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Influence of enhancing dynamic scapular recognition on shoulder disability, and pain in diabetics with frozen shoulder: A case report and review of the literature

Mohamed AA. Scapular recognition for diabetic frozen shoulder

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Abstract

BACKGROUND

Frozen shoulder (FS) is a familiar disorder. Diabetics with FS have more severe symptoms and worse prognosis. Thus, this study investigated influence of enhancing dynamic scapular recognition on shoulder disability and pain in diabetics with FS.

CASE SUMMARY

Forty-five years-old male person with diabetes mellitus and a unilateral FS (stage II) for at least 3 mo with shoulder pain and limitation in both passive and active ranges of motion (ROMs) of the glenohumeral joint of $\geq 25\%$ in 2 directions participated in this study. This person received dynamic scapular recognition exercise was applied to a diabetic person with a unilateral FS (stage II). The main outcome measures were upward rotation of scapula, shoulder pain and disability index, and shoulder range of motion of flexion, abduction, and external rotation. The dynamic scapular exercise was performed for 15 min/session and 3 sessions/wk lasted for 4 wk. After 4 wk-intervention, there were improvements between pre-treatment and post-treatment in shoulder pain, shoulder pain and disability index, shoulder ROM, and upward rotation of scapula.

CONCLUSION

This case report suggested that enhancing dynamic scapular recognition may improve shoulder pain and disability, upward rotation of scapula, and shoulder ROM of shoulder abduction, flexion, and external rotation after 4 wk.

Key Words: Scapular recognition; Pain; Range of motion; Disability; Frozen shoulder; Case report

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INTRODUCTION

Frozen shoulder (FS) is a common shoulder problem^[1]. Diabetes mellitus (DM) causes more severe FS symptoms than patients without DM^[2]. Also, DM causes worse outcomes and a prolonged course of treatment^[3]. DM may lead to an increased shoulder joint synovitis^[4]. In DM, adipocytes produce ³ cytokines and proteins such as interleukin-6 (IL-6) and tumor necrosis factor-alpha (TNF- α). These proteins cause an overproduction of other pro-inflammatory cytokines, which exacerbate inflammation. Adipocytes also secrete excess IL-13, which causes synovial and connective tissue fibrosis^[3].

Shoulder problems interest any researcher due to the complexity of shoulder motions that occur with interactions between the scapula, clavicle, and humerus^[5]. Restriction in the capability to grasp overhead targets is a key problem in patients with FS. Thus, significance restriction in performing their daily living activities and jobs, such as taking a shower and hair care^[6].

FS causes an alteration in scapular position motion sense (proprioception)^[7]. Patients with FS complain of an abnormal change in their scapular biomechanics as an increased lateral rotation of scapular. This occurs due to the restriction in the range of motion (ROM) of the glenohumeral joint^[8]. The persistent change in normal scapular

biomechanics leads to an additional harm to the muscle proprioception system, which consequently harms muscle spindles^[9]. These muscle spindles are key sensory receptors in sensing joint position^[10].

Research on motion and position sense yet has numerous unsolved questions; particularly, on rehabilitating shoulder proprioception in patients with FS^[11]. Moreover, the association between the enhancement of proprioception and its therapeutic effect of FS is not entirely understood^[12].

Previously, we investigated the effect of a newly developed technique called dynamic scapular recognition ¹ on shoulder pain, range of motion, and disability ¹ in non-diabetics with FS^[13]. Thus, this case study investigated the effect of this technique ¹ on shoulder pain, range of motion, and disability ¹ in diabetics with FS.

CASE PRESENTATION

Chief complaints

The patient complained shoulder pain and limitation in shoulder range of motion.

History of present illness

The patient had a history of FS and DM.

Physical examination

Physical examination contained upward rotation of scapula; ⁶ shoulder pain and disability index (SPADI); and shoulder abduction, flexion, and external rotation (Figure 1).

Imaging examinations

Imaging examinations performed and determined by the referring orthopedist.

FINAL DIAGNOSIS

The patient was diagnosed as FS and DM.

TREATMENT

The participant received 12 sessions of treatment. The treatment was in the form of dynamic scapular exercise that was performed for 15 min/session and 3 sessions/wk lasted for 4 wk. The 3 sessions were performed every other day. The participant was instructed to stand up and perform the maximum possible active shoulder abduction by paying more attention to scapular movements. The therapist stood behind the participant and put one hand over the superior border of the scapula and the other hand on the inferior angle of the scapula to guide and correct any abnormal scapular movement.

OUTCOME AND FOLLOW-UP

The outcome measures included SPADI, upward rotation of scapula, and shoulder abduction, flexion, and external rotation. After 4 wk of the intervention, there were improvements ⁸ between pre-treatment and post-treatment in upward rotation of scapula, SPADI, and shoulder ROM of flexion, abduction, and external rotation. The greatest improvement was in shoulder flexion 36%, while the least improvement was in shoulder external rotation 14% (Table 1).

DISCUSSION

This case study studied influence of enhancing dynamic scapular recognition on SPADI, upward rotation of scapula, and shoulder abduction, flexion, and external rotation in diabetics with FS.

Upward rotation of scapula

This case study suggested that enhancing dynamic scapular recognition may enhance upward rotation of scapula and lessen shoulder disability and pain after 4 wk. This study is exclusive and innovative because it was the initial study to use a scapular

recognition exercise on scapular motion, SPADI, and shoulder ROM in diabetics with FS.

In this case study, the dynamic scapular exercise enhanced upward rotation of scapula after 4 wk. This enhancement in upward rotation of scapula occurred due to the enhancement in central and peripheral recognition of scapular motion. The central mechanism was explained by Kaya^[10] and Eriksson^[21]. They found that proprioceptive training improves proprioceptive feedback through modifying muscle spindles mechanisms and stimulating plastic corrections in central nervous system (CNS). Muscle spindles transfer data on position and motion of the spinal cord^[22]. Thus, it appears realistic to suppose that sensory data from muscle spindles play a crucial role in delivering data about both position sense and kinaesthesia^[22].

Muscle spindles role decreases with immobility and injury. Anderson *et al*^[30] demonstrated that sensitivity of muscle spindles decreases after suspension of hindlimb in mice. This reduction occurred due to declining stiffness of both the muscle spindle and muscle-tendon unit. Conversely, Kaya^[10] reported that regular training enhances muscle spindle signals, which leads to plastic modifications in the CNS. These plastic modifications include increasing the strength of connections in synaptic areas or/and structural modification in composition and networks numbers in central neurons. Prolonged plastic modifications yield plastic regulations in the cortex. After time, the cortical plots of the body change by enhancing the cortical image of the joints, producing a huge enhancement in joint proprioception.

Peripherally, proprioceptive training creates morphological modifications in muscle spindles themselves. These morphological modifications happen because of the micro-adaptations that happen in the intrafusal muscle fibers through metabolic changes^[24].

SPADI

In this case study, there was a decline in pain and disability between pre-treatment and post-treatment findings. This decrease happened due to the enhancement in transmitting information from mechanoreceptors to the CNS through myelinated A-

delta nerve fibers which are quicker than unmyelinated C fibers. Therefore, a block in the transmission of pain signals at the dorsal horn cell occurs (pain gate theory)^[25]. Moreover, the improvement in scapular movements loosens the adhesions among thorax and scapula leading to an improvement in movement and a decrease in disability^[26]. In FS, the scapula moves upward to compensate for the lack of shoulder movement (dyskinesia); this decreases normal upward rotation of scapula leading to limited shoulder movements^[27]. Thus, restoring the normal awareness of the patient about the proper movement of the scapula enhances its movements and decreases the adhesions formed between the scapula and thorax. Consequently, an improvement in upward rotation of scapula occurs leading to an improvement in overhead reach and daily living activities.

These study findings came followed the findings of earlier studies^[28-30]. Dilek *et al*^[35] found that using proprioception exercises in addition to any shoulder rehabilitation program for rotator cuff syndrome significantly increased shoulder ROMs.

Balci *et al*^[29] reported that any effective rehabilitation protocol for shoulder disorders should focus on scapular movements and function because the integral role of the scapula is necessary for underlying feedback processes and motion sense that affect the subject's action and control. Inman *et al*^[37] showed that the enhancement in scapula motion may play a little impact on shoulder motions that happen with no elevation of shoulder since scapular motions and glenohumeral joint motions during the range of 60-65 degrees is small. Therefore, scapular movements are important in overhead movements.

Shoulder ROM

This case study founded that there were increase in shoulder abduction, flexion, and external rotation. These improvements caused by enhancing scapular dynamic recognition happened due to the restoration of normal scapular biomechanics and correction of the abnormal scapular elevation that occurs before upward rotation of scapula (shrug sign).

In detail, FS causes a reduction in the shoulder girdle motions in multiple planes^[31]. Most overhead movements need complex, full, and synchronized movements of the whole shoulder girdle, not only the glenohumeral joint^[32]. Scapular motions are one of the chief motions necessary to accomplish complete humerus-to-trunk and scapular-plane elevation^[32]. Various studies^[8,32,33] have revealed that FS causes alterations in scapular motions in the shape of initial scapular elevation with arm raise to recompense the reduced glenohumeral joint motion. Interventions to enhance upward rotation of scapula help improve shoulder ROM.

This study findings followed the findings of the study conducted by Surenkok *et al*^[33]. They found that the improvement in scapular movements positively affects shoulder ROM.

The chief limitation in this case study was patient age. We went for this range of age as this is the usual age of FS. Also, we chose 80 degrees of shoulder abduction because abduction of 80 degrees or lower has little scapular movement involvement. Upcoming studies are considered necessary to conduct a randomized controlled study to reach a strong conclusion on this effect of the technique in diabetics with FS. Also, future studies should investigate the effect of this technique in other patients, for instance, patients with FS and cervical disorders or radiculopathy.

CONCLUSION

This case report suggested that enhancing dynamic scapular recognition may enhance shoulder disability and pain, scapular upward rotation, and shoulder abduction, flexion, and external rotation after 4 weeks.

Figure Legends

Figure 1 Physical examination.

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Table 1 Dependent T-test between pre-treatment and post-treatment

	Pre-treatment	Post-treatment	Percentage of improvement
Upward rotation of scapula (degrees)	15.36	19.83	29%
Flexion (degrees)	79.03	108.12	36%
Abduction (degrees)	85.67	99.11	16%
Ex. Rotation (degrees)	44.13	50.32	14%
SPADI (%)	99.00	80.00	23%

6%

SIMILARITY INDEX

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