You Don’t have to Live with Shoulder Pain

Pain in the Arm

You know that feeling in your shoulder? It’s a nagging ache that goes down your deltoid. You can’t lie on your favorite side when you sleep and you can’t even rest well. You’re starting to have problems washing your hair and let’s not even get started with the putting on of T-shirts or hanging clothes. This pain is affecting your swing/ stroke/bat. Come to think of it, it is travelling to your other shoulder too.

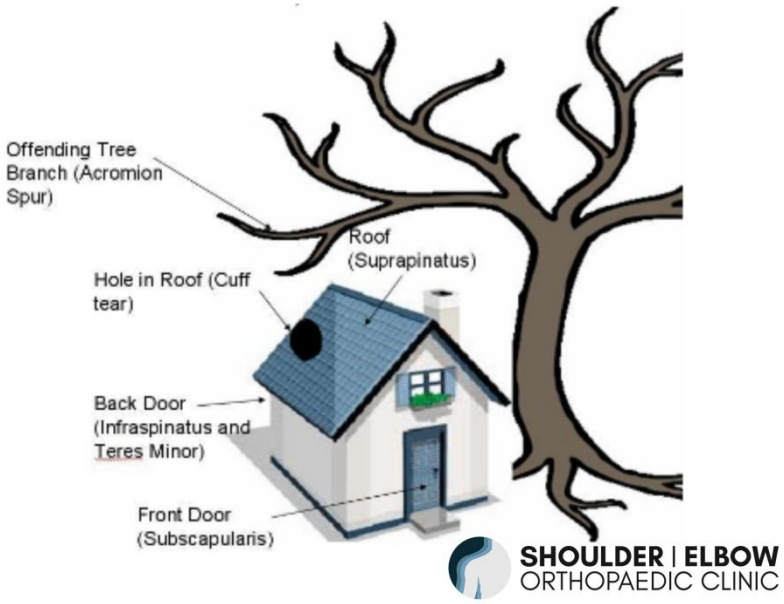
These are the common problems my patients with shoulder pain have to deal with on a daily basis. Three main issues bothering such patients are - **Pain, Movement and Function** - which is a symptom translated from the pain and lack of motion.

The pain often radiates down the arm but stops short at the deltoid because the inflammation of the bursae (fluid filled sac) extends there. There is usually no numbness of the arm unlike a pinched neck nerve (cervical spine radiculopathy).

Functionally, the patient cannot raise their arm and thus is unable to wash their hair or face. The pain affects their sports performance. Often, the patient finds that they can’t follow through during a golf swing, have weaker strokes at the baseline, or have a weaker pitch.

Not all shoulder pain means a frozen shoulder

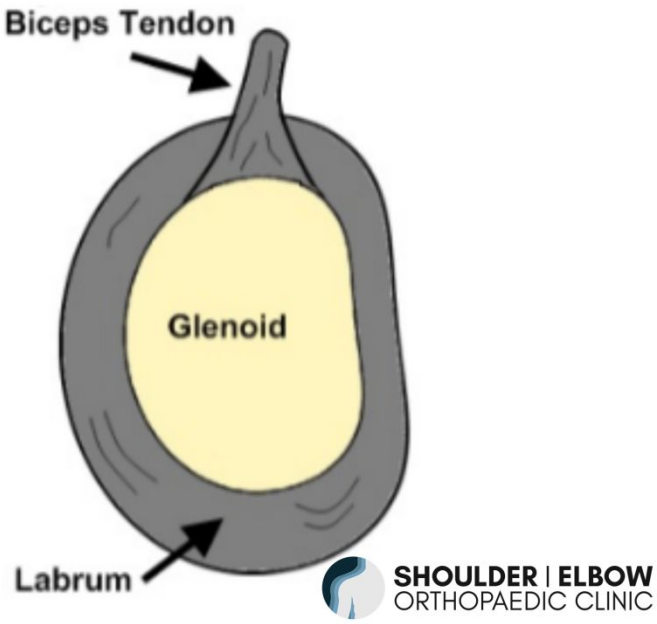
The shoulder joint is a ball and socket joint. It is akin to golf ball on a golf tee (with the ball 3 times the size of tee) within a House.



Looking at the diagram, there is a Roof (Supraspinatus tendon), a Front door (Subscapularis tendon) and a Back door (Infraspinatus and Teres Minor).

Above the Roof, there is a Tree Branch (Acromion Spur). One of the reasons why there is a tear is because the Tree Branch keeps hitting the Roof and makes a Hole in the Roof (Cuff Tear). With a Hole, it leaks when it Rains and that can be quite a Pain!

The Golf Tee (glenoid) is pretty flat and there is a CUP made of material that looks like Young Coconut Flesh (Labrum). This deepens the golf tee and makes the shoulder joint a more congruent one.



There are 3 main common causes:

- Rotator cuff problems
- Instability (labral problems)
- Frozen shoulder

In my practice, Rotator Cuff problems outnumber instability by 3:1 and Rotator Cuff problems outnumber Frozen Shoulder by 4:1. Therein lies the necessity for a proper diagnosis. This is where a "completely new and innovative INVESTIGATION" technique becomes extremely important.

Let me introduce a Proper History and Physical Examination

Before we recommend any investigations/scans, I believe in assessing the patient's problems and symptoms first. This helps to find out exactly what is affecting the patient. A targeted physical examination then is carried out to look for specific signs so a proper provisional diagnosis can be made. Using this knowledge, the Xrays and scans can then guide us, like a satellite navigation map, to decide what needs to be done for the patient.

Cuff problems

This is commonly also known as 五十肩 (50 year old Shoulder), Urat Bahu Bengkak and commonly includes:

- Impingement
- Cuff Tendinosis
- Cuff Tears which can be incomplete, complete or
- Massive tear which can be Irreparable
- Cuff tear Arthropathy (CTA)

Frozen Shoulder

This is also known as Adhesive Capsulitis. As its name suggests, the shoulder is FROZEN. This means that the shoulder is stuck both actively (moves by its own power) and passively (moved by the other arm or by someone else). It can be Primary (no one really knows why) vs Secondary (caused by something else).

Risk factors for Primary Frozen Shoulder commonly include Endocrine causes (Diabetes Mellitus, Thyroid problems), Neurological causes (Stroke), and the heart (Heart attack).
Secondary Frozen Shoulder can be due to shoulder fractures, cuff issues or labral issues.

Labral Injuries

Labral tears often occur after an injury. Patients may have experienced a dislocation or a subluxation (partial dislocation) previously, and the symptom of the shoulder being unstable is recurring now. The labrum may tear at different areas and in addition to instability, patients may often complain of pain and may have hurtful clicks in the shoulder during certain movement. A proper examination will include looking for signs of instability, other types of labral tears and signs of generalised hyperlaxity (loose jointed).

Don't live with it!
“See your doctor because something can be done”.
I cannot emphasise enough that a Proper History taking and Physical Examination leading to targeted Investigations will bring about a Proper Diagnosis. This will include locating the source of pain, Range of Motion tests and Special tests. For labral injuries, we look out for Hyperlaxity Signs too. Thereafter, X Rays, Ultrasound and/or MRI/ CT scans are carried out and interpreted together with looking at the patient’s problems.

Get back your Swing
This will be based on the diagnosis and looking at exactly what is bothering the patient. (At Shoulder Elbow Orthopaedic Clinic, We Help Patients not Treat Scans).

<u>Cuff problems</u>

This depends on whether there is a hole in the roof, and how big the hole is, and if it is a complete hole.

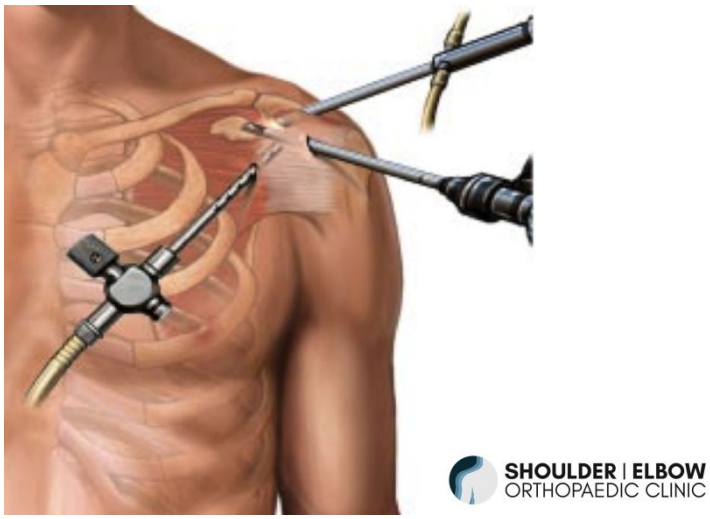
If there is no hole, an incomplete hole or small hole, NON-OPERATIVE management lasting for 3-6 months is often started. (There is nothing CONSERVATIVE about not operating)

This includes:

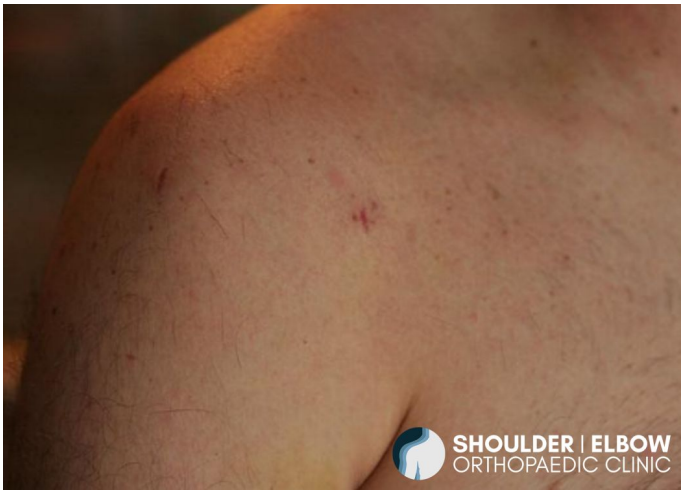
- Controlling Inflammation and pain – Analgesia (pain killers) and/or NSAIDs (Non Steroidal Anti Inflammatory Drugs)
- Subacromial (below the tree branch) Hydrocortisone & Lignocaine injections (I usually use 1% lignocaine with Triamcinolone
- Physiotherapy
    - Mobility Exercises
    - Strengthening of the
        - External and Internal Rotators
            - Biceps
            - Triceps
            - Deltoid
            - Scapular Stabilizers

For patients with Acute Tears (occurring after an injury), Large Complete Tears or patients that have failed non-operative management, surgery is offered. In my practice, a large majority of cuff problems which require surgery are done through KeyHole techniques. This includes:

- Arthroscopic Subacromial Decompression and Rotator Cuff Repair which is shaving down the offending tree branch above the roof, and repairing the roof and/or repairing the front door too if that is torn
- Arthroscopic Mumford procedure (Distal Clavicle Resection) if that is giving the patient problems
- Addressing the biceps tendon (tenotomy or tenodesis) if necessary.



A large majority of shoulder problems are treated using keyhole (Arthroscopic) techniques as they can usually produce equal results to open surgery. Patients often experience less pain, a shorter hospital stay and the scars are cosmetically more pleasing.



However, this is not suitable in all cases and depends on the condition and severity of the problem.

Frozen Shoulder

Primary Frozen shoulders follow a process of Freezing, Frozen and Thawing. The Thawing process can occasionally, unfortunately, last for a very long time of up to a year or two. Seeing a doctor early will allow us to:

- Ensure that it is truly a Frozen shoulder. (again through a proper history/ physical examination/ appropriate scan/s)
- Find out if it is caused by another shoulder problem (Secondary Frozen Shoulder)
- Speed up the thawing process or if necessary - BREAK the ICE!

Speeding up the thawing process comprises of:
Non-operative management of Glenohumeral H&L (injecting into the house itself), physiotherapy, and painkillers and anti-inflammatory medications. It is important to treat underlying issues if it is a secondary cause.

In my practice, if all else fails, I offer to break the ice but under direct vision. I like to see what I intend to break. As such, I offer an Arthroscopic Capsular Release.

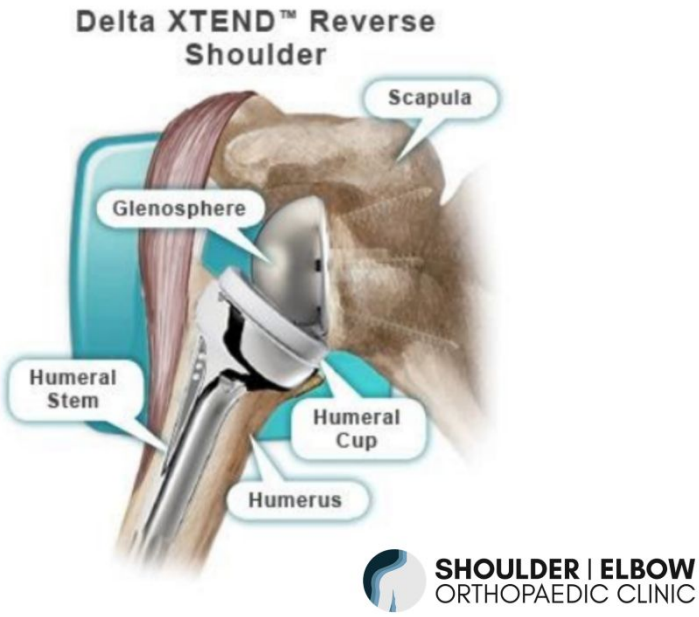
Instability

For patients with labral injuries, if recurrent instability is the main problem, surgery should be considered early. This is because in younger patients, the risk of persistent instability is very high. With each dislocation, the risk of getting a large piece of the golf tee being broken off (Bony Bankart) or the golf ball being cored in (Hil sachs Lesion) becomes higher.

As such, I offer Arthroscopic Shoulder Stabilization (Keyhole Stabilization Surgery) where the torn labrum can be repaired. This is for patients without a large piece of the golf tee that is broken off or a large part of the golf ball being cored. Unfortunately, if that happens, open procedures to restore the bone loss, usually at the side of the golf tee, may then be suitable.

For some patients with SLAP (Superior Labrum Anterior Posterior) tears (top part of the cup) or a posterior labral tear (back part of the cup), pain and clicking is the main problem. For patients with SLAP tear, I believe that a trial of non-operative management should first commence. This must include Scapular Stabilization exercises so as to provide a stable platform for the shoulder joint to mobilise. Only if that fails, I will then offer surgery to address the SLAP tear. In patients with posterior labral injuries who complain of pain and clicks, arthroscopic labral repair will be offered to repair the cup.

What if the Whole House is Damaged?
For patients with Cuff Tear Arthropathy (damage to the shoulder cartilage due to prolonged roof tendon tear) and usually for patients > 65years, the option of a joint replacement is offered. This is because with the cartilage being worn out, a repair or replacement of the roof tendons will not resolve the arthritis causing the pain. In patients with CTA, a Reverse Shoulder Arthroplasty (RSA) is usually offered.



This is a replacement surgery which offers excellent pain relief, a good functional Range of Motion of 140-150 degrees of forward flexion. Patients can return to daily upper limb activities like combing/ washing hair, washing face, and brushing teeth after surgery.

In conclusion, you don't have to live with shoulder pain. Seek help early if the shoulder strain doesn't go away after 2-3 weeks. A proper History and Physical Examination and appropriate investigations will usually lead to a diagnosis and proper Treatment.

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