

The Patient with Longstanding Symptoms

CHAPTER

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A regular presentation in sports medicine is that of a patient who has already consulted a number of practitioners for diagnosis and treatment about what appears to be a musculoskeletal problem but whose symptoms remain unresolved.

Presentations of patients with longstanding symptoms may include:

- chronic low back pain or neck pain
- persistent tendinopathies
- multiple painful sites
- a persistent joint problem
- a non-healing fracture
- persistent foot pain.

Longstanding symptoms may be due to the conditions that masquerade as sports injuries (Chapter 4) but they may also be true musculoskeletal problems. Note that a condition that masquerades as a sports medicine condition may not produce longstanding symptoms as it may produce significant symptoms in the short term if not diagnosed (e.g. deep venous thrombosis and pulmonary embolism masquerading as a calf injury). We also suggest that the reader reviews Chapter 3, which discusses the multifactorial nature of chronic musculoskeletal pain with contributions from joints, muscles and neural structures. Unless all these contributors are recognized and eliminated, the result will be unsatisfactory.

The purpose of this chapter is to provide a clinical approach to the 'difficult' presentation. We do not suggest we have the answers for all, or even most, such presentations. Nevertheless, a systematic approach to this presentation can lead to successes. We use case histories to illustrate our suggestions. In our experience, the presentation of unresolved pain generally presents as a diagnostic challenge, or

a therapeutic challenge, so the chapter is structured to reflect this.

What is the diagnosis?

When you are referred a patient known to have a long history of problems, you may wish to schedule extra time when making the appointment to permit a thorough evaluation. If there is no forewarning that the patient has longstanding symptoms, we suggest explaining to the patient the need to revisit the entire history, examination and investigations thoroughly and that an additional appointment time will be needed to do this. In this way, the initial, perhaps 10–20 minute, consultation can be used to emphasize the importance of the problem and the rationale for treating it differently from a straightforward presentation.

Going back to square one

By definition, the problem began a long time earlier so it is crucial to obtain details of the earliest symptoms in the patient's own words rather than from a referral letter or discharge summary. For example, what has been evaluated as chronic knee pain for the past few years may have begun with a childhood knee injury that had been overlooked. After a thorough assessment of the presenting complaint, its time course and response to therapy, remember to ask about the past medical history and the past family history. Associated musculoskeletal symptoms that provide a clue to an alternative diagnosis may only arise by specific questioning.

For example, a 33-year-old woman who presented with chronic wrist pain unresponsive to physical

therapies eventually recalled several episodes of joint swelling and pain in childhood that were attributed to playing sport. The history provided a vital clue to her final diagnosis of rheumatoid arthritis. A stockbroker with longstanding shoulder pain was surprised to be asked about previous neck pain. She had fallen from her horse two years earlier but an X-ray of her neck was normal and, as her neck pain settled, she no longer gave it any consideration. Failed therapy to her shoulder, including several corticosteroid injections, led to a review, and the history of neck injury, together with C3–4 tenderness on careful palpation, led to the eventual diagnosis of a significant facet joint hypomobility.

It is important for the practitioner to ask about the demands of work, as active individuals often attribute symptoms to sport when this may not always be the case. An executive attributed his shoulder pain to weight training, particularly to resting the squat bar on his shoulders, but careful history taking revealed that he always jammed the telephone into the crook of his shoulder for upwards of five hours per day. Examination revealed loss of triceps jerk and weakness in the C5–6 distribution. CT scan confirmed a lateral disk bulge that impinged the nerve root at its foraminal exit. Treatment consisted of a headset for the telephone and therapy to the neck, rather than avoidance of squats with weight on the neck.

A history of non-musculoskeletal symptoms may provide evidence of a systemic condition manifesting as long-term pain. A 42-year-old basketball coach was surprised to learn that his years of recalcitrant, but intermittent, midfoot pain could be linked to his psoriasis. These two aspects of his history had not been linked previously as he had provided the information about each in isolation when he saw different doctors and therapists about these problems.

Thorough examination

In cases of longstanding symptoms, the physical examination must be thorough (in scope) and meticulous (in attention to subtle details). The practitioner must always examine the spine, as referred pain commonly goes undiagnosed. A 44-year-old policeman who finally presented to the sports medicine clinic because of persistent chest pain had undergone a lot of cardiac and gastrointestinal investigations. Clearly, these conditions are important to rule out. Examination was able to reproduce his chest pain precisely by palpation of the mid-thoracic zygapophyseal joints. Careful observation and monitoring of his response to treatment confirmed this source of pain.

Continue to examine the patient thoroughly even if one abnormality has been found as there may be a combination of factors contributing to the current problem. A 65-year-old retired executive had an obvious clinical case of rupture of the proximal head of biceps. He functioned well but complained of persisting shoulder pain while sleeping. Examination revealed wasting of the infraspinatus and weakness of shoulder external rotation. Ultrasound confirmed a torn rotator cuff that may, or may not, have predated his biceps rupture. A strengthening program focused on the rotator cuff relieved his shoulder pain. This illustrates that although Occam's razor (to minimize the assumptions, i.e. aim to link symptoms to one diagnosis rather than multiple) is generally valid, and an extremely valuable medical principle, there can be exceptions.

The routine physical examination is not a very sensitive test for pain in athletic individuals, particularly elite performers. This is particularly true in ballet dancers and gymnasts. The diagnosis of a large central lumbar disk herniation was overlooked for months in a principal dancer with calf pain as he had 'full' flexion and 'normal' straight leg raise on examination. However, he was unable to lift his partners and, on closer examination, his straight leg raise was significantly reduced for him, although still greater than that for most patients. Thus, functional testing is an essential part of the examination, particularly if it is not possible to reproduce the patient's pain otherwise. If a patient has exercise-associated leg pain that only comes on after running, or riding, he or she should be encouraged to come to the consultation prepared to reproduce the pain by undertaking the activity.

Reassess the results of investigations

If an investigation provides a false negative result or is not interpreted correctly, it may lead to prolonged misdiagnosis.¹ Thus, practitioners must be prepared to re-examine investigation results, or repeat tests, where clinical suspicion demands. A 25-year-old woman with a classic longstanding history of traumatic rupture of her rotator cuff had undergone an ultrasound scan by very skilled ultrasound technicians that was reported correctly by the radiologist as being normal. Upon presentation as a patient with longstanding symptoms, MRI was performed, which revealed a full thickness tear of the cuff. Furthermore, it is possible for radiologists to miss subtle diagnoses, particularly if the clinical notes are brief or inaccurate. Remember that the radiologist may have over 60 images to examine for each MRI of the knee, or over 20 slices of a spine. If the clinical picture suggests