Impingement syndrome

What is it?

The rotator cuff tendons attach to the edge of the shoulder joint (humeral head). These deep muscles are crucial for coordinating movements of the shoulder with the overlying more powerful muscles (deltoid, trapezius, pectoralis major). The rotator cuff tendons can rub or catch against an overlying bony or fibrous arch, giving rise to subacromial impingement syndrome.

Pain is felt in the region of the shoulder when reaching outwards or upwards. If this continues over a long period of time, the rotator cuff tendons can tear. By this stage there will be loss of movement and weakness within the shoulder.

How is it diagnosed?

Impingement syndrome is diagnosed on the basis of the history described above, and with special tests during clinical examination.

An ultrasound scan or MRI scan will confirm the diagnosis and severity of disease.

What is my approach to treatment?

Approximately 90% of individuals with impingement will completely recover following a course of local steroid injection and physiotherapy.

Those that fail to improve can be successfully treated with keyhole surgery (subacromial decompression).

What does an operation involve?

Surgery is normally carried out under a general or regional anaesthetic, either as a day case or overnight stay in hospital.

A small, pencil size telescope is introduced into the shoulder joint, and under direct vision the diagnosis is confirmed.

If a rotator cuff tear is detected, additional treatment may be required. Excess bone and soft tissue overlying the rotator cuff tendons, which have caused the rubbing, are then removed using special instruments.

At the end of the procedure, the skin is closed using non-absorbable sutures. A long acting local anaesthetic injection may then be administered to provide pain relief. Finally, a dressing, bandaging and sling are applied.

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What is the recovery period?

Bandaging is removed and intensive physiotherapy commences the day following surgery in order to stop the shoulder from stiffening up.

The patient has to be prepared for some discomfort, although strong pain killing medicines can be given via tablet or injection once the local anaesthetic has worn off, normally 6 to 8 hours.

Sutures and dressings are removed in the clinic after two weeks. Use of the sling should be discontinued as soon as possible.

Physiotherapy and a home exercise programme need to be continued for up to three months.

Most pain will have settled after four weeks.

Driving will usually be possible after 3 to 4 weeks.

When a patient is ready to return to work depends on their specific job role and may also vary from individual to individual. It may be possible to return to light keyboard work within two weeks. Heavy manual work should be avoided for a minimum of 4 to 6 weeks.

Are there any possible complications?

Over 90% of patients are satisfied with the final result.

However, as with any treatment, there are always risks involved: Infection: 1% or less, Frozen shoulder: Less than 2%, Nerve injury: Less than 1%, Recurrence: Less than 5%

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