2026
WORK RELATED
Injuries Workshop

# Most Educational Shoulder Workers' Comp Cases of the Year

Chairperson: Buzz Schneider, Esq.

Monday, March 23rd, 2026

1:15-2:05pm

2026 WORK RELATED Injuries Workshop

# Most Interesting Shoulder Work Injury - Case 1

## 53yo Chef with Acute Traumatic Rotator Cuff Tear

Joseph John Czarnecki, MD

Director, Cartilage Care Center and Senior Managing Partner, Excel Orthopaedic Specialists

jczarnecki@excelortho.com

# Disclosures

Vericel – Speaker’s bureau

- Not relevant for this talk

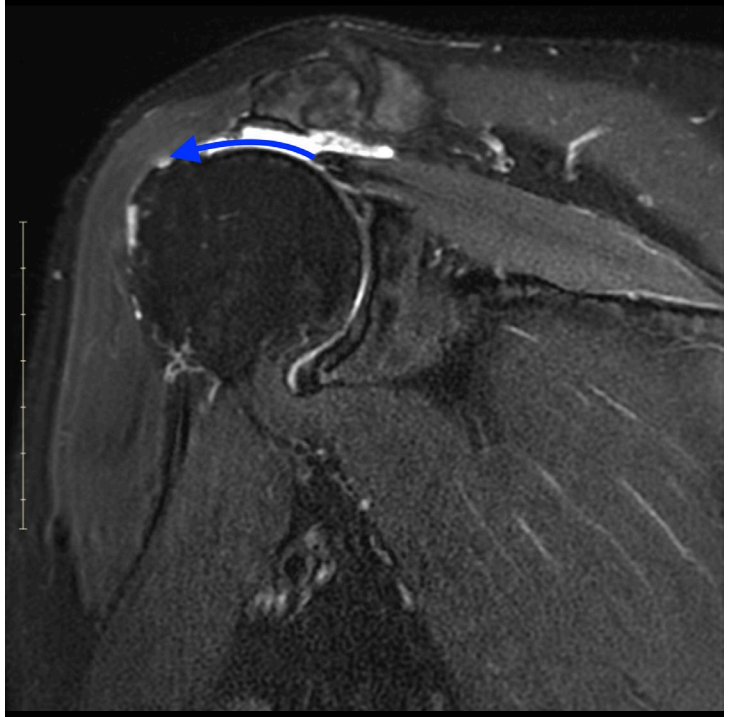
# Why These Cases Can Be Challenging

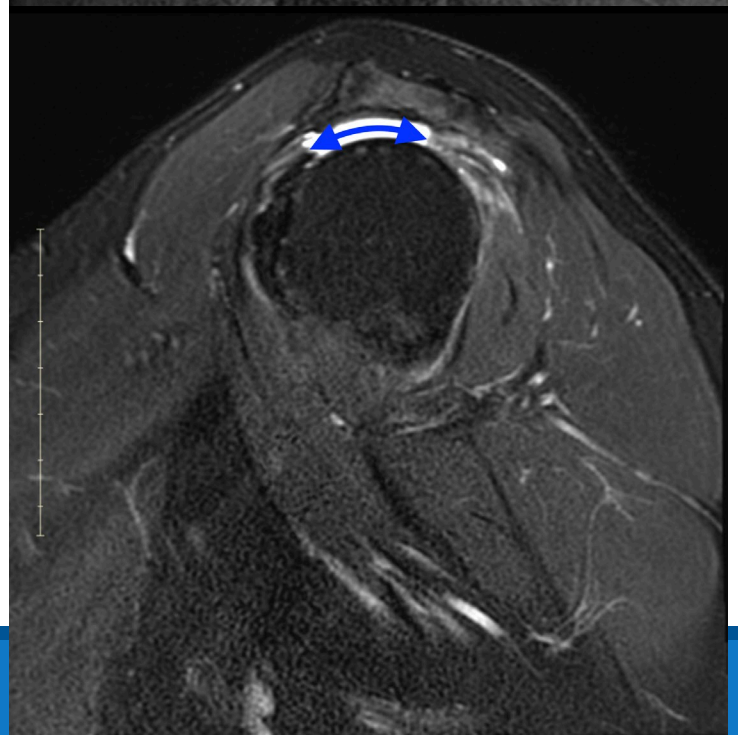
- Rotator cuff healing is biologically demanding
- Large tears carry higher structural risk
- Symptoms don’t always match imaging
- Return-to-work timelines add pressure

# Case Presentation

53 year old chef
Acute lifting injury at work
Immediate pain and weakness
MRI:

- Large supraspinatus + infraspinatus tear
- Retraction to medial humeral head
- No muscle atrophy





# Surgical Considerations

- Large tear
- Significant retraction
- High-demand occupation
- Good muscle quality

## Decision:

- Repair + biologic augmentation

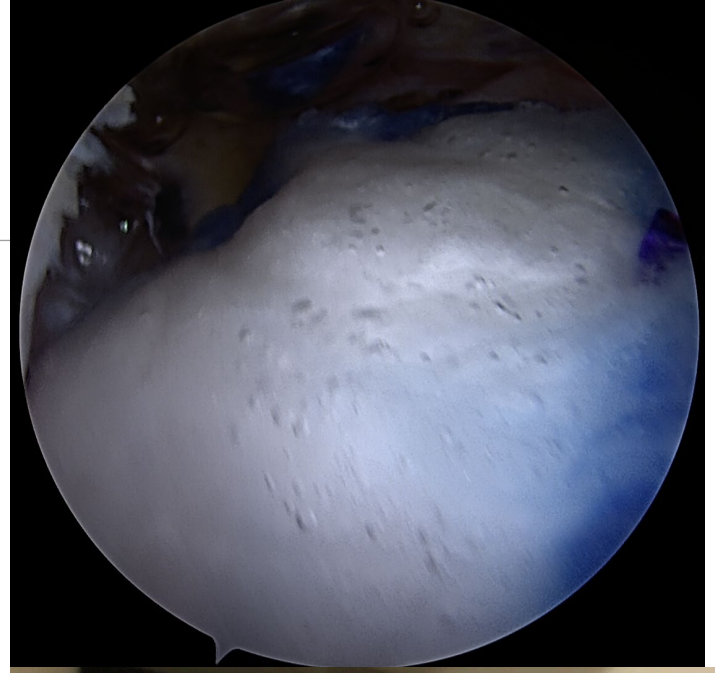
# Structural Healing ≠ Clinical Recovery

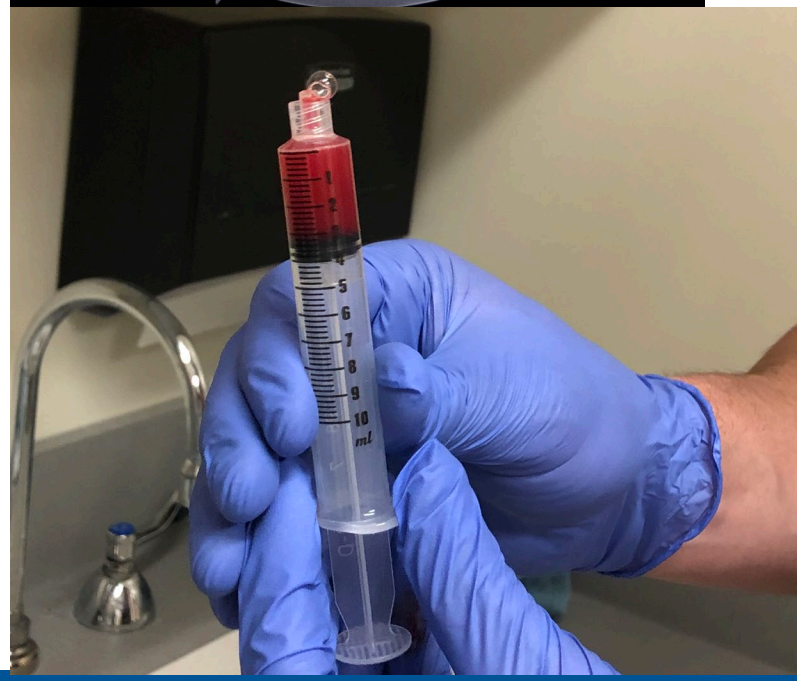
- Tendon-to-bone healing takes months
- Larger tears have higher re-tear rates
- Early mechanical load challenges biology
- Pain can occur even with intact repair

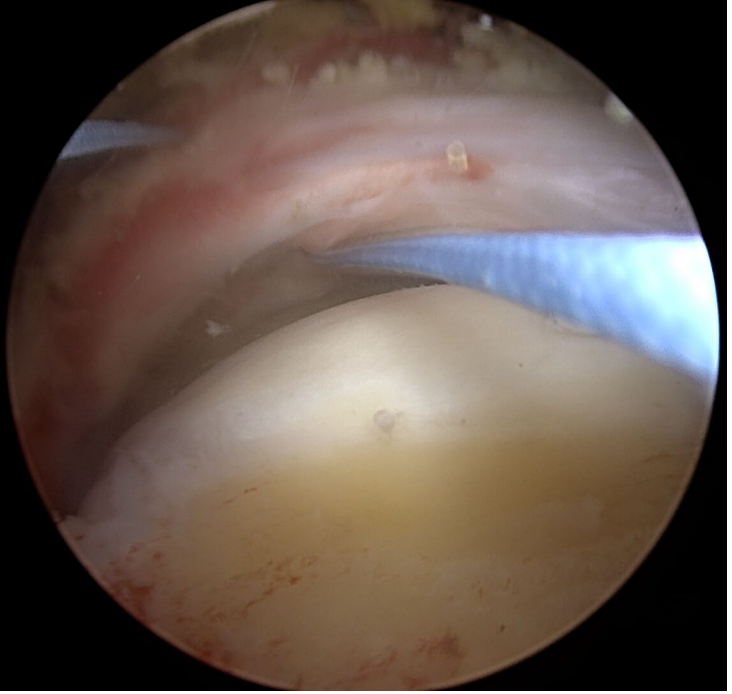
# Strategies to Support Healing

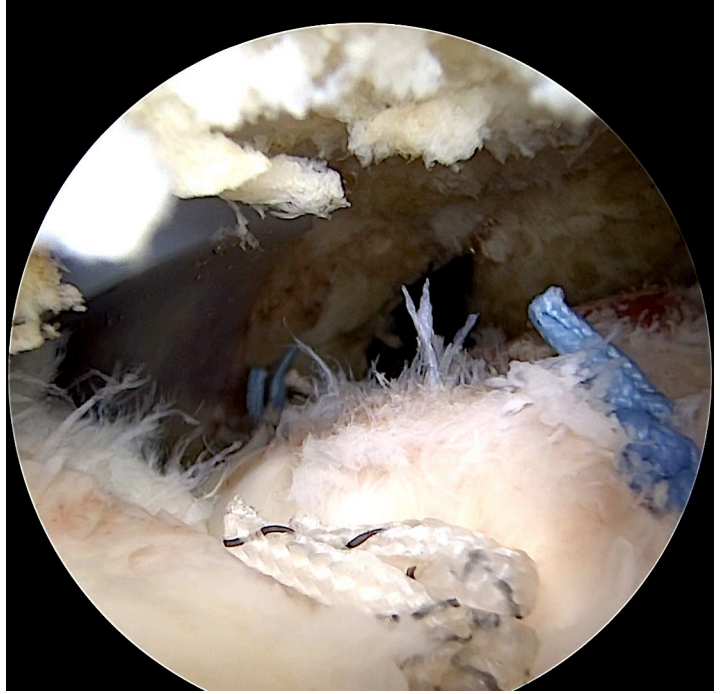
- Structured rehabilitation and compliance
- Patient risk factors – smoking, diabetes

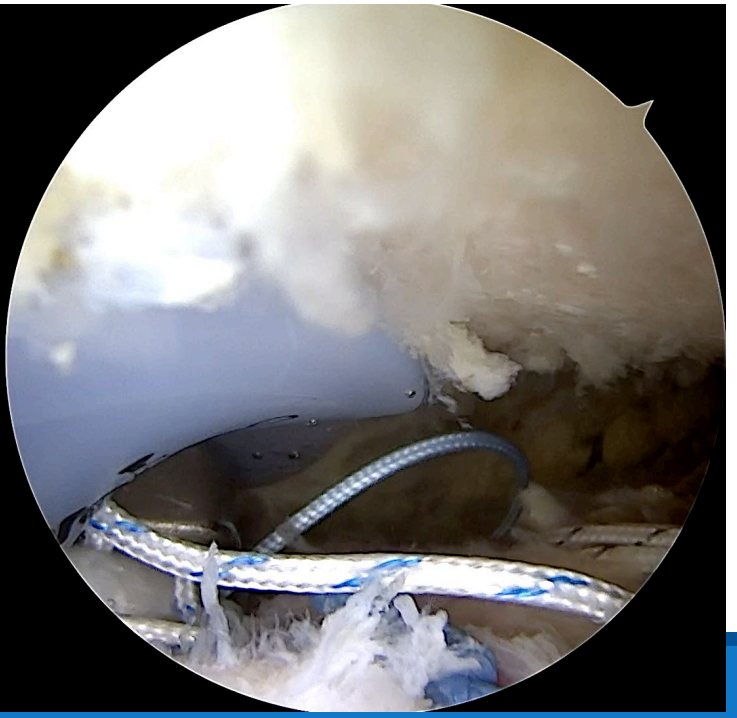
- Dermal allograft
- Collagen scaffold augmentation
- Bioinductive patch
- Platelet-rich plasma

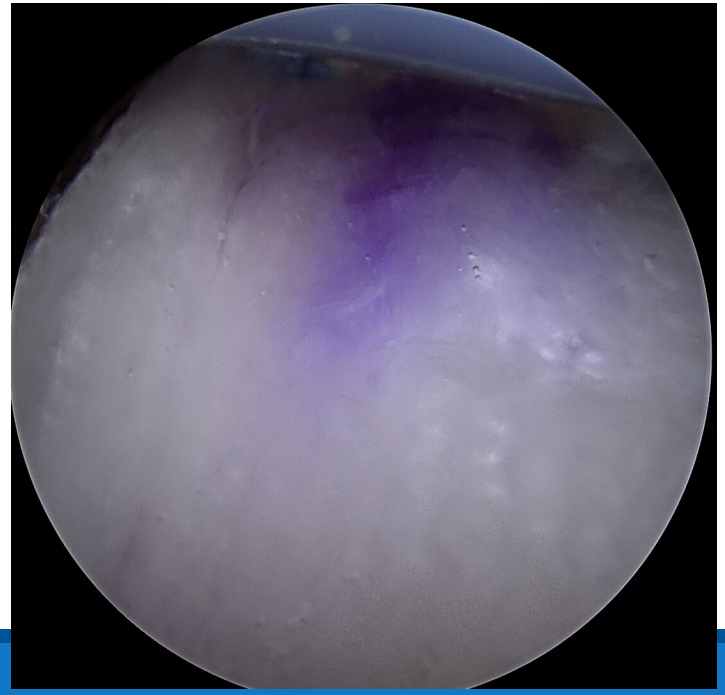












## Intraoperative Repair

- Repair of retracted tear
- Augmentation for biologic support

# Postoperative Course

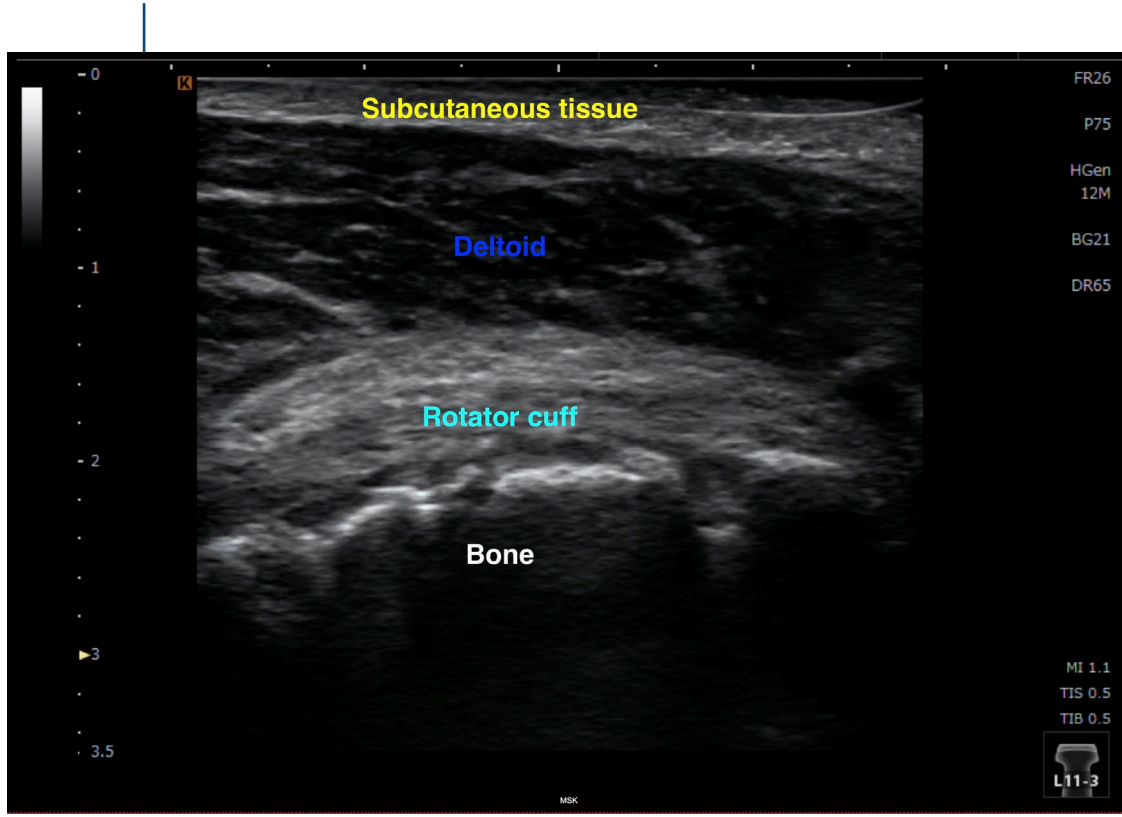
- Protected early phase
- Gradual strengthening progression
- Close coordination with therapy

Outcome:

- Successful structural healing
- Returned to work 4 months light duty, 6 months full

# Ongoing Objective Monitoring

- In-office dynamic ultrasound
- Real-time assessment of repair integrity
- Correlates symptoms with structure
- Facilitates communication with care team



# Common Reasons for Persistent Symptoms

- Postoperative stiffness
- Incomplete biologic maturation
- Muscle deconditioning
- True structural failure

# Key Takeaways

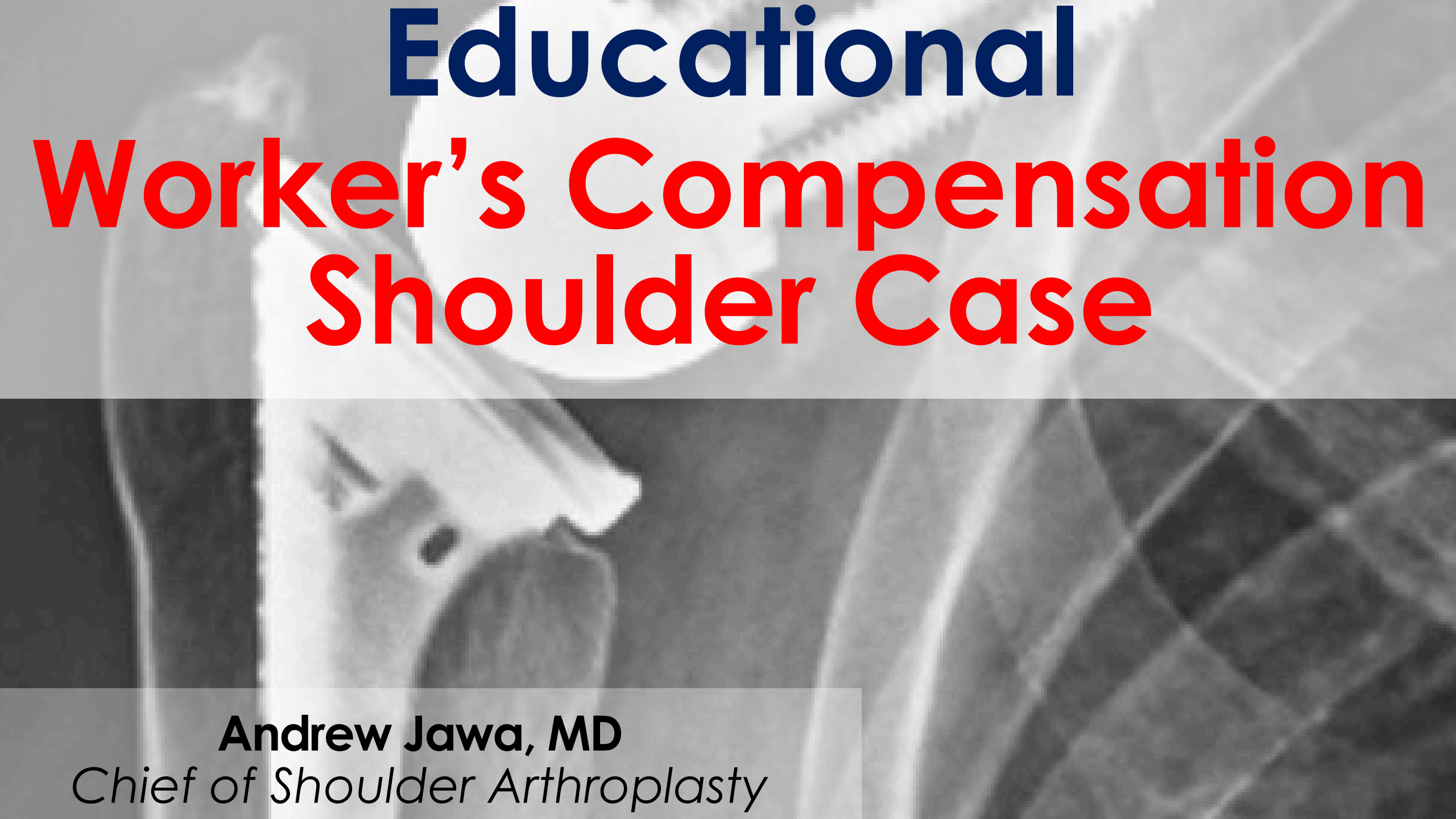
- Large tears require thoughtful strategy
- Healing biology drives outcomes
- Imaging and symptoms don’t always align
- Adjuncts may enhance structural integrity
- Coordinated care improves return to work

2026
WORK RELATED
Injuries Workshop

# Thank you!

# Educational

# Worker's Compensation Shoulder Case



**Andrew Jawa, MD**
*Chief of Shoulder Arthroplasty*

# Conflicts

- **Depuy-Synthes: Consulting, Royalties**
- **Ignite**: Royalties, Equity
- **SCAP: Consulting, Equity**
- **Boston Outpatient Surgical Suites**: Equity
- **JSES**: Editorial Board

# *Lessons Reinforced*

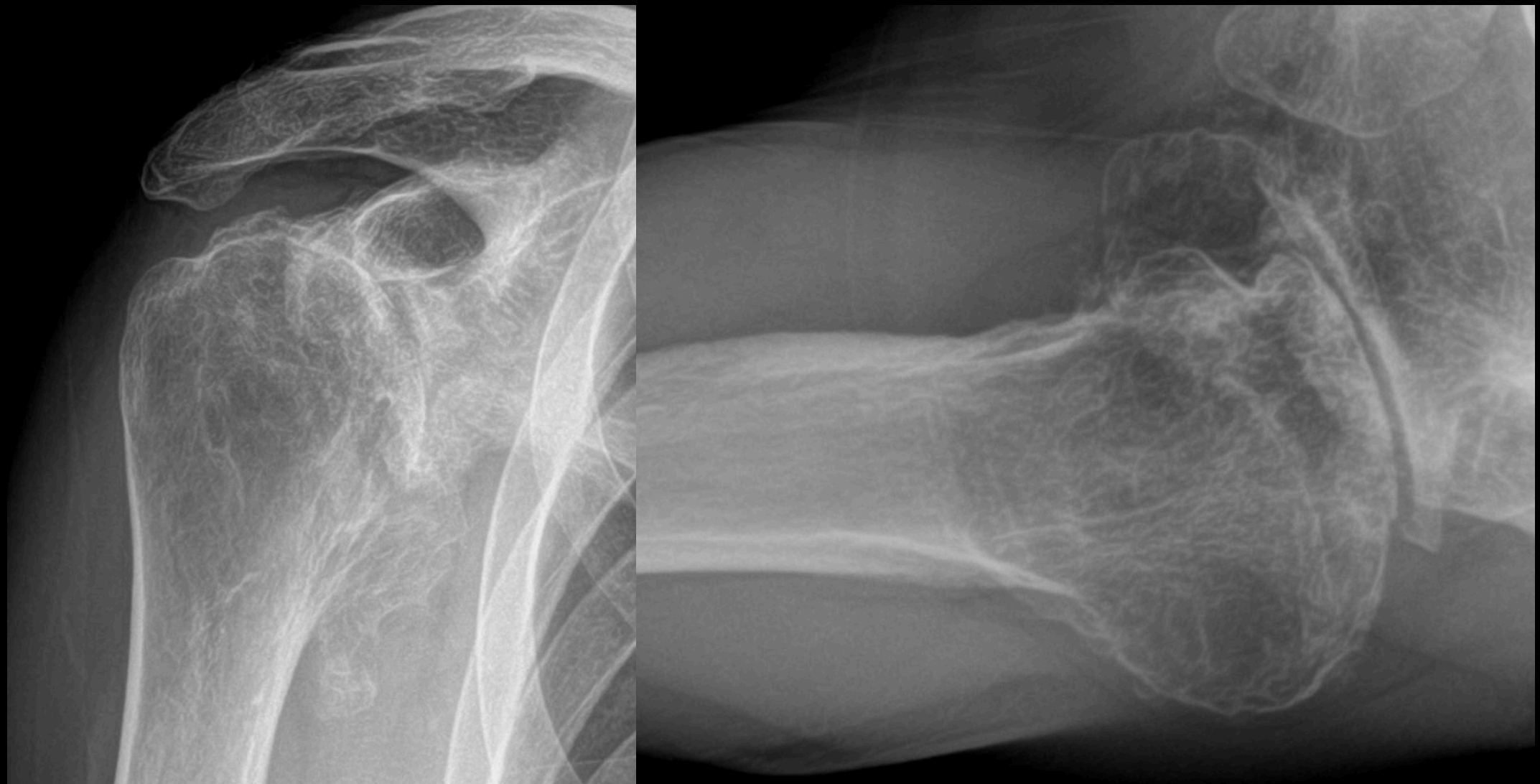
**Treat the entire patient (job, age…)**

**Counseling is critical**

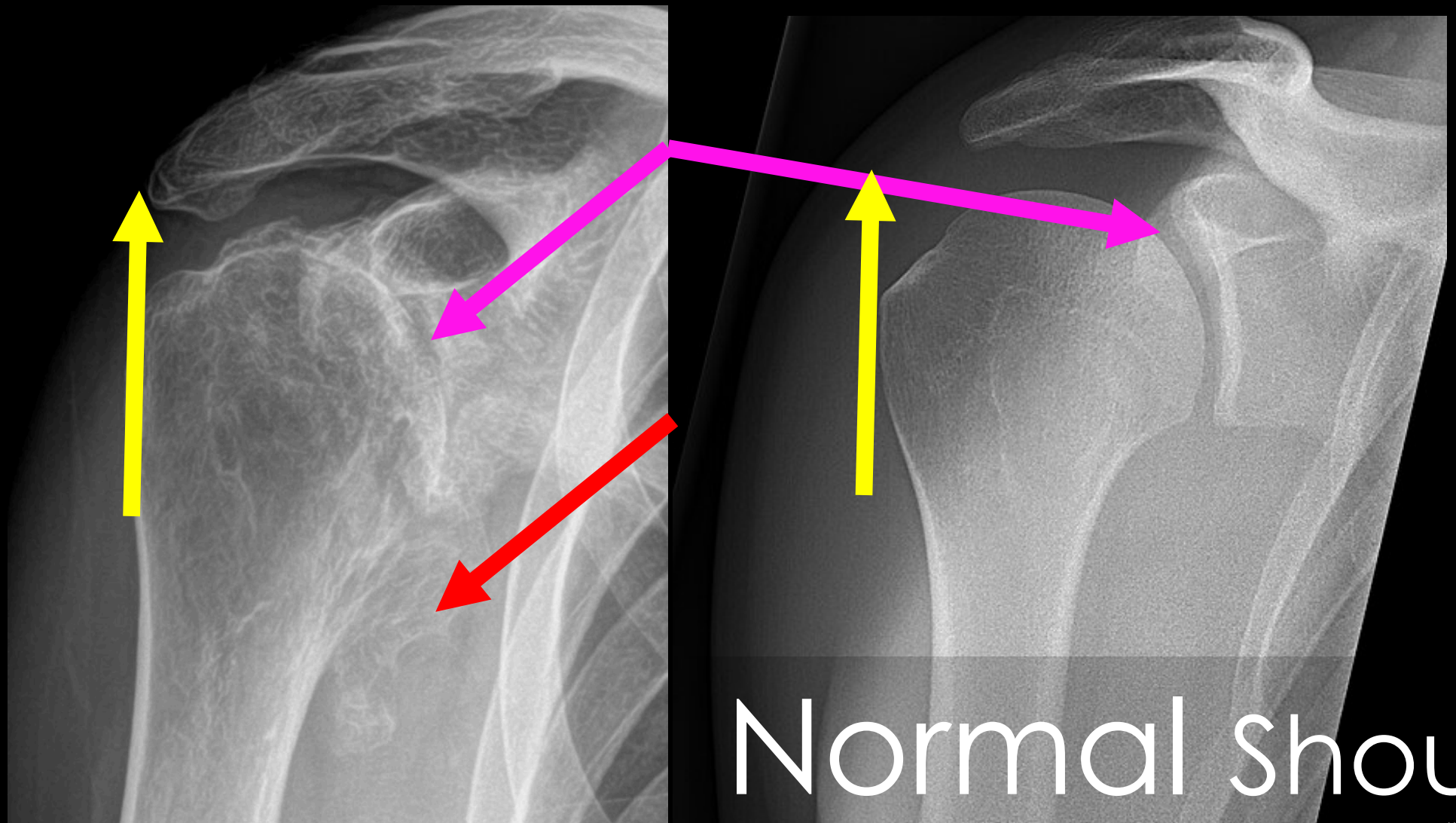
**Follow and know the data**

**RSA patients can return to physical work**

# 44 yo M. Police officer. 5/10 pain. SANE 33. Previous clean out. FF 90, ER -5, IR L5

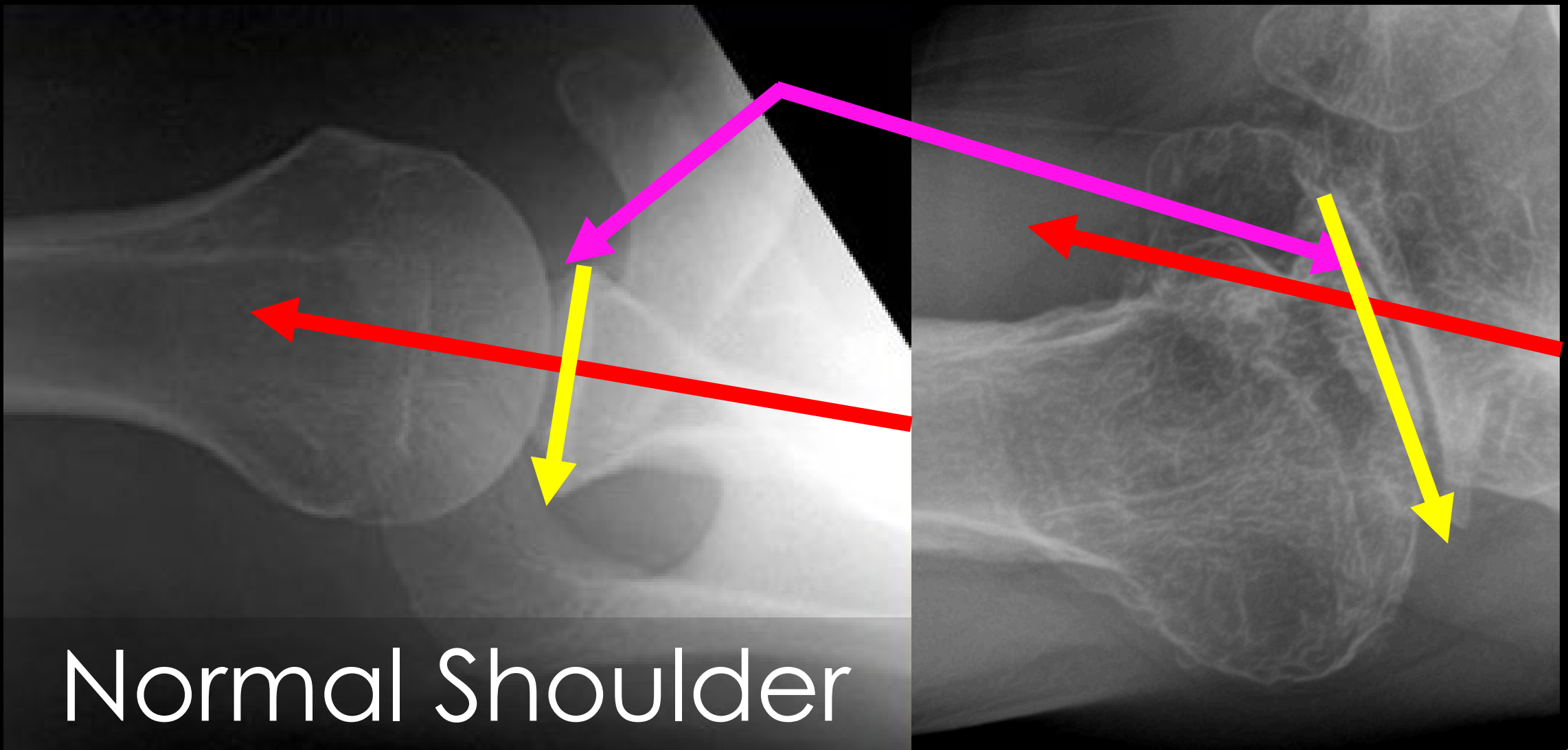


44 yo M. Police officer. 5/10 pain. SANE 33.
Previous clean out. FF 90, ER -5, IR L5



Normal Shoulder

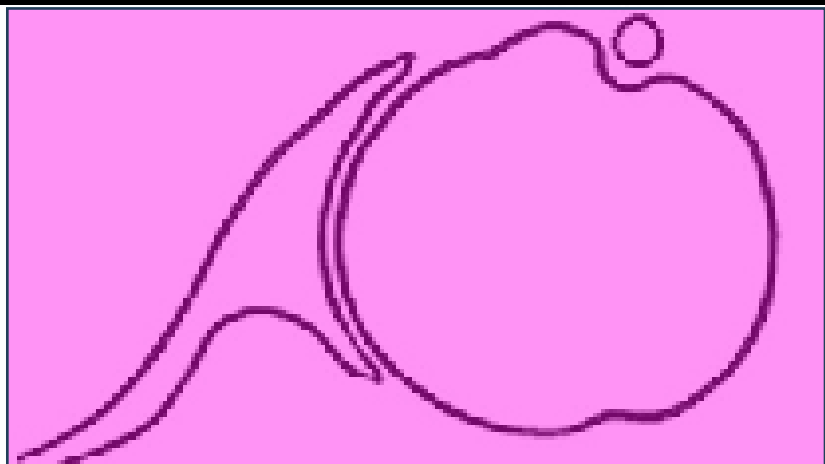
44 yo M. Police officer. 5/10 pain. SANE 33.
Previous clean out. FF 90, ER -5, IR L5



Normal Shoulder

B1

B2



B3

# RSA Do Better than TSAs in B2/B3

**Anatomic and reverse shoulder arthroplasty for management of type B2 and B3 glenoids: a matched-cohort analysis**

Teja S. Polisetty, BS[a], Daniel P. Swanson, BS[b], Paul-Anthony J. Hart, BA[b], Dylan J. Cannon, MD[c], Evan A. Glass, BS[b], Andrew Jawa, MD[b,d], Jonathan C. Levy, MD[e], Jacob M. Kirsch, MD[b,d,*]

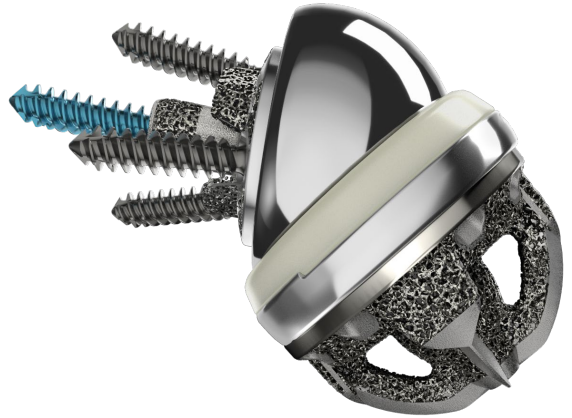
**Loosening/Failure of Anatomic Replacement vs Reverse**

Not FDA Approved

Stemless Anatomic

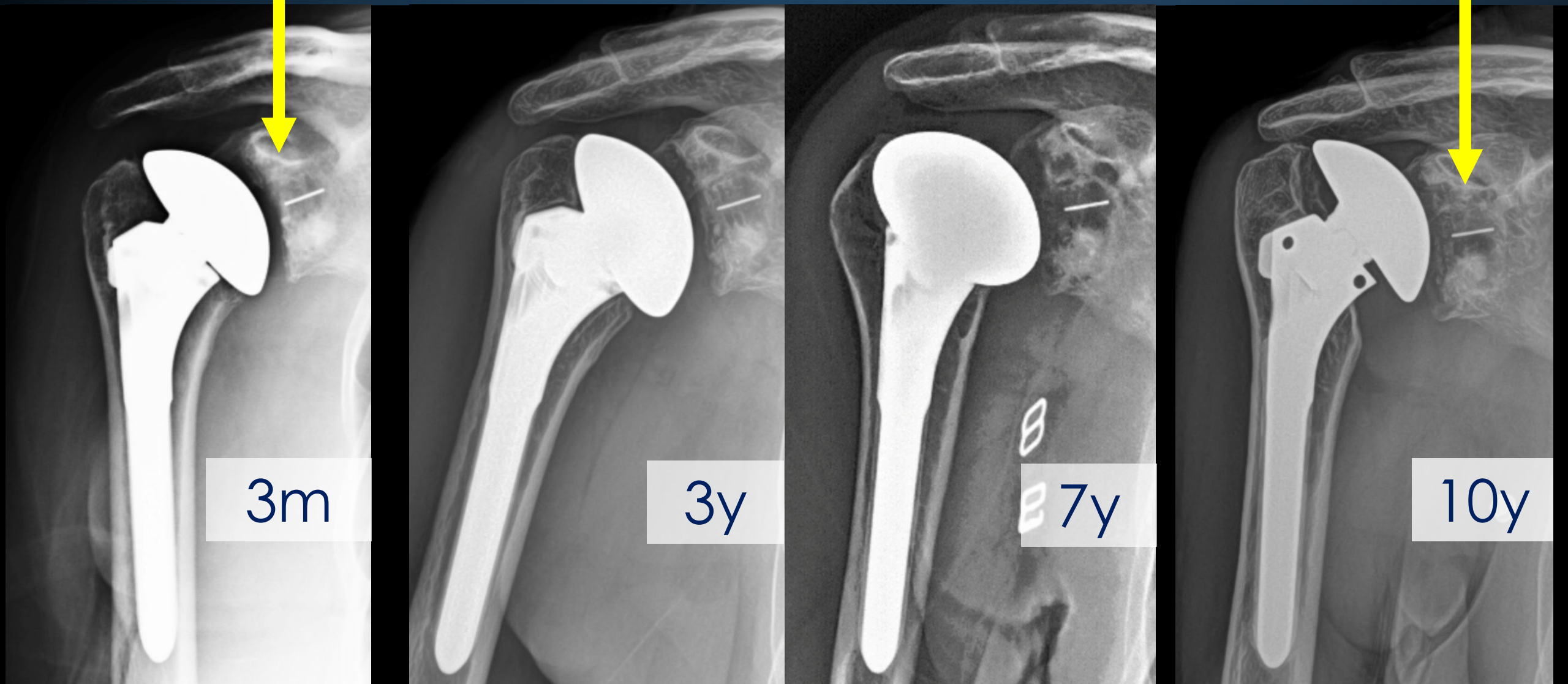
Stemmed Anatomic

Stemmed Reverse



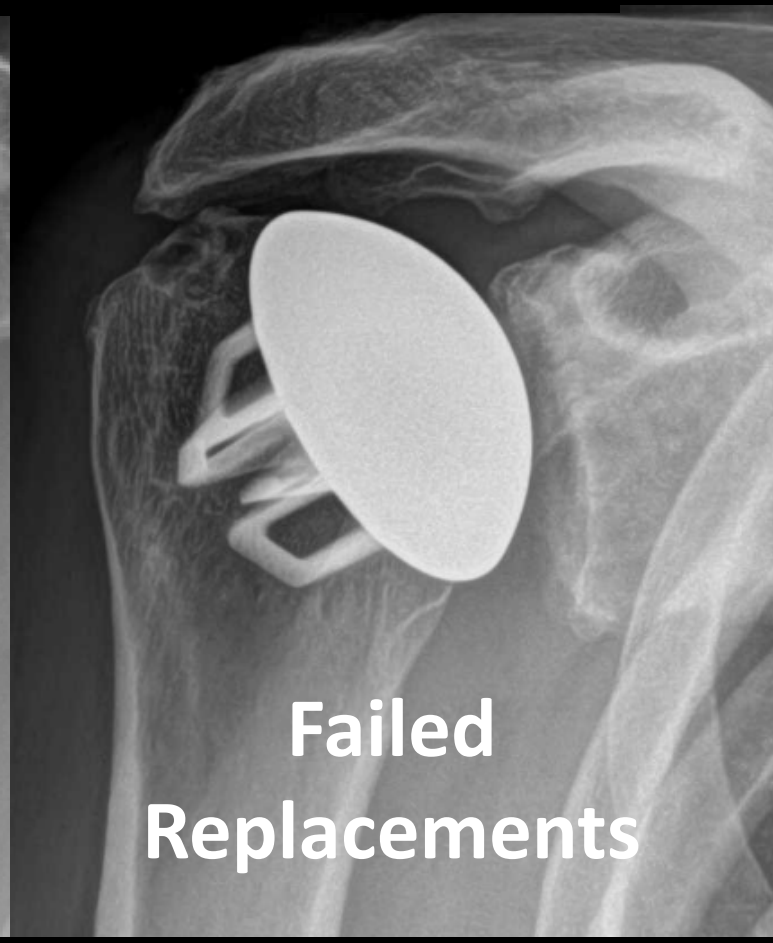
Stemless Reverse

# Glenoid Components Loosen



# Outcomes Vary by Indications



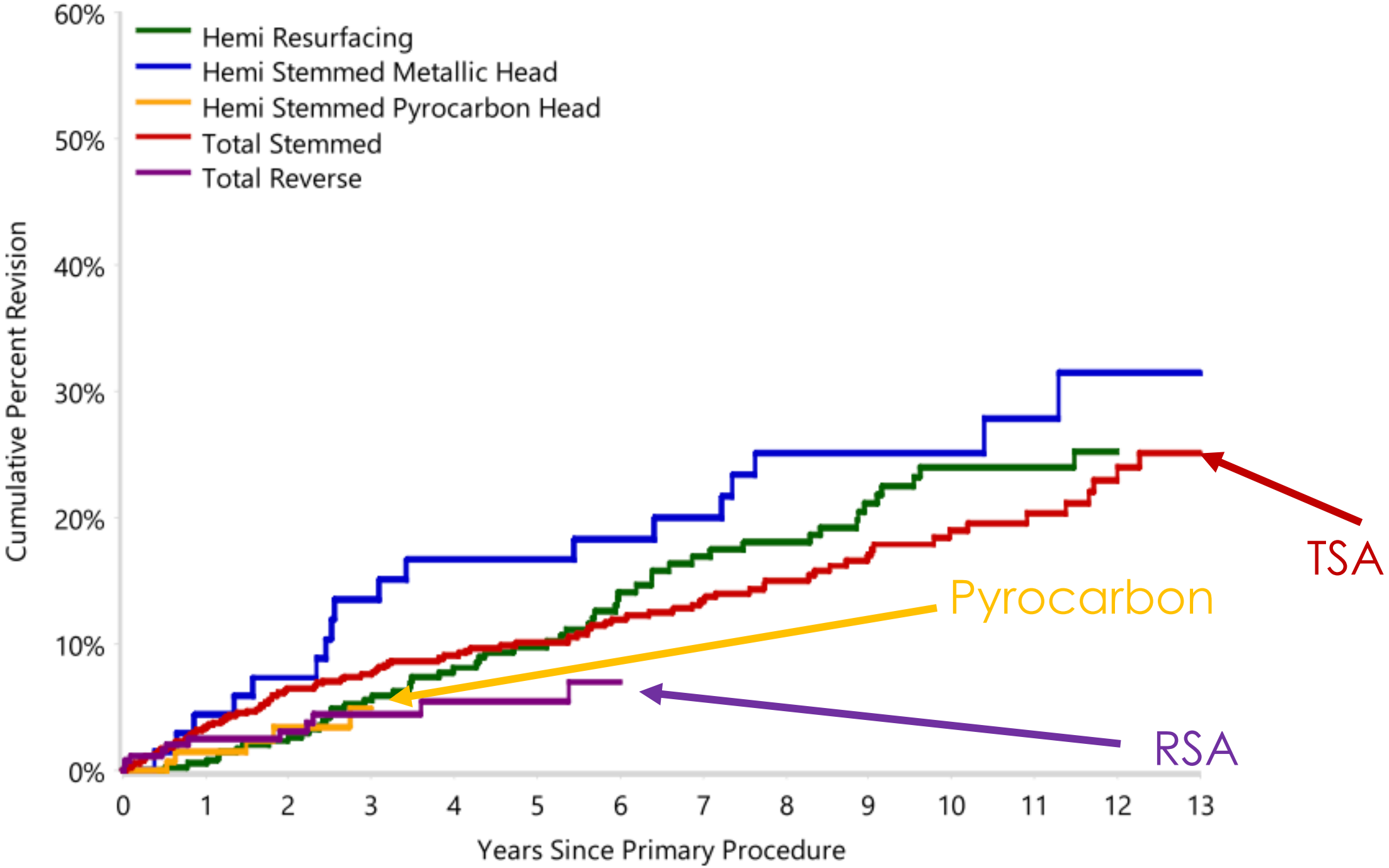

**In Between** **Do the Best!** **In Between** **Do the Worst!**

Australian Orthopaedic Association

# Survivorship of shoulder arthroplasty in young patients with osteoarthritis: an analysis of the Australian Orthopaedic Association National Joint Replacement Registry

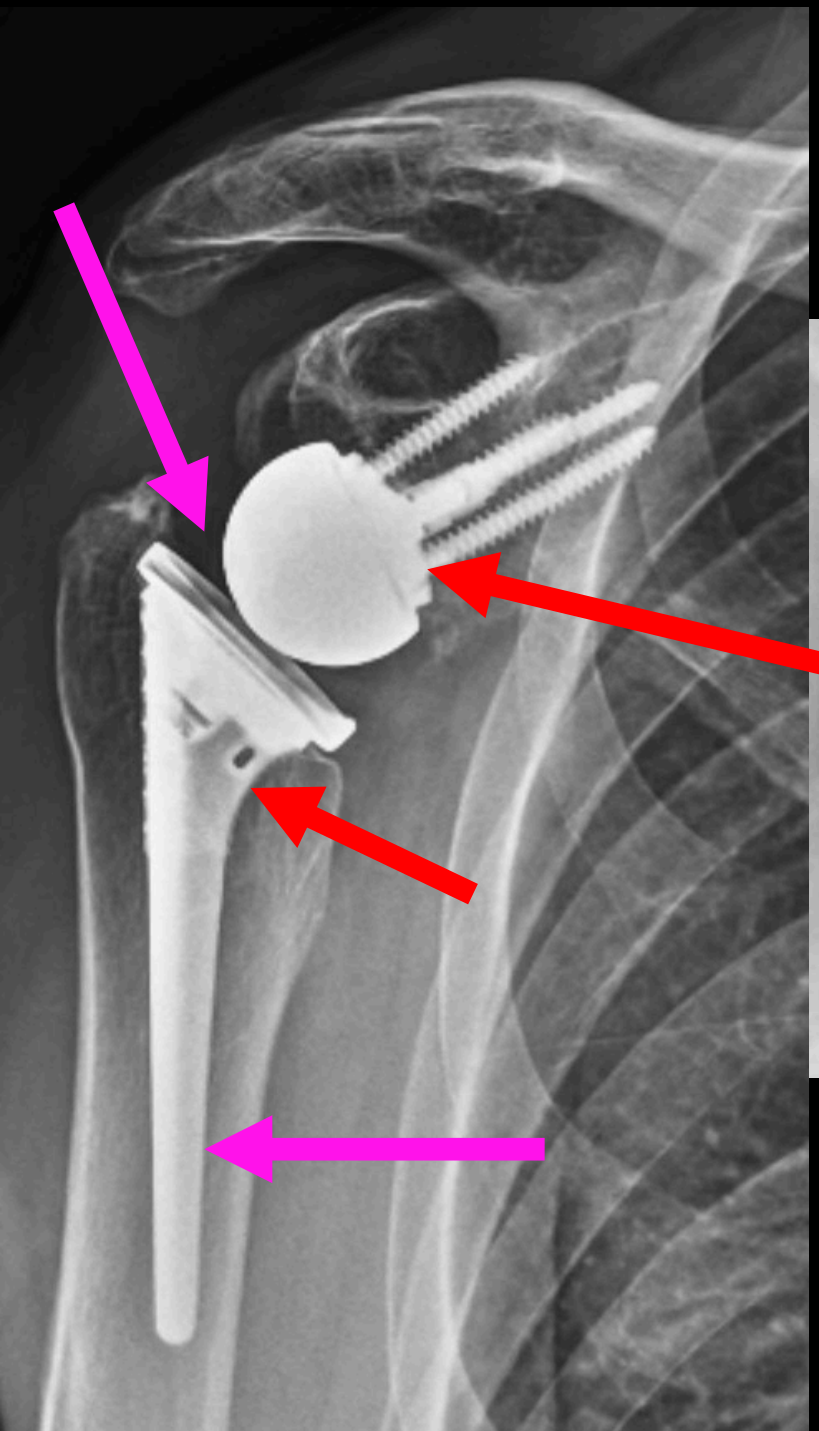
Al-achraf Khoriati, MBBS, BSc, FRCS[a,b],
Andrew P. McBride, BPHTY, MBBS, FRACS, FAOA[a,c,*],
Mark Ross, MBBS, FRACS, FAOA[a,b], Phil Duke, MBBS, FRACS, FAOA[a,b],
Greg Hoy, MBBS, FRACS, FAOA[d], Richard Page, MBBS, FRACS (Orth), FAOrthA[e,f],
Carl Holder[f], Fraser Taylor, BSC, MBCHB, FRACS, FAOA[c]

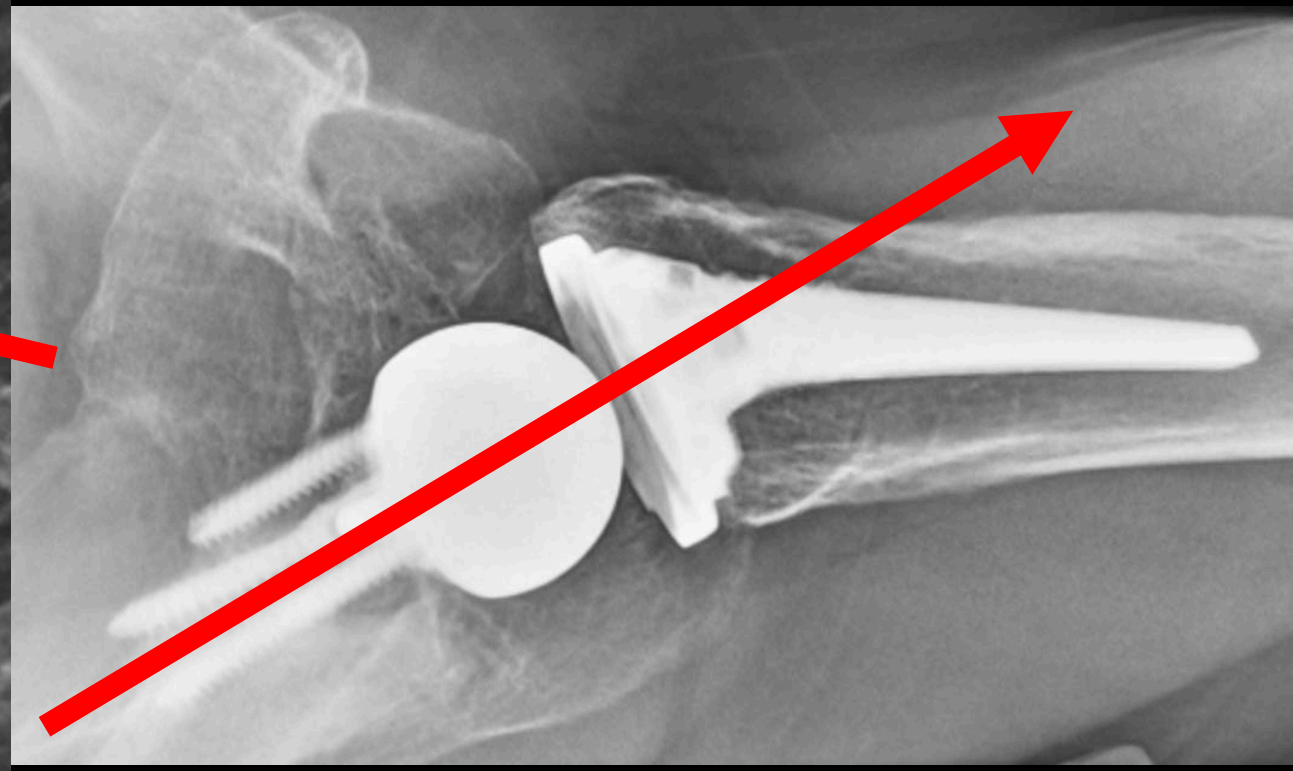
and Shoulder Arthroplasty

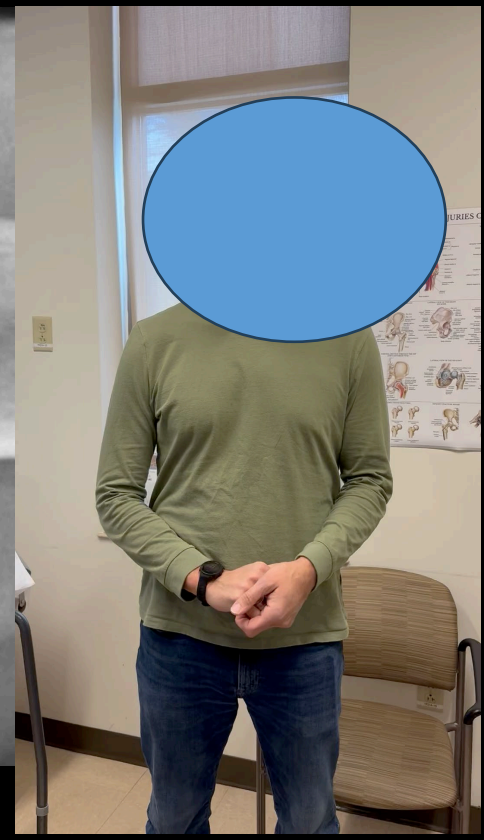

60%
50%
40%
30%
20%
10%
0%
Cumulative Percent Revision
Hemi Resurfacing
Hemi Stemmed Metallic Head
Hemi Stemmed Pyrocarbon Head
Total Stemmed
Total Reverse
0
1
2
3
4
5
6
7
8
9
10
11
12
13
Years Since Primary Procedure
TSA
Pyrocarbon
RSA

# So What Was Done?

# 2 years







# Return To Work: Multifactorial

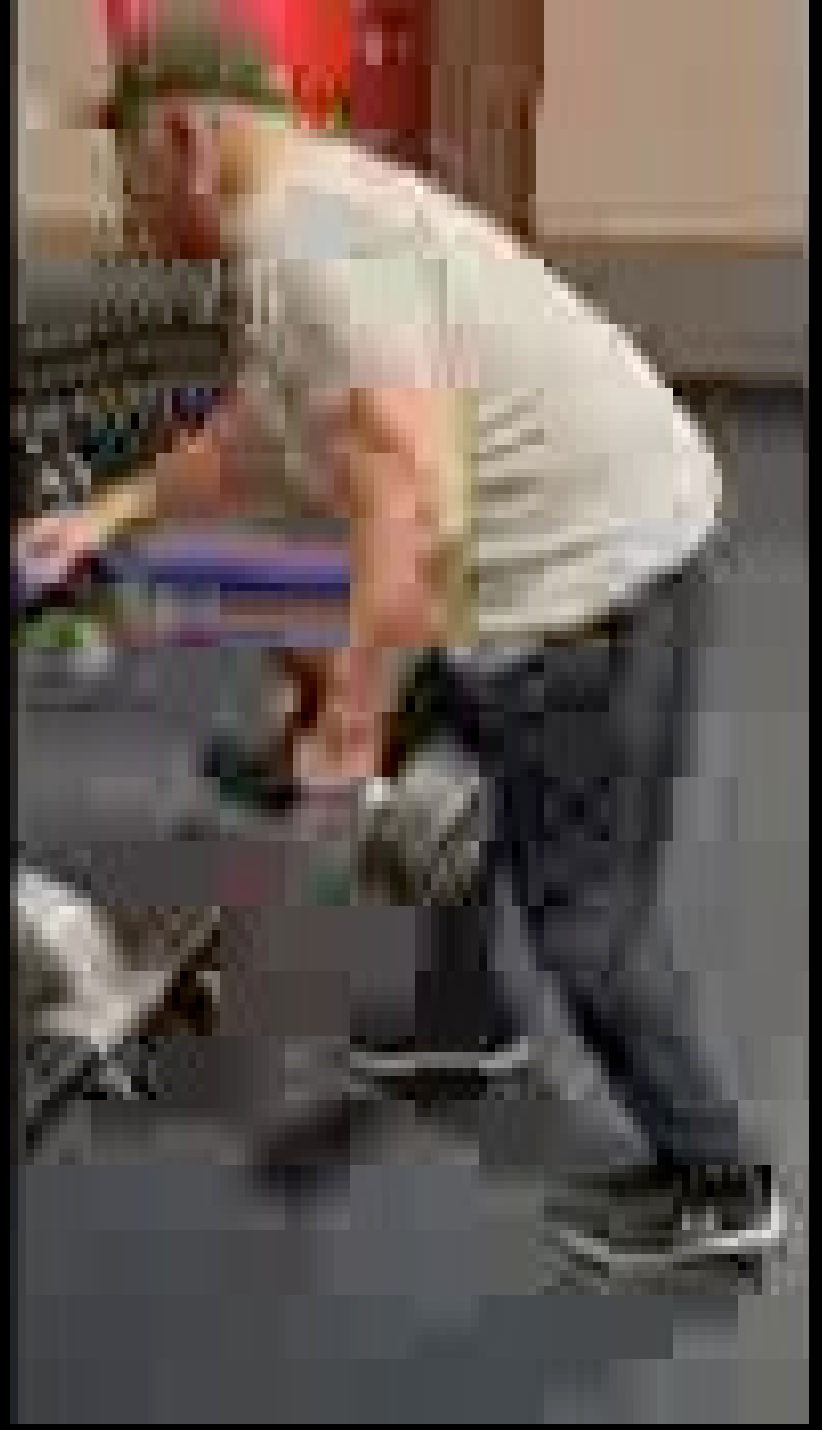
**Anatomic total shoulder arthroplasty for patients receiving workers' compensation**

Andrew Jawa, MD[a,b,c,*], Umer R. Dasti, MD[b], Sydney M. Fasulo, BA[c], Max H. Vaickus, BA[c], Alan S. Curtis, MD[b,c], Suzanne L. Miller, MD[b,c]

1. Type of Work
2. Type of Injury
   - Rotator Cuff vs Arthritis
3. Number of Previous Surgeries
4. Age
5. Work Requirements
6. Psychology

3 years

275 lbs



# *Conclusions*

Treat the entire patient (job, age…)

Counseling is critical

Follow and know the data

RSA patients can return to physical work

2026
WORK RELATED
Injuries Workshop

# Shoulder Case Presentation: Appropriate use of History, Physical, and Diagnostic Study Requests.

Stefan C. Muzin, MD/Physical Medicine and Rehabilitation

Senior Medical Director, ForHealth Consulting/UMASS Chan, Disability Evaluation Services

Contact Information: smuzin@gmail.com , Stefan. Muzin@umassmed.edu

# Disclosures

Nothing to disclose.

# Goals

Do not underestimate the value of a thorough history and exam.

Over-reliance on diagnostic testing can steer you down the wrong path.

Know when to order what study and what you are looking for.

Know limitations of each study.

# Case of J. H.

66 year old right hand dominant Welder presenting to clinic with relatively sudden onset of severe right posterolateral shoulder pain 11 days ago. Pain has improved from initial onset but notices significant weakness and inability to elevate arm above shoulder and some shoulder region paresthesias.

No traumatic incident described, no pop, but noticed at end of shift, was working on a lot of parts in awkward position, arm was in elevated position. Also significant pain at night.

Recalls previous right shoulder pain several years ago, not as severe, improved with PT and MT.

PMH/PSH: HTN, HLD,  DM2 (HgA1c 6.9 recently, managed on oral medications), Viral URI few weeks ago, prior left RCR several year ago (work related).

# Differential Diagnosis?

**Cervical Radiculopathy?**

**Rotator cuff tear?**

**Impingement/Bursitis/tendinitis?**

**Adhesive Capsulitis?**

**PostHerpetic Neuralgia?**

**Brachial Plexitis/Thoracic Outlet?**

# PHYSICAL EXAM

**Right Shoulder ROM (active):** Flexion to 170, abduction 100 (passive to 170), extension 50, adduction 50, ER 25 (passive 80), IR T12 (symmetric).

Cervical ROM full and painless, Spurling's negative.

**Strength Testing:** Right suprapinatus 2/5, infraspinatus 2/5, subscapularis 5/5. Other upper extremity muscle groups 5/5 in all myotomal levels.

**Special Test:** Negative Neer's, positive Hawkin's, negative crossed body adduction, Speed's Yergason's, O'Brien's, apprehension.

No scapular winging, skin rashes, no sensory loss, symmetric upper extremity reflexes, no pathologic reflexes.

# What's the Differential Now?

**Cervical Radiculopathy?** (normal cervical ROM, negative Spurling's, no myotomal weakness, no dermatomal sensory loss, normal reflexes).

**Rotator cuff tear?** (possible due to weakness and night pain- but no traumatic mechanism. Do you expect to have positive findings?)

**Impingement/Bursitis/tendinitis?** (possible, would presentation support this)

**Adhesive Capsulitis?** (passive ROM > active ROM can rule this out).

**PostHerpetic Neuralgia?** (no rashes/skin lesions noted).

**Brachial Plexitis/Thoracic Outlet?** (possible-does this follow a specific nerve root, brachial plexus trunk, cord, peripheral nerve distribution).

# What next test would you order?

# MRI Findings

- diffuse supraspinatus and infraspinatus muscle edema.

-partial 30% supraspinatus tear with tendinopathy.

-infraspinatus tendinopathy.

-type 2 acromium, subacromial bursitis.

-possible superior labral tear and biceps tendiopathy.

# EMG/NCS Study Results

Evidence of supraspinatus neuropathy with acute denervation changes of supraspinatus and infraspinatus.

# Parsonage Turner Syndrome (Neuralgic Amyotrophy/Brachial Neuritis

Rare autoimmune-mediated neuromuscular disorder characterized by sudden, severe, and often nightly, pain in the shoulder, arm, or hand.

Pain typically lasting a few days to weeks, is followed by rapid, progressive, and often debilitating muscle weakness and atrophy.

Causes: Viral infections (e.g., HIV, EBV) or recent illnesses.

Surgeries, trauma, recent intense physical exercise.

Recent vaccinations (including COVID-19 mRNA vaccines).

# Parsonage Turner Syndrome

**Most Common Nerves Affected:** Long thoracic nerve - can cause scapular winging, **suprascapular nerve,** axillary nerve, musculocutaneous nerve, radial nerve

**Less Common:** Cervical roots, anterior interosseous nerve (AIN), posterior interosseous nerve (PIN), lateral antebrachial cutaneous nerve (LABC)

Prognosis for functional recovery is usually good in most cases.

One of the largest natural history studies that 89% of patients had fully functional recovery at 3 years Factors associated with poor prognosis.

**Positive Prognostic Factors:** Upper trunk involvement, male gender.

# Parsonage Turner Syndrome

**Poor Prognostic Factors:** Female gender, lower trunk involvement, persistent pain and no motor function recovery by 3 months

**Timing of Recovery:** 66% have recovery of motor function within 1 month. Recovery rated "excellent" in 36% at 1 year, 75% at 2 years and 89% at 3 years

Can take years to full recover depending on nerve (s) distrubtions affected and other prognostic factors as indicated.

**Diagnosis:** Rule out other conditions. EMG/NCS (need to specify rule out diagnoses).

# References

Feinberg JH, Radecki J. Parsonage-turner syndrome. HSS J. 2010 Sep;6(2):199-205. doi: 10.1007/s11420-010-9176-x. Epub 2010 Jul 30. PMID: 21886536; PMCID: PMC2926354.

Rinad Al Hinai, Linda Kelly, Michael O'Connor, Hannah Berman, Linda Abdul Jalil, Aubrie Sowa, Jake M. McDonnell, Roisin Dolan, Unraveling the mysteries of parsonage turner syndrome: A journey towards optimal management. A systematic review, Journal of Hand and Microsurgery, Volume 16, Issue 5, 2024.

Tsairis P, Dyck PJ, Mulder DW. Natural history of brachial plexus neuropathy. Report on 99 patients. Arch Neurol. 1972;27:109–117. doi: 10.1001/archneur.1972.00490140013004.

https://www.orthobullets.com/shoulder-and-elbow/3065/brachial-neuritis-parsonage-turner-syndrome

https://www.hss.edu/health-library/conditions-and-treatments/list/parsonage-turner-syndrome

2026
WORK RELATED
Injuries Workshop

# Thank you!