Shoulder pain is the third most common presentation complain in primary care practice. Age is a factor which plays an important role in predicting injuries. Clavicular fracture is due to traumatic mostly seen in children and adults whereas fractures of the head of the humerus are most commonly seen in the elderly. Shoulder dislocations are more common in teens to the fourth decade. Other conditions which can give rise to acute shoulder pain are impingement syndrome, frozen shoulder, bursitis etc. Diagnosis of these conditions are mostly clinical and radiological investigation supports the diagnosis, with the management, depending on the etiology.

Definition

Shoulder refers to a common symptom that indicates intrinsic shoulder problem or pain from another structure referred to the shoulder. Common causes of referred shoulder pain include pain from the diaphragm, heart, and neck.

Shoulder pain originates from the structures that make up the shoulder joint which include; humerus, glenoid, scapula, acromium 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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## Fracture and Dislocation

### Clavicle fracture

Fractured clavicle accounts for five percent 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. The majority of fracture occurs in middle third followed by lateral and medial. Mostly this fracture result from trauma or fall.

### Examination

In the event of a fracture likely physical findings include:

- Pain and tenderness over the fracture region
- Swelling due to edema
- Loss of function of the shoulder joint more so abduction of the shoulder joint
- 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 the 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) and rarely, for a painful nonunion of the clavicle

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 Lockwood depending upon their severity. The system was further summarized to a three-grade system by Allman.

Diagnosis

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:

1. **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. Most common type of dislocation.
   3. **Sub clavicular**: The head lies below the clavicle.

2. **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. Patient resists external rotation and abduction. Shoulders may look identical in bilateral dislocation, making it a commonly missed injury.

3. **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 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:** 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 manoeuvre

**The surgical method 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**

- Incidence is 2 percent among population
- In diabetic patients, the incidence is higher i.e. 20—30 %
- Female gender is more susceptible this disease
- Mostly occur in middle age persons with age more than 40 years
- Just more than 10 % cases have bilateral distribution

**Causes**

- Idiopathic
- Tendinitis of 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 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**

X-ray usually reveal normal appearance of the joint, but few cases shows 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 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**

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 Hydrocortisone in the subacromial space

**Rotator cuff lesions**

Rotator cuff lesions include:
- Rotator cuff impingement syndrome
- Rotator cuff tear

1) **Impingement syndrome** commonly associated with supraspinatus tendons.

Following are the causes of impingement syndrome:
- Supraspinatus tendonitis
- Calcific deposits
- Subacromial bursitis
- Subdeltoid bursitis
- Peri-arthritis
- Bicipital tendonitis
- Fracture of greater trochanter

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 persons more than 40 years. 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, Sclerosis
- Single contrast arthrogram is considered gold standard
- Ultrasonography
- MRI are very accurate but expensive

Treatment

Conservative treatment: heat massage, NSAIDSs, 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 at 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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