

Guidance for healthcare professionals on the management of upper limb disorders in working-age people

Background

- Prevalence of upper limb disorders (ULDs) is very high in the general population, with up to one in two people experiencing symptoms in the neck or arm each week (2, 16)
- Symptoms are often recurrent and present in more than one region at a time (adjacent sites or bilaterally) (2)
- Most ULDs are difficult to diagnose accurately, however, exact diagnosis does not usually change management (2, 10)
- Influencing factors can include prolonged repetitive tasks, awkward postures, sustained or excessive force, lack of suitable rest breaks, use of power tools, and poor organisational or environmental factors. Exposure to these factors does not mean that an individual will develop upper limb pain (17)

Exclusion criteria

- This guidance does not apply to fractures, hand–arm vibration syndrome (HAVS), rheumatological or systemic connective tissue disease, vasculitis, or circulatory problems
- Evidence regarding cumulative exposure to repetitive actions and excessive force as causative factors is limited (2, 5). Therefore, some diagnostic labels, such as “repetitive strain injury” (“RSI”) that suggest that the mechanism of injury is due to a certain activity and that rest is required to resolve it (10) are generally unhelpful and should be avoided (2)
- Although ULDs cause difficulties with normal activities, most workers, for most episodes, with the correct support, should be able to remain at work (2)



Symptoms of ULDs which commonly affect function

- Reduced range of movement and stiffness (17)
- Pain and tenderness (17)
- Weakness (17)
- Altered sensation (numbness, tingling) (17)

Assessment

- To include general OH principles (18)
- A biopsychosocial approach should be taken, paying particular attention to limitations in function or movement that could affect the individual's ability to perform their working tasks, or safety critical roles

Management of ULDs

- The way to regain normal activity is often the same no matter what the diagnosis is (10)
- Early activity improves pain and stiffness, can speed up a return to full function (2) and lead to better long-term outcomes (4)
- A cognitive behavioural and multi-disciplinary approach has been shown to have favourable outcomes in both the short and long term, with psychosocial factors strongly influencing the success of occupational outcomes (2)
- Successful recovery is difficult if a person has fixed, negative health beliefs, does not receive reassurance, avoids activities and becomes anxious or depressed (10)
- Work with the patient to set realistic goals to return to full function (10)

Treatment approaches

- A stepped approach to care should be used, encouraging self-management of symptoms and staying active (2, 3, 10)
- Proactive symptomatic relief is advocated using regular, over-the-counter pain relief and/or anti-inflammatory medication, heat or cold, massage, stretches, exercise to reduce pain or a combination of all (10) to allow appropriate levels of activity (2)
- Modify any aggravating activities as required rather than advocating rest (2, 3, 10)
- Resting and avoiding use of the arm leads to loss of flexibility and muscle strength (10). By contrast, movement stimulates blood flow, providing the chemicals required for the healing process and prevents muscle wasting (10)
- Exercise therapy is supported as a first-line treatment (14)
- If the patient does not improve, they may benefit from corticosteroid injections (7) or other therapies and should be referred to a suitable health practitioner (10). Surgery is rarely required for arm pain

Positive messages and health beliefs

- Provide reassurance by normalising discomfort. Provide information about the fact that many people suffer with upper limb pain and that it is expected that they can make a good return to activities with the right approach
- Fear avoidance and catastrophising increases pain and disability (6, 11)
- Give reassurance that an increase in symptoms on return to work is unlikely to mean harm in most cases
- When managing arm pain, the belief that “work causes injury” through a gradual build-up of strain over time is incorrect, proven by the fact that not every person performing the same job suffers with pain or injury (10). This can be true for certain pathologies, such as carpal tunnel syndrome or tenosynovitis, which can be related to the use of tools, but most people will not experience these problems (10)
- Use positive, activity-based language, such as “TRY TO STAY ACTIVE” and encourage the patient to continue with normal day-to-day activities, as far as possible.
- Avoid terms such as “REST”; instead use terms such as “MODIFIED ACTIVITY”
- Minor setbacks are to be considered normal as improvements are made, this can cause frustration and the patient must be aware of this possibility and reassured (10)

Workplace management

- Short or long-term modification to aspects of work may include: reduced hours if strenuous activity is involved, regular change in activity, avoiding over-reaching, reduced weight of items handled, increased breaks, avoiding activities that aggravate the condition (10), working from home, and providing specialist equipment. These should help most people to remain at work, or return to work without making their condition worse (2, 10)
- Effective communication, established between the patient, their workplace and any health professional involved, leads to more positive outcomes (10). Individuals should be encouraged to contact their occupational health service, where available
- Ergonomic interventions can improve comfort and positively contribute to multimodal interventions, which address both biomechanical and psychosocial aspects (2)

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