Acute Shoulder Pain — Common Causes and their Management

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Acute shoulder pain occurs from injury to shoulder tissues or can be a referred pain from the thoracic or cervical area. There are several causes of acute shoulder pain, among them: fracture of the clavicle and scapula, shoulder dislocation, rotator cuff lesions, adhesive capsulitis and subacromial bursitis. The pain history and physical examination of the shoulder are needed to make the diagnosis. The specific cause and its severity are determined by imaging such as X-rays. Treatment is based on medication and orthopedic management.

Definition of Acute Shoulder Pain

Shoulder pain is a common symptom that might originate from an intrinsic shoulder problem or an extrinsic problem. The most common causes of extrinsic referred shoulder pain include myocardial ischemia and neck pathology.

Intrinsic shoulder pain originates from the structures that make up the shoulder joint which include: the humerus, glenoid, scapula, acromion clavicle, and surrounding soft tissues.
Causes of Shoulder Pain

According to the duration of pain, the causes of shoulder pain can be classified into acute and chronic:

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<th>Acute shoulder pain</th>
<th>Chronic shoulder pain</th>
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<td>Fracture and dislocation</td>
<td>Osteoarthritis of shoulder</td>
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<td>Rotator cuff lesions</td>
<td>Rheumatoid arthritis</td>
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<td>• Impingement syndrome</td>
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<td>• Rotator cuff tear</td>
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<td>• Painful arc syndrome</td>
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<td>Adhesive Capsulitis (Frozen shoulder)</td>
<td>Partial rotator cuff tear</td>
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<td>Subacromial bursitis</td>
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Specific Provocative Tests for the Diagnosis of Shoulder Pain

**Hawkin’s test:** Internal rotation with shoulder/elbow flexion to 90°. Pain indicates rotator cuff pathology.

**Empty can test:** Resistance when shoulders abducted to 90° and forward flexed 30°. Weakness on downward pressure suggests supraspinatus tear.

**Lift-off test:** Arm internally rotated across patients lower back. Weakness in lifting hand straight off indicates pathology of subscapularis tendon.

**External rotation test:** Arms at sides and elbow flexed to 90°. Weakness on external rotation suggests infraspinatus tendon pathology.

**Speed’s test:** Shoulder flexed to 60° and active resistance to pressing downward on elbow. Pain or weakness suggests biceps tendonitis or tear.

**Cross-body abduction test:** Abduction of the arm across the chest of the patient. Pain indicates possible AC joint disease.

Fracture and Dislocation

Clavicle fracture

A fractured clavicle accounts for 5% of all fractures and it also accounts for more than 50% of injuries around the shoulder joint. It is one of the most common childhood fractures. Most fractures occur in the middle third of the clavicle. The most common cause of clavicular fractures is trauma.

**Examination**
Patients with a clavicular fracture present with pain and tenderness over the clavicle. Swelling is another common finding. The patient is unable to abduct his or her shoulder. Deformity over the shoulder with the unopposed action of pectoralis major muscle, the lateral fragment is displaced downwards and medially while the proximal segment is displaced upwards by the unopposed action of the sternocleidomastoid muscle.

**Diagnosis**

Diagnosis is simple in most cases and based on:

- A recent history of trauma followed by pain, swelling, deformity, and loss of function at the site of fracture and involved joint.
- One must look for any evidence of a neurovascular deficit in the distal limb.
- The diagnosis can be confirmed on an X-ray.

**Treatment**

Clavicular fractures rarely require rigid fixation as the strong muscles surrounding the bone act to reduce and hold the fractured segments together. In adults, immobilization using a triangular sling suffices in cases with minimum displacement. A figure-of-8 bandage may be applied to a young adult with a displaced fracture. Immobilization and reduction serve the purpose of pain relief in the acute setting and later allow for the formation of callus and healing without deformities.

Open reduction and internal fixation with a plate or a nail are indicated in:

- Fractures associated with the neurovascular deficit.
- In some severely displaced fractures, where it may be more of a cosmetic concern.

**Complications**

- **Early complications:** Injury to the neurovascular bundle more so the subclavian vessels or brachial plexus.
- **Late complications:** Shoulder stiffness, malunion and nonunion (the latter being very rare).

**Scapular fracture**

Fractures of the scapula are less common, and, in most cases, unimportant because patients recover well without much treatment.

**The scapula can break at four sites:**

- Body
- Neck
- Acromion process
- Coracoid process

Most often, the fracture is undisplaced because the fragments are held in position by the surrounding muscles.

**Treatment**

The mainstay of treatment is to restore shoulder mobility by active exercises as soon as the pain subsides. A triangular sling for the period of pain and swelling (usually 1 week – 10 days) is usually sufficient.
Subluxation or dislocation of the acromioclavicular joint

This is an uncommon injury, caused by a fall on the outer prominence of the shoulder.

Pathology

The injury may result in a partial or complete rupture of the acromioclavicular or coracoclavicular ligaments. Acromioclavicular joint injuries are classified according to the 6-grade system described by Rockwood depending upon their severity.

The following table summarizes the most recent classification of acromioclavicular joint injuries:

<table>
<thead>
<tr>
<th>Type</th>
<th>Clavicle position</th>
<th>Acromioclavicular ligament</th>
<th>Coracoclavicular ligament</th>
<th>Joint capsule</th>
<th>Deltoid muscle</th>
<th>Trapezius muscle</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Not displaced</td>
<td>Mildly sprained</td>
<td>Intact</td>
<td>Intact</td>
<td>Intact</td>
<td>Intact</td>
</tr>
<tr>
<td>II</td>
<td>Elevated, but not above the acromion</td>
<td>Ruptured</td>
<td>Sprained</td>
<td>Ruptured</td>
<td>Slightly detached</td>
<td>Slightly detached</td>
</tr>
<tr>
<td>III</td>
<td>Elevated with a coracoclavicular distance &lt; 25 mm</td>
<td>Ruptured</td>
<td>Ruptured</td>
<td>Ruptured</td>
<td>Detached</td>
<td>Detached</td>
</tr>
<tr>
<td>IV</td>
<td>Posterior to trapezius</td>
<td>Ruptured</td>
<td>Ruptured</td>
<td>Ruptured</td>
<td>Detached</td>
<td>Detached</td>
</tr>
<tr>
<td>V</td>
<td>Elevated with a coracoclavicular distance &gt; 25 mm</td>
<td>Ruptured</td>
<td>Ruptured</td>
<td>Ruptured</td>
<td>Detached</td>
<td>Detached</td>
</tr>
<tr>
<td>VI</td>
<td>Inferior to the coracoclavicular ligament and biceps tendon</td>
<td>Ruptured</td>
<td>Ruptured</td>
<td>Ruptured</td>
<td>Detached</td>
<td>Detached</td>
</tr>
</tbody>
</table>

Diagnosis

Diagnosis is depicted by pain and swelling localized to the acromioclavicular joint. In a Grade III injury, the lateral end of the clavicle may be unusually prominent.

Investigations

Bilateral shoulder X-ray with the acromioclavicular joints of both sides exposed for comparison. Subluxation or dislocation of the joint may be seen.

Treatment

Grades I and II injuries are treated by rest in a triangular sling and analgesics. Grade III injury in young athletic individuals is treated by surgical repair.

Dislocation of the shoulder

This is the commonest joint in the human body to dislocate. It occurs more commonly in adults and is rare in children. Anterior dislocations account for more than 95% of dislocations, with posterior dislocations making up 4% and inferior dislocations (luxatio erecta).

Superior and intrathoracic dislocations are extremely rare.

A smaller number have an atraumatic origin and may be related to congenital, acquired, or degenerative conditions.
Shoulder instability refers to the condition where the head of the humerus is not stable in the glenoid. It has a wide spectrum – from minor instability or a ‘loose shoulder’ to a frank dislocation. In the former, the patient may present with just pain in the shoulder, more on using the shoulder. Pain occurs due to stretching of the capsule, as the head ‘moves out’ in some direction without dislocating. A patient with frank instability may present with an ‘abnormal’ movement of the head of the humerus. This could be partial movement (subluxation) which gets spontaneously reduced or a dislocation.

The instability may be in one direction (unidirectional) or more (bidirectional). It may be in multiple directions – anterior, inferior, posterior, where it is called multidirectional instability (MDI).

Classification

Dislocations of the shoulder may be of the following types:

**Anterior dislocation:** In this injury, while the arm is held in slight abduction and external rotation, the shoulder is “squared off” (i.e., boxlike) with the loss of deltoid contour compared to the contralateral side. The humeral head is palpable anteriorly (in the subcoracoid region, beneath the clavicle). The patient resists abduction and internal rotation and is thus unable to touch the opposite shoulder. It may be further classified into three subtypes depending on the position of the dislocated head.

1. **Preglenoid:** The head lies anterior to the glenoid.
2. **Subcoracoid:** The head lies inferior to the coracoid process which is the most common type of dislocation.
3. **Sub clavicular:** The head lies below the clavicle.

**Posterior dislocation:** In this injury, the arm is held in adduction and internal rotation. The anterior shoulder is “squared off” and flat with the prominent coracoid process. The head of the humerus comes to lie posteriorly behind the glenoid. The posterior shoulder is full of humeral head, palpable beneath the acromion process. The patient resists external rotation and abduction. Shoulders may look identical in bilateral dislocation, making it a commonly missed injury.

**Luxatioerecta (inferior dislocation):** This is a rare type, where the head comes to lie in the sub glenoid position.

**Clinical feature and diagnosis:**

The patient’s shoulder is held in abduction and the elbow supported with the opposite hand. There is a history of a fall on an outstretched hand, followed by pain and loss of function at the shoulder. There may be a history of similar episodes in the past.

**On examination:**

The patient keeps his arm abducted. There is an obvious deformity with the normal round contour of the shoulder joint being lost.

On careful inspection, one may notice fullness below the clavicle due to the displaced head. This can be felt by rotating the arm. Tests that indicate anterior dislocation include:

- **Dugas’ test:** The inability to touch the opposite shoulder.
- **Hamilton ruler test:** Because of the flattening of the shoulder, it is possible to place a ruler on the lateral side of the arm. This touches the acromion and lateral condyle of the humerus simultaneously.
The diagnosis is easily confirmed on an anteroposterior X-ray of the shoulder. An axillary view is sometimes required.

**Treatment**

Treatment of acute dislocation is reduction under sedation or general anesthesia, followed by immobilization of the shoulder in a chest-arm bandage for three weeks. Shoulder reduction is done by:

- Kocher’s maneuver
- Hippocrates maneuver

**The surgical methods adopted for treatment are:**

- Putti-Platt operation
- Bankert’s operation
- Bristow’s operation
- Arthroscopic Bankert repair

**Adhesive Capsulitis (Frozen shoulder)**

**Definition**

It is defined as a clinical syndrome characterized by painful restriction of movement of both active and passive shoulder movement due to causes within the shoulder joint or remote.

**Epidemiology**

- Prevalence is 2 % among the population
- In diabetic patients, the prevalence is higher i.e. 20—30 %
- The female gender is more susceptible
- It mostly occurs in middle-aged people
- 10 % of the cases have bilateral distribution

**Causes**

- Idiopathic
- Tendinitis of the rotator cuff, bicipital tendinitis
- Fracture and dislocation of shoulder joints
- Other diseases which increase the risk of frozen shoulder are diabetes, cardiovascular disease, reflex sympathetic dystrophy, Colle’s fracture etc.

**Clinical features**

- Pain
- Decreased range of movement (external rotation > abduction > internal rotation)
- Accessory joint movement restriction
- Unable to do a routine daily activity

**Staging**

Adhesive capsulitis has three stages:

- **Stage I:** Stage of pain
- **Stage II:** Stage of stiffness
- **Stage III:** Stage of recovery
**Investigation**

An X-ray usually reveals a normal appearance of the joint, but a few cases show sclerosis around greater tuberosity.

**Treatment**

- NSAIDS
- Intra-articular steroids
- Exercise – both active and passive

**Rotator cuff lesions**

**Painful arc syndrome**

**Definition**

It is also known as shoulder impingement syndrome or subacromial impingement. It arises from the irritation or inflammation of the rotator cuff muscles and tendons as they pass through the subacromial space. This causes pain in the shoulder and upper arm during the mid-range of glenohumeral abduction.

**Causes**

The subacromial space is a narrow space that is narrowed further during abduction; thus, any lesion that takes up space is likely to cause a painful arc syndrome because, once the space between the upper end of the humerus and the acromion gets compromised, during mid-abduction the tendon of the rotator cuff gets nipped between the greater tuberosity and acromion. Examples of such conditions include:

- Minor tears of the supraspinatus tendon
- Supraspinatus tendinitis
- Calcification of supraspinatus tendon
- Subacromial bursitis
- Fracture of the greater tuberosity

**Investigations**

An X-ray of the shoulder may show a calcific deposit or a fracture of the greater tuberosity or acromion.

**Treatment**

- Ultrasonic to the tender point
- Anti-inflammatory drugs
- Injection of hydrocortisone in the subacromial space

**Rotator cuff lesions**

Rotator cuff lesions include:

- Rotator cuff impingement syndrome
- Rotator cuff tear

**1) Impingement syndrome** is commonly associated with supraspinatus tendons. The following are the causes of impingement syndrome:
- Supraspinatus tendonitis
- Calcific deposits
- Subacromial bursitis
- Subdeltoid bursitis
- Peri-arthritis
- Bicipital tendonitis
- Fracture of a greater trochanter

The most common cause is supraspinatus tendonitis. The most vulnerable structures for impingement between under surface of acromion and head of the humerus.

2) Rotator cuff tear:

It occurs mostly in people over 40 years old. People who have an occupation demanding repetitive overhead movement are most prone. Athletes like throwers, swimmers, tennis players are also vulnerable. Most occur in the male population.

Classification of Rotator cuff tear
- Small (< 1 cm)
- Medium (1 – 3 cm)
- Large (3 – 5 cm)

Clinical features
- Pain
- Swelling
- Limitation of movement
- Muscle atrophy
- Tenderness of greater tuberosity

Differential diagnosis
- Frozen shoulder
- Cervical spondylosis
- ACM and shoulder joint arthritis
- Bursitis
- Snapping scapula
- Suprascapular neuropathy

Investigations
- X-ray changes in rotator cuff lesions are decreased sub acromion space, anterior spurring of ACM joint, humeral head degeneration and sclerosis
- A single contrast arthrogram is considered the gold standard
- Ultrasonography
- MRI is very accurate but expensive

Treatment

Conservative treatment: heat massage, NSAIDs, local infiltration of steroids, subacromial steroid injections, exercise, and temporary immobilization.

Surgical treatment
- Arthroscopic repair of small and partial tears
- Open methods in major tears
Subacromial bursitis

Bursitis commonly occurs in the shoulder of the subacromial area. Inflammatory bursitis usually results from injuries resulting from repetitive injury to the bursa. The subacromial bursa assists the supraspinatus tendon with any overhead movements of the shoulder.

- **Subacromial bursitis symptoms** include tenderness at the tip of the shoulder, pain with passive abduction, and symptoms of shoulder impingement syndrome.
- **Treatment** includes rest, nonsteroidal anti-inflammatory medications, and orthopedic referral.

References


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