Editorial

Primary frozen shoulder can it be treated with hydrodilatation

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Frozen shoulder (adhesive capsulitis) is a common, painful and disabling condition, which is typically slow to resolve. A wide variety of treatment modalities are available, some more effective than others.

We strongly believe that at present the primary treatment for hydro dilation should be hydro dilation. Our own results below strongly suggest that. The other options manipulation, surgical release and physiotherapy should be used as an adjunctive therapy or in case of failure of the above. We recommend that as long as patients are happy this treatment could be repeated without major consequence.

This study prospectively evaluated the efficacy of hydro dilatation under local anaesthesia and under sedation, in the treatment of primary adhesive capsulitis.

A total of 89 patients were diagnosed with primary frozen shoulders on Magnetic resonance imaging (MRI). Patients with other shoulder pathologies were excluded.

The cohort of patients was divided into two treatment groups; hydrodilatation under local anaesthesia with patients in sitting position (n=49) and under sedation (n=40).

In patients who underwent hydrodilatation under local anaesthesia group, a posterior entry was used for needle insertion. An 1ml of radiopaque dye (Omnipaque) was given for confirmation before 30ml of 0.9% saline with 80mg of Depo-medrone and 10ml of 0.25% of Bupivacaine was injected under the control of image intensifier. No manipulation was performed

In the sedation group, patients were supine and sedated with a target controlled infusion of 1% propofol via a Diprifusor (AstraZeneca). An anterior approach was used for needle insertion. The same amount of radiopaque dye and hydrodilatation fluid were given.

Both groups were then assessed at 6, 12, and 36 weeks for range of motion (ROM), visual analogue scale (VAS) for pain and Oxford Shoulder Score (OSS).

Range of motion improved in 80% of patients who underwent hydrodilatation with a mean VAS score of 3 and OSS of 19 at 36 weeks. This was achieved in the sedation group at 6 weeks.

There were 7 patients from the local anaesthetic group who required sedation and a second procedure. In the sedation group, one patient had a 2nd procedure.

Overall, patients who underwent hydrodilatation under sedation have a better satisfaction and improved faster post-procedure. In our study, hydrodilatation under sedation is a better option; however, both choices should be discussed formally with patients during consultations prior to hydrodilatation.

We are currently undetaking a study between ultrasound guided hydro dilation and image intensifier guided technique. We have also added an additional hyloraunic acid injection group which might reduce recurrence. The recurrence remains higher in patients with type I diabetes and with poor compliance.

Acknowledgments

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Conflicts of interest

None.