

[IMAGE]

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Is That Really Frozen Shoulder?

By Whitney Lowe, LMT

It is easy to get excited about being able to help a client that comes to you with a specific pain condition. In fact, this is one of the most rewarding aspects of doing clinical massage.

With only your hands you can perform therapeutic procedures that help relieve the pain and suffering that your client has been experiencing. However, in our enthusiasm to help as many people as possible we must avoid a common clinical mistake: oversimplification and overgeneralization of our client's complaints. This can lead to inaccurate identification of the problem, improper treatments, and unsubstantiated claims about clinical efficacy, which simply aren't true. These mistakes are detrimental to all of us in the long run.

One of the most frequent situations where I have seen this occur is with shoulder pain that is commonly labeled "frozen shoulder." Practitioners will show treatment methods and make claims for healing a frozen shoulder in one or two treatments. Healing a true frozen shoulder in one or two treatments is highly unlikely due to the nature of the pathology. In order to understand why this is unlikely, it is first necessary to understand a little more about frozen shoulder.

CAP Underside of the capsule that will adhere to itself in adhesive capsulitis. Figure 1: The glenohumeral joint capsule slackened on the underside when the shoulder is in a neutral position. Mediclip image (c)1998, Williams and Wilkins. All rights reserved.

The term "frozen shoulder" is a clinically inaccurate term because it doesn't specify the nature of the pathology in the shoulder, only that there is some limited motion at the glenohumeral joint. The true frozen shoulder is a pathology called adhesive capsulitis. This is a situation where a pouch of tissue on the underside of the glenohumeral joint capsule becomes adhered to itself and prevents full motion at the shoulder (Figure 1).

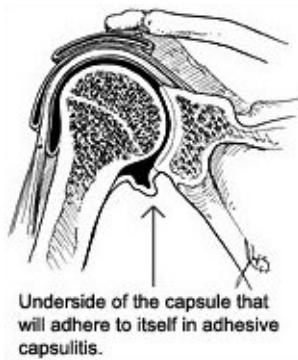


Figure 1: The glenohumeral joint capsule slackened on the underside when the

shoulder is in a neutral position. Mediclip image ©1998, Williams and Wilkins. All rights reserved. A person that has shoulder pain and limited abduction is often described as having a frozen shoulder; however, there are a number of problems that may actually cause shoulder pain and limited range of motion in abduction. For example, subacromial bursitis, shoulder impingement syndrome, arthritis, supraspinatus tendinosis, calcific tendinitis, or rotator cuff tears may all cause shoulder pain and limited motion in abduction, just like adhesive capsulitis. This is why the term "frozen shoulder" is so misleading. There are other conditions, such as paralysis of the trapezius or serratus anterior muscles that may also cause limitation in abduction although they are not likely to produce pain sensations, as some of these other problems will.

Adhesive capsulitis is a problem that does not resolve quickly. Due to the adhesion of joint capsule fibers, it usually takes more than one or two treatments to encourage capsular stretching and breaking of the adhesions that hold the sides of the capsule together. So, how do we determine if this is a true adhesive capsulitis, one of the other problems mentioned above, or something we might not have thought of? Luckily, there are a number of assessment procedures that can help us make that distinction.

First, and most importantly, is the client history. There are unique characteristics in the onset of adhesive capsulitis compared to some of these other conditions. It will often come on slowly for no apparent reason, or it may be associated with some other traumatic event in the shoulder. In addition to information from the history, one of the most important characteristics to evaluate is whether or not the client is demonstrating a capsular pattern of restriction for the shoulder.

The capsular pattern is a concept that was first described by the well-known British orthopedic physician, Dr. James Cyriax. The joint capsule has certain motions that it limits more than others. If there is a problem in the joint capsule, the limitation in these motions will usually follow a common pattern. For example, the capsular pattern in the glenohumeral joint is such that motion will be most limited in lateral rotation, second

in abduction, and third in medial rotation. This is due to the way the capsular tissues are stretched during those motions. For instance, if there is a problem like adhesive capsulitis involving the joint capsule, the motion that will be most restricted is lateral rotation. Abduction will be the motion next most likely to have limited range, and limitation in medial rotation will be less likely. The worse the condition gets, the more limitation you will see in all those different motions.

In most of the other conditions described above, the primary problem exists because of compression or irritation of various soft tissues underneath the coracoacromial arch. Therefore, motion in abduction is painful and limited, as these structures get pinched in abduction (Figure 2).

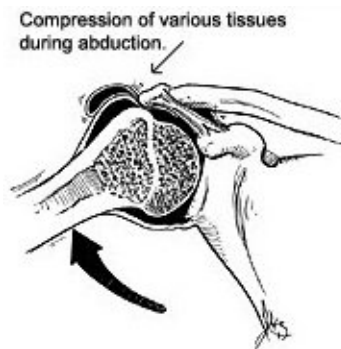


Figure 2: Compression of tissues on the underside of the coracoacromial arch. Medclip image ©1998, Williams and Wilkins. All rights reserved. However, if the arm is laterally rotated from a neutral position, there is not likely to be pain because there is no increase in compression or tension on these structures. Yet, if there is a capsular problem, lateral rotation should be the first motion to show restriction. Therefore, if there is pain and limitation in lateral rotation from a neutral position, this is more indicative of a capsular problem like adhesive capsulitis.

It will be important to go through other assessment strategies, such as active motion, passive motion, manual resistive tests, and any other special orthopedic tests that might help you either identify or rule out other problems. If, after performing a thorough evaluation, you are convinced that you are dealing with a true adhesive capsulitis, then your treatment strategies should reflect methods that will reduce capsular adhesions and encourage elongation of the inferior portion of the capsule. This is usually a long process, because it requires the capsule to stretch tissues that have been stuck together, and is unlikely to occur over just one or two treatments.

CAP Compression of various tissues during abduction. Figure 2: Compression of tissues on the underside of the coracoacromial arch. Medclip image (c)1998, Williams and Wilkins. All rights reserved.

It is essential that we be as accurate as possible when evaluating these problems for several reasons. First, it is crucial you know as much about who and what you are dealing with so you can construct a beneficial treatment plan. In addition, it is essential that we are accurate in our descriptions and claims about what we are able to do in treatment. Making inaccurate or unsubstantiated claims about miracle recoveries is one sure way to decrease our credibility in the eyes of our fellow health care professionals.

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