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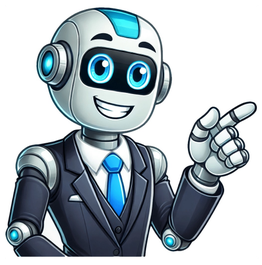

The most common symptoms of bursitis in your shoulder include:Shoulder painSwellingStiffnessA reduced range of motion (how far you can move your shoulder without pain)Tenderness to even a light touchDiscoloration or redness on your skinA feeling of heat or warmthWhat does shoulder bursitis feel like?Shoulder pain from bursitis can come on suddenly or build up gradually. You may feel a dull ache all the time. But the pain may become sharp or feel like a pinch inside your shoulder when you lift your arm over your head.You'll probably feel more (or worse) pain if you sleep or lay on your affected shoulder.What causes shoulder bursitis?Injuries and overusing your shoulder are the most common causes of bursitis. Specifically, sports injuries or repetitive strain injuries are usually what cause chronic and acute shoulder bursitis.Any injury that damages your shoulder can irritate the bursae and cause inflammation. Using your shoulder for a repetitive motion can irritate your bursae. That's especially true for movements that require a lot of force — like swinging a hammer or throwing a ball. A motion may not hurt at first, but if you keep doing it often, your shoulder may not have time to heal and irritation can build up over time.Infections from another place in your body that spread to the bursae in your shoulder cause infectious shoulder bursitis. Bacterial infections (like staph infections) are the most common causes.What are the risk factors?Anyone can experience shoulder bursitis. But you have a higher risk if you:Play a sport that requires you to do repetitive motions with your shoulder (like throwing, rowing or swinging a bat, club or racket)Do physical work that puts a lot of stress on your shoulders, like working with tools or lifting heavy objects; people like painters, carpenters, landscapers, plumbers and warehouse workers have a higher risk than other types of workersHave a health condition that causes inflammation in your bodySome conditions that may increase your risk of bursitis include:Inflammatory arthritis (like rheumatoid arthritis, gout or psoriatic arthritis)DiabetesChronic kidney diseaseThyroid diseaseWhat are the complications of shoulder bursitis?Chronic shoulder bursitis and repeated flare-ups (periods of symptoms that come and go) can damage your bursae. Over time, this may affect your shoulder's mobility (how well you can move it).Bacteria that cause infectious (septic) shoulder bursitis can spread to organs and other parts of your body if the infection isn't treated. Severe infections can cause sepsis, which can be fatal. This is rare, but it's important to see a healthcare provider right away if you think you have an infection. Subacromial Bursitis: The outermost aspect of shoulder contains a fluid filled sac called the subacromial bursa. When this sac gets inflamed due to any reason it results in pain in the shoulder. This pathological condition of the shoulder is called as Subacromial Bursitis. This article deals with the following: Subacromial Bursitis is a pathological condition of the shoulder in which the subacromial bursa, which is a fluid filled sac located on the outer aspect of the shoulder gets inflamed resulting in pain in the shoulder. The function of the subacromial bursa is to act as a lubricant and reduce friction between the bony prominence of acromion and the tendon of the supraspinatus muscle. With activities which involve frequent elevation of the arms, rotation of the shoulders, repetitive lifting, pushing or pulling, or lying on the shoulder causes friction and increases pressure on the bursa. This pressure may also be caused as a result of a direct fall to the shoulder or hand. When this pressure becomes too excessive for the bursa to handle then the inflammation of bursa develops causing Subacromial Bursitis. Subacromial Bursitis develops usually due to repetitive activities, which places excessive strain on the subacromial bursa. The following activities increase strain on the subacromial bursa: Repetitive overhead activities Repetitive activities involving elevation of the arm Repetitive activities with the arm placed in front of the body Activities which involve rotating the shoulders Repetitive lifting, pushing, or pulling At times, Subacromial Bursitis can also develop due to a direct blow to the shoulder or arm such as in a fall. Certain sporting activities like baseball, swimming especially butterfly style, tennis, weightlifting also cause excessive strain on the subacromial bursa causing Subacromial Bursitis. Individuals affected with Subacromial Bursitis usually experience pain on the top, front, and outer parts of the shoulder. There may be radiation of pain to the upper part of the arm and may go to the elbow. If the inflammation is not significantly severe, individuals may only have stiffness or an aching sensation in the shoulder which tends to worsen after certain activities. These activities generally are repetitive lifting, pushing, pulling, doing activities which require placing the arm in front of the body. With gradual progression of the condition, individuals start experiencing increasing pain with activities and may not be able to do their tasks appropriately. Affected individuals may also have pain with palpation of the shoulder. To diagnose Subacromial Bursitis, a detailed history and physical examination will be done by the treating physician. An ultrasound of the shoulder is usually done to confirm the diagnosis of Subacromial Bursitis. An x-ray, MRI, or CT scan may be done to look at severity of the condition and to look for potential other disease conditions. Subacromial Bursitis can be treated conservatively with the use of physical therapy using ultrasound and cryotherapy. In certain instances where physical therapy is not providing adequate relief then steroid injections maybe utilized. In case, if all these treatments fail to provide adequate relief then surgery is the route taken for relief of symptoms using an arthroscope to visualize the damaged structures and repair them. The most vital treatment for Subacromial Bursitis is adequate rest to the shoulder and doing exercises diligently. The exercises detailed below are usually prescribed for individuals diagnosed with Subacromial Bursitis. The affected individual needs to consult with the physical therapist before starting these exercises. It should be done at least three times a day and should not be done if there is an exacerbation of the pain. The physical therapist can appropriately advise as to when to start the exercises and when to advance the exercises. Shoulder Blade Squeeze: To start this exercise, you need to stand or sit keeping the back straight. The chin needs to be slightly tucked in and the shoulders should be back a bit. Now, slowly start squeezing the shoulder blades as hard and far as you can do without aggravating the pain. Hold the position for about 6 seconds and repeat the exercise about 15 times. Pendular Exercises: To start this exercise, start by leaning forwards with the unaffected hand placed on a table for support. Keeping the back straight and shoulders relaxed gently start swinging the injured arm in the forward and backward direction as far as possible without increasing symptoms. This needs to be done at least 10 times. Repeat the exercise but now swing the arm sideways. Pendular Circles: To start this exercise, lean in the forward direction with the unaffected arm placed on a table for support. With the back kept straight and relaxing the shoulders, start swinging the arms gently in circles as far as possible without aggravating the symptoms, first clockwise and then anticlockwise. Do this for about 10 times in each direction. Foam Roller Stretch: For this exercise you need to place a foam roller under the back as shown in the picture. Breathe normally while keeping the back and neck in a relaxed position. You need to hold this position for about a minute if it does not cause any increase in symptoms. Also Read: Shoulder Joint Bursitis: Causes, Symptoms, Treatment- Conservative, PT, Surgery Bursitis: Shoulder, Hip, Ankle, Prepatellar, Retrocalcaneal, Subacromial, Ischial, Wrist, Iliopsoas What is Deltoid Bursitis, know its Treatment, Recovery, Exercises, Prognosis, Symptoms and Causes Shoulder bursitis is a common condition that causes shoulder pain and difficulty moving your arm. It can be caused by overuse, injury, or repetitive movements. Exercises for shoulder bursitis can help to reduce pain, improve range of motion, and strengthen the muscles around the shoulder. These exercises should be done gently and gradually, and pushing yourself into painful stretches should be avoided. In this article, we'll go through the best stretches and exercises for shoulder bursitis, as well as exercises to avoid it. These exercises should not be used without supervision from a shoulder surgeon or physical therapist. Dr. Mehta is a board-certified orthopedic surgeon who can help you recover from your joint condition. If you: Are Suffering From Pain and Mobility Issues Need Orthopedic Assessment and Advice Want Treatment From a Top Orthopedic Doctor We Can Help Shoulder bursitis refers to inflammation of the bursae of the shoulder joint which are sacs filled with synovial fluid. These bursae usually reduce friction and cushion the bones, tendons, and muscles in the shoulder joint. When there is too much friction bursae become irritated and inflamed, leading to bursitis. Skin, tendons, and ligaments would likewise wear out if there were no bursa between them and bony surfaces. Shoulder bursitis (inflammation of a bursa) is one of the leading causes of shoulder pain. It can lead to taking time off work and, in some cases, inability to function in your daily activities. When you first notice the signs of shoulder pain and inflammation, you should visit your local orthopedic surgeon. They will assess your shoulder joint and can provide information on what exercises you should start with. The trick is to start with gentle exercises and stretches for shoulder bursitis as directed by your shoulder doctor, building these up over time. You should never push yourself to the point of worsening shoulder pain. If you're unsure, consult your doctor or a physical therapist before continuing with these exercises. *If you have had shoulder surgery, please check with your orthopedic surgeon when you can start exercises* It is recommended to perform this exercise with your fingers slightly extended as opposed to straight up and down. Stand facing a wall, about 30 to 45 centimetres away. Put your hand's shoulder height on the wall. Bring your face to the wall while bending your elbows gradually. Straighten your back and hips. Retrace your steps to where you began. Repeat this 10 times, doing 3 sets of this throughout the day. 2. Posterior Stretching Exercise Grasp the elbow of your injured arm with your other hand. Pull your damaged arm carefully across your body with the aid of your hand. A little stretch will be felt over the affected shoulder's back. Hold for between 15 and 30 seconds, minimum. Next, gradually lower your arm. Do this 2 to 4 times. You might need to hold off on performing this stretch until you've mostly regained your range of motion and strength, according to your shoulder surgeon or physical therapist. This stretch can be performed in a variety of ways. Any of these shoulder stretches should be held for between 15 and 30 seconds, two to four times each. Put your hand in your back pocket. Let it rest there to stretch the shoulder. Hold your injured arm behind your back by the wrist with your other hand, palm facing outward. To extend your shoulder, gently raise your arm. Use a cloth for this more difficult stretch Place the afflicted arm's hand behind your back. Now hold the back end of the towel. With the other hand, hold the front end of the towel in front of your body. Pull gently on the front end of the towel. This will bring your hand farther up your back to stretch your shoulder. Grab a solid surface from approximately an arm's length away. A tabletop, a doorknob, or the back of a solid chair might all be used. Bend forward with your legs slightly bent and your arms straight. Lower your upper body and extend your shoulders. You may need to take a step or two backward as your shoulders stretch farther. Maintain for at least 15 to 30 seconds. Then get up and stretch. Step forward if you stepped back throughout your stretch to keep your hands on the firm surface. Repeat 2–4 times more. To perform external rotation of your shoulder, start by taking something elastic, like an exercise band, in both of your hands. Holding your elbows at your side, hold the exercise band out in front of you at waist height, so that your elbows are at a roughly 90-degree angle. Gently pull the band apart, keeping your elbows stuck to your side, until you feel a gentle stretch in your arm. Bring your hands back together slowly until you are back in the initial posture. This should be done ten times. Finish this set of ten exercises three times during the day. You will need elastic exercise material for this workout, such as surgical tubing or Thera-Band. Put the band around a solid object at about waist level (A bedpost will work well). Each hand should hold the end of the band. Pull the band back with your elbows at your sides and bent to 90 degrees. Your shoulder blades should be moving in the same direction. Then return your arms to where they began. Repeat 8 to 12 times. If you have a good range of motion in your shoulders, try this exercise with your arms lifted out to the sides. Keep your elbows at a 90-degree angle. Raise the elastic band to about shoulder level. Pull the band back to move your shoulder blades toward each other. Then move your arms back where you started. Squeeze your shoulder blades together while standing with your arms at your sides. As you squeeze, do not elevate your shoulders. Hold 6 seconds. Repeat 8 to 12 times. Start by attaching an elastic workout material to a doorknob. Surgical tubing or Thera-Band can be used. Standing or sitting, relax your shoulders and bend your elbow 90 degrees. Your upper arm should be relaxed against your side. Hold one end of the elastic band in the hand of the painful arm. Slowly rotate your forearm toward your body until it touches your belly. Slowly move it back to where you started. Keep your elbow and upper arm firmly tucked against the towel roll or at your side. Repeat 8 to 12 times. For added comfort, place a wrapped towel between your elbow and your torso. This will assist you in keeping your arm at your side. Doctors typically recommend physical therapy as a key part of your recovery after shoulder bursitis surgery. If you have recently had shoulder surgery, physical therapy can help you maximize the results of your operation and get your shoulder working again. Let's take a look at some of the exercises that your physical therapist may show you after shoulder surgery, as your shoulder is ready and becomes stronger: Put your hands together (cup your fingers together) and lift your arms above your head. For 10 to 20 seconds, maintain the elevation with your elbows as straight as possible. After 10 to 20 seconds, slowly lower your arms in front of you. Increase the height of your hands above your head as you progress. You can also do this activity by raising your arms upward with your fingertips pointing to the ceiling. Keep your elbows straight. Hold this position for 10 seconds, then lower your arms slowly in front of you. Repeat this up to 10 times, though ensure you don't push yourself too hard or through pain. While sitting or standing, rotate the lower half of your arm (the forearm) so your hand is next to your waist on the opposite side of your body. Keeping your forearm at the same height, slowly rotate it back and forth, so your hand is moving from one point to the other. Use your fingers on the affected arm to "crawl" up a wall as high up as possible. Once you've reached your hand as high up as possible (and in a comfortable position), hold this position for 10 to 20 seconds. Slowly crawl your fingers back down the wall. Stand with your back against a wall. Put your arms straight out at your sides, and place your hands on the wall. Stay in this position for 5 seconds and then relax. The movements you should be avoiding are dependent on what stage of recovery you are in and your fitness level. Ultimately, your symptoms will dictate what you should and shouldn't be doing. Yet, some moves are more aggravating than others and can lead to a rotator cuff injury or tendinitis. These are the moves to keep in mind. Repetitive overhead reaching Overhead throwing Heavy lifting, particularly anything that strains the rotator cuff Arm exercises with the thumbs pointing down, such as an upright row, to prevent unnecessary shoulder impingement Triceps dips. Any movement that feels unstable or painful Some people are at higher risk for shoulder bursitis because they use their shoulders more than others. Examples of those who are more prone to bursitis include: Carpenters Musicians Athletes Gardeners These will have to avoid doing this work for at least a couple of months. Compared to other tissues in your body, tendon tissue recovers far more slowly. For instance, your skin will usually mend in seven to ten days if you cut yourself. However, the tissue of the rotator cuff tendon recovers over the course of three months. Depending on the severity of the rotator cuff rupture, it usually takes another two to three months to regain complete shoulder strength after a span of three months. Compared to other tissues in your body, tendon tissue recovers far more slowly. For instance, your skin will usually heal in seven to ten days if you cut yourself. However, the tissue of the rotator cuff tendon recovers over the course of three months. So after a period of 3 to 4 months, you can resume initial light exercises and then gradually and slowly shift onto the other ones. You should not do any reaching, lifting, pushing, or pulling with your shoulder during the first six weeks after surgery. Subacromial bursitis has similar symptoms to Supraspinatus tendinitis. In particular, shoulder pain over a 60-degree arc as you lift your arm out sideways. Symptoms of subacromial bursitis can be similar to those of supraspinatus inflammation and consist of: Pain and weakness in the armA painful 60-degree arc when abducting your armPressing in over the inside, and front of the shoulder is painful and tenderLittle or no pain when abducting your arm against resistance (compared with supraspinatus tendonitis) Subacromial bursitis is inflammation of the subacromial bursa which sits between the supraspinatus tendon and the bone in the shoulder. A bursa is a small sack of fluid. Its function is to help lubricate the movement of the shoulder joint. The Supraspinatus muscle runs along the top of the shoulder blade (scapula) and inserts via the tendon at the top of the arm or humerus (upper arm) bone. The muscle lifts the arm up sideways and is important in throwing sports. As one of the rotator cuff muscles, it holds the arm in the shoulder when you release what you are throwing. Overuse is usually the underlying cause, especially in overhead sports, for example, badminton and tennis. The bursa becomes trapped causing pain and inflammation. Injury to the supraspinatus tendon also causes inflammation. As a result, space in the joint reduces, therefore increasing the likelihood the subacromial bursa impinges. Foam Rollers UPMedical.co.uk (UK) Amazon.com (USA) Large forces are involved when throwing, in particular when slowing the arm down after releasing the throwing implement. Few athletes people bother to train the rotator cuff muscles, preferring to concentrate more on the muscles which accelerate the arm rather than decelerate it. A heavy fall onto the shoulder can also result in injuring the supraspinatus muscle, which may also lead to bursitis. Rest – until there is no pain. Rest is important as every time movement causes pain in the shoulder the time taken to recover will be longer as the bursa becomes inflamed and swollen.Mobility – is possible however continue pain-free mobility exercises to keep the full range of movement in the shoulder. This is important to prevent loss of movement in the shoulder and eventually muscle weakness.Ice – apply cold therapy to reduce pain and inflammation. A cold pack or wrap can be applied every hour for 10 minutes reducing it to 4 times a day as required.Advice – see a sports injury specialist or doctor who can advise on subacromial bursitis treatment and rehabilitation. Medication – a doctor may prescribe anti-inflammatory medication such as ibuprofen. This will help reduce pain and inflammation quite quickly although always consult a doctor before taking medication. Ibuprofen should not be taken if you have asthma.Rehabilitation – they may prescribe a full rehabilitation program to include mobility and strengthening exercises.Aspirate – if Subacromial bursitis does not respond to normal conservative treatment of rest and cold therapy then a doctor may aspirate the bursa which involves extracting the extra fluid through a needle injected into the bursa.Surgery – a surgeon may operate on persistent subacromial bursitis injuries. The aims of Subacromial bursitis rehabilitation are to reduce pain and inflammation, improve or maintain mobility and strengthen the shoulder with the right exercises. The following guidelines are for information purposes only. We recommend seeking professional advice before attempting any Subacromial bursitis rehabilitation. Before beginning a subacromial bursitis rehabilitation program it is important to be aware that the athlete's chance of the injury recurring is increased by any of the following: If they have an unstable shoulder joint where there is a lot of movement and weakness in the joint for example from a previous injury or a shoulder dislocation. If you are not sure, see a sports injury professional. Failure to recognize this may mean the injury is likely to recur.Poor technique or bad training habits. Overuse or training too hard is just as likely to cause injury as poor technique. If not sure, find a good coach.Weakness in the rotator cuff muscles. Strengthening exercises should not be neglected just because the pain has gone. The first priority of Subacromial bursitis rehabilitation is to reduce pain, inflammation and bursa swelling. Apply cold therapy or ice to the shoulder. This will help reduce pain and inflammation. Apply ice for up to 15 minutes every hour, gradually reducing the frequency of applications as the shoulder improves.Rest the shoulder. Do not do anything that causes pain. Every time the athlete causes pain, they may be making the injury worse. If necessary, use a sling to restrict movement then do so but only for a few days.NSAID or anti-inflammatory medication (e.g. ibuprofen) may help in the early stages. Always check with your doctor before taking medication if you are not sure. The aim of stage 2 is to re-establish the shoulder range of motion and strength. This is usually 5 to 7 days after injury. Range of motion is done through shoulder mobility exercises, gradually increasing the range of motion the joint will go through pain-free and specific stretching exercises to stretch all muscles around the shoulder joint.Sports massage techniques can help to improve greatly the condition of the rotator cuff muscles, so allowing more joint flexibility and better response to strengthening exercises.Strengthening exercises concentrate more specifically on the external rotator muscles (the ones that rotate the arm out) and the scapular stabilizers (muscles that support the shoulder blade). It is also important to strengthen the whole joint.Strengthening exercises must be done pain-free and in conjunction with stretching exercises. To return the athlete to competition or specific training These exercises need to be specifically tailored to the athlete's sport. For example, throwers would start throwing a tennis ball against a wall. Five sets of 20 throws, gradually increasing the number of sets and number of repetitions assuming no pain during, after, or the next day. Obviously, every injury is different, however, the athlete is usually able to resume sports-specific training after between 1 and 3 weeks. If the injury is neglected it could become chronic and be very difficult to treat resulting in a cycle of rotator cuff injury and impingement of the shoulder joint. If bursitis is severe or keeps coming back, the inflamed bursa may need to be surgically drained or even removed (but this is rare). If you have bursitis, you might be able to refer yourself directly to services for help with your condition without seeing a GP.To find out if there are any services in your area:ask the reception staff at your GP surgerycheck your GP surgery's websitecontact your integrated care board (ICB) – find your local ICBsearch online for NHS treatment for bursitis near you 1 A bursa is a fluid-filled sac that lubricates joints. They're located in places around your body that experience a higher level of wear and friction, such as your elbows, hips, and knees. The bursa sacs in your shoulders help ease the rubbing between the bone, muscle, and tendon tissue. 2 Subacromial bursitis is inflammation of your shoulder bursa. Subacromial is the medical term for the space in your shoulder where your ligaments connect to your muscles. In that space, the subacromial bursa helps to lubricate the region and reduce friction between the muscles, joints, and ligaments. But if the bursa becomes inflamed, it can lead to a painful condition known as subacromial bursitis. 1 The most common causes are repetitive motions and stress on the joint. Repetitive motions such as throwing a baseball or lifting boxes over your head over and over and put a lot of stress on your shoulder joint, which can lead to bursitis. Additionally, putting pressure on the joint by laying in a position that stresses your shoulder joint can also cause bursitis.[1] 2 Bursitis can also be caused by an infection. This type of subacromial bursitis is more serious. Bacteria can infect the bursa in your shoulder, leading to painful inflammation and swelling. If the infection spreads, it could cause more serious medical issues.[2] 3 Traumatic injury or inflammation can also cause bursitis. An injury like a fall that directly impacts your shoulder can lead to bursitis.[3] Certain medical conditions, such as arthritis, can cause inflammation around your joints, which can put a lot of stress on the bursa and cause bursitis.[4] 4 Gout, diabetes, and uremia can make bursitis more likely. Some preexisting medical conditions can cause your shoulder bursa to swell, which can lead to bursitis, or make it easier to develop. While it's less common, other underlying medical conditions can contribute to bursitis.[5] 1 Your shoulder can feel achy and hurt when you move it. It's common for folks with bursitis to feel like their shoulder is stiff and painful whenever they move their arm. It may also hurt whenever you press or lean on your shoulder.[6] 2 You may have swelling around your shoulder. Swelling around your shoulder is pretty common, and sometimes you may not have any pain at all. The skin around your shoulder may not be red, but the swelling just won't subside.[7] 3 Warmth around the inflamed bursa could be a sign of infection. If your bursitis is caused by an infection, you may have some redness and warmth along with pain and stiffness. The warmth is a sign that your body is actively fighting the infection.[8] 4 An infected bursa may make you feel sick, feverish, and tired. If the infection is getting worse or spreading to other areas of your body, it can make you feel like you're ill. You could have chills and body aches in other places besides your shoulder. You may also have a fever and feel tired and groggy.[9] 1 Get a physical exam to diagnose bursitis. Oftentimes, your doctor will be able to look at your medical history and ask questions about your daily activities. They'll then be able to physically examine your shoulder and check for signs of bursitis. This is usually enough to determine whether or not you're suffering from bursitis.[10] 2 Your doctor may order X-rays to rule out other causes. If they can't quite fully confirm a bursitis diagnosis, your doctor may want to make sure there isn't another cause for your symptoms. An X-ray can't determine whether you've got bursitis, but it can rule out other potential causes and help your doctor make a diagnosis.[11] 3 Lab tests of the fluid around the inflamed bursa can pinpoint the cause. Although it's more rare, your doctor may extract some of the fluid in the swelling around your shoulder. Lab tests can help determine if there's an infection and what type. It can also help rule out other potential causes for your symptoms.[12] 1 Stop doing the activity that caused the swelling to treat chronic bursitis. Chronic bursitis refers to persistent bursitis that keeps coming back. The main treatment for it is to reduce or stop any activities that seem to make it worse.[13] For instance, if there's a specific activity that causes your bursitis to flare up, such as throwing a football or doing overhead shoulder presses, you may need to stop or reduce these activities to prevent future occurrences. 2 Wear a splint to help immobilize your shoulder. A shoulder splint can help keep your shoulder from moving around and aggravating your bursitis. You may need to wear a splint to prevent further injury and to help the healing process.[14] 3 Take oral NSAIDs to treat pain and inflammation. Non-steroidal anti-inflammatory drugs (NSAIDs) such as aspirin, ibuprofen, and naproxen help reduce the inflammation and swelling around your shoulder. If you can get your swelling to go down, it can put less pressure on the joint, which can reduce your pain.[15] Your doctor may recommend an over-the-counter NSAID or they may prescribe you a stronger one depending on the severity of your bursitis. 4 Do physical therapy to help prevent bursitis from recurring. Your doctor may refer you to a physical therapist or recommend specific exercises you can do to strengthen the muscles around your shoulder joint. If the muscles are stronger and better able to support the joint, it can reduce your pain and potentially prevent future occurrences of bursitis.[16] 5 Take antibiotics to treat bursitis caused by an infection. If your doctor determines that your bursitis is caused by an infection, they'll want to knock out the infection ASAP. Antibiotics will help your body fight the infection. Once it's gone, there won't be as much swelling and inflammation around your shoulder, and your bursitis can clear up.[17] 6 Get cortisone injections to relieve severe pain and inflammation. If your bursitis won't improve after trying other treatment options, your doctor may resort to steroid injections. Cortisone is a steroid that your doctor can inject directly into your shoulder joint and help reduce the swelling, pain, and inflammation.[18] 7 Get surgery in rare but sometimes necessary cases. If all else fails, your doctor can surgically drain the swollen bursa. In extreme cases, they may surgically remove the bursa altogether.[19] For most people, the condition doesn't have a long-term impact. The prognosis for subacromial bursitis is good! With therapy and treatment, most people's symptoms improve. If it doesn't with simple treatment options, steroid injections or surgical options can often do the trick. While some older folks may have trouble fully recovering from bursitis, for most people, the condition doesn't have a long-term effect on your everyday life.[20] Add New Question Question What would be some of the most common treatments for bursitis? Kevin Stone, MD Board Certified Orthopaedic Surgeon Dr. Kevin Stone is an orthopaedic surgeon and the founder of The Stone Clinic, a leading orthopaedic surgery, sports medicine, and rehabilitation clinic in the San Francisco Bay Area. With over 30 years of experience, Dr. Stone specializes in knee, shoulder, and ankle repair, using biologic reconstruction and joint replacement. He holds a BS in Biology from Harvard University and a Doctor of Medicine (MD) from the University of North Carolina at Chapel Hill. Dr. Stone completed his residency in Internal Medicine and Orthopaedic Surgery at Harvard University and in General Surgery at Stanford University. He then completed a fellowship in Orthopaedic Research and Surgery at the Hospital for Special Surgery and Tahoe Orthopaedics. He lectures around the world as an expert in cartilage and meniscal growth, replacement, and repair and holds over 40 U.S. patents on novel inventions to improve healthcare. Dr. Stone is a physician for Smuin Ballet and has served as a physician for the U.S. Ski Team, the U.S. Pro Ski Tour, the United States Olympic Training Center, and World Pro Ski Tour. Take over-the-counter anti-inflammatory medications, such as ibuprofen or injections of either cortisone or injections of anabolic factors that are potent anti-inflammatories, such as PRP and amniotic fluid to relieve pain and reduce inflammation of bursitis. Ask a Question Thanks Co-authored by: Board Certified Orthopaedic Surgeon This article was co-authored by Kevin Stone, MD. Dr. Kevin Stone is an orthopaedic surgeon and the founder of The Stone Clinic, a leading orthopaedic surgery, sports medicine, and rehabilitation clinic in the San Francisco Bay Area. With over 30 years of experience, Dr. Stone specializes in knee, shoulder, and ankle repair, using biologic reconstruction and joint replacement. He holds a BS in Biology from Harvard University and a Doctor of Medicine (MD) from the University of North Carolina at Chapel Hill. Dr. Stone completed his residency in Internal Medicine and Orthopaedic Surgery at Harvard University and in General Surgery at Stanford University. He then completed a fellowship in Orthopaedic Research and Surgery at the Hospital for Special Surgery and Tahoe Orthopaedics. He lectures around the world as an expert in cartilage and meniscal growth, replacement, and repair and holds over 40 U.S. patents on novel inventions to improve healthcare. Dr. Stone is a physician for Smuin Ballet and has served as a physician for the U.S. Ski Team, the U.S. Pro Ski Tour, the United States Olympic Training Center, and World Pro Ski Tour. This article has been viewed 10,413 times. Co-authors: 4 Updated: December 6, 2021 Views: 10,413 Thanks to all authors for creating a page that has been read 10,413 times. Medical conditionSubacromial bursitisShoulder jointSpecialtyRheumatology Subacromial bursitis is a condition caused by inflammation of the bursa that separates the superior surface of the supraspinatus tendon (one of the four tendons of the rotator cuff) from the overlying coraco-acromial ligament, acromion, and coracoid (the acromial arch) and from the deep surface of the deltoid muscle.[1] The subacromial bursa helps the motion of the supraspinatus tendon of the rotator cuff in activities such as overhead work. Musculoskeletal complaints are one of the most common reasons for primary care office visits, and rotator cuff disorders are the most common source of shoulder pain.[2] Primary inflammation of the subacromial bursa is relatively rare and may arise from autoimmune inflammatory conditions such as rheumatoid arthritis, crystal deposition disorders such as gout or pseudogout, calcific loose bodies, and infection.[1] More commonly, subacromial bursitis arises as a result of complex factors, thought to cause shoulder impingement symptoms. These factors are broadly classified as intrinsic (intratendinous) or extrinsic (extratendinous). They are further divided into primary or secondary causes of impingement. Secondary causes are thought to be part of another process such as shoulder instability or nerve injury.[3] In 1983 Neer described three stages of impingement syndrome.[4] He noted that "the symptoms and physical signs in all three stages of impingement are almost identical, including the 'impingement sign'..., arc of pain, crepitus, and varying weakness". The Neer classification did not distinguish between partial-thickness and full-thickness rotator cuff tears in stage III.[4] This has led to some controversy about the ability of physical examination tests to accurately diagnose between bursitis, impingement, impingement with or without rotator cuff tear and impingement with partial versus complete tears. In 2005, Park et al. published their findings which concluded that a combination of clinical tests were more useful than a single physical examination test. For the diagnosis of impingement disease, the best combination of tests were "any degree (of) a positive Hawkins–Kennedy test, a positive painful arc sign, and weakness in external rotation with the arm at the side", to diagnose a full thickness rotator cuff tear, the best combination of tests, when all three are positive, were the painful arc, the drop-arm sign, and weakness in external rotation.[5] Subacromial bursitis often presents with a constellation of symptoms called impingement syndrome. Pain along the front and side of the shoulder is the most common symptom and may cause weakness and stiffness.[3] If the pain resolves and weakness persists other causes should be evaluated such as a tear of the rotator cuff or a neurological problem arising from the neck or entrapment of the suprascapular nerve. The onset of pain may be sudden or gradual and may or may not be related to trauma. Night time pain, especially sleeping on the affected shoulder, is often reported. Localized redness or swelling are less common and suggest an infected subacromial bursa. Individuals affected by subacromial bursitis commonly present with concomitant shoulder problems such as arthritis, rotator cuff tendinitis, rotator cuff tears, and cervical radiculopathy (pinched nerve in neck).[citation needed] Impingement may be brought on by sports activities, such as overhead throwing sports and swimming, or overhead work such as painting, carpentry, or plumbing. Activities that involve repetitive overhead activity, or directly in front, may cause shoulder pain. Direct upward pressure on the shoulder, such as leaning on an elbow, may increase pain.[citation needed] The literature on the pathophysiology of bursitis describes inflammation as the primary cause of symptoms. Inflammatory bursitis is usually the result of repetitive injury to the bursa. In the subacromial bursa, this generally occurs due to microtrauma to adjacent structures, particularly the supraspinatus tendon. The inflammatory process causes synovial cells to multiply, increasing collagen formation and fluid production within the bursa and reduction in the outside layer of lubrication.[6] Less frequently observed causes of subacromial bursitis include hemorrhagic conditions, crystal deposition and infection.[citation needed] Many causes have been proposed in the medical literature for subacromial impingement syndrome. The bursa facilitates the motion of the rotator cuff beneath the arch, any disturbance of the relationship of the subacromial structures can lead to impingement. These factors can be broadly classified as intrinsic such as tendon degeneration, rotator cuff muscle weakness and overuse. Extrinsic factors include bone spurs from the acromion or AC joint, shoulder instability and neurologic problems arising outside of the shoulder.[3] It is often difficult to distinguish between pain caused by bursitis or that caused by a rotator cuff injury as both exhibit similar pain patterns in the front or side of the shoulder.[7] Subacromial bursitis can be painful with resisted abduction due to the pinching of the bursa as the deltoid contracts.[8] If the therapist performs a treatment direction test and gently applies joint traction or a caudal glide during abduction (MWM), the painful arc may reduce if the problem is bursitis or adhesive capsulitis (as this potentially increases the subacromial space).[citation needed] The following clinical tests, if positive, may indicate bursitis: The patient actively abducts the arm and a painful arc occurs between 60° and 120°. This is due to the compression of the supraspinatus tendon or subacromial bursa between the anterior acromial arch and humeral head. When lowering from full abduction there is often a painful "catch" at midrange. If the patient can achieve adequate muscle relaxation, passive motion tends to be less painful.[9] The patient performs an isometric flexion contraction against resistance of the therapist (Speed's Test). When the therapist's resistance is removed, a sudden jerking motion results and latent pain indicates a positive test for bursitis.[8] Neer's Sign: If pain occurs during forward elevation of the internally rotated arm above 90°. This will identify impingement of the rotator cuff but is also sensitive for subacromial bursitis.[9] Irritation or entrapment of the lower subscapular nerve, which innervates the subscapularis and teres major muscles, will produce muscle guarding at the shoulder that will restrict motion into external rotation, abduction, or flexion. The aforementioned tests will assist in diagnosing bursitis over other conditions. The diagnosis of impingement syndrome should be viewed with caution in people who are less than forty years old, because such individuals may have subtle glenohumeral instability.[10] X-rays may help visualize bone spurs, acromial anatomy and arthritis. Further, calcification in the subacromial space and rotator cuff may be revealed. Osteoarthritis of the acromioclavicular (AC) joint may co-exist and is usually demonstrated on radiographs.[citation needed] MRI imagining can reveal fluid accumulation in the bursa and assess adjacent structures. In chronic cases caused by impingement tendinosis and tears in the rotator cuff may be revealed. At US, an abnormal bursa may show fluid distension, synovial proliferation, and/or thickening of the bursal walls.[11] In any case, the magnitude of pathological findings does not correlate with the magnitude of the symptoms.[11] In patients with bursitis who have rheumatoid arthritis, short term improvements are not taken as a sign of resolution and may require long term treatment to ensure recurrence is minimized. Joint contracture of the shoulder has also been found to be at a higher incidence in type two diabetics, which may lead to frozen shoulder (Donatelli, 2004). Many non-operative treatments have been advocated, including rest; oral administration of non-steroidal anti-inflammatory drugs; physical therapy; chiropractic; and local modalities such as cryotherapy, ultrasound, electromagnetic radiation, and subacromial injection of corticosteroids.[12] Shoulder bursitis rarely requires surgical intervention and generally responds favorably to conservative treatment. Surgery is reserved for patients who fail to respond to non-operative measures. Minimally invasive surgical procedures such as arthroscopic removal of the bursa allows for direct inspection of the shoulder structures and provides the opportunity for removal of bone spurs and repair of any rotator cuff tears that may be found.[citation needed] Initial phase of physiotherapy rehabilitation Goals of treatment Reduce inflammation Reduce pain Prevent weakness and atrophy of muscles as a result of disuse Increase the patient's awareness of bursitis Prevent/reduce impingement and further tissue damage Treatment Justification Advice and education Educate the patient about their condition and advise to avoid painful activities and the importance of relative rest of the shoulder Prevention of pain and impingement which delays the healing process Educate the patient about the importance of correct posture Puts muscles in the optimal length tension relationship, reducing impingement Manual therapy Grade 1 and 2 accessory mobilisations of the glenohumeral joint Has a neurophysiological effect reducing pain and improving synovial fluid flow, improving healing Soft tissue massage Lengthens tight muscles and reduces muscle spasm Therapeutic exercise Gentle pendulum range of motion exercises Maintenance of range of motion and prevention of adhesive capsulitis Scapular exercises such as shoulder shrugs and shoulder retraction exercises Improve muscular control and scapular coordination Centering of humeral head Helps to facilitate adequate muscle timing and recruitment Stretching of tight muscles such as the levator scapulae, pectoralis major, subscapularis and upper trapezius muscle To lengthen tight muscles which may improve scapulohumeral rhythm, posture and increase the subacromial space Rotator cuff strengthening - isometric contractions in neutral and 30 degrees abduction Improves rotator cuff strength which is integral to the stability of the shoulder and functional activities Electrophysical modalities Ice To reduce inflammation and pain elevate Low intensity pulsed ultrasound (3 megaHz) To reduce inflammation and facilitate healing External physical aids May use head of humerus repositioning tape To maintain the head of humerus in its central position for optimal muscle recruitment Intermittent phase of physiotherapy rehabilitation Goals of treatment Improve muscle control Improve scapulohumeral rhythm Improve active and passive range of motion Restore strength of scapular and rotator cuff muscles Treatment Justification Advice and education Advise the patient that they must perform all activities and exercises pain free To prevent reinjury and damage to the bursa Manual therapy Grade 3 and 4 accessory mobilizations of the glenohumeral joint Improves range of motion and increases synovial fluid movement, improving healing Proprioceptive neuromuscular facilitation (PNF) in functional diagonal patterns Strengthens muscles, improves motor control and scapulohumeral rhythm Mobilization with movement e.g. caudal glide with active abduction Improves range of motion and decreases pain Therapeutic exercise Specific muscle strengthening exercises especially for scapular stabilization (serratus anterior, rhomboids and lower trapezius muscles) e.g. strengthening lower trapezius muscle - bilateral external rotation using a theraband, strengthening of serratus anterior, punching with theraband resistance Improves stability during scapular motion which may decrease impingement of the bursa in the subacromial space. Active assisted range of motion - creeping the hand up the wall in abduction, scaption and flexion and door pulley manoeuvre Help to improve active range of motion and gravity assists with shoulder depression Active internal and external rotator exercises with the use of a bar or a theraband Improves strength of rotator cuff and improves mobility in internal and external rotation Electrophysical modalities Heat Improves muscle extensibility Low intensity pulsed ultrasound (3 megaHz) Facilitates healing External physical aids May use head of humerus repositioning tape if necessary To maintain the head of humerus in its optimal position for optimal muscle recruitment Return to function phase of physiotherapy rehabilitation Goals of treatment Return the patient to their previous level of function Achieve full active and passive range of motion Treatment Justification Education and advice Education about the importance of a home based exercise program in the late stage of rehabilitation Ensures patient compliance Correction of techniques performed Ensures that the correct target muscles are being used Education to ensure that the patient performs activities and exercises within pain free limits This reduces the chance that the patient may work too hard and cause reinjury Manual therapy PNF functional patterns with increasing resistance Continues to strengthen muscles, improves motor control and scapulohumeral rhythm Therapeutic exercise Exercises specific for the patient's functional needs e.g. functional reaching To improve the patients functional ability Proprioception exercises e.g. Wall push ups with the hands resting on medicine balls or dura disks Improves proprioception important to reduce reinjury as return to function/sport Strengthen the shoulder elevators – deltoid, flexors and also latissimus dorsi. Important in this phase of the rehabilitation following strengthening of the shoulder depressors Progress strengthening exercises to incorporate speed and load to make more functional Adding speed and load to exercises ensures that the patient is prepared for more functional tasks and activities Electrophysical modalities Ice after exercise May assist to reduce any inflammation post exercise External physical aids May use head of humerus repositioning tape if necessary May assist with return to function In 1997 Morrison et al published a study[13] that reviewed the cases of 616 patients (636 shoulders) with impingement syndrome (painful arc of motion) to assess the outcome of non-surgical care. An attempt was made to exclude patients who were suspected of having additional shoulder conditions such as, full-thickness tears of the rotator cuff, degenerative arthritis of the acromioclavicular joint, instability of the glenohumeral joint, or adhesive capsulitis. All patients were managed with anti-inflammatory medication and a specific, supervised physical-therapy regimen. The patients were followed up from six months to over six years. They found that 67% (413 patients) of the patients improved, 28% did not improve and went to surgical treatment, and 5% did not improve and declined further treatment. Of the 413 patients who improved, 74 had a recurrence of symptoms during the observation period and their symptoms responded to rest or after resumption of the exercise program. Younger patients (20 years or less) and patients between 41 and 60 years of age, fared better than those who were in the 21 to 40 years age group. This may be related to the peak incidence of work, job requirements, sports and hobby related activities, that may place greater demands on the shoulder. Patients who were older than sixty years of age had the "poorest results". This was thought to be potentially related to "undiagnosed full-thickness tears of the rotator cuff".[13] It is known that the rotator cuff and adjacent structures undergo degenerative changes with ageing.[citation needed] Most patients improve with conservative therapy,[14] and experience symptoms for only a few weeks.[15] ^ a b Salzman KL, Lillegard WA, Butcher JD (1997). "Upper extremity bursitis". Am Fam Physician. 56 (7): 1797–806, 1811–2. PMID 9371010. ^ Arcuni SE (2000). "Rotator cuff pathology and subacromial impingement". Nurse Pract. 25 (5): 58, 61, 65–6 passim. doi:10.1097/00006205-200025050-00005. PMID 10826138. ^ a b c Bigliani LU, Levine WN (1997). "Subacromial impingement syndrome". J Bone Joint Surg Am. 79 (12): 1854–68. doi:10.2106/00004623-199712000-00012. PMID 9409800. ^ a b Neer CS (1983). "Impingement lesions". Clin. Orthop. Relat. Res. (173): 70–7. PMID 6825348. ^ Park HB, Yokota A, Gill HS, El Rassi G, McFarland EG (2005). "Diagnostic accuracy of clinical tests for the different degrees of subacromial impingement syndrome". J Bone Joint Surg Am. 87 (7): 1446–55. doi:10.2106/JBJS.D.02335. PMID 15995110. ^ Ishii et al., 1997. ^ Hartley, 1990 ^ a b Buschbacher & Braddom, 1994. ^ a b Starr & Harbhajan, 2001. ^ Jobe FW, Kvitne RS, Giangarra CE (1989). "Shoulder pain in the overhand or throwing athlete. The relationship of anterior instability and rotator cuff impingement". Orthop Rev. 18 (9): 963–75. PMID 2797861. ^ a b Arend CF. Ultrasound of the Shoulder. Master Medical Books, 2013. Free chapter on ultrasound findings of subacromial-subdeltoid bursitis at ShoulderUS.com ^ Blair B, Rokito AS, Cuomo F, Jarolem K, Zuckerman JD (1996). "Efficacy of injections of corticosteroids for subacromial impingement syndrome". J Bone Joint Surg Am. 78 (11): 1685–9. doi:10.2106/00004623-199611000-00007. PMID 8934482. S2CID 36977069. ^ a b Morrison DS, Frogameni AD, Woodworth P (1997). "Non-operative treatment of subacromial impingement syndrome". J Bone Joint Surg Am. 79 (5): 732–7. doi:10.2106/00004623-199705000-00013. PMID 9160946. S2CID 30707675. ^ Faruqi, Taha; Rizvi, Tara J. (May 1, 2025). StatPearls. StatPearls Publishing. PMID 31082140 – via PubMed. ^ "How Do I Get Rid of Bursitis in My Shoulder?". Cleveland Clinic. Anderson, D., M, (2000), Dorland's Illustrated Medical Dictionary, 29th ed, W.B. Saunders Company, Canada, 965-967. Buschbacher, R., M, Braddom, R., L. (1994). Sports medicine & rehabilitation: A sport-specific approach. Hanley and Belfus Inc, Philadelphia. Hartley, A. (1990). Practical joint assessment: A sports medicine manual, St Louis, Sydney. Arend CF. Ultrasound of the Shoulder. Master Medical Books, 2013. Free chapter on bursae around the shoulder joint. Wilk, Kevin E.; Andrews, James R. (1994). The Athlete's shoulder. Edinburgh: Churchill Livingstone. ISBN 978-0-443-08847-6. Blaine TA, Kim YS, Voloshin I, et al. (2005). "The molecular pathophysiology of subacromial bursitis in rotator cuff disease". J Shoulder Elbow Surg. 14 (1 Suppl S): 84S – 89S. doi:10.1016/j.jse.2004.09.022. PMID 15726092. Brox JI, Gjengedal E, Uppheim G, et al. (1999). "Arthroscopic surgery versus supervised exercises in patients with rotator cuff disease (stage II impingement syndrome): a prospective, randomized, controlled study in 125 patients with a 2 1/2-year follow-up". J Shoulder Elbow Surg. 8 (2): 102–11. doi:10.1016/S1058-2746(99)90001-0. PMID 10226960. Butcher JD, Salzman KL, Lillegard WA (1996). "Lower extremity bursitis". Am Fam Physician. 53 (7): 2317–24. PMID 8638508. Donatelli, Robert (2004). Physical therapy of the shoulder. Edinburgh: Churchill Livingstone. ISBN 978-0-443-06614-6. Handa A, Gotoh M, Hamada K, et al. (2003). "Vascular endothelial growth factor 121 and 165 in the subacromial bursa are involved in shoulder joint contracture in type II diabetics with rotator cuff disease". J. Orthop. Res. 21 (6): 1138–44. doi:10.1016/S0736-0266(03)00102-5. PMID 14554230. S2CID 29665718. Hartley, Anne (1990). Practical joint assessment: a sports medicine manual. St. Louis, MO: Mosby Year Book. ISBN 978-0-8016-2050-8. Sports Medicine and Rehabilitation: A Sport-Specific Approach. Hagerstown, MD: Lippincott Williams & Wilkins. 1994. ISBN 978-1-56053-133-3. Lo IK, Boorman R, Marchuk L, Hollinshead R, Hart DA, Frank CB (2005). "Matrix molecule mRNA levels in the bursa and rotator cuff of patients with full-thickness rotator cuff tears". Arthroscopy. 21 (6): 645–51. doi:10.1016/j.arthro.2005.03.008. PMID 15944617. Ishii H, Brunet JA, Welsh RP, Uhthoff HK (1997). ""Bursal reactions" in rotator cuff tearing, the impingement syndrome, and calcifying tendinitis". J Shoulder Elbow Surg. 6 (2): 131–6. doi:10.1016/S1058-2746(97)90033-1. PMID 9144600. McAfee JH, Smith DL (1988). "Olecranon and prepatellar bursitis. Diagnosis and treatment". West. J. Med. 149 (5): 607–10. PMC 1026560. PMID 3074561. Perry J (1983). "Anatomy and biomechanics of the shoulder in throwing, swimming, gymnastics, and tennis". Clin Sports Med. 2 (2): 247–70. doi:10.1016/S0278-5919(20)31406-X. PMID 9697636. Reilly JP, Nicholas JA (1987). "The chronically inflamed bursa". Clin Sports Med. 6 (2): 345–70. doi:10.1016/S0278-5919(20)31035-8. PMID 3319205.Trojian T, Stevenson JH, Agrawal N (2005). "What can we expect from nonoperative treatment options for shoulder pain?". J Fam Pract. 54 (3): 216–23. PMID 15755374. Shamus, Jennifer; Shamus, Eric (2001). Sports injury: prevention & rehabilitation. New York: McGraw-Hill Medical Pub. Div. ISBN 978-0-07-135475-2. Starr M, Harbhajan K (June 2001). "Recognition and Management of Common Forms of Tendinitis and Bursitis" (PDF). The Canadian Journal of Continuing Medical Education: 155–63. ISSN 0843-994X. Trojian T, Stevenson JH, Agrawal N (2005). "What can we expect from nonoperative treatment options for shoulder pain?". J Fam Pract. 54 (3): 216–23. PMID 15755374. van Holsbeeck M, Strouse PJ (1993). "Sonography of the shoulder: evaluation of the subacromial-subdeltoid bursa". AJR Am J Roentgenol. 160 (3): 561–4. doi:10.2214/ajr.160.3.8430553. PMID 8430553. Yanagisawa K, Hamada K, Gotoh M, et al. (2001). "Vascular endothelial growth factor (VEGF) expression in the subacromial bursa is increased in patients with impingement syndrome". J. Orthop. Res. 19 (3): 448–55. doi:10.1016/S0736-0266(00)90021-4. PMID 11398859. S2CID 20098903. Retrieved from "