IDIOPATHIC ADHESIVE CAPSULITIS

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I. Definition

A. Frozen Shoulder (Codman)
- same as adhesive capsulitis (J.S. Neviaser)

B. No significant intrinsic shoulder pathology
1. No DJD
2. No trauma
3. No surgical arthrofibrosis

C. No Cause of shoulder stiffness identified

D. Restriction of both passive and active shoulder ROM
Passive motion
1. <100 degrees abduction
2. >50% external rotation opposite shoulder

II. Natural History

A. Codman(1934) - ' Even the most severe cases recover with or without treatment in about two years .'

B. Recent studies show that there is a residual restriction of motion In 40~60% of patients

C. Functional limitations are only mild

III. Pathology

A. Decreased capsular volume
1. Loss of axillary pouch
2. Loss of subscapularis bursa

B. Chronic inflammatory response
1. Synovium
2. Capsule
a) increase in cytokines (growth factors)

C. Contracted rotator interval

IV. Clinical Course

A. Painful inflammatory" freezing phase "

B. Frozen phase
C. Thawing phase
    1. Each phase lasts approx.4-6 months

V. Office Work Up

A. History and physical
B. X-rays - r/o tumor, DUJD, Ca++
C. Arthrogram confirms diagnosis but is not necessary
D. MRI not necessary
E. Send to internist for medical work-up and blood test to r/o diabetes and thyroid disease

VI. Treatment Options

A. Benign neglect
    1. patients do not want to wait 1~2 year
B. anti-inflammatory medications
    1. NSAID's usually not helpful
    2. oral corticosteroids
        a) helpful in some patients in the freezing phase
        b) use only for short time period (i.e. Medrol dose pak)
C. Cortisone Injections
    1. Should be intra-articular
    2. Can be helpful
    3. Difficult to tell in the office if you are in joint
D. Physical therapy
    1. Efficacy?
    2. Expensive
    3. Can make patient worse by vigorous stretching
        a) Increase inflammation
        b) Increase stiffness
    4. A good therapist can help by making patients do their own exercises
    5. I will try one 6 week course of PT, then evaluate patient
E. Distending joint with fluid
    1. During arthrography
    2. Office management of frozen shoulder
    (Fareed, CORR, 1989)
F. Close manipulation with arthroscopy
    1. Only necessary in small % of patients
    2. Recommend after no improvement in motion after 3 months with a shoulder that only externally rotates to neutral
G. Closed manipulation with arthroscopy

1. arthroscopy may improve the results
2. Confirms pathology i.e., synovitis and visualizes capsular tearing

H. Arthroscopic Capsular Release

1. Valuable in patients that are osteopenic and difficult to manipulate
2. Not as destructive as a manipulation
3. Can release rotator interval, anterior capsule, and posterior capsule
4. I release from 1 to 5 in front and 7 to 11 in back. If full elevation is not obtained, a gentle manipulation will tear inferior capsule (can arthroscopically divide the axillary panel through a posterior portal but must be careful not to injure axillary nerve

I. Open capsular release

1. Not needed in idiopathic frozen shoulder

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