Letter to the Editor

Letter to the Editor: Effectiveness of Sustained Stretching of the Inferior Capsule in the Management of a Frozen Shoulder

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To the editor,

We have read the article by Paul and colleagues [5] with great interest. The authors concluded that the use of a countertraction apparatus had a positive effect on improvement of shoulder function in patients with a frozen shoulder. We have some comments on this study and think that the conclusions of this article should be seen in the light of these remarks.

The first inclusion criterion was “restriction of shoulder movements.” No amount of restriction was defined, and also, no direction of the limitations was reported. The characteristic pattern of limitation of both active and passive loss of external rotation [7] was not a criterion in this study. The duration of symptoms was not reported in the inclusion and exclusion criteria. Radiologic examinations were performed, but it was not specified if this consisted of conventional radiographs or ultrasound. It might be possible that patients with painful shoulder conditions (such as rotator cuff pathology or osteoarthritis) other than a frozen shoulder were included in the study. Furthermore, it is important to know if patients with diabetes mellitus were excluded in this study. If not, were

patients with diabetes mellitus equally distributed among the treatment groups? This is relevant information, because diabetes mellitus is associated with a more protracted course with less response to conservative treatment [3].

We consider the treatment intervention by Paul and colleagues – a countertraction apparatus and physiotherapy compared to physiotherapy alone with a treatment period of only 2 weeks – as rather short for a condition that is known to last between 1 and 3 years on average [1, 6]. As described by the authors, the patient needs to sit upright in a chair with a back rest, directly under the pulleys. The treated arm is elevated, and distracted with weights. This requires that the affected arm needs to be elevated to an average of 160° to 180°. It seems to us that this would be fairly difficult in a painful, contracted frozen shoulder. The amount of analgesia used in the different treatment groups is not reported by the investigators. This is a relevant outcome measure when reporting the results of a treatment of a pathology that is characterized by pain and stiffness.

The outcome parameters were VAS scores for pain, shoulder flexion and

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abduction measured by goniometer and the Oxford Shoulder Score. External rotation and a health-related quality of life score was not measured. The outcome was only assessed after two weeks of treatment without additional follow up. VAS and ROM did not reach statistical significant difference between the intervention and control group. The amount of ROM gained in both groups is one of the best reported results compared to other studies [2, 8]. This raises the important question of whether the underlying condition of all patients truly was a frozen shoulder.

We agree with the authors that physiotherapy is a commonly used treatment modality in the treatment of frozen shoulders. In the current article, the authors referred to a Cochrane Review [4] in which they emphasized the wide variety in physiotherapy treatment modalities and also the lack of evidence for an effective treatment

strategy. Based on our arguments as stated above, we think that the authors introduce an additional treatment modality without proper evidence. With our concerns stated as above, we suggest that the results of this study need to be interpreted with caution..

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