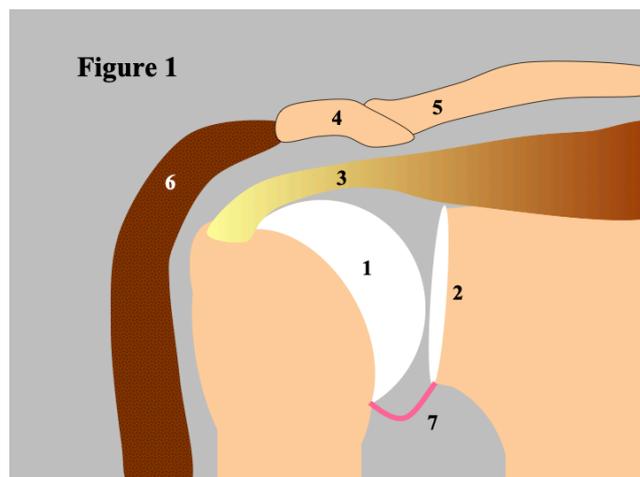


## Acromioclavicular joint arthritis and its treatment

Figure 1 is a cartoon diagram looking directly at a right shoulder:

- 1 - humeral head, the ball of the main ball & socket joint of the shoulder
- 2 - glenoid, the socket of the main joint
- 3 - rotator cuff, the strong tendons around the shoulder from the shoulder blade muscles
- 4 - acromion, the bony roof of the shoulder which is part of the shoulder blade
- 5 - clavicle - the collar bone which joins to the acromion as the acromioclavicular joint or ACJ
- 6 - deltoid, the big muscle around the outside of the shoulder which gives its shape
- 7 - capsule, the deepest lining of the shoulder



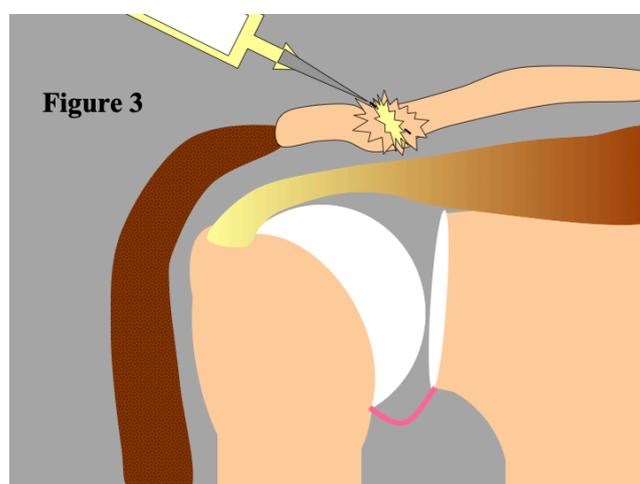
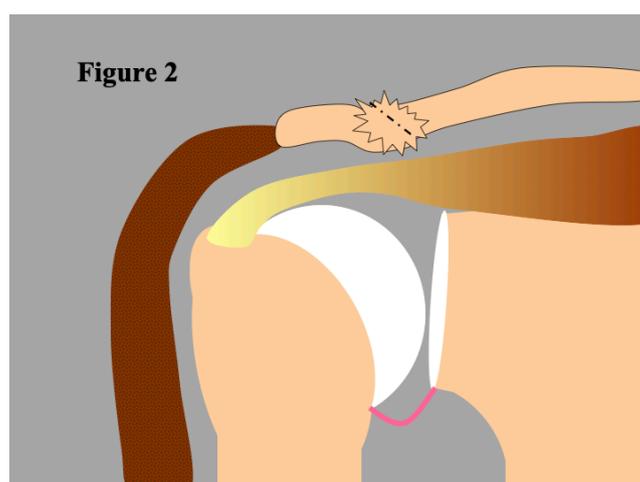
The [acromioclavicular joint](#) or ACJ is the small joint at the top of the shoulder where the clavicle collar bone (5) joins to the roof of the shoulder the acromion (4). As life progresses it is a common site of degenerate change or arthritis and may be an incidental finding on X-rays whilst causing no significant symptoms. Minor injury to an ACJ with degenerate change can precipitate pain and dysfunction or pain can develop insidiously without known trigger. Figure 2 depicts a degenerate ACJ with narrowed joint space, irregular surfaces and sharp osteophytes.

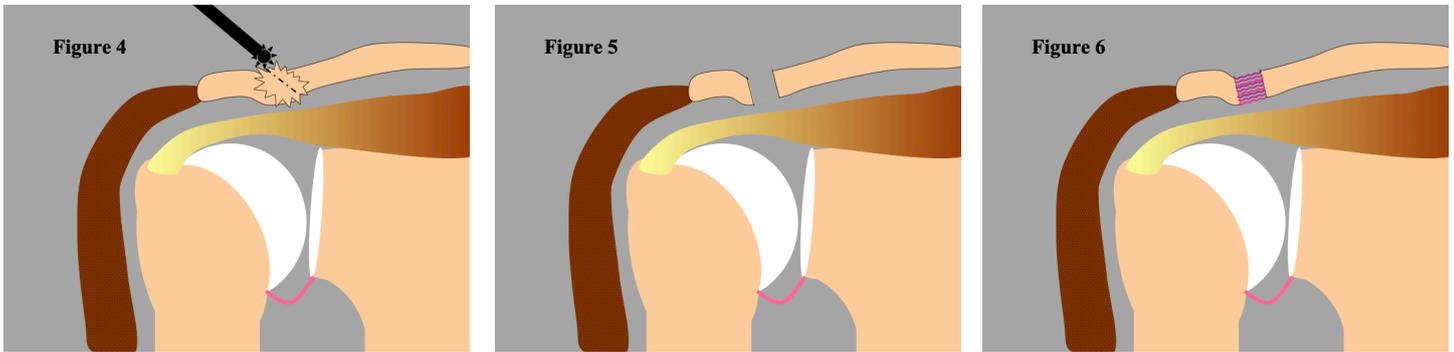
Patients describe pain at the top of the shoulder sometimes radiating up towards their neck. The area can be tender to touch or pressure and made worse with bringing the arm across the front of the body as if throwing a scarf over the opposite shoulder.

Treatment should always start with simple measures such as activity modification (avoiding the actions that bring on the pain), rest, tablet painkillers (eg paracetamol 1g = 2 tablets four times per day) and anti-inflammatories (eg ibuprofen 400mg = 2 tablets three times per day after food) and simple exercises. Application of anti-inflammatory gel or cream to the tender area can be very effective. These measures in isolation or more often in combination can all help break the painful cycle and allow movement, strength and function to return to normal.

The next stage is to consider a steroid and local anaesthetic injection into the ACJ (Figure 3). This can be done in the outpatient clinic or with guidance from an ultrasound scan. This injection has very few minor risks and potential complications or side effects. The steroid is a strong anti-inflammatory which bathes the inflamed joint capsule and reduces symptoms.

If the beneficial effect of an injection is good for several months it could be repeated but if only short-lived or transient then the [shoulder surgeon](#) may suggest surgical intervention to remove the degenerate joint.





The operation to excise the degenerate contents of the ACJ and the arthritic surfaces of both sides of the joint can be done as a mini-open procedure or with arthroscopic keyhole surgery. Figure 4 shows a surgical instrument removing the ACJ contents to leave a clear joint space in Figure 5. This space fills in with scar tissue as seen in Figure 6 reducing pain and restoring function.

ACJ arthritis often coexists with subacromial impingement (see information sheet on Subacromial Impingement) and keyhole surgery to address both issues can be combined at the same time if necessary.

This is almost always performed as a daycase operation under a short general anaesthetic and rarely needs sling immobilisation allowing early active shoulder movement.

The risks and potential complications of such surgery are small but include failure to achieve the desired outcome with persistent pain, weakness, stiffness, nerve or blood vessel damage (some bruising is normal), numbness, infection, further surgery for whatever reason, prolonged rehabilitation, the medical risks of any operation such as blood clots in the legs or lungs (DVT or PE), heart attack (MI) or stroke (CVA).

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