

Conservative Management of Shoulder Adhesive Capsulitis:
Integration of the Physician, Therapist and Patient
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It is common for patients to put off treatment for persistent shoulder pain in hopes that the pain will resolve on its own. After several months of waiting and protecting their arm, they realize that they have less movement than before onset of pain. Those patients that delay or lack proper follow up can result in a condition typically known as frozen shoulder or adhesive capsulitis.

Pain and stiffness are the most common symptoms that are reported. The possible causes of adhesive capsulitis can be categorized into two types; Primary (idiopathic) or Secondary (intrinsic, extrinsic or systemic). In the primary or idiopathic form, there is no known cause or incident that can be identified. The secondary form can be due to illness, injury or another external cause.

Patients with idiopathic adhesive capsulitis tend to be women more than men, between the ages of 50 and 70 with no correlation between hand dominance. Approximately 10% of these patients develop bilateral symptoms. Secondary adhesive capsulitis can result from a number of reasons some including diabetes, trauma, or rotator cuff tendonitis/tear.

Adhesive capsulitis is said to go through three stages: a freezing stage, frozen stage, and thawing stage (1). Durations of each phase have been estimated, but completed recovery of this condition is still unclear and with a wide variance. Patients should be discouraged from waiting when successful conservative treatment options are available. The goal initially is to reduce pain and inflammation, then improve their range of motion and strength to ultimately return functional movement back as quickly as possible.

There are several treatment options for individuals with frozen shoulder. A primary care provider or specialist can provide options that can range from conservative to more aggressive. A referral to a physical therapist can be an excellent option for patients with adhesive capsulitis to restore mobility, strength and function.

A physical therapist can provide a structured rehabilitative program that can utilize manual therapy techniques (joint and soft tissue mobilizations), stretching and exercises for gaining range of motion and strength, and incorporate modalities (ultrasound, electric stimulation, ice, moist heat) for pain relief. Patients with adhesive capsulitis often have pain and difficulty when attempting to move the shoulder joint on their own. External force from a qualified physical therapist is often required to restore mobility. This process can be uncomfortable during the initial stages of therapy. The physician can provide either injections or oral medicines to help with the pain. It is important to assess and treat all the joints of the shoulder, particularly the scapulothoracic joint, along with maintaining good cervical range of motion and posture.

The therapist can closely follow the patient's progress and make necessary modifications- such as when to begin a strengthening phase as well as monitoring for functional gains. A therapist can provide useful information about how the patient is progressing to the referring physician to help determine the best plan of care.

The patient's motivation, pain tolerance, and understanding of the plan of care and setting goals play a vital role in rehabilitation. Patient education is also an integral part of the rehabilitation, while compliance is the key to a successful outcome. If the patient understands the rationale for the treatment given, then they can mentally and physically prepare for the program. The patient must learn to be an active participant in their rehabilitative process.

Ideally, once the program is put together, the patient should be able to complete the program independently. Education throughout their program will prevent them from being either too aggressive or too passive at home and at the clinic.

1. Reeves B: The natural history of the frozen shoulder syndrome. *Scand J Rheumatol* 1975; 4(4): 193-196