Management of shoulder pain in patients with stroke

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Abstract

Shoulder pain affects from 16% to 72% of patients after a cerebrovascular accident. Hemiplegic shoulder pain causes considerable distress and reduced activity and can markedly hinder rehabilitation. The aetiology of hemiplegic shoulder pain is probably multifactorial. The ideal management of hemiplegic stroke pain is prevention. For prophylaxis to be effective, it must begin immediately after the stroke. Awareness of potential injuries to the shoulder joint reduces the frequency of shoulder pain after stroke. The multidisciplinary team, patients, and carers should be provided with instructions on how to avoid injuries to the affected limb. Foam supports or shoulder strapping may be used to prevent shoulder pain. Overarm slings should be avoided. Treatment of shoulder pain after stroke should start with simple analgesics. If shoulder pain persists, treatment should include high intensity transcutaneous electrical nerve stimulation or functional electrical stimulation. Intra-articular steroid injections may be used in resistant cases.

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Shoulder pain is a common complication after a cerebrovascular accident. From 16% to 72% of stroke patients develop hemiplegic shoulder pain.1–3 It may occur in up to 80% of stroke patients who have little or no voluntary movement of the affected upper limb.4

Hemiplegic shoulder pain has been shown to affect stroke outcome in a negative way.5 It interferes with recovery after a stroke: it can cause considerable distress and reduced activity and can markedly hinder rehabilitation.6,8 Roy et al demonstrated that the presence of hemiplegic shoulder pain is strongly associated with prolonged hospital stay and poor recovery of arm function in the first 12 weeks after stroke.9

The cause of hemiplegic shoulder pain is the subject of considerable controversy. The following processes have all been postulated as causes of a painful hemiplegic shoulder: glenohumeral subluxation, spasticity of shoulder muscles, impingement, soft tissue trauma, rotator cuff tears, glenohumeral capsulitis, bicipital tendinitis, and shoulder hand syndrome.1 2 10–11 Traction neuropathy of the brachial plexus may also play a part.4 Unusual patterns of motor recovery or spasticity or unusually severe focal atrophy may suggest brachial plexus injury. Poor handling of a hemiplegic limb may exacerbate a pre-existing condition such as osteoarthritis. Thus, pre-morbid disease of the shoulder may predispose to hemiplegic shoulder pain.7 Stroke patients may suffer from pain that is caused by the stroke itself (central post-stroke pain).6 The role of central post-stroke pain in the aetiology of hemiplegic shoulder pain is uncertain. Abnormal tone (both spasticity and flaccidity) has been suggested as an aetiological factor in hemiplegic shoulder pain. However, clinical observations suggest that shoulder pain does not occur until spasticity develops. Most authorities agree that the aetiology of hemiplegic shoulder pain is probably multifactorial.8

Prevention

The ideal management of hemiplegic stroke pain is to prevent it happening in the first place. Various strategies have been employed in the prophylaxis of hemiplegic shoulder pain. For prophylaxis to be effective, it must be begun immediately after the stroke. Once the patient has pain, resultant anxiety and overprotection will follow.12

Handling

Poor handling and positioning of the affected upper limb in stroke patients contribute toward shoulder pain.13 The mobility of the recovering stroke patient is dependent on the assistance of nurses, therapists, doctors, other ancillary staff, and family members. It is also dependent on his/her own efforts. Handling, positioning, and transferring on a day-to-day basis can exert great stress on the vulnerable shoulder. The problem may be exacerbated by the patient’s sensory and perceptual deficits. There has been concern that trauma to the constituent components of the shoulder joint may be caused by poor handling of the patient’s affected arm.14 Wanklyn et al studied the prevalence of hemiplegic shoulder pain and associated factors in patients with stroke.15 Sixty three per cent of the patients developed hemiplegic shoulder pain in the first six months after their stroke. Patients who needed help with transfers were more likely to develop hemiplegic shoulder pain. Certainly, patients with markedly decreased voluntary movement after a cerebrovascular accident frequently experience shoulder joint malalignment or subluxation in the early stages of recovery.16 Careful positioning and handling of the limb are thought to prevent hemiplegic shoulder pain, but there is a range of opinions about how correct limb positioning is best achieved.2 9 17
Braus et al investigated the efficacy of an information and education programme in the prevention of hemiplegic shoulder pain. They found that patients who used the overhead pulley had the highest risk of developing shoulder pain and concluded that the use of the pulley should be avoided during stroke rehabilitation.

If impingement during range of motion exercises is determined to be the cause of hemiplegic shoulder pain, the amplitude of passive movement should be kept within the pain-free range. Caldwell et al reported that pain subsided in 43% of patients with hemiplegic shoulder pain when the amplitude of passive range of motion was reduced.

Wanklyn et al reported an increase in the prevalence of shoulder pain in the first weeks after discharge in patients who did not continue to exercise properly.

**Treatment**

Radiological investigations should exclude dislocation or fracture of the shoulder before further management is instigated. Various treatments have been suggested as being beneficial in shoulder pain after stroke: these include physiotherapy, localised cooling, infrared, ultrasound, and intra-articular injections of steroids and local anaesthetics. Until recently there has been a shortage of prospective controlled clinical trials.

**Physiotherapy**

Physiotherapy has been used in the treatment of hemiplegic shoulder pain. There are two major approaches to therapy in this field: those that focus on the problem as a localised mechanical one; and those that view the problem as a neurological one. Local treatments used have included heat and cold therapy. Slings and shoulder supports have also been used. Positioning is also considered important by many authors. Other physiotherapy approaches include those of Bobath, Brunstrom, and proprioceptive neuromuscular facilitation. Until recently, the evidence for the effectiveness of these methods of physiotherapy has been poor. Partridge examined the effectiveness of two methods of physiotherapy in the treatment of hemiplegic shoulder pain: cryotherapy or the Bobath approach. The cryotherapy approach involved the application of ice to the affected shoulder. The Bobath approach is a neurologically based holistic approach that is frequently used in the UK.

There were no significant differences between the two treatments in terms of severity of pain at rest or on movement or for reported distress. However the proportion of patients who reported no pain after treatment was greater in those who received the Bobath approach.

**Drug Treatment**

Analgesic, anti-inflammatory, and antispastic drugs have all been used to treat hemiplegic shoulder pain. Simple analgesics and non-steroidal anti-inflammatory drugs should be tried first. Antispasmodic medication may be helpful in spasticity of cerebral origin. Antispasmodic agents may supplement inhibition.
and relaxation techniques in physiotherapy. These agents have a modest effect on post-stroke hypertonicity but their cognitive side effects may limit their usefulness.

Braus et al conducted a trial on 36 stroke patients with hemiplegic shoulder pain. In a placebo controlled, non-blinded trial, they found that 31 of the 36 patients became almost symptom-free within 10 days of treatment with low dose oral corticosteroids (methylprednisolone 32 mg daily). A two week course of treatment was given followed by a two week taper. There were no major adverse events due to the drugs. Davis et al reported complete resolution of symptoms in 68 patients with hemiplegic shoulder pain using oral steroids and an intensive rehabilitation programme.

Dekker et al investigated the effect of intra-articular triamcinolone acetonide on pain and passive range of motion in seven patients with a painful hemiplegic shoulder. Four out of the seven patients had significant reduction in pain. There was improvement in range of motion but it did not reach statistical significance.

FUNCTIONAL ELECTRICAL STIMULATION

Leandri et al evaluated the effectiveness of high intensity versus low intensity transcutaneous electrical nerve stimulation (TENS) versus placebo for patients with hemiplegic shoulder pain. Low intensity TENS involves electrical stimulation just above the level of the skin sensory threshold. High intensity TENS is sufficient to elicit muscle contraction and an almost painful sensation. The investigators found that patients who received high intensity TENS had significant improvements in passive range of motion for flexion, extension, abduction, and external rotation at the shoulder. The patients who received high intensity TENS also reported very satisfactory pain relief.

BOTULINUM TOXIN

Bhakta et al evaluated the impact of botulinum toxin on disability caused by upper limb spasticity after stroke. They demonstrated improvement in shoulder pain in six of nine patients treated with complete resolution in two patients.

SURGERY

Various authorities in the treatment of hemiplegic shoulder pain have recommended surgery on the structures of the shoulder. There is a lack of trial evidence in this area. Surgery may be of use if conservative methods have failed and the shoulder has become very painful and stiff. Recent improvements in rehabilitation techniques have reduced the need for surgical intervention.

The following procedures have been used to treat hemiplegic shoulder pain: operative surgery on the contractures in muscle tendons, surgical repair of a rotator cuff tear, stellate ganglion block, and scapular mobilisation.

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Hemiplegic shoulder pain has been shown to affect stroke outcome in a negative way.

Most authorities agree that the aetiology of hemiplegic shoulder pain is probably multifactorial.

Poor handling and positioning of the affected upper limb in stroke patients contribute toward shoulder pain.

High intensity TENS can relieve pain and improve range of motion in hemiplegic shoulder pain.

Functional electrical stimulation has been shown to improve parameters such as pain, range of motion, and arm function in patients with hemiplegic shoulder pain.

Chaco and Wolf also demonstrated the importance of the supraspinatus muscle in preventing downward subluxation of the humerus. Two studies have investigated the application of electrical stimulation to the supraspinatus and posterior deltoid muscles: Baker and Parker demonstrated the beneficial effects of FES in stroke patients with a chronic shoulder dislocation. However, patients deteriorated after withdrawal from treatment though not back to pre-treatment levels. Linn et al carried out a prospective randomised study to determine the efficacy of FES in the prevention of shoulder subluxation in stroke patients. They found that FES does prevent shoulder subluxation, but this effect was not maintained after the withdrawal of treatment.

As an extremely mobile joint, the shoulder sacrifices stability for mobility. Basmajian determined through electromyographic studies that the supraspinatus, and to a lesser extent the posterior deltoid muscles, played a key part in maintaining glenohumeral alignment.
became pain-free in contrast to a control group whose pain remained.53

Indications for surgery in various series have included range of motion limitation to the point of functional impairment, pain of such intensity that it interfered with skin hygiene or prevents participation in rehabilitation.54

Surgery is usually delayed until at least six months after the stroke to allow as much spontaneous functional improvement as possible.55

Future

There are a number of obstacles to clinical research in this area. It is often very difficult to ascertain the patient’s pre-morbid shoulder function or a history of trauma to the shoulder after the stroke. Most of the work done in this area has been in the form of case series; randomized double blind trials have thus far been sparse. However, further trials are needed to establish the optimal management of patients with hemiplegic shoulder pain.

Answers

1. Hemiplegic shoulder pain affects stroke outcome in a negative way. It interferes with recovery after a stroke: it can cause considerable distress and reduced activity and can markedly hinder rehabilitation. Hemiplegic shoulder pain has been associated with prolonged hospital stay and poor recovery of arm function in the first 12 weeks after stroke.

2. The cause of hemiplegic shoulder pain is the subject of considerable controversy. The following processes have all been postulated as causes of a painful hemiplegic shoulder: glenohumeral subluxation, spasticity of shoulder muscles, impingement, soft tissue trauma, rotator cuff tears, glenohumeral capsulitis, bicipital tendinitis, and shoulder hand syndrome. The aetiology of hemiplegic shoulder pain is probably multifactorial.

3. The mobility of the recovering stroke patient is dependent on the assistance of nurses, therapists, doctors, other ancillary staff, and family members. It is also dependent on the patient’s own efforts. Poor handling and positioning of the affected upper limb in stroke patients contribute toward shoulder pain.

4. Important outcomes include pain relief, improved passive and active range of motion and arm function.

5. Indications for surgery in patients with hemiplegic shoulder pain include limitation of range of motion to the point of functional impairment, pain of such intensity that it interferes with skin hygiene or prevents participation in rehabilitation.