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Acromioclavicular Joint Pain

Steven D

Clinical Associate Professor, USA

Initial treatment of pain and functional disability associated with the acromioclavicular joint should include a combination of the nonsteroidal antiinflammatory agents or cyclooxygenase-2 inhibitors and physical therapy. The local application of heat and cold also may be beneficial. For patients who do not respond to these treatment modalities, an intra-articular injection of local anesthetic and steroid may be a reasonable next step.4

Intra-articular injection of the acromioclavicular joint is performed by placing the patient in the supine position and preparing with antiseptic solution of the skin overlying the superior shoulder and distal clavicle. A sterile syringe containing 1 mL of 0.25% preservative-free bupivacaine and 40 mg of methylprednisolone is attached to a 1½-inch 25-gauge needle using strict aseptic technique. With strict aseptic technique, the top of the acromion is identified, and at a point approximately 1 inch medially, the acromioclavicular joint space is identified. The needle is carefully advanced through the skin and subcutaneous tissues, through the joint capsule into the joint (Fig. 59-4). If bone is encountered, the needle is withdrawn into the subcutaneous tissues and redirected slightly more medially. After entering the joint space, the contents of the syringe are gently injected. There should be some resistance to injection because the joint space is small, and the joint capsule is dense. If significant resistance is encountered, the needle is probably in a ligament and should be advanced slightly into the joint space until the injection proceeds with only limited resistance. If no resistance is encountered on injection, the joint space is probably not intact, and MRI is recommended. The needle is removed, and a sterile pressure dressing and ice pack are placed at the injection site.

The major complication of intra-articular injection of the acromioclavicular joint is infection. This complication should be exceedingly rare if strict aseptic technique is adhered to. Approximately 25% of patients complain of a transient increase in pain after intra-articular injection of the shoulder joint, and patients should be warned of this possibility.

References

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***Corresponding author:** Steven D. Wood, Clinical Associate Professor, Department of Anesthesia, USA,

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