



## **Adhesive Capsulitis**

This condition, also known as “frozen shoulder”, implies there is some inflammation of the capsule, which is the lining of the shoulder joint. This is a poorly understood condition. There is usually no known cause and it can begin suddenly or at times very gradually. It may follow a surgery, injury or a period of immobilization. The result is a stiff joint. Stiffness can occur in other joints as well but there seems to be something unique about the stiff or “frozen” shoulder.

It commonly affects middle-aged women. But it can also affect older women and men in either of these age groups as well. It does not affect children, and it is not hereditary. It also tends to occur more commonly in patients with diabetes. However, it is not caused by diabetes. Diabetic patients who develop frozen shoulder do tend to have more severe cases, which take longer to resolve. They may also be more resistant to the usual treatments. It is not a disease, which spreads to other joints, although, if you have it on one side there is a 50% chance of developing it on the other side. The good news is that once you have had it, the condition does not tend to re-occur at a later date.

While it is easy to diagnose in the later stages of the condition, in the earlier stages it is often confused with bursitis or tendonitis of the shoulder. Patients often search for an event or something that they did that may have brought this pain on, yet often there is no cause. Pain is the first symptom of this condition. Often for no apparent reason, you notice pain with movements such as reaching, bathing, grooming, etc. As time goes on, the pain gets worse and you begin to notice that you are losing motion in the shoulder. You can't reach your back or things on a shelf. By this time it is usually straightforward to accurately diagnose the problem. After a while, the pain will reach its peak and begin to subside. The stiffness, however, may continue to get worse resulting in more difficulty with daily care or work. The usual course of events has demonstrated more often than not that over time even the stiffness resolves completely or almost completely.

While there are similarities amongst patients with this condition in terms of the general pattern to pain and stiffness, there are differences also. Some patients don't have the same degree of pain, as do others. In some, the stiffness is not as disabling. For others, the condition begins and resolves all within a few months and responds quickly to treatment. However, sometimes the process takes a year or more and is resistant to treatment. One thing is for certain. There is no quick fix for patients with this condition.

Once the pain begins, the only thing to do is take anti-inflammatory medicines to reduce the inflammation, and take pain medications for better sleep. Using the arm will not worsen the condition even though it may hurt. It is better to not “baby it” rather you should promote motion within your limits of pain. Putting your arm in a sling and waiting for the pain to resolve will contribute to loss of motion. For some patients, cortisone injections early in the course of the process may reduce inflammation in the lining of the joint and allow quicker resolution. Physical therapy is one of the mainstays of treatment. If therapy is started too early, in the “freezing phase” when there is a lot of pain, it will often be very painful and a waste of resources. It has been found that if therapy is delayed until the pain is resolving and the stiffness remains, then it will be more productive. This may require waiting for a few months before beginning therapy.

Patients are encouraged to be their own therapists. A skilled physical therapist can teach the patient many helpful techniques to do daily at home to promote better motion and function. It is imperative that the patient be diligent in daily stretches. A patient motivated to work aggressively on their motion daily makes the job and progress of the therapist much more successful.

If therapy and time fail to result in satisfactory pain relief, motion and function, then there is a role for surgical management. The primary modes of treatment include manipulation under anesthesia and arthroscopic capsular release.

Manipulation under anesthesia is just what it sounds like. The patient is given anesthesia either in the form of general or an injection into the shoulder and neck area to numb the nerves in that arm and then the shoulder scar tissue is broken up by the surgeon. This can be successful in restoring motion, however there is risk. The bone can be broken causing potentially serious consequences, more pain and worse motion. It may require surgery to fix the fracture. Even after an uneventful manipulation, once the anesthesia wears off, the pain returns and may be quite severe. Therapy starts soon and these sessions are fairly uncomfortable. Another option is a surgical procedure called arthroscopic capsulotomy. The patient is given a general anesthesia and a telescope is inserted into the shoulder joint. Another small puncture wound is made in the shoulder and instruments are placed into the joint to release the scar tissue. This also has risk such as those associated with general anesthesia, injury to nerves and blood vessels, recurrence of the pain and stiffness.

Despite the fact that this seems to paint a pretty grim picture for this condition, the fact remains that most patients actually do very well with just some medicines and therapy. There is a back up plan for the more difficult cases. Patients need patience.

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