Classification

Primary: No identifiable causes

Secondary: More common, period of restricted shoulder motion (rotator cuff pathology, trauma, surgery)

Can be caused by thyroid problems and diabetes (both types) - usually associated with poorer clinical outcome and recovery
- Female 55 years of age, non-dominant side

Stages

Stage 1: Achiness, sharpness at end range

Stage 2: painful/freezing gradual, progressive loss of shoulder ROM lasting weeks to months

Stage 3: frozen, pain and significant loss of ROM for 12-24 months

Stage 4: thawing stage , progressive decrease in pain and stiffness can last up to 9 months

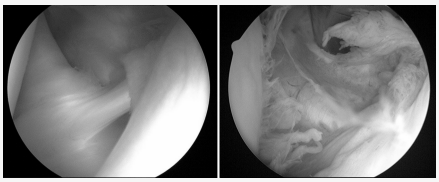
Presentation

- Progressive pain either after an event (secondary) or came on suddenly (primary)
- Pain focal to the deltoid with sharpness at end range
- Night pain and sleep disturbances
- Difficulty with overhead movements , behind the back or to the side
- Loss of shoulder ROM (passive and active) in two or more planes of motion in the following order(external, abduction, internal rotation, forward flexion)
- Atrophy of shoulder muscles may be present with no weakness
- Look for scapula dyskinesis and shoulder hitching, upper crossed
- CX spine restrictions can be found
- Neurological exam unremarkable
- Secondary AC can mimic rotator cuff pathology (+ve Hawkins Kennedy, Neers, Jobes, Speeds)

Imaging

- Only to rule out other pathologies (OA/dislocation)
- MRI to rule out Rotator cuff pathology/ no improvement with conservative care
- MRI can show axillary recess thickening , joint volume reduction, rotator cuff interval thickening, synovitis
- Arthroscopy

Pathophysiology



- Inflammation in the joint capsule and synovial fluid
- Reactive fibrosis and adhesions of the synovial lining of the joint
- Athroscopy showing a normal shoulder (L) and subacromial fibrosis, proliferative synovitis and capsular thickening (R)

Ddx

- F#
- Infection
- Neoplasm
- Calcific tendinitis
- Bursitis
- CX radioculopathy
- Fibromyalgia
- Shoulder impingement
- Rotator cuff pathology
- OA
- systemic arthropathy
- Sprain/strain
- Referred scleratogenous (cardiac/digestive)
- PMR

Management

- Active and passive stretching of shoulder capsule
- Scapula mobilisation
- CX and TX SMT
- Passive shoulder exercises (cane and Torbay exercises)
- Upper postural correction(upper crossed, scapula dyskenisis)
- Heat/ice
- Explain to patient that this recovery is a slow process and self limiting (most get better suddenly within 18-30 months)
- Spencer technique
- NSAIDs & Corticosteroids
- Referral to orthopaedic surgeon if:
- Symptoms are not improving within 10-12 months with conservative care
- Steroids/ NSAIDs do not help
- No response to GH/SA injections
- **Surgery contraindications:**
- Inadequate course of steroids/NSAIDs
- Patient has not undergone conservative care
- Acute infection
- Concomitant malignancy in the shoulder
- Neurological deficit/nerve complaint from the cx