

FROZEN SHOULDER (ADHESIVE CAPSULITIS)

INTRODUCTION

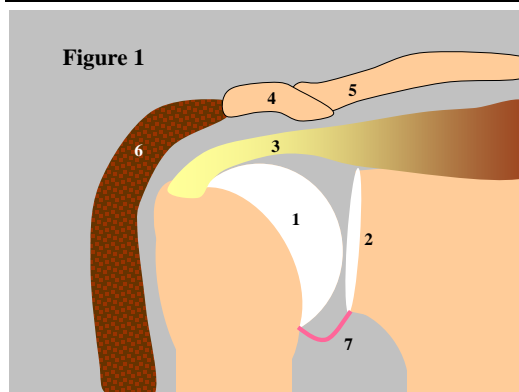


Figure 1 About your Shoulder

The shoulder is a ball (1) and socket (2) joint. The rotator cuff tendons (3) pass beneath the roof of the shoulder, the acromion (4) and attach around the ball to move the joint. The acromion attaches to the collar bone (5) forming the AC joint and the whole shoulder is surrounded by the big deltoid muscle (6). The deepest layer of the shoulder is the capsule (7).

Frozen shoulder, also known as adhesive capsulitis, is a condition which affects the capsular lining of the shoulder joint itself. The capsule and related ligaments become inflamed, thickened and contracted. There are recognised associations with diabetes mellitus and Dupuytren's contractures of the hands but most of the time the exact cause is unknown. It may affect both sexes in the middle ages of life. It may start after a trivial or minor injury, a period of immobility or

after treatment such as heart bypass surgery or radiotherapy. It is also a recognised complication of unrelated shoulder surgery.

It usually presents as a painful, stiff shoulder which may disturb sleep at night. Jerky or quick movements of the arm and shoulder are particularly painful and pain can radiate down the whole length of the arm. Occasionally patients describe pins and needles sensation down to the hand and often find relief by resting the arm slightly forward and away from their body perhaps on the arm of a chair.

Frozen shoulder can mimic other painful shoulder conditions but classically there are 3 phases of the condition:

1. The freezing phase ☹ – during this time the shoulder is very painful and starts to stiffen up
2. The frozen phase 😐 – pain starts to settle but the stiffness remains.
3. The thawing phase 😊 – gradually the stiffness disappears and the shoulder returns to normal.

TREATMENT

The natural history is that this is generally a self-limiting condition which on average resolves by 18 months. The exact timing is difficult to predict.

Initially rest and activity modification to avoid those functions that make the pain worse should be tried in combination with simple painkillers (paracetamol or codeine) and anti-inflammatory tablets (ibuprofen or diclofenac). In the early

phase stretching exercises or formal physiotherapy can be unhelpful and even make things worse.

Your doctor or a [shoulder surgeon](#) may consider an injection into the joint to bathe the inflamed tissues with local anaesthetic and anti-inflammatory steroid (Figure 2) and this can be very effective as an early measure.

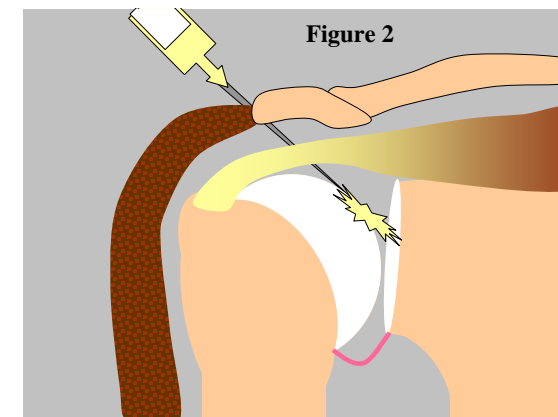


Figure 2 Local anaesthetic and Cortisone works well.

Occasionally surgery is recommended to try to improve a persistently stiff shoulder.

Traditionally an MUA (manipulation under anaesthetic) has been performed. Under general anaesthetic the shoulder is stretched through a range of movements to break down adhesions.

Since the advent of arthroscopic (keyhole) surgery, an MUA is often preceded by release of the capsule from the inside of the joint using a variety of keyhole instruments. This allows the [shoulder surgeon](#) to release the tight lining of the shoulder (Figure 3).

This release allows your movement to improve immediately. This type of operation is also performed under general anaesthetic usually in combination with a nerve block performed into the neck by the anaesthetist to help with pain relief and allow early rehabilitation exercises with a physiotherapist to start as soon as possible.

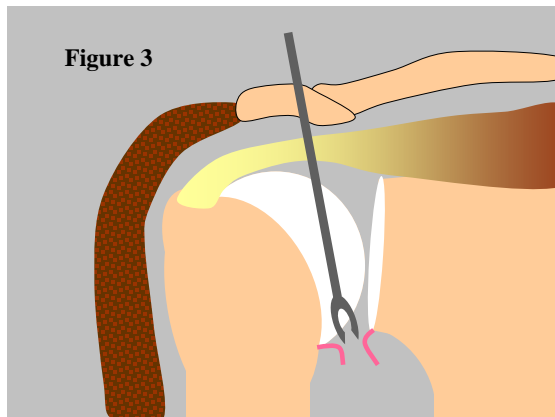


Figure 3 Release of capsular adhesion by day case surgery

A sling is often not required following routine surgery and the two simple stitches are removed by the surgeon or GP practice nurse at 2 weeks.

The operation has good success rates especially when patients have completed a course of physiotherapy rehabilitation to gain maximum benefit.

Driving is allowed as soon as a patient feels safe and able to do so – usually within 2 weeks. Return to work is dependant on the activities required – sedentary work 2 weeks, heavy manual work 6 weeks.

The risks of infection and wound problems are minimal (less than 1%). For any further information please ask your surgeon or physiotherapist.



Frozen Shoulder

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