Adam Rumian MD FRCS(Tr&Orth) MA MRCS MBBS
www.shoulderandelbowspecialist.co.uk

Shoulder MUA +/- Capsular Release Protocol

Procedure summary

Arthroscopic capsular release is indicated for cases of frozen shoulder which are both stiff and painful and not responded to other measures. It allows a more controlled way of releasing the shoulder joint capsule than a manipulation by itself, so has less risk of causing intra-articular damage such as cuff tear or labral tear or bone fracture. It is however more complex, takes longer and is more expensive than an MUA alone. The inflamed, contracted rotator cuff interval tissue is completely excised and then the anterior and posterior capsule is divided under direct vision. If it is done for post-traumatic stiffness, it is often necessary to divide subacromial adhesions also. It is rare to perform any other associated procedure, e.g. subacromial decompression or cuff repair, as this would just predispose to more stiffness and be counter-productive. Thus these pathologies might have to be addressed by further surgery once ROM has been restored.
MUA alone can be performed as a first, simpler measure, rather than arthroscopic surgery, or for a repeat procedure if arthroscopic capsular release fails.

Notes: in both MUA and capsular release, a good or normal ROM is achieved intra-operatively. The challenge is to maintain this post-op despite pain and prevent relapse. So in contrast to normal rehab principles, these patients need to do ROM exercises and stretches even through the point of pain immediately post op otherwise the capsule will just scar up again

AIM: Patients should have 80% ROM by 6 weeks

Protocol

No restrictions and sling should be discarded as soon as possible.

Please note:-

- Needs ++ physiotherapy post op to ensure FROM is maintained and patient is aware to continue exercises as much as can tolerate at home
- Try to see patient on ward when nerve block still in situ to gain maximum movement with lest pain (the nerve block will last between 12 to 24 hours).
- Exercises are expected to be painful however if pain is effecting exercise ability before d/c patient should be kept in until pain is well controlled.

Exercises taught on ward
Pendulum
AA shoulder flexion
AA shoulder ER
AA IR/ hand behind back
Hand, wrist and elbow AROM

Follow-up Physiotherapy
Usually at 1/52 post op. Progress to Active ROM when tolerated. End of range stretches as soon as possible, especially posterior capsular stretches (ie arm across chest)