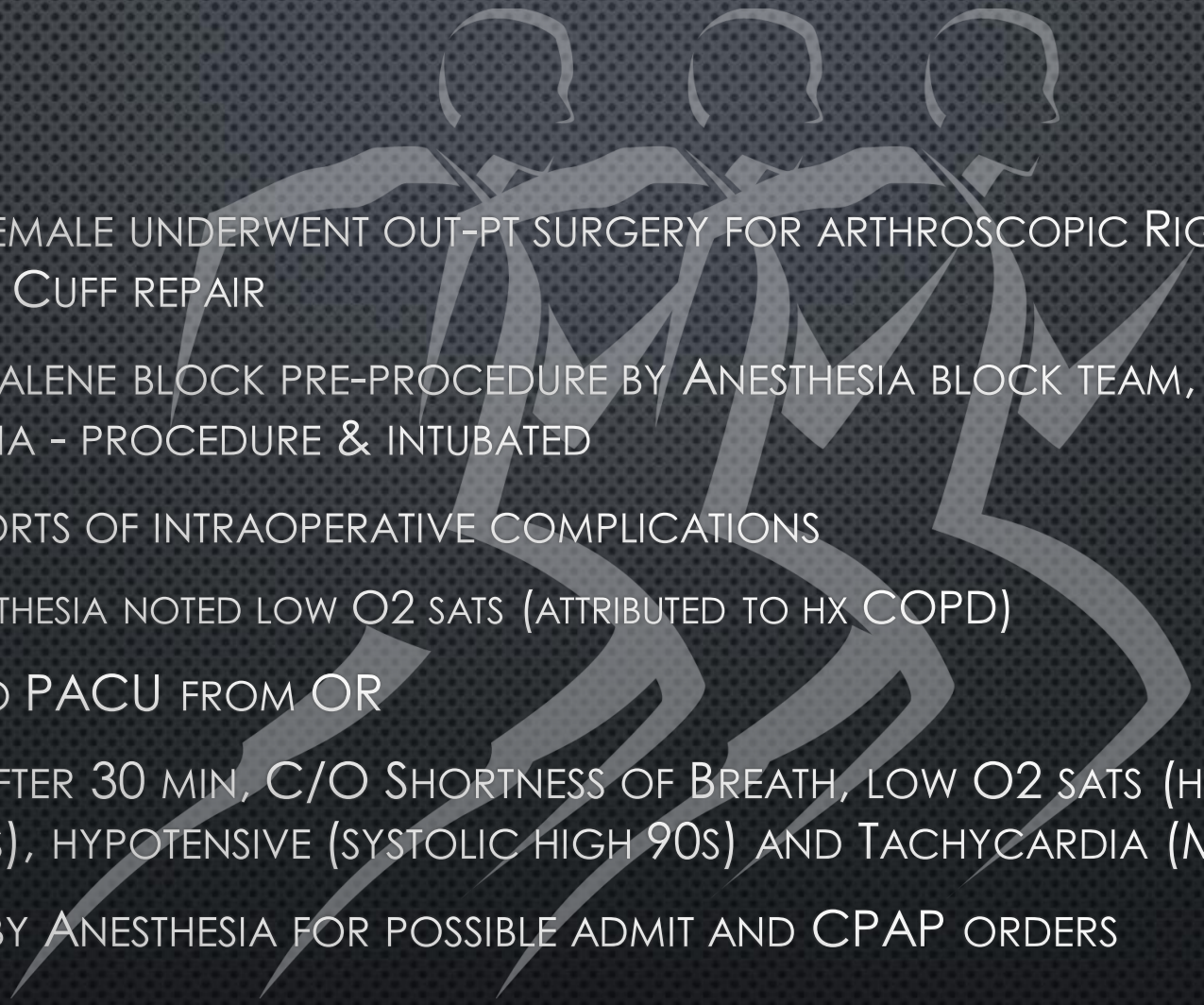
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RIGHT ROTATOR CUFF REPAIR



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ROTATOR CUFF REPAIR

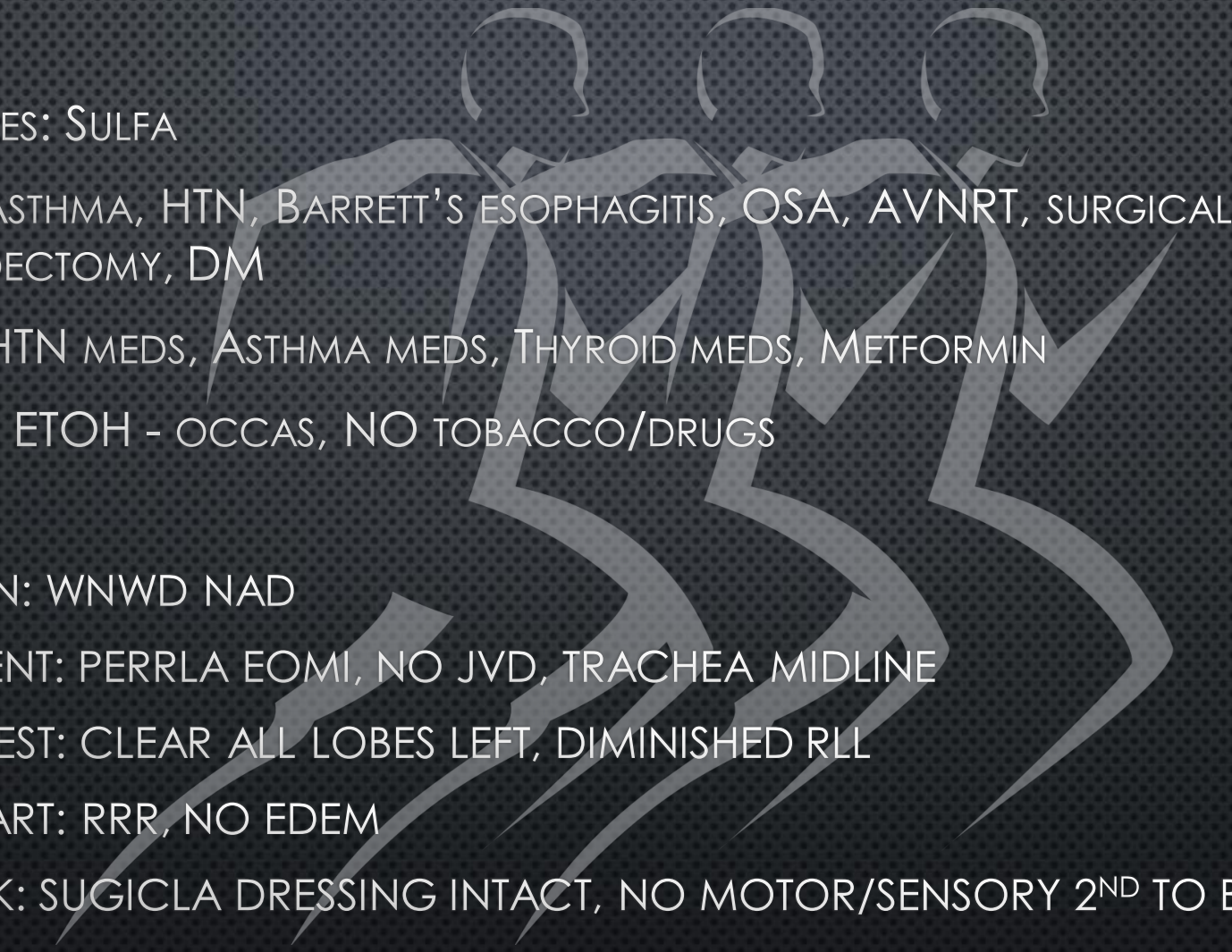


HPI:

- 62 YO female underwent out-pt surgery for arthroscopic Right Rotator Cuff repair
- Intra-Scalene block pre-procedure by Anesthesia block team, General anesthesia - procedure & intubated
- NO reports of intraoperative complications
  - Anesthesia noted low O2 sats (attributed to hx COPD)
- Stable to PACU from OR
- PACU after 30 min, C/O Shortness of Breath, low O2 sats (high 80s-low 90s), hypotensive (systolic high 90s) and Tachycardia (Mid-90's)
- Called by Anesthesia for possible admit and CPAP orders

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ROTATOR CUFF REPAIR



- ALLERGIES: SULFA
- PMH: ASTHMA, HTN, BARRETT'S ESOPHAGITIS, OSA, AVNRT, SURGICAL THYROIDECTOMY, DM
- MEDS: HTN MEDS, ASTHMA MEDS, THYROID MEDS, METFORMIN
- SOCHX: ETOH - OCCAS, NO TOBACCO/DRUGS
- EXAM:
  - GEN: WNWD NAD
  - HEENT: PERRLA EOMI, NO JVD, TRACHEA MIDLINE
  - CHEST: CLEAR ALL LOBES LEFT, DIMINISHED RLL
  - HEART: RRR, NO EDEM
  - MSK: SUGICLA DRESSING INTACT, NO MOTOR/SENSORY 2ND TO BLOCK

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ROTATOR CUFF REPAIR

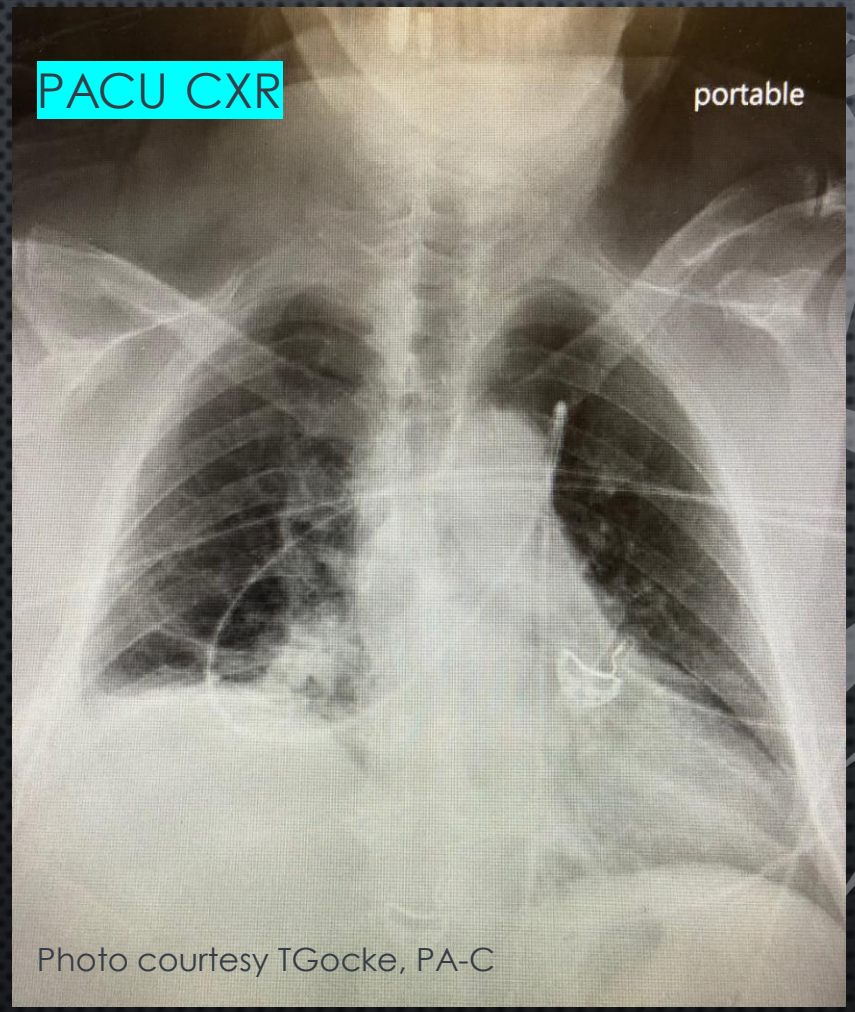


Photo courtesy TGocke, PA-C

What is your Diagnosis?

Aspiration Pneumonia
Acute Myocardial Infarction
Exacerbation OSA
Phrenic Nerve paresis
Pulmonary embolus
Pneumothorax

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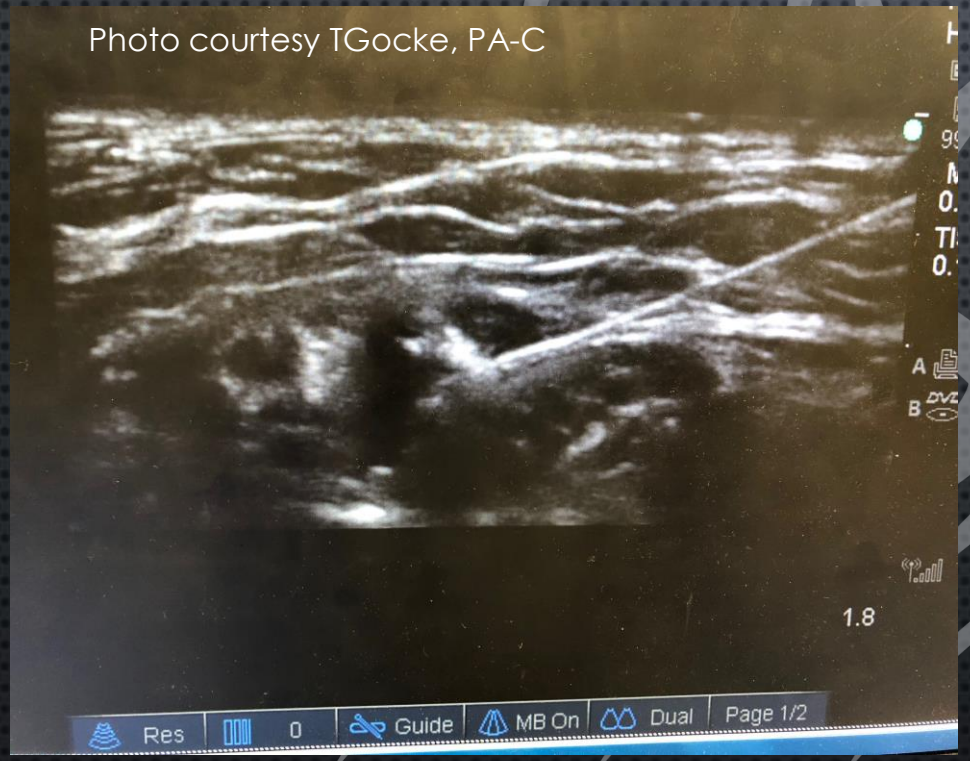
ANSWER

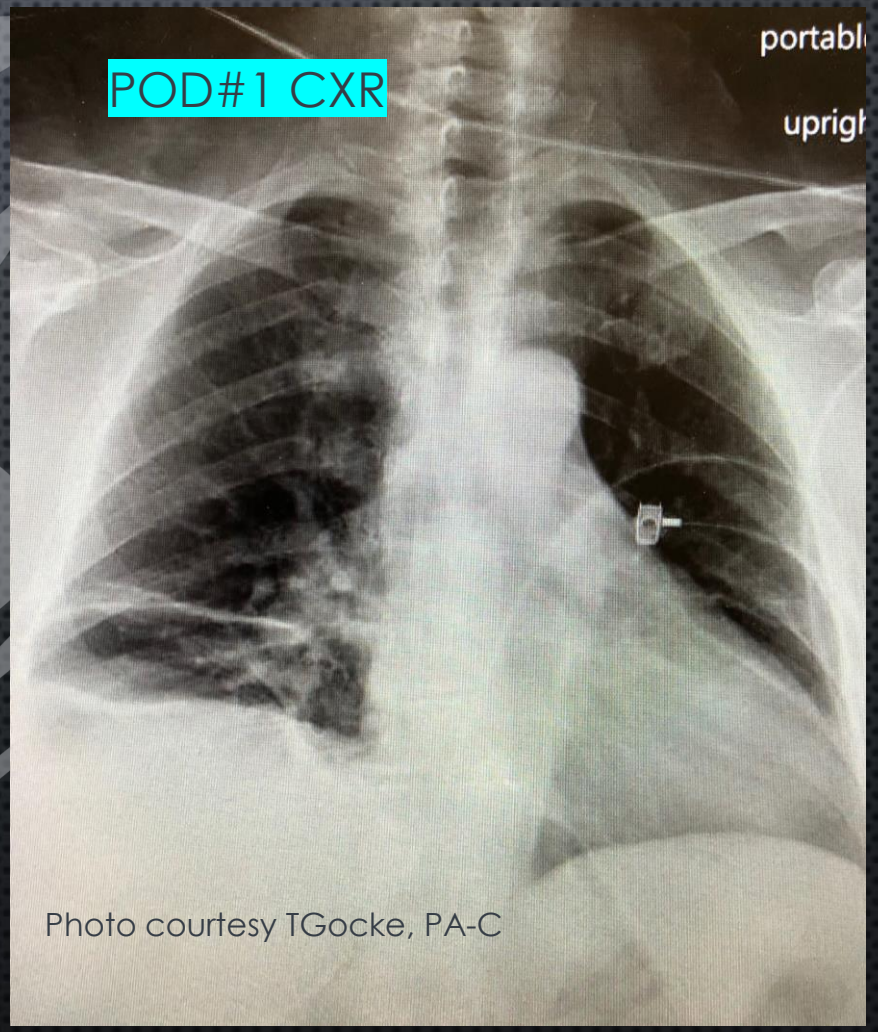
Phrenic Nerve paresis(1,2)

- **Interscalene** brachial plexus (ISB) **block** is often associated with **phrenic nerve block** and **diaphragmatic paresis.**
- Increasing popularity with out-pt surgery and pain mgmt
- Causes
  - C3-C4-C5 nerve root block 2ND to cranial spread of anesthetic agent (blind injection & Large volume)
  - **Direct Phrenic nerve block with anterior Scalene Fascia injection**
- **Not recommended for pts with Pulmonary function impairment**

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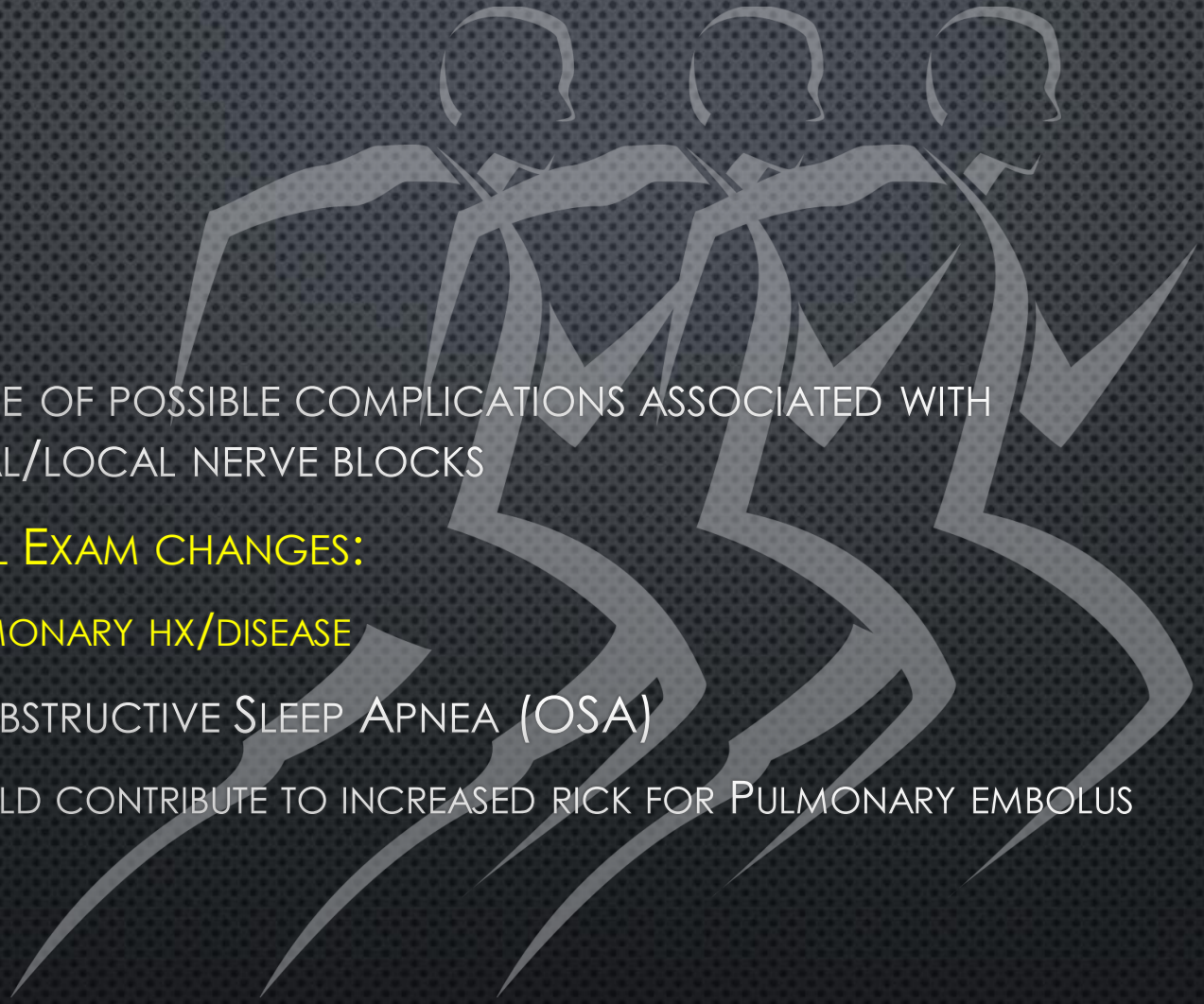
ROTATOR CUFF REPAIR





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TAKE HOME POINTS



- Be aware of possible complications associated with regional/local nerve blocks
- Physical Exam changes:
  - Pulmonary hx/disease
- PMH: Obstructive Sleep Apnea (OSA)
  - Could contribute to increased rick for Pulmonary embolus

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Blue Ridge Parkway
Ashe Co., NC
Picture courtesy TGocke, PA-C

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