Acupuncture for Shoulder Pain

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A function of the Society is to promote practical clinical discussion. There should be a forum at our meetings comprising treatment methods, approaches to diagnosis and discussion of treatment outcome, where all members are free to contribute their ideas. This is the origin of this paper. It is proposed to discuss the topic of acupuncture treatment for shoulder pain and to show how I arrive at a diagnosis and treatment programme.

Diagnosis and Prognosis
My approach to acupuncture treatment in a painful shoulder is naturally that of a western trained rheumatologist, based on my knowledge of pathology and anatomy gained from my training.

The causes of shoulder pain can be classified into those that are intrinsic and those that are extrinsic, either periartricular because of referred pain or from other local conditions. The causes of intrinsic pain are the least common collectively. These are arthritis, particularly rheumatoid and other inflammatory arthropathies, crystal arthropathy, capsulitis, trauma haemarthrosis, tumour and aseptic necrosis. The periartricular extrinsic causes are probably the commonest group. These include all the rotator cuff lesions, lesions of the biceps, calcific tendinitis, bursitis and lesions of the acromio-clavicular joint.

Referred extrinsic causes of shoulder pain include those due to gall bladder and liver disease, intra-abdominal sepsis, median nerve compression, cervical spondylosis and other neck conditions, and heart disease. There are many other extrinsic causes of shoulder pain due to local conditions, the most common neurological causes are brachial neuritis and central nervous system lesions. Conditions such as post mastectomy and chest wall surgery, polymyalgia rheumatica, the shoulder-hand syndrome, post myocardial infarction, pancoast and other tumours, thyroid disease and amyloidosis, can also cause shoulder pain.

It is important, before starting treatment, to give the patient an accurate diagnosis and some idea of the problems involved and the prognosis. In my experience, the efficacy of acupuncture is about equal to other treatments in bringing relief from pain, although possibly better than many for night pain. It does not cut short the actual length of symptoms in the true frozen shoulder, nor does it alter the prognosis in an inflammatory arthropathy. Therefore when one is starting treatment with acupuncture, one should be as truthful as possible to the patient.

To arrive at a diagnosis and prognosis, a full medical history is mandatory. Certain points in this are important. First, night pain is almost universal. Morning stiffness that lasts more than 30 minutes indicates inflammation and arthritis should be suspected. Paraesthesiae in the hands or chest are an indication of nerve irritation and one should look very carefully either for trigger points or evidence of spinal disease. Restriction of active or passive movement is also universal and one should determine to what degree movement is restricted. A history of trauma, even several years previously, should also be sought, as this alters the prognosis. Osteoarthritis of the shoulder is very rare, osteoarthritis of the acromio-clavicular joint is much more common.

Finally, men do not notice restriction of movement until quite late on whereas women notice this more early. Therefore men are likely to have had the symptoms for a longer period of time, making the prognosis worse.

Examination
Examination of the shoulder is relatively simple and I would suggest that one should follow Cyrlax rules. His description of how to examine and diagnose shoulder pain is probably the best available. First we break down the movements into their individual components. Active and passive movements should be examined in both shoulders, remembering that shoulder movements decrease with age. Restriction of passive movement implies capsule stiffness. Look also at resisted movements. Always examine from behind and look for selective muscle wasting either from disuse or neurological abnormality. Again this is vitally important in determining the prognosis, and treatment aims.

Always examine the cervical spine. Always look for individual muscle loss or pain with and without active resistance. Always look for trigger spots. However, in frozen shoulder, local simple treatment of trigger spots with acupuncture is totally inadequate. Look for swelling and changes in skin colour. This may indicate inflammation, particularly crystal, or of course haemarthrosis.

In considering the treatment and prognosis, look for allied conditions. The frozen shoulder that occurs in conjunction with diabetes mellitus has a very much worse prognosis than that of other conditions. Although ultimately it usually will get better, it lasts for up to three times as long and is much more resistant to all forms of treatment. In addition to careful physical examination one may add any or all of the so called invasive investigations. Specialised arthrography can for instance identify total rupture of the rotator cuff, impingement in the humerus and the acromion, the very restricted capsule of capsulitis, etc. Radiology is also important for excluding more serious conditions, such as the severe inflammation of rheumatoid arthritis, which can develop in less than a year. Calcareous tendonitis implies Chronicity of the condition when it develops with symptoms over a period of time, although this is not necessarily so with calcareous bursitis, which can develop quickly and can be easily treated. Radiological examination might also exclude local tumours, such as Ewing's tumour, which can present as frozen shoulder.

Treatment
The treatment of the painful stiff shoulder is unsatisfactory. A true frozen shoulder, ie with passive movements restricted as well as active ones, responds poorly to attempts to cut short its natural his-
tory. Hence I started to add acupuncture, for its pain relieving capacity. However, I never add acupuncture without first warning the patient that movement cannot be restored easily. What I have found, however, is that acupuncture may reduce the pain level far more quickly than any other treatment and enable one to move on from there to manipulation under anaesthetic. However, the number of patients that I refer for manipulation is still small as most patients would rather wait.

**Acupuncture**

When I have arrived at a diagnosis, I have a basis for treatment. Certain acupuncture points are used commonly, alone or in combination. I use Large Intestine 4 and Small Intestine 3 and also Large Intestine 9 and 11. I use the C7 transverse process sometimes using periosteal pecking and Gall Bladder 20 and 21. I use the anterior and posterior joint capsule, which roughly coincide with points of the Lung meridian and Small Intestine. These are often points of maximal tenderness and are the points which one uses for joint injections, and also Large Intestine 16.

I will then add points according to the pathology and neuro anatomy and always trigger points. Sometimes follow traditional Chinese methods but always based on a careful western diagnosis.

However, sometimes attempts at needling trigger points simply produce more pain and a violent reaction to the acupuncture. Moving the needle away from the trigger points and treating more peripheral points, results almost in complete loss of symptoms in these cases.

My personal experience has shown that acupuncture is as successful or unsuccessful as other treatments for shoulder pain. There is, however, a long waiting list for acupuncture and it is therefore quicker for patients who present to our clinics to be treated by conventional methods before we move on to acupuncture. I have treated one or two acute frozen shoulders, due to capsulitis, with acupuncture, but have not found it very much more satisfactory than any other method, except that it gave the patients better pain relief at night. However, on a number of occasions I have moved on to acupuncture treatment as a last resort and I have always found it to be effective. I would in fact advocate acupuncture as the treatment of choice in preference to the very painful corticosteroid injections, and the largely useless physiotherapy. I cannot emphasize enough how important it is to be honest with the patients about what can be expected from the treatment. One can be honest only if one knows exactly what one is dealing with, and what will be the likely outcome especially when treating a condition which might last for a long time.

Finally, a friendly word of warning from one who has on average five new patients per week referred with shoulder pain. In the last five years, a number of patients were referred by general practitioners, with a diagnosis of frozen shoulder in the referring letter, and with a request for physiotherapy or hydrocortisone injection. The correct diagnoses were as follows: one Ewings sarcoma, two Pancoast tumours, one primary synovioma, one carcinomatosis following mastectomy 30 years previously, one solitary secondary deposit from a penile carcinoma, two further secondaries from carcinoma of the breast actually in the humerus with direct invasion, one leukemia, one scurvy which presented as a haemorrhosis and two septic arthritis.

These twelve patients, two per year, show how vitally important it is to examine patients carefully and be aware of other diagnoses when one is using acupuncture.

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**References:**

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