

Shoulder Conditions

- Sub-Acromial Impingement Syndrome
- Adhesive Capsulitis (Frozen Shoulder)
- Acromio-Clavicular Joint Arthritis
- Instability (Subluxation/Dislocation) of Shoulder
- Rotator Cuff Tears
- Gleno-Humeral Joint Arthritis
- Rotator Cuff Tear Arthropathy

Elbow Conditions

- Lateral Epicondylitis (Tennis Elbow)
- Medial Epicondylitis (Golfers Elbow)
- Cubital Tunnel Syndrome
- Olecranon Impingement Syndrome
- Elbow Joint Arthritis

Hand & Wrist Conditions

- Carpal Tunnel Syndrome
- Dupuytren's Disease
- DeQuervain's Tenosynovitis
- Trigger Finger
- Ganglions, Giant Cell Tumour of Tendon Sheath
- Wrist & hand Joint Arthritis



Mr Vishal Sahni

Renacres Hospital  
[www.renacreshospital.co.uk](http://www.renacreshospital.co.uk)  
 Tel : 01704842020  
[susan.smith@ramsayhealth.co.uk](mailto:susan.smith@ramsayhealth.co.uk)  
[karen.murphy@ramsayhealth.co.uk](mailto:karen.murphy@ramsayhealth.co.uk)

Fulwood Hall Hospital  
[www.fulwoodhallhospital.co.uk](http://www.fulwoodhallhospital.co.uk)  
 Tel : 01772707411  
[alison.walmsley@ramsayhealth.co.uk](mailto:alison.walmsley@ramsayhealth.co.uk)  
[emma.smith@ramsayhealth.co.uk](mailto:emma.smith@ramsayhealth.co.uk)

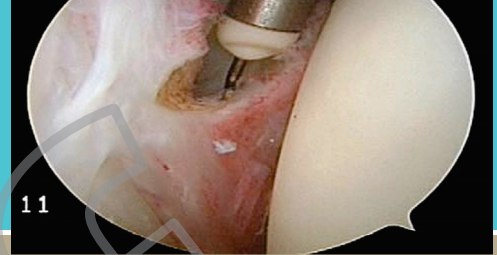
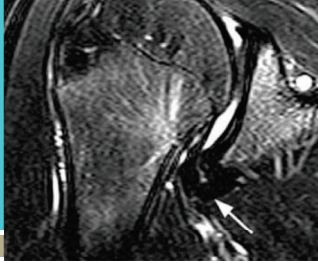
Euxton Hall Hospital  
[www.euxtonhallhospital.co.uk](http://www.euxtonhallhospital.co.uk)  
 Tel : 01257 237002  
[rebecca.holmes@ramsayhealth.co.uk](mailto:rebecca.holmes@ramsayhealth.co.uk)  
[helen.king2@ramsayhealth.co.uk](mailto:helen.king2@ramsayhealth.co.uk)



Mr Vishal Sahni

Consultant Orthopaedic Surgeon with  
 Special Interest in Shoulder, Elbow & Hand  
 Surgery

Southport & Ormskirk Hospital NHS Trust  
 Renacres Hall Hospital  
 Fulwood Hall Hospital  
 Euxton Hall Hospital



## Adhesive Capsulitis (Frozen Shoulder Syndrome)

Codman originally coined the term frozen shoulder to describe a condition with shoulder pain, localised discomfort near the deltoid insertion, an inability to sleep on the affected side, stiffness especially of external rotation and normal radiographs. It is primarily a clinical diagnosis based on clinical motion loss and symptoms.

## Epidemiology

Frozen Shoulder Syndrome (FSS) usually affects patients aged 40-70 years. It is estimated that 3% of people develop the disease over their lifetime. Males tend to be affected less frequently than females and there is no predilection for race. A higher incidence of FSS exists among patients with diabetes (10-20%) compared with the general population (2-5%). Incidence among patients with insulin dependent diabetes is even higher (36%), with an increased frequency of bilateral shoulder involvement.

## Patho-physiology

An autoimmune theory has been postulated with elevated levels of C-reactive protein and an increased incidence of HLA-B27 histocompatibility antigen reported in patients with FSS versus controls. FSS also has been associated with cervical disease, hyperthyroidism and ischemic heart disease.

## Investigations

Routine radiographs of the shoulder should be obtained in all cases to rule out other pathologies. These radiographs should include the anteroposterior (AP) view of the glenohumeral joint, the supraspinatus outlet view and the axillary view. MRI is not initially indicated as it is an expensive and non specific test. However, if the patient does not improve after a period of time 6-8 weeks, then MRI is appropriate to rule out a possible rotator cuff tear or intra-articular pathology.

## Management - Conservative

In almost all cases a trial of conservative treatment must be initiated before considering operative management. Conservative management includes NSAIDs, Steroid & Local Anaesthetic Injections, Activity modification and Physiotherapy. A discussion about surgical option must be initiated with the patient only when conservative treatment fails.

## Management – Surgical

A subgroup of patients with frozen shoulder syndrome often fail to improve despite treatment with aggressive nonsurgical therapy and medication. In these cases MUA (Manipulation Under Anaesthetic), more invasive techniques (eg, manipulation, distention arthrography, open surgical release) may be needed.

## Evidence

Ogilvie-Harris et al have demonstrated the efficacy of Arthroscopic Capsular Release for FSS and it is considered the gold standard. Warner and colleagues reported an improvement in the Constant score of 48 points with a mean follow-up of 39 months. Pearsall and colleagues found that 83% of patients reported their shoulder to be normal or near normal at an average of 22 months following capsular release. A review of literature indicates that in patients with FSS, an excellent result of 75-90% can be expected with ACR.

## Cost effectiveness

A study published by Dattani, Parker et al in Journal of Shoulder & Elbow Surgery 2013 shows that ACR results in a significant improvement in the range of movement and functional outcome in most patients with contracture of the shoulder within six months of surgery. The improvement in the quality of life as measured by the EQ-5D index was within 1 SD of an age and gender matched cohort of the general population. It is generally accepted that any intervention that generates one extra QALY at a cost of < £30,000 is deemed to be cost effective. The cost per QALY for ACR was £2,563 which is dramatically lower than the cost of a QALY after most medical interventions.