5 facts about physiotherapy and frozen shoulder

1 Differential diagnosis of frozen shoulder (FS) must be deliberate and active

Clinical signs include:

- progressive pain followed by stiffness
- global restriction where active range is similar to passive range
- a clear loss of external rotation compared with the other side.

2 Stage and irritability should dictate FS mobilising

Treat pain first, before moving on to stretching and mobilisation:

- use low-grade joint mobilisation and graded exposure to functional movement when shoulder irritability is high
- use end-range mobilisation, sustained stretching and progressive strengthening once the irritability settles and stiffness is the main limiter.

3 FS prognosis is variable and beliefs can affect outcomes

Patient beliefs can derail progress. Physiotherapists can:

- normalise the typical trajectory without promising deadlines
- explain that stiffness is not always just a tissue length problem; pain sensitivity and capsular restriction can both contribute.

4 Early pain control can unlock better FS rehab

Stages of rehabilitation can include:

- early pain control through corticosteroid injection
- hydrodilation to enlarge the capsule
- a progressive physiotherapy program the patient can do at home.

5 Escalation decisions in FS should be shared and staged

There is no strict timeline for interventions. Physiotherapists should:

- share decision-making with the patient
- raise escalation options early if the patient isn't progressing
- consider metabolic risk factors like diabetes or thyroid disease.