

**Report Date:** 27 Jun 2012

**Summary Report for Individual Task  
081-833-0222  
Treat Common Musculoskeletal Disorders  
Status: Approved**

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DESTRUCTION NOTICE: None

**Condition:** You have a patient who presents with a musculoskeletal complaint. You will need a shoulder sling, splint, ace wrap, crutches anti-inflammatory drugs, ice packs, and patient's medical record. You are not in a CBRN environment.

**Standard:** Treat common musculoskeletal or foot complaints without causing further harm to the patient.

**Special Condition:** None

**Special Standards:** None

**Special Equipment:**

**Safety Level:** Low

**MOPP:**

<b>Task Statements</b>
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**Cue:** None

<b>DANGER</b>
None

<b>WARNING</b>
None

<b>CAUTION</b>
None

**Remarks:** None

**Notes:** None

## Performance Steps

1. Review the patient's medical record, if available.

2. Obtain a history.

a. O = onset. When did it start? What were you doing when it started? What was the position of the foot (inverted, supinated)?

b. P = provocative and palliative factors. What makes it better? What makes it worse? Is there any pain without weight bearing?

c. Q = quality. Is it sharp, dull, aching, pounding, constant, or intermittent? What is the character of the pain?

d. R = region and radiation. Where exactly is the pain? Does it seem to spread anywhere or does it stay right there? Is there any involvement of other joints?

e. S = severity. How bad is the pain? Is it incapacitating? Does it cause you to change your activity?

f. T = time, temporal characteristics (duration). When does it hurt? How long does it last? Have you had prior episodes? Any history of trauma or prior surgery?

3. Manage cervical pain.

a. Cervical strain.

(1) A strain happens when a muscle-tendon unit is overloaded or stretched.

(2) Motion of the neck becomes painful.

(3) Peaks after several hours or the next day.

(4) Treat with nonsteroidal anti-inflammatory drugs (NSAIDs), heat, massage, and other therapeutic modalities.

b. Cervical sprain.

(1) Movement is limited.

(2) Ligamentous disruption may be extensive enough to result in instability with associated neurologic involvement.

(3) Routine cervical spine radiographs are indicated.

(4) Treatment of a cervical sprain consists of immobilization, rest, support, and NSAIDs.

(5) Return to participation is permitted when motion and muscle strength normalize.

c. Cervical fracture. Any patient suspected of cervical fracture or having any neurologic deficit as a result of a cervical injury requires x-rays and must be evaluated by a medical officer.

4. Manage low back pain (Lumbosacral strain mild to moderate).

a. Signs and symptoms.

- (1) Usually have reduced range of motion.
- (2) Discomfort which is localized to the lumbar-sacral area.
- (3) Palpable muscle tenderness/spasm.
- (4) Negative straight leg raise (SLR).

b. Treatment. Decrease activity and ice massages. Medications, if required, usually consist of anti-inflammatory drugs and/or muscle relaxants. Often obesity is a factor in low back pain and patients should be encouraged to lose weight.

#### 5. Manage shoulder pain.

##### a. Rotator cuff tear.

- (1) Usually presents with shoulder pain/tenderness.
- (2) History of trauma.
- (3) Patient is unable to abduct the arm or hold it abducted against gravity.

(4) Treat initially with a shoulder sling and oral anti-inflammatory drugs (ASA, Motrin). Any shoulder complaint with a history of trauma must be referred to a medical officer.

##### b. Impingement Syndrome (shoulder pain).

- (1) Most common cause of shoulder pain and refers to mechanical compression and/or wear of the rotator cuff tendons.
- (2) Any process which compromises this normal gliding function may lead to mechanical impingement.
- (3) Most commonly seen in tennis players, pitchers and swimmers.
- (4) The first step in treating shoulder impingement is to eliminate any identifiable cause or contributing factor.
- (5) Non-steroidal anti-inflammatory medication may be used.
- (6) The mainstay of treatment involves exercises to restore normal flexibility and strength to the shoulder girdle.

##### c. Acute bursitis.

- (1) Usually produces pain with movement.
- (2) Follows overuse in most instances.
- (3) Most frequently tender to palpation over subdeltoid bursa.

(4) Treated with anti-inflammatory drugs and progressive shoulder exercises. There should be a reduction of certain physical activities including lifting, pushups and pulling for 7 days.

##### d. Septic arthritis.

(1) Should be considered if the patient has a fever or other signs and symptoms of inflammation.

(2) Emergent referral to a medical officer is indicated.

e. Dislocation.

(1) Usually follows a history of trauma but may occur spontaneously in some people.

(2) Sudden onset of pain with gross deformity of shoulder joint.

(3) Severe limitation of motion.

(4) X-ray should be done to rule out (R/O) associated fracture if a history of trauma. Often deferred until after reduction in order not to delay.

(5) Splint and assess distal pulses.

(6) Prompt referral to a medical officer.

(7) Pain medication and/or muscle relaxant may be used to relieve anxiety, pain and muscle spasm prior to reducing.

6. Manage knee pain.

a. Septic knee joint.

(1) Hot, tender knee with or without swelling.

(2) Orthopedic emergency requiring referral to a medical officer.

b. Sprain/strain.

(1) Tenderness over medial collateral ligament (MCL) or lateral collateral ligament (LCL) without laxity may indicate grade I sprain or strain.

(2) If mild laxity and tenderness of MCL/LCL is present, possible grade II sprain.

(3) If ecchymosis, effusion present with laxity, possible grade III sprain (torn ligament).

(4) Initial treatment consists of ice packs, ace wrap and elevation for the first 24 hours. Crutches may be indicated for comfort. Anti-inflammatory agents are used as required.

c. Patellar dislocation. Gross instability of the patella indicates that injury to the soft tissues of the medial aspect of the knee has been extensive.

(1) When dislocation of the patella occurs alone, it may be caused by a direct force or activity of the quadriceps, and the direction of dislocation of the patella is usually lateral.

(2) Spontaneous reduction may occur if the knee joint is extended.

(3) Initially treat with rest, ice, compression, elevation (RICE), NSAID, profile, and crutches if unstable. Will need ortho referral to evaluate for arthroscopic surgery.

d. Retropatellar (patellofemoral) pain syndrome.

(1) ) The symptoms probably represent the majority of knee pain complaints in athletes.

(2) Vague knee pain, which is usually after several hours of exercise.

(3) Walking downhill or downstairs, bending at the knees, and kneeling exacerbates pain.

(4) Initially treat with RICE, NSAID, stretches and exercises to strengthen quadriceps. Physical therapy consult for prolonged cases.

7. Manage foot pain.

a. Perform a physical examination (PE).

(1) Inspect the problem area.

(2) Determine the range of motion.

(3) Palpate the problem area.

(4) Check muscle strength.

b. Refer to a medical officer (MO) for x-rays of problem area, if appropriate and available.

c. Formulate assessment based upon history, PE and/or x-rays.

8. Manage ankle injuries.

a. Grade I ankle sprain.

(1) Antalgic gait.

(2) Able to bear weight.

(3) Minimal edema.

(4) Mild tenderness of malleolar area.

(5) Negative drawer sign.

(6) Initially treated with ice, compression, and elevation for 24-48 hrs. Crutches are indicated for up to 48 hrs in Grade I sprains. Anti-inflammatory agents (Motrin) and ace wrap protection are indicated for 5-7 days; with gradually increased exercises.

b. Grade II ankle sprain.

(1) Unable to bear weight.

(2) Edema.

- (3) Possible ecchymosis.
- (4) Acute tenderness.
- (5) Negative drawer sign.
- (6) Neurovascular status intact.
- (7) Range of motion reduced.
- (8) An x-ray should be done to rule out an associated fracture.

(9) May require posterior or "U" splinting for 3-5 days with ice, elevation, crutches and analgesics (Motrin). An ace wrap is indicated with gradual increase of activity after 72 to 96 hours.

c. Grade III ankle sprain.

- (1) Unable to bear weight.
- (2) Edema.
- (3) Ecchymosis present.
- (4) Acute tenderness.
- (5) Positive drawer sign.
- (6) Neurovascular status may be compromised.
- (7) Range of motion markedly reduced.
- (8) Should be referred to a MO for x-rays to be done to rule out an associated fracture.

(9) Immobilization using either a splint or non-weight bearing cast. Initially, ice, compression, and elevation are used to reduce edema and pain. Crutches, without weight bearing, and follow-up with podiatry or orthopedics is usually indicated. Nonsteroidal anti-inflammatory drugs or a mild narcotic will often be needed for pain relief. In all sprains, physical activity must be reduced appropriately and will vary in length from 72 hours to several weeks.

9. Manage achilles tendonitis.

- a. Pain, swelling, tenderness along tendon.
- b. Treat Achilles tendonitis with RICE, NSAIDs, ice for twenty minutes after activity, heel lift, and crutches if severe.

10. Manage metatarsalgia.

- a. Pain under the metatarsals that is exacerbated with functional activities and may present as burning.
- b. Commonly seen in women and in the second metatarsal.
- c. Important to rule out stress fracture, neuroma, and avascular necrosis of the metatarsal head.

- d. Conservative management is directed at relieving the pressure beneath the area of maximum pain.
- e. The patient should obtain a shoe of appropriate style and adequate size to allow an orthotic device to be inserted.

11. Manage bunion.

- a. Excessive bony growth (exostosis) on the head of the first metatarsal.
- b. Callous formation and bursal inflammation.
- c. The patient should be encouraged to wear shoes of adequate size and shape.
- d. Pads may be placed in the first web space or over the median eminence to help take pressure off of a painful median eminence.
- e. Pads are also may be placed underneath the metatarsal heads to take pressure off painful calluses or sesamoids.
- f. Podiatric surgical intervention may be considered.

12. Manage plantar fasciitis.

- a. Inflammation of plantar aponeurosis.
- b. Tenderness along plantar fascia.
- c. Treatment of pain 1-2 weeks in duration is with NSAIDs, rest, and stretches.
- d. The patient should perform ice massages with a cold bottle under the arch after activity.
- e. Over the counter insole arch support may help alleviate tension on the arch.
- f. Chronic pain may require a podiatry consult.

13. Record all treatment in the patient's medical record.

(Asterisks indicates a leader performance step.)

**Evaluation Preparation:** Setup: For training and evaluation, use another Soldier as the simulated patient.

Brief Soldier: Tell the Soldier that they have a patient with a common musculoskeletal complaint that requires treatment.

PERFORMANCE MEASURES	GO	NO-GO	N/A
1. Reviewed the patient's medical record if available.			
2. Obtained history.			
3. Managed cervical pain.			
4. Managed low back pain.			
5. Managed shoulder pain.			
6. Managed knee pain.			
7. Managed foot pain.			
8. Managed ankle injuries.			
9. Managed Achilles tendonitis.			
10. Managed Metatarsalgia.			
11. Managed Bunion.			
12. Managed plantar fasciitis.			
13. Recorded all treatment in the patient's medical record.			

**Supporting Reference(s):**

Step Number	Reference ID	Reference Name	Required	Primary
	BERHOW, R (16)	The Merck Manual of Diagnosis and Therapy, 16th Edition; Merck Company	No	No

**Environment:** Environmental protection is not just the law but the right thing to do. It is a continual process and starts with deliberate planning. Always be alert to ways to protect our environment during training and missions. In doing so, you will contribute to the sustainment of our training resources while protecting people and the environment from harmful effects. Refer to FM 3-34.5 Environmental Considerations and GTA 05-08-002 ENVIRONMENTAL-RELATED RISK ASSESSMENT.

**Safety:** In a training environment, leaders must perform a risk assessment in accordance with FM 5-19, Composite Risk Management. Leaders will complete a DA Form 7566 COMPOSITE RISK MANAGEMENT WORKSHEET during the planning and completion of each task and sub-task by assessing mission, enemy, terrain and weather, troops and support available-time available and civil considerations, (METT-TC). Note: During MOPP training, leaders must ensure personnel are monitored for potential heat injury. Local policies and procedures must be followed during times of increased heat category in order to avoid heat related injury. Consider the MOPP work/rest cycles and water replacement guidelines IAW FM 3-11.4, NBC Protection, FM 3-11.5, CBRN Decontamination.

**Prerequisite Individual Tasks :** None

**Supporting Individual Tasks :** None

**Supported Individual Tasks :** None

**Supported Collective Tasks :**

Task Number	Title	Proponent	Status
N/A	N/A	Not Selected	Obsolete