

Case Study 5

Richard is a 48 yo male and is a keen dragon-boat enthusiast . He presented with a 8 month history of slowing increasing L shoulder pain which he experienced when flexing his shoulder above 90 ° and abduction above 80 °. He had 3 months of physiotherapy including massage, posture advice and rotator cuff strengthening exercises. Given therapy had failed to improve his symptoms he presented for a diagnostic ultrasound , with the view to have a cortisone injection for pain relief.

On observation he had some catching pain with shoulder flexion, abduction and internal rotation. He also had stiffness with all movements but particularly external rotation and abduction. He had full strength with all shoulder movements .He had modified his paddling to stroke only on the left side of the body to prevent aggravating his shoulder pain.

An ultrasound revealed a normal subacromial bursa and supraspinatus tendon showing only minor tendinopathy and enthesopathy of the anterior tendon (see Figure 1 & 2). Dynamic scanning revealed no significant bunching of the tendon or bursa when Richard reported pain with abduction.

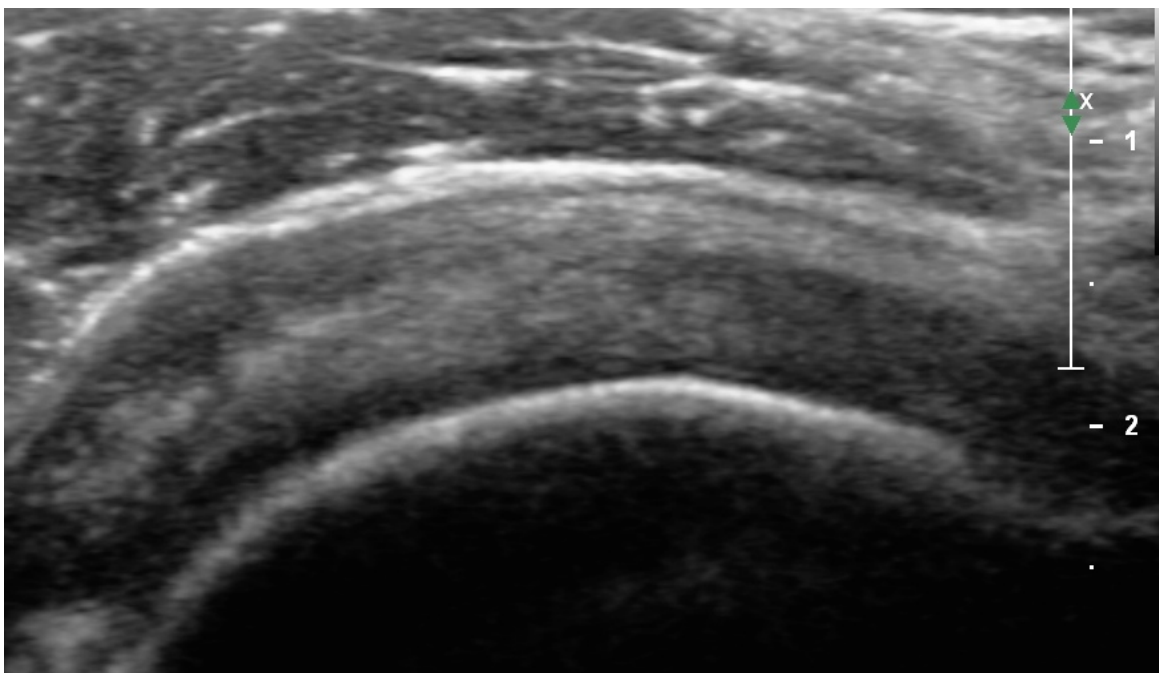


Figure 1 Supraspinatus tendon in transverse plane

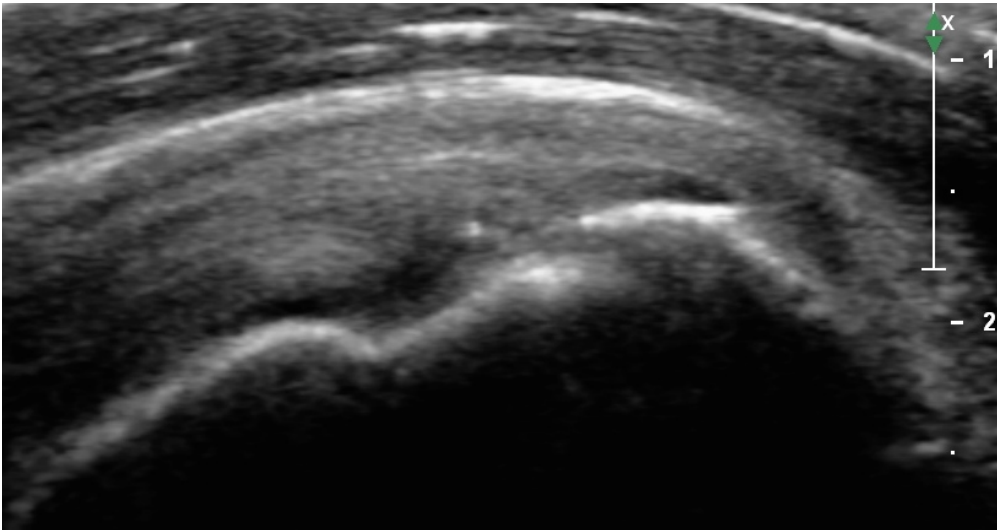


Figure 2 - Image of anterior supraspinatus tendon in long axis with minor enthesopathy

The rotator interval was imaged with colour doppler revealing increased flow in the fibro-ligamentous tissue adjacent to the long head of the biceps (see Figure 3). The axillary recess was then imaged to show extensive thickening of the left inferior gleno-humeral ligament compared to the right (see Figure 4).

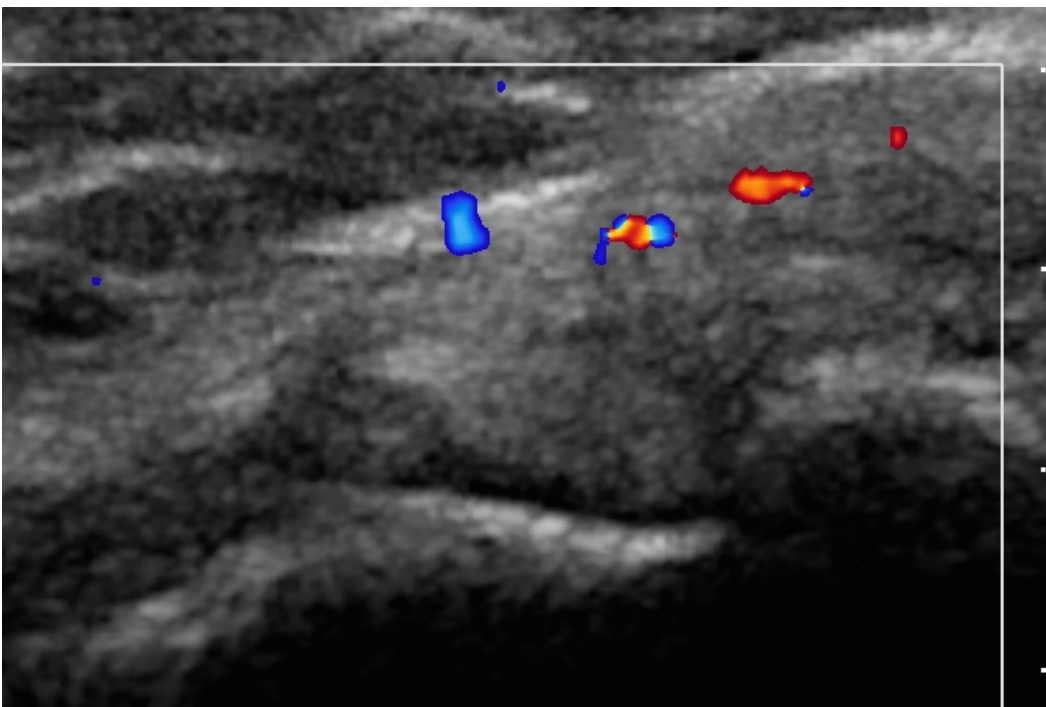


Figure 3 - Image of the L rotator interval showing increased vascularity

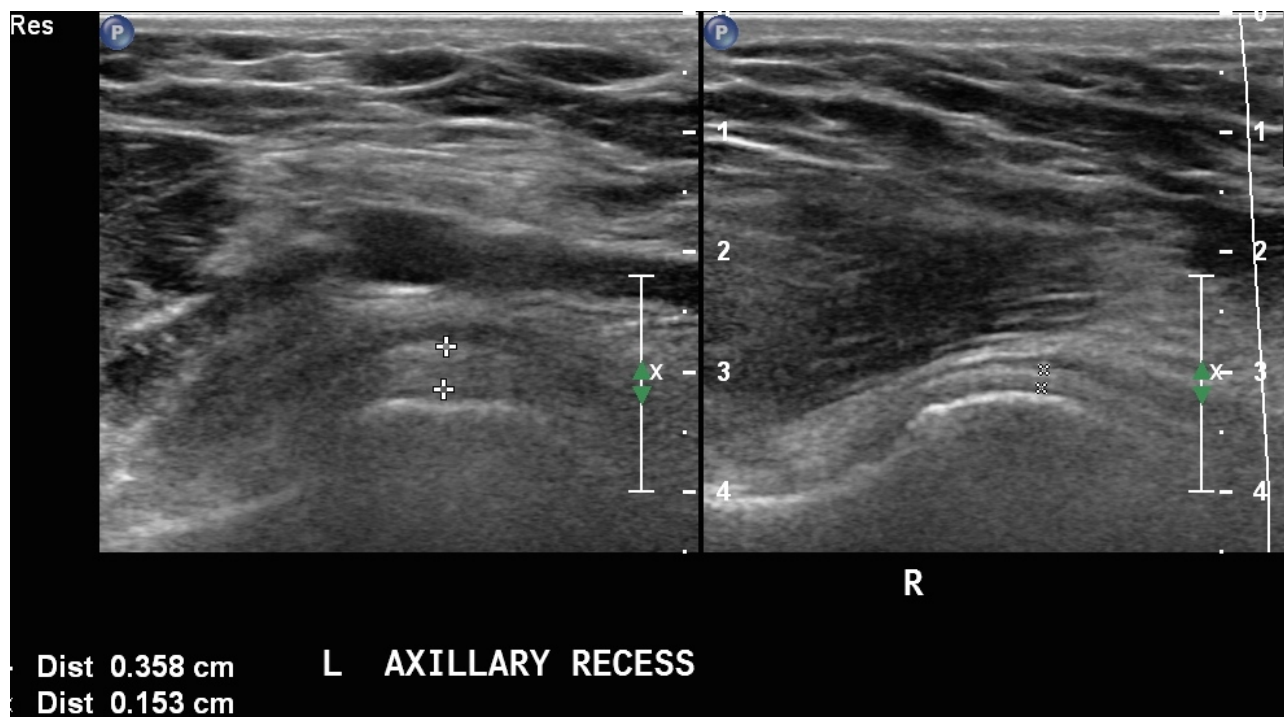


Figure 4 Comparative images of the left and right axillary recess

It was concluded in consultation with the radiologist that a cortico-steroid injection into the bursa was not appropriate. An alternative diagnosis of left adhesive capsulitis was given to the referring physiotherapist. Patient was informed to return for advise and appropriate exercises from their physiotherapist.

Figure 4 Left Achilles tendon post paratenon stripping