shoulder2shoulder UPDATE

Dr. Terry Hammond SHOULDER SURGEON
MBBS FRACS

Summer 2011

Welcome to the first edition of the **shoulder2shoulder UPDATE.** This will be a quarterly publication with each edition highlighting a common shoulder condition. I hope you find it educational and interesting. I would be delighted to receive any feedback (positive or negative!) and any suggestions for future topics.

Profile

Dr. Terry Hammond has specialized exclusively in disorders of the adult shoulder since finishing his orthopaedic training in 2003. He has undertaken a six month travelling shoulder fellowship in the USA and Canada and an twelve month upper limb fellowship in the world renowned Pulvertaft unit in Derby, England. Since returning to Queensland he has established his private practice in association with Dr. Chris Vertullo at Pindara Place in the grounds of Pindara Hospital, Benowa.

Contact

DR. TERRY HAMMOND
The Shoulder and Sports Medicine Centre
Pindara Place, 13 Carrara Street
Benowa Queensland 4217

Phone 07 55976024
Fax 07 55970644
Website www.terryhammond.com.au
Email mail@kneesports.com.au

PINDARA PRIVATE HOSPITAL

Frozen Shoulder

Frozen shoulder is one of the commonest conditions seen in my practice. It is also the most commonly misdiagnosed. This often leads to the wrong treatment – making an already painful condition even worse.

What is it?

Pain and stiffness caused by constriction in the capsule of the shoulder.

What is the cause?

Unknown – usually occurs spontaneously, sometimes with a minor traumatic event (throwing a ball, reaching behind to the back seat in a car). Very common after shoulder surgery or any shoulder trauma.

Who gets it?

Classically women 40-60 but any age or sex. I have seen it in a 19 yr old girl and an 83 yr old man. Much more common in diabetics.

Is it common?

Very! I see at least 250 new cases per year – many of which are misdiagnosed.

What are the symptoms?

Pain – constant, aching pain in shoulder and especially down the mid upper arm, worse at night (can't sleep), often severe pain with sudden movements.

Stiffness – can't do up bra, put on underarm deodorant, wash hair or reach up.

What is the time frame?

Very typical – 1-2 months of pain without much stiffness (very difficult to diagnose at this time), 6-8 months of pain and stiffness, another year of slowly resolving stiffness (patients often feel so good without the pain they don't notice the stiffness), eventually resolves nearly completely

Does it occur in both shoulders?

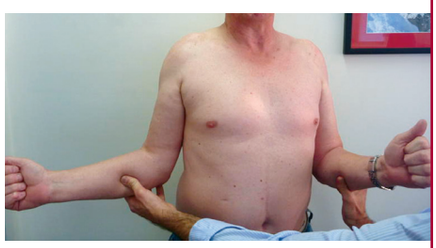
Commonly but usually at different times. Rarely recurs in same shoulder.

Can it occur after significant trauma?

Yes, it is common after shoulder dislocations and acute traumatic rotator cuff tears. Very important to establish if this may be the case – acute large rotator cuff tears retract quickly, and rapidly become irreparable. An MRI is needed if you suspect significant precipitating trauma.

The ultrasound reports a cuff tear – should I believe it?

Short answer – no. Unfortunately ultrasounds are often inaccurate when the shoulder is stiff. An MRI is much more accurate but is not needed in most cases.



How can I diagnose it?

The typical history and likely middle aged female demographic should help but the big giveaway is the loss of movement. By far the easiest way to recognize this is to compare the range of external rotation between sides. Hold the elbows at 90 degrees and keep the elbows firmly held in by the patient's side. Then rotate outwards. As shown in the photo of an actual patient with frozen shoulder the difference is often quite dramatic. The only other diagnosis which gives this loss of movement is osteoarthritis which is usually in a different age group and will be excluded by an xray.

What is the treatment?

There is no cure and in most cases we simply wait for it to resolve. Strong analgesics are needed and NSAIDs can help. Above all, NO STRETCHING! This has been shown to make the shoulder worse (see reference below). The arm should be used in the comfortable range only. Physios must not do any stretching. Simply getting the patient to avoid all stretching can relieve much of the pain. The range of motion will return naturally.

Injections of steroid into the shoulder (glenohumeral) joint is definitely worth trying (good pain relief in about 50% but doesn't help the range of movement). Often worth repeating at 6 weeks. Hydrodilation is injection of steroid under pressure – I think it helps mainly due to the steroid.

Is surgery useful?

Can be used in two situations. In painful stage (6-8 months) will give some pain relief but doesn't help range of motion so only used when patients are in severe pain. When pain has gone (after 6-8 months) can then be used to restore motion.

Gentle thawing of the frozen shoulder: A prospective study of supervised neglect versus intensive physical therapy in seventy-seven patients with frozen shoulder syndrome followed up for two years. Ronald L. Diercks, and Martin Stevens, Journal of Shoulder and Elbow Surgery 2004;13:499 –502.

More information and a patient handout which can be downloaded, can be found on my website www.terryhammond.com.au