5 Common Causes of Shoulder Pain

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Rotator Cuff Syndrome:
Inflammation of rotator cuff tendons and subacromial bursitis, can proceed rotator cuff tear.

**History:** Insidious onset of anterior and lateral shoulder pain, worse with reaching overhead and behind (putting dishes away in upper cabinet, reaching into the back seat of car). Patients often report positional night pain. Symptoms may be partially alleviated with NSAIDs and ice.

**Exam:** Pain at the extremes of shoulder range of motion, no significant loss of motion. Strength is intact although may be slightly guarded due to pain. Impingement tests positive.

**Treatment:** NSAIDs, Physical Therapy for scapular stabilizing exercises and rotator cuff strengthening.

**When to refer:** If no improvement with 6 weeks of NSAIDs and PT, consider MRI to rule out rotator cuff tear. Consider referral to shoulder surgeon for ultrasound guided subacromial cortisone injection. Surgery can be considered for refractory cases.

If there is significant loss of motion (see adhesive capsulitis) or weakness (may have rotator cuff tear), consider immediate referral as NSAIDs and PT may not be as effective in these cases. A history of trauma resulting in shoulder weakness should lead to a prompt referral to a shoulder surgeon, as this may represent an acute RCT.

Instability:
Subluxation or dislocation of the glenohumeral joint. Can be acute and traumatic and unidirectional; or recurrent, atraumatic and multidirectional.

**History:** Patient may report a traumatic injury to the shoulder resulting in a dislocation requiring a reduction maneuver; or a more nonspecific history of shoulder pain and sense of instability that the patient is able to self-reduce.

**Exam:** Acutely the shoulder will have a very guarded range of motion, and significant apprehension in the Abducted Externally Rotated position. Chronic or multidirectional instability cases may present with hypermobility of joints, with pain and apprehension at the extremes of motion. Rotator Cuff Strength should be preserved.

**Treatment:** Gentle PT to restore ROM and strengthen scapular stabilizers and rotator cuff can be initiated. MRI should be ordered sooner rather than later to define the extent of the injury to the labrum, capsule, bone and rotator cuff, as this will dictate further care (further PT versus surgery).

**When to Refer:** If shoulder instability is suspected, referral to a shoulder surgeon should be initiated promptly, as the indications for non-operative vs operative treatment are multifactorial and not only involve the shoulder pathology, but the patient age, arm dominance, activity level and number of dislocation episodes.

Acromioclavicular Joint Pain:
Traumatic or Atraumatic injury to the AC joint can result from a fall directly onto the shoulder, or repetitive overuse. Often seen in overhead weightlifters, snowboarders and hockey players.

**History:** Pain located directly on the top of the shoulder at the palpable AC joint. Worse with lifting overhead and reaching across the body. May be painful to sleep on the affected shoulder at night.
**Exam:** Pain and swelling (sometimes deformity) at the AC joint. Full ROM of the shoulder, normal rotator cuff strength. Pain with forceful cross chest adduction.

**Treatment:** NSAIDs, avoiding the aggravating activity and postural PT can help.

**When to Refer:** If symptoms persist, referral to a shoulder surgeon should be considered. An ultrasound guided AC joint injection can result in significant pain reduction. If symptoms recur, a distal clavicle resection can be performed. In the case of an acute AC joint injury with significant deformity, sometimes acromioclavicular joint reconstruction is performed in the acute setting.

**Adhesive Capsulitis:**

“Frozen Shoulder” is most often idiopathic as is seen most frequently in women between the ages of 40-60. It can be associated with endocrine disorders or a mild trauma to the shoulder / neck / chest on the affected side. It is a severe inflammatory process involving the shoulder capsule resulting in pain and stiffness.

**History:** Often times patients report an insidious onset of nonspecific shoulder pain. Stage I is characterized by pain only (good ROM and strength), Stage II is characterized by pain and loss of motion. Loss of internal rotation (difficulty fastening bra) is the earliest sign. Loss of motion can become global and severe. In Stage III, the pain relents, but the shoulder remains stiff. Stage IV is “thawing” and symptoms begin to resolve. If untreated, the course of all 4 stages can take 18-24 months.

**Exam:** Early stages are characterized by pain, particularly with internal rotation, as the process progresses, patients may present with profound loss of motion. Strength can be difficult to assess due to pain.

**Treatment:** Because this is a highly inflammatory process, anti-inflammatories are the mainstay of treatment. Often, we will combine oral and topical NSAIDS, recommend ice, and occasionally prescribe a Medrol dose pack. When a patient is in stage I or II, and ultrasound guided glenohumeral joint injection can be extremely helpful in shortening the duration of the disease process. PT should be pain-free and focus on scapular stabilization exercises and gentle progressive passive ROM.

**When to Refer:** If a patient doesn’t show significant improvement within 4 weeks with the use of regular NSAIDs and appropriate PT, the patient should be referred for an ultrasound guided glenohumeral joint injection. Occasionally an MRI is indicated if there is a question of an underlying cause of the symptoms. Surgical manipulation under anesthesia and lysis of adhesions is sometimes necessary.

**Shoulder Arthritis:**

Osteoarthritis (degenerative arthritis) of the shoulder can occur insidiously or develop post-traumatically.

**History:** Patients usually report progressive loss of motion, pain and subsequent weakness over a period of months. Sometimes symptoms can escalate quickly related to some aggravating activity. Patients tend to tolerate shoulder arthritis better than hip or knee arthritis since the shoulder is not a weight bearing joint.

**Exam:** Painful, stiff arc of motion, often with crepitation. Some patients will present with swelling about the shoulder. In later stages patients develop rotator cuff weakness due to disuse atrophy. Diagnosis is made by plain X-ray.

**Treatment:** As with the treatment of other arthritic joints, treatment consists of ice, NSAIDs, injections and shoulder replacement surgery. Physical therapy can sometimes be helpful, however, in some cases can worsen a patient’s symptoms.

**When to Refer:** If a patient has pain interfering with activities of daily living and other activities they enjoy, they should be referred for an ultrasound guided glenohumeral joint cortisone injection or consider shoulder replacement surgery.