

# Does the outcome of diagnostic ultrasound influence the treatment modalities and recovery in patients with shoulder pain in physiotherapy practice?

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## ABSTRACT

### Study Design

Prospective cohort study including 389 patients with shoulder pain in primary care physiotherapy.

### Background

There is an increased tendency to use diagnostic ultrasound to aid the diagnostic strategy and target treatment. It is a relatively cheap and accessible imaging technique but the implications for practice and patients are unknown.

### Objectives

To study the influence of diagnostic ultrasound (US) on diagnostic work-up, treatment modalities and recovery in patients with shoulder pain in physical therapy practice.

### Method

Participants with a new episode of shoulder pain were assessed at baseline and followed for 26 weeks. Diagnostic work-up, including the use of diagnostic US, and treatment strategies were reported by the therapists at 3, 6 and 12 weeks. Patients reported on recovery at 6, 12 and 26 weeks follow-up.

### Results

Most patients were diagnosed with subacromial impingement/pain syndrome after physical examination or diagnostic US. Diagnostic US was used in 31% of the participants. Tendinopathy was the most found abnormality in this sub-population. The patients who underwent diagnostic US were more frequently treated using exercise therapy. Patients that did not have a diagnostic US were more likely to receive massage therapy, trigger point therapy or mobilisation techniques. In the non-US-group (64%) more patients reported being recovered than in the US group (53%). Logistic regression analyses did not show a significant association between diagnostic US and recovery after 26 weeks (0.88, 95%CI:0.50-1.57).

### Conclusion

Diagnostic US as a work-up component does not seem to influence diagnosis or recovery but does influence the choice of treatment modality. High quality randomized trials should study the effect of diagnostic US on recovery.

## INTRODUCTION

Shoulder complaints are the third most common musculoskeletal complaint in the Netherlands.<sup>18</sup> Studies have shown an unfavourable recovery for 40-70% of patients with shoulder pain after 6 months and high indirect costs attributed to sick leave.<sup>6, 15, 19, 29</sup> In Dutch general practice about 50% of patients receive medication, 32% a wait-and-see policy and 16% are referred to a physical therapist.<sup>8</sup>

Initial management of patients with shoulder complaints is usually conservative except for younger patients with an acute traumatic rotator cuff tear.<sup>1</sup> When primary care treatment fails to improve the patient's symptoms, a referral to secondary care can be made.

According to the Dutch guidelines, physical therapists (PTs) and general practitioners (GPs) are recommended to classify patients into one of three groups: 1) with reduced passive range of motion (complaints due to glenohumeral deficit), 2) without reduced passive range of motion but with a painful abduction range (subacromial deficit), 3) without reduced passive range of motion and without a painful abduction range (shoulder instability).<sup>9, 13</sup> This classification can give the clinician an indication of the nature of the complaint. Research has shown that based on history taking and physical examination a more detailed classification of diagnostic labels is not reliable and not likely to change the initial therapeutic approach chosen by the GP.<sup>4, 11, 12</sup>

In primary care there is an increased tendency to use diagnostic ultrasound (US) to aid the diagnostic strategy and target treatment. It is a relatively cheap and accessible imaging technique. Some clinicians believe that determining an accurate diagnosis is essential to be able to provide the appropriate treatment. However, there is a lack of correlation between rotator cuff tears and symptoms experienced by the patient.<sup>21</sup> Therefore our aim was to study the influence of diagnostic US on clinical reasoning, treatment modalities and recovery in physical therapy practice.

## METHOD

### Study design

This study was part of a prospective cohort study with a follow-up of 26 weeks in PT practice including patients with non-specific shoulder complaints: named "X". Details of the study design are published elsewhere.<sup>16</sup> The Medical Ethics Committee of the Erasmus Medical Center approved the study protocol (MEC-2011-414).

## Study population

*Physical therapists* (n=125) from the South West region on the Netherlands participated in the study and recruited patients from November 2011 till November 2012. Patients were either referred by their GP or consulted the PT through direct access.

*Patients* with shoulder pain were eligible when they were 18 years or over and adequately understood the Dutch language. Exclusion criteria were: patients with serious pathologies (infection, cancer or fracture), shoulder surgery in the past 12 months or diagnostic imaging techniques (musculoskeletal ultrasound, magnetic resonance imaging or radiography) performed on the shoulder in the past 3 months. The PTs using diagnostic US in usual care had to have at least one year of experience with diagnostic US and at least made 100 US scans of the shoulder.

## Data collection

Data from PTs were collected at baseline, 3, 6 and 12 weeks after inclusion using digital questionnaires. Patients received a questionnaire at baseline, 6, 12 and 26 weeks after inclusion. Informed consent was received of patients and rights were protected. Clinical characteristics of the PTs (age, sex, work experience and/or specialization) and of the patients (age, gender, pain, duration of complaints and recurrence) were reported at baseline. The Shoulder Pain and Disability Index (SPADI) was used to measure level of disability. The Numeric Rating Scale (NRS-11) was used to score pain intensity. The scale ranges from 0 to 10, with 0 representing "no pain" and 10 "severe disabling pain".<sup>6</sup>

PTs reported the planned management at baseline in terms of initial clinical diagnosis (diagnostic label), the use of US (yes/no), pathological findings on diagnostic US, changes in clinical diagnosis after diagnostic US and initial therapeutic management of the patient. The diagnostic US could either be performed before or after physical examination. Whenever a treatment plan changed during follow-up, the PTs reported the reasons for change and the new treatment goal(s). Possible interventions were categorized into: information/advice, exercise therapy, massage, manual joint mobilization/manipulation, extracorporeal shockwave therapy (ESWT), transcutaneous electrical nerve stimulation (TENS), trigger point therapy, taping/bracing or posture correction. Exercise therapy was subdivided in a) exercise of (muscle) function (strength/length), b) exercise of activities, c) stabilisation techniques for the rotator cuff/ scapulo-thoracic sliding mechanism.

## Outcome measures

*Diagnostic US.* The following pathological findings were listed: tendinopathy, calcification, full thickness/partial thickness tears, biceps tendon rupture, bursitis, subacromial impingement syndrome, glenohumeral discontinuity, acromion discontinuity, osteoarthritis, labrum tear/SLAP, capsular thickening, and rotator cuff atrophy. One patient could

have more than one US finding but the first diagnosis was considered the most relevant to the complaints.

*Recovery.* Recovery status of the patient was measured with the Global Perceived Effect scale (GPE). The GPE uses a 7-point Likert scale indicating whether the patient's condition had improved or deteriorated since the start of their treatment. The outcome was dichotomised into "recovered" and "not recovered", with "recovered" defined as "completely recovered" or "much improved". The GPE is validated for patients with musculoskeletal complaints.<sup>14</sup>

## Statistical analysis

Descriptive statistics of both baseline characteristics and outcome measures were presented in mean scores for continuous data with a normal distribution. Otherwise, median scores and the interquartile range (IQR) were used. Pearson's chi-square test was used to compare categorical data between groups. The Fisher exact test was used for small samples ( $n < 10$ ). If distribution was non-parametric, medians were compared using the Independent Sample Median Test. Distributions was compared using the Mann-Whitney U test. For the parametric distributions means were compared using the two-sample t-test. A p-value  $\leq 0.05$  was considered statistically significant. Binary logistic regression analysis was used to estimate the effect of diagnostic US on recovery, controlled for confounders. The variables age, duration of complaints, level of disability and pain were considered as possible confounders from previous literature. Crude and adjusted ORs with 95% confidence intervals (CI) were obtained. Complete case analysis was used on all the analyses. The number of missings is reported with all data. SPSS 22.0 was used for all analyses.

## RESULTS

### Study population

A total of 389 patients with a mean age of 50 years were included. In total 267 patients received a treatment solely based on history taking and physical examination (non-US-group), and 122 patients underwent a diagnostic US at baseline performed by a PT and were treated based on a post-ultrasound diagnosis (US-group).

### Baseline

There was no significant difference in the gender distribution between the US and non-US-group (Table 1). The age of patients ranged from 19 to 83 years, with the majority between 45 and 54 years old. The mean difference of 4.7 years (95% CI 1.8-7.6) between the patients in the US and non-US-group was small but statistically significant.

**Table 1.** Baseline characteristics

Baseline characteristics	Total N=389	Non-US group N=267	US-group N=122
Female n (%)	206 (55)	145 (56)	61 (53)
Age mean (sd)	49.9 (13.2)	48.5 (12.8)	53.2 (13.6)*
Age groups n (%)			
≤34	50 (13)	37 (14)	13 (11)
35-44	78 (21)	62 (24)	16 (14)
45-54	108 (29)	78 (30)	30 (26)
55-64	79 (21)	53 (21)	26 (23)
≥65	59 (16)	29 (11)	30 (26)*
Duration of complaints in weeks, median (IQR)	12 (6-26)	12 (6-26)	12 (7-28)
Disability SPADI, mean (SD)	47 (21)	45 (22)	52 (20)*
Pain NRS-11, median, (IQR)	6 (4-7)	6 (4-7)	7 (5-7)*
Recurrent complaint yes, n (%)	158 (43)	106 (42)	52 (46)
Cause yes (%)			
Unexpected movement	23 (6)	13 (5)	10 (9)
Overuse	132 (36)	100 (39)	32 (28)
Trauma	24 (7)	16 (6)	8 (7)
Sports injury	32 (9)	21 (8)	11 (10)
Unclear	128 (35)	85 (33)	43(38)
Other	29 (8)	20 (8)	9 (8)

N Number, SD Standard Deviation, IQR Inter Quartile Range, SPADI Shoulder Pain And Disability Index, NRS Numeric Rating Scale

\*p-value <0.05

When divided into age groups, there were significantly more patients in the age group between 35 and 44 years and in the age group of 65 years and older in the US-group (Table 1).

The median duration of complaints at inclusion in both groups was 12 weeks. The mean difference in disability score (SPADI) was 6.68 (95%CI 1.98- 11.37). The pain intensity score (NRS-11) at time of inclusion was significantly higher for the US-group (Table 1).

In the non-US-group 39% of the patients stated that their complaints were caused by overuse. This was significantly more compared to the US-group in which overuse accounted for 28% of the cases. There was no difference between the two groups for other probable causes of shoulder pain. An overview of the PT characteristics is presented in table 2.

**Table 2.** Characteristics of physiotherapists

	Total (n=102)	PTs without diagnostic US machine (n=64)	PTs with diagnostic US machine (n=38)
Sex men, N (%)	91 (77)	43 (68)	35 (92)*
Age in years, mean (SD)	44 (11)	44 (12)	45 (9)
Experience in years, N (%)			
<5	20 (20)	14 (22)	6 (16)
5-10	21 (21)	14 (22)	7 (18)
>11	61 (60)	36 (56)	25 (66)
Specialization, N (%)			
Manual therapist	51 (50)	34 (53)	17 (45)
Sports	21 (21)	11 (17)	10 (26)
Geriatrics	2 (2)	2 (3)	0
Pediatrics	2 (2)	2 (3)	0
Psychosocial	1 (1)	1 (2)	0
Vocational	5 (5)	3 (5)	2 (5)
Lymphatic	6 (6)	3 (5)	3 (8)
Worktime, N (%)			
Parttime	28 (22)	21 (36)	7 (19)
fulltime	67 (54)	38 (64)	29 (81)

N number, SD standard deviation

\*pvalue <0.05

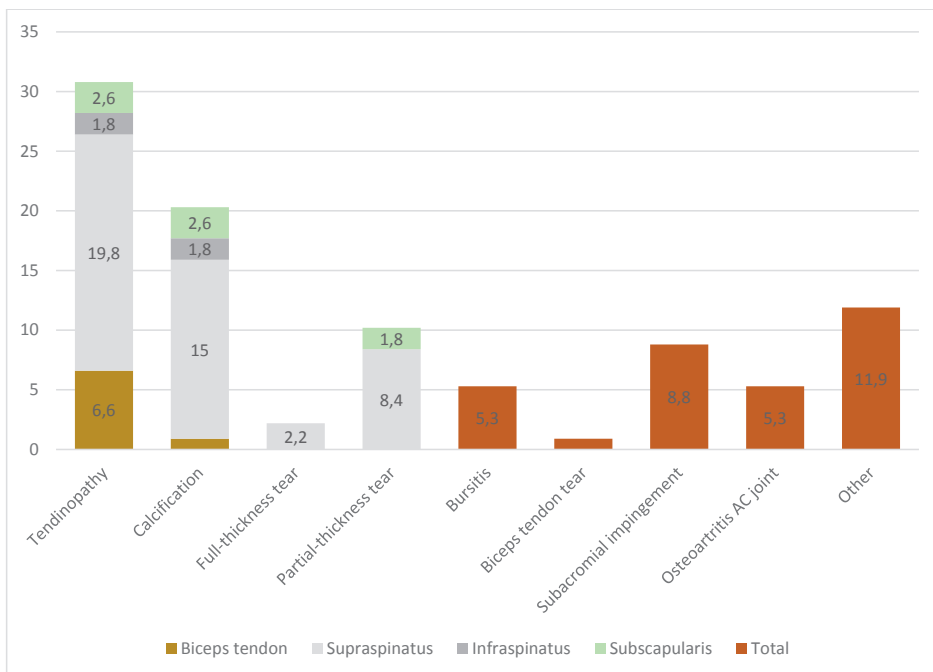
## Diagnostic US findings

Of the 122 patients who underwent diagnostic US 99 had complete data. The number of abnormalities ranged from 0 to 5 per patient. The majority of patients (n=42) had 2 abnormalities, 1 patient had 5.

Tendinopathy was the most found abnormality (30.8%), followed by calcification (19.5%), partial-thickness tendon tears (10.2%) and subacromial impingement (8.8%). The supraspinatus tendon was the most affected tendon. In 7 patients (3.1%) no pathology was found (Figure 1).

## Reasons for using diagnostic US

In 34% (42/122) of all patients receiving a diagnostic US the reason was that the PT expected this would lead to a more specific clinical diagnosis, and in 13% (16/122) that it would help the PT in selecting the most appropriate intervention. In 12% of the patients (15/122) the PTs used the US findings to confirm their initial diagnosis and in another 11% (14/122) to better inform the patient about their complaints. Other reasons were 1) that it was a routine procedure in the physical examination, 2) that it would serve



**Figure 1.** Percentage of US findings per pathology for each anatomical structure in the shoulder (colours) (n=116).

as a baseline measurement, 3) it was a request by a colleague and 4) that it would improve their professional position towards other health professionals. These were not selected frequently. Results suggest that US was most frequently performed when there was a suspicion of subacromial pathology.

### Clinical diagnoses

Subacromial impingement syndrome (SIS) was the most reported diagnosis overall (Table 3). In the non-US-group this was followed by a disorder of the cervicothoracic spine (CTS) and costae, frozen shoulder/capsulitis and instability of the glenohumeral joint. In the US-group this was followed by a non-specific diagnosis, sprain or strain and instability of the glenohumeral joint (Table 2). In the US-group 75 patients also had a pre-US diagnosis, based on history taking with or without physical examination. SIS was the most occurring pre-US diagnosis (57.3%), followed by sprain or strain (12%), another non-specific diagnosis (6.7%) and acromioclavicular (AC) or sternoclavicular (SC) joint disorder. The clinical diagnosis changed in 29% (35/122) of patients after diagnostic US. In 31% (11/35) the clinical diagnosis changed from various diagnoses to a sprain (trauma) or strain.



**Table 3.** Clinical diagnosis for each group

Diagnostic groups (n, %)	Total (n=340)	Non-US-group* (n=241)	US-group* (n=99)
Subacromial impingement syndrome	139 (40.9)	79 (32.8)	60 (60.6)
Disorder of cervicothoracic spine (CTS) and costae	53 (15.6)	51 (21.2)	2 (2)
Frozen shoulder/capsulitis	29 (8.5)	27 (11.2)	2 (2)
Instability of the glenohumeral joint	27 (7.9)	22 (9.1)	5 (5.1)
Sprain or strain in neck/shoulder region	19 (5.6)	12 (5.0)	7 (7.1)
Internal (posterior) impingement syndrome	18 (5.3)	17 (6.4)	1 (1)
Acromioclavicular (AC) or sternoclavicular (SC) joint disorder	15 (4.4)	13 (5.4)	2 (2)
Biceps tendinopathy	10 (2.9)	6 (2.5)	4 (4)
Myofascial trigger point in neck/ shoulder	2 (0.6)	2 (0.8)	0
SLAP lesion (Superior Labral tear from Anterior to Posterior)	1 (0.3)	0	1 (1)
Muscular hypertonia in neck/shoulder	0	0	0
Other non-specific	21 (6.2)	11 (4.6)	12 (12.1)
Unclear/ Not possible to specify a clear diagnosis	4 (1.2)	1 (0.4)	3 (3)

\* Non-US-group= diagnosis set after history and/or physical examination; US-group= diagnosis set after ultrasound. Missing non-US-group: 26; US-group: 23

## Treatment

Patients were usually treated with a selection of different treatment modalities. In the non-US-group the maximum number of different modalities (including the different forms of exercise therapy) was 7. In the US-group there was a maximum number of 6 different modalities. In both groups the median of different modalities was 3 ( $p = 0.13$ ).

The median number of treatment sessions in both groups was 7 and did not differ statistically significant between the US and non-US groups.

In the non-US-group 8.3% of the patients were referred (back) to their GP, 3.8% were referred to another healthcare professional (HP). In the US-group 13.2% were referred to their GP and 8.3% to another HP. The difference between the two groups for referral to GP or another HP was not statistically significant.

Informing, advising, counselling and coaching were the most used approaches regardless of the clinical diagnosis (Table 4). Table 4 shows the number of patients receiving a treatment modality per clinical diagnosis (left side of the table) and overall between the US and the non-US group (right side of the table).

Patients labelled with SIS received statistically significant more often stabilisation of the rotator cuff in the non-US group compared with the US group. There were significantly more patients treated with trigger point therapy through stretching and/or dry needling in the non-US-group (12.7 % vs 1.7%).

**Table 4.** Treatment modalities per clinical diagnosis and for the non-US-group and the US-group

Treatment modalities (n, %)	Total n=387	Sub-acromial impingement n=139	Disorder CTS/ costae n=53	Frozen shoulder n=29
Informing, advising, counselling and coaching	332 (85.8)	128 (92.1)	49 (92.5)	29 (100)
Exercise therapy:	320 (82.7)	133 (95.7)	37 (69.8)	23 (79.3)
<i>exercise of (muscle) function</i>	230 (59.4)	88 (63.3)	27 (50.9)	22 (75.9)
<i>exercise of activities</i>	76 (19.6)	22 (15.8)	12 (22.6)	8 (27.6)
<i>stabilisation rotator cuff/ scapula</i>	212 (54.8)	*99 (71.2)	13 (24.5)	11 (37.9)
Massage	33 (8.5)	6 (4.3)	13 (24.5)	5 (17.2)
Manipulation and mobilisation techniques	215 (55.6)	73 (52.5)	49 (92.5)	19 (65.5)
Extracorporeal shock wave therapy	41 (10.6)	29 (20.9)	1 (1.9)	1 (3.4)
Passive modalities	5 (1.3)	0	0	2 (6.9)
Trigger point therapy (stretching/ dry needling)	32 (8.3)	*11 (7.9)	**5 (9.4)	3 (10.3)
Stabilisation shoulder (tape/bandaging)	54 (14)	26 (18.7)	0	0
No treatment	2 (0.5)	1 (0.7)	0	0
Other	37 (9.6)	*7 (5)	8 (15.1)	5 (17.2)

\*p-value  $\leq 0.05$  = statistically significant in favour of the non-US-group *within that specific diagnostic group*.

\*\*p-value  $\leq 0.05$  = statistically significant in favour of the US-group *within that specific diagnostic group*.

\*\*\* 2-sided p-value for comparison between non-US-group and US-group (the last two columns)

ESWT= extracorporeal shock wave therapy, CTS= cervicothoracic spine, AC= Acromioclavicular, SC= sternoclavicular.

Treatment for SLAP lesion and Unclear diagnosis are not shown in this table, due to small sample sizes.

No patients were diagnosed with muscular hypertonia

For patients labelled with a disorder of the cervicothoracic spine statistically significant more patients were treated with triggerpoint therapy in the non-US-group compared to the US-group.

A statistically significantly higher number of patients in the US-group received advice, counselling and coaching or extracorporeal shockwave therapy. Patients that did not have a diagnostic US were more likely to receive massage therapy, trigger point therapy or manipulation and mobilisation techniques.

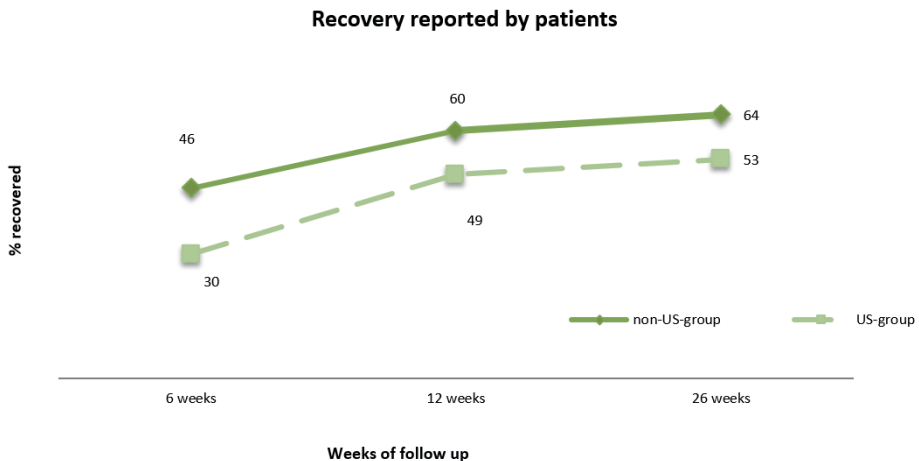
Also, more patients in the US group were treated with ESWT. Pts could use ESWT in case of calcifications but only 33.6% of patients with calcifications were treated with ESW.

## Recovery

The proportion of missing data on recovery was high for both the non-US-group and the US-group, ranging from 23% to 33% (Figure 2). At 6 weeks there were statistical significantly more patients in the non-US-group (46.2%) that reported being recovered

Instability n=27	Sprain/ Strain n=19	Internal impinge- ment n=18	AC/SC Joint n=15	Biceps tendino- pathy n=10	Other non- specific n=21	non-US group n=265	US-group n=122
23 (85.2)	15 (78.9)	17 (94.4)	11 (73.3)	10 (100)	20 (95.2)	222 (83.8)	110 (90.2)
26 (96.3)	18 (94.7)	17 (94.4)	12 (80)	9 (90)	17 (81)	209 (78.9)	111 (91)***
20 (74.1)	17 (89.5)	7 (38.9)	8 (53.3)	8 (80)	16 (76.2)	155 (58.5)	75 (61.5)
8 (29.6)	5 (26.3)	4 (22.2)	3 (20)	2 (20)	5 (23.8)	54 (20.4)	22 (18)
22 (81.5)	14 (73.7)	14 (77.8)	6 (40)	4 (40)	7 (33.3)	142 (53.6)	70 (57.4)
1 (3.7)	1 (5.3)	1 (5.6)	3 (20)	0	1 (4.8)	28 (10.6)	5 (4.1)***
7 (25.9)	6 (31.6)	13 (72.2)	13 (86.7)	*5 (50)	11 (52.4)	159 (60)	56 (45.9)***
0	0	5 (27.8)	1 (6.7)	0	0	23 (8.7)	18 (14.8)***
0	1 (5.3)	0	1 (6.7)	0	0	3 (1.1)	2 (1.6)
2 (7.4)	2 (10.5)	3 (16.7)	2 (13.3)	0	2 (9.5)	27 (10.2)	5 (4.1)***
11 (40.7)	2 (10.5)	4 (22.2)	**3 (20)	0	2 (9.5)	32 (12.1)	22 (18)
1 (3.7)	0	0	0	0	0	2(0.8)	0
0	1(5.3)	2 (11.1)	3 (20)	3 (30)	3 (14.3)	31 (11.7)	6 (4.9)***

compared to the US-group (30.2%). The difference in recovery was not statistically significant at 12 and 26 weeks but still the proportion of patients reporting recovery was higher for the non-US-group.



**Figure 2.** Patients that reported ‘strongly improved’ or ‘completely recovered’ on the Global Perceived Effect (GPE) scale.  
 Missings non-US-group and US-group at week 6: 26% and 30%, week 12: 33% and 25%, week 26: 33% and 23% resp.

## Association between diagnostic US and recovery

Binary logistic regression analysis found a statistically significant crude OR of 0.53 (CI 0.30-0.92), meaning a negative association between diagnostic US and recovery at 6 weeks. The estimate changed after adjusting for confounders to 0.64 (0.36-1.14) and was not statistically significant anymore. Both adjusted ORs after 12 weeks (0.73, CI:0.42-1.28) and 26 weeks (0.88, CI:0.50-1.57) were also not statistically significant.

## DISCUSSION

The most common clinical diagnosis was SIS and for the US-group the clinical diagnosis did not change after the diagnostic US. The referral rate was slightly higher in the US-group but not statistically significant. The use of diagnostic US did seem to have some influence on the applied treatment modalities by the PTs. There were slightly more patients treated with exercise therapy in the US-group, but when subdivided in different subgroups of exercise therapy, no statistically significant differences were found. In the non-US-group statistically significant more patients were treated with manipulation and mobilisation techniques, massage and triggerpoint therapy. No major differences were found in other diagnostic groups. In the non-US-group more patients reported being recovered. The difference was only significant at 6 weeks follow-up. The use of diagnostic US seemed to have a negative effect on recovery at 6 weeks but this effect might be confounded by indication: i.e. patients with a worse prognosis based on for example age, duration of symptoms, level of disability and pain and/or variable which we did not measure have a higher chance to receive a diagnostic US.

## Comparison with the literature

Baseline characteristics were similar to other studies done in primary care. This study had slightly more (56%) female patients, which was in line with other literature.<sup>5, 25, 28</sup> Most patients were between 45 and 64 years of age; this age group consults their PT most often for all kind of musculoskeletal complaints in the Netherlands.<sup>3</sup> Similar to the results in our study, SIS, in particular rotator cuff tendinopathy, is the most frequently diagnosed disorder.<sup>28</sup>

In our study the PT that made a diagnostic US found a tendinopathy in the majority of patients, and only 5.2% of the patients had a full-thickness tear. A retrospective observational study under 240 patients who were referred by GPs to make a diagnostic US, concluded that in most cases there was a calcific tendonitis (29%), a tendinopathy in 11% of cases and a full-thickness tear in 8%.<sup>24</sup> A prospective study where patients with acute shoulder pain were referred to a radiologist for a diagnostic US also found calcific tendonitis to be the most frequent pathology (50.4%) followed by tendinopathy

(28.7%) and full thickness tears (3.1%).<sup>22</sup> A systematic review with secondary care studies, showed that tendinopathy (30-39%) and full thickness tears (24-70%) were the most observed disorders.<sup>23</sup> The differences of pathologies on diagnostic US between studies can be attributed to the different criteria used for obtaining a diagnostic US or selection criteria of patients. PTs with sufficient experience were selected but no explicit criteria were set for performing a diagnostic US; it was left to the discretion of the PT. This might influence the validity of the pathological findings. The majority of PTs in this study used US to identify a more specific clinical diagnosis.

In our study no pathology on diagnostic US was found in 6% of the patient, which is in contrast to the 40% described in previous literature where US was performed by radiologists in a primary care population.<sup>24</sup> This might indicate that PTs already use diagnostic US in a patient group where they suspect to find pathology. In line with other literature the supraspinatus tendon was the most frequently affected tendon.<sup>17, 24</sup>

Research shows that after the 5th decade an increase in asymptomatic rotator cuff tendon tears are found, linearly increasing every decade.<sup>20</sup> In the US-group in our study 26% of the patient were 65 years or older confirming the earlier results. In this group less patients had US diagnosed tendinopathy and calcifications. These US findings may have been due to degeneration and may not have been the cause of the symptoms described by the patients. Furthermore, more than one abnormality was frequently found in patients, but they may not have had any clinical implications. Research performed in 51 men without complaints of the shoulder, showed that in 96% asymptomatic abnormalities were found.<sup>10</sup> Subacromial bursal thickening was found in 78%, osteoarthritis of the AC joint in 65% and supraspinatus tendinosis in 39%.<sup>10</sup>

A cross-sectional study has shown that MRI and diagnostic US have equally high accuracy for identifying biceps pathology and rotator cuff tears, while physical examination has modest accuracy.<sup>2</sup> In addition, US could not detect glenoid labral tears and bone erosion.<sup>2</sup> This confirms that the choice for the use of additional imaging should be based on clinical information and might not be helpful as a standard method of assessment. Otherwise no assessment of the relevance of the abnormalities found through US can be made.

## Strengths and limitations

Our study was set in a primary care patient population. Little is known about US findings in primary care populations. Most studies on diagnostic US are performed in secondary care where US is usually used for the work-up to a surgical intervention.<sup>23, 24</sup>

Our study was first to evaluate diagnostic US performed by PTs. In most literature on the accuracy of diagnostic US the scan was performed by a radiologist. PTs in contrast to radiologists tend to find more tendinopathy and partial-thickness tears.<sup>27</sup> Furthermore, the reliability between PTs and radiologists in this study is borderline substantial for

full-thickness tears only.<sup>27</sup> These results suggest that the diagnosis after diagnostic US performed may have questionable validity.

The PTs who participated in this study had knowledge of diagnostic US and showed interest in determining its value in the diagnostic process. The PTs decided which patients were to have an US, therefore there might be a selection in the patients that received an US. Baseline factors between these groups did not differ.

Furthermore, there is no uniformity in the definition of the various diagnostic labels used in different studies and the labels only have fair to moderate inter-observer reproducibility. This challenges the ability to compare various study results.<sup>26</sup>

## Implications

The need for a specific diagnosis is mainly driven by the desire to influence the outcome of a patient by a specific treatment modality and thereby establish a more efficient and cost-effective treatment plan. Where patients with calcification should be treated with rest and analgesics due to its self-limiting nature, ESWT can be considered or a referral in younger patients with an acute traumatic rotator cuff tear.<sup>1, 13</sup> In our study only 33.6% of patients with calcifications were treated with ESWT. Of all patients with full thickness tears only one was referred to the GP and none were referred to other health care professionals. As full thickness tears may not heal and may require surgery, especially in the younger athlete, the orthopaedic surgeon will have to consider which management would be appropriate. This advice is also recommended in the evidence statement for PTs.<sup>13</sup> The evidence statement recommends exercise therapy, which most PTs used in their treatment regime. Whether the diagnostic US provided more information to choose exercise therapy more often remains unknown. Trigger point therapy was still used in a small number of patients while the evidence statement discourages this.

## CONCLUSION

Diagnostic US as a work-up component does not seem to influence diagnostic work-up, and recovery but the choice of treatment differed between the groups. The patients who underwent diagnostic US were more frequently treated using exercise therapy. Patients that did not have a diagnostic US were more likely to receive massage therapy, trigger point therapy or manipulation and mobilisation techniques. High quality randomized trials should study the effect of diagnostic US on recovery.

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