

# A 62-Year-Old Woman With Right Shoulder Pain

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What's the Take Home?

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**Introduction.** A 62-year-old right-handed woman presents with chronic right shoulder pain that she has been feeling for more than 1 year.

**Patient history.** The patient noted that her consistent, aching pain becomes more severe in certain positions, movements, and uses. Specifically, she feels a sharp pain at night when lying on her right side. She also feels an increased pain intensity when reaching overhead for high objects, when placing her right arm behind her back in the shower, putting on a coat, or toward the end of a pickleball session.

The patient feels symptomatic pain relief with varying combinations of nonsteroidal anti-inflammatory drugs (NSAIDs) and acetaminophen. Although she is unable to trace the shoulder issue to any prior acute traumatic event, she remains an active athlete. Indeed, the patient is quite healthy with no major medical diagnoses or chronic medications. When she was younger, she played competitive field hockey and volleyball.

A focused office orthopedic examination revealed some tenderness to probe palpation of the upper biceps and coracoid process areas with pain exacerbation during overhead motions (abduction). There was relative strength weakness when resistance was placed again with overhead and abduction movements of the right shoulder. When the right arm is passively elevated to 180° and the patient is asked to lower it actively, she reports no pain initially but increasing pain as it drops toward the halfway point of the downward arc then decreasing pain to the resting ends point ("painful arc test.")

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**Correct answer: B. Initiate a structured program of physical therapy and non-opioid analgesics with re-evaluation at 3 months.**

**Discussion.** Shoulder pain is second only to back pain as the most common orthopedic syndrome prompting ambulatory physician visits in the United States.<sup>1</sup> The most common etiology of shoulder pain is rotator cuff disorder. Although most patients with this condition are referred to orthopedic surgeons, the ubiquity of the diagnosis warrants an introductory overview, so all physicians understand the basics of its presentation, examination findings and radiology reporting, and treatment options to our patients.

The rotator cuff is comprised of four tendons belonging to the supraspinatus, subscapularis, infraspinatus, and teres minor muscles respectively from top down. These tendons insert onto the top of the humerus. Picture a hand with four fingers curling around the knob of a baseball bat or top of a broom stick. This "cuff" functions to maintain the proper relationship of the humerus to the shoulder (scapular) socket in both adduction and abduction. Damage to the rotator cuff involves any of these four tendons with the most common and serious being the supraspinatus.

The presented case demonstrates several features of rotator cuff disorder, including the chronic presentation rather than an acute identifiable injury (e.g. motor vehicle accident, serious fall) from a patient older than 40 years of age. These are both inter-related. When an acute injury is noted (often in a patient younger than 40 years of age) a more rapid evaluation, such as an immediate magnetic resonance imaging (MRI), is indicated and opinion consensus favors prompt surgical repair for better long-term results.<sup>1</sup>

But a much larger population, including the current patient, has a more chronic development, with a presentation now termed degenerative rotator cuff disorder—a usage and wear chronic fraying process with eventual tearing generally seen in adults older than 40 years of age.<sup>2</sup> The characteristics of chronic and degenerative form of rotator cuff disorder include nocturnal pain, pain and weakness with overhead shoulder use as with high shelves, and behind the back actions as with putting on a coat.

A variety of time-tested physical examination techniques can essentially "confirm" a diagnosis, particularly weakness/pain on external rotation and abduction of the shoulder and loss of ability to place and use the hand behind the back. These maneuvers can be easily performed in the office.<sup>3</sup> But the definitive diagnostic for evaluation of rotator cuff disorders is MRI because it is the most accurate imaging for the entire spectrum of pathology evaluation: location and tendon(s) involved; extent of the tear (full or partial thickness); degree of separation (e.g. how wide is the gap between the ends of the tear); extent of chronic sequelae such as loss of muscle mass.<sup>3</sup>

Therapy considerations for chronic rotator cuff disorder should involve the needs and expectations of the patient such as occupational, recreational, tolerance for pain, and ability/willingness to participate in genuine, professional rehabilitation. Thus, a middle-aged patient with a physically demanding job and less time for recovery to resume work may require different decision making than an elderly retired patient rendered comfortable with well tolerated non-opioid analgesia even if these two patients have essentially identical MRI studies and pathology. For example, a non-operative regimen for an older patient with degenerative rotator cuff disorder would include, in order:

1. Referral for a standardized physical therapy regimen
2. Appropriate non-opioid analgesia regimen (topical NSAIDs, for example)
3. Corticosteroid injections to the subacromial area, which can result in short-term (4 weeks) pain relief.<sup>2</sup>
4. Re-evaluation after 3 months to determine whether the symptoms and function have improved and to what extent.

For non-operative therapy, a patient's prognosis would generally be improved with shorter duration of symptoms prior to presentation, partial rather than full thickness tears on MRI, and cessation or avoidance of heavy labor during the initial treatment interval with the latter being perhaps the biggest obstacle of all.<sup>2</sup> Patients will likely ask about biological therapies, such as platelet rich plasma, stem cells, or other related techniques. In my view, there is insufficient data (eg, randomized placebo-controlled trials) to justify, recommend, or support their use. Additionally, these therapies are not FDA approved, and patients will likely pay out of pocket.<sup>4</sup>

Finally, there are surgical options, where technical advances have helped reduce both patient pain and complication rates. Yet, controversies remain. For example, in a 2024 *New England Journal of Medicine* general review of degenerative rotator cuff disorders, authors Nitin B Jain, MD, MSPH and Michael S. Khazzam, MD write: "Surgery is not the initial recommendation in most patients with degenerative rotator cuff tears, although surgery may be considered in some patients whose condition does not improve with conservative treatment".<sup>2</sup> Additionally, randomized trials comparing surgery, physiotherapy alone, and surgery with physiotherapy demonstrated substantial improvements in all groups with no statistically significant differences between the groups as regards both pain and function at both 1, 2 and 5 years follow-up.<sup>5,6</sup> Ultimately, when considering a surgical option, both the patient and physician should discuss the needs and expectations of the patient.

**Patient follow-up.** Based upon the patient's preliminary history and physical examination findings, degenerative rotator cuff disorder was suspected. The patient was anxious for a definitive diagnosis, so clinicians performed an MRI, which revealed a chronic fragmented partial thickness tear of the supraspinatus tendon. Treatment options were discussed. As she has an executive position rather than manual work, the combined decision was to initially proceed with a standardized physical therapy regimen and topical/oral non-opioid

analgesics to strengthen the musculature of the shoulder. After 3 months, she had improved with significantly less pain (including no nocturnal pain), improved range of motion, and strength in the shoulder. She is satisfied with this outcome. She knows glucocorticoid injections are available should there be painful recurrence. She hopes to be active with travel and athletic activities such as golf and pickleball as she approaches retirement. If there is deterioration in the next 1 to 2 years, she likely will opt for surgery while she is still relatively young and more able to consistently perform the required post-operation rehabilitation.

**What's The Take Home?** Shoulder pain is a common cause for physician visits in the United States. The most common etiology is rotator cuff disorder with a spectrum of pathology findings ranging from tendinopathy to partial tendon tears, full tears, and shoulder arthropathy with migration of the humerus head in order of severity. The most common and severe lesion of the four tendons comprising the rotator cuff is the tearing of the supraspinatus tendon. General symptoms include shoulder pain, often worse when lying down on the affected side at night, weakness of overhead reaching for items, and behind the back actions like putting on a coat. There are several office testing maneuvers that indicate rotator cuff disorder. Having said that, MRI testing is a non-invasive and accurate procedure of choice to confirm presence, degree, and location of the rotator cuff pathology. Therapeutics remains controversial with regards to balance and timing of medical, physical rehabilitation, and surgical repair modalities. There is agreement that acute traumatic tears as in falls/accidents, which are demographically diverse, should proceed to early surgical repair. The timing of surgery in the far more common chronic degenerative form, which usually occurs in patients older than 40 years of age, is more controversial. Therefore, treatment options should involve the needs and expectations of the patient, including occupational, recreational, tolerance for pain, and ability/willingness to participate in genuine, professional rehabilitation.

A reasonable treatment schedule for patients choosing non-operative management involves a standard and vigorous physical therapy program and non-opioid topical/oral analgesics for 3 months. Interval corticosteroid subacromial injections can be helpful in the short term. If this program fails to deliver adequate pain relief and shoulder function, then surgical repair using arthroscopic techniques is indicated. But several randomized placebo-controlled trials have found equivalent efficacy results for physical medicine/analgesia groups and early surgery groups at 1-, 2-, and 5-years using pain symptoms and shoulder function end points.<sup>5,6</sup>

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## DISCLOSURES

The author reports no relevant financial relationships.

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