International Journal of Homoeopathic Sciences

E-ISSN: 2616-4493
P-ISSN: 2616-4485
Impact Factor (RJIF): 5.96
www.homoeopathicjournal.com
IJHS 2025; 9(4): 1511-1518
Received: 23-09-2025
Accepted: 27-10-2025

Dr. Angad Kumar Saroj
MD Scholar, Department of Homoeopathic Materia Medica, State Lal Bahadur Shastri Homoeopathic Medical College & Hospital, Phaphamau, Prayagraj, Uttar Pradesh, India
Affiliated to Mahayogi Guru Gorakhnath Ayush University, Gorakhpur, Uttar Pradesh, India

Saroj Verma
Professor, Department of Homoeopathic Materia Medica, State Lal Bahadur Shastri Homoeopathic Medical College & Hospital, Phaphamau, Prayagraj, Uttar Pradesh, India

Dr. Aswini Kumar Das
Professor & Head of the Department, Department of Homoeopathic Materia Medica, State Lal Bahadur Shastri Homoeopathic Medical College & Hospital, Phaphamau, Prayagraj, Uttar Pradesh, India

Rajanish Kumar
MD Scholar, Department of Homoeopathic Materia Medica, State Lal Bahadur Shastri Homoeopathic Medical College & Hospital, Phaphamau, Prayagraj, Uttar Pradesh, India
Affiliated to Mahayogi Guru Gorakhnath Ayush University, Gorakhpur, Uttar Pradesh, India

Anjali Singh
MD Scholar, Department of Homoeopathic Materia Medica, State Lal Bahadur Shastri Homoeopathic Medical College & Hospital, Phaphamau, Prayagraj, Uttar Pradesh, India. Affiliated to Mahayogi Guru Gorakhnath Ayush University, Gorakhpur, Uttar Pradesh, India

Corresponding Author:
Dr. Angad Kumar Saroj
MD Scholar, Department of Homoeopathic Materia Medica, State Lal Bahadur Shastri Homoeopathic Medical College & Hospital, Phaphamau, Prayagraj, Uttar Pradesh, India
Affiliated to Mahayogi Guru Gorakhnath Ayush University, Gorakhpur, Uttar Pradesh, India

Homoeopathic approaches in the management of frozen shoulder: A clinical review

Dr. Angad Kumar Saroj, Saroj Verma, Dr. Aswini Kumar Das, Rajanish Kumar and Anjali Singh

DOI: https://www.doi.org/10.33545/26164485.2025.v9.i4.W.2108

Abstract
Frozen shoulder has been defined as a condition of uncertain aetiology, characterized by substantial restriction of active and passive shoulder movement. The condition was first described by Duplay (1872) as scapulohumeral periarthritis [2]. Participants presenting with Frozen Shoulder often report an insidious onset with a progressive increase in pain and a gradual decrease in active and passive range of motion (ROM). Pain is more during night times. In 1945, Neviaser gave the name adhesive capsulitis [2]. Homoeopathy, by addressing underlying constitutional and miasmatic tendencies, offers a holistic approach to management. Integrating individualized homoeopathic treatment with dietary and lifestyle modifications may restore digestive balance, alleviate symptoms, and enhance quality of life. This article explores the therapeutic potential of homoeopathy in the effective management of Frozen Shoulder.

Keywords: Frozen Shoulder, scapulohumeral periarthritis, homoeopathic medicine

Introduction
Frozen Shooulder, commonly known as Adhesive capsulitis, is characterized by painful and progressive loss of range of motion due to fibrotic joint capsule changes [3]. This condition predominantly affects middle-aged adults, especially those with diabetes or thyroid dysfunction, which can predispose individuals to more severe forms of the disease [4, 5]. The pathophysiology remains only partially understood, and the condition is often under-recognized, leading to delays in treatment and prolonged disability [6]. Frozen shoulder can be either primary or secondary, which refers to whether the condition has come on spontaneously without any known cause (primary FS), or whether condition is associate with trauma, surgery or other pathology [7], such as subacromial pain (secondary FS).
Frozen shoulder typically progresses through three stages, the first stage associated with the predominant symptoms of pain and loss of motion (inflammation/'freezing' (I stage), and second stage start with stiffness ('frozen stage' (II stage) and then third stage is resolution stage of symptoms ('thawing' (stage III)) [8].
Common conservative treatment include physiotherapy, steroid injection, oral medications and hydro dilatation [9]. In clinical practice, to treat frozen shoulder the basic strategy dependss on stage of frozen shoulder. While such treatments may temporarily suppress the symptoms, recurrence is common, often leading to a cycle where the effectiveness of therapy diminishes over time. In contrast, the homoeopathic approach aims to address the underlying causes of the disorder. Homoeopathy treat the person as whole [10]. By considering the individual's totality of symptoms, homoeopathy seeks to correct the root imbalance and, over time, reduce the tendency for recurrence. A miasmetic tendency is also often taken into chronic frozen shoulder. In this article, we have discussed the epidemiology, clinical features, diagnostic investigations, and therapeutic indications of various homoeopathic remedies in the management of frozen shoulder.

Epidemiology
Frozen shoulder (FS) usually affects patients aged 40-60 years. The incidence of FS is not precisely known; however, it is estimated that 2% to 5% of the general population develops the disease over their lifetime [11]. Women tend to be affected more often than men [12]. In general, bilateral shoulder involvement is rarely simultaneous and instead

occurs sequentially. Diabetes mellitus is an independent risk factor for frozen shoulder [13-15]. A meta-analysis by Zreik concluded that diabetic patients are 5 times more likely to develop adhesive capsulitis compared with non-diabetic controls. They reported a 13.4% overall mean prevalence of adhesive capsulitis in patients with diabetes [13], and a 30% mean prevalence of diabetes in a population with adhesive capsulitis. Zreik found no significant difference in the prevalence of the disorder with type 1 versus type 2 diabetes, or between patients on insulin therapy and those on oral hypoglycemic agents. Thyroid disease has also been linked to frozen shoulder. A meta-analysis by Chuang *et al.* found significantly higher rates of hypothyroidism (odds ratio [OR] = 1.92, P = 0.02) and subclinical hypothyroidism (OR = 2.56, $P<0.00001$) in patients with FSS than in those without FSS [14]. A nationwide longitudinal population-based study from Taiwan concluded that hyperthyroidism is an independent risk factor for FS, with an adjusted hazard ratio of 1.22. The literature indicates that the incidence of FS is 2 to 5% worldwide.

The prevalence among the diabetic population and those suffering from pathologies of the thyroid gland, especially hypothyroidism may increase as high as 10 to 38% [15]. Most people who develop frozen shoulder do so between 40 and 60 years of age, being unusual in patients over 70 with the exception of secondary traumatic FS.

The incidence among women is 1.6 to 4-fold higher than in men. Black/African Americans and Hispanic/Latinos also show a higher prevalence. Type 1 diabetes is the greatest risk factor for the development of FS, where the incidence can reach 59% in patients over 45 years of age with a lifetime prevalence of 76%. This group of patients has greater associated disability, along with a greater reduction in their range of mobility. The accumulated level of glycated hemoglobin A1c (HbA1c) is a determining factor, hence those patients with poorer blood glycemia control accumulate an increased risk for the development of FS. Finally, incidence is also expressed with significant contralateral differences $p<0.01$: the non-dominant arm is affected more than the dominant arm (58.9-41.1%) and the left arm more than the right (53.4-46.6%) (16). Interestingly, a hypothesis to explain FS is proposed by the authors of the aforementioned study which states that the pathology could be more related to an asymmetric control of the brain rather than to some traumatic factor. The prognosis of FS is highly variable. In contradiction to the common assumption that FS completely resolves over time, a meta-analysis found this to be scientifically invalid and that if left untreated, FS may persist for the more than 3 years or even never resolve.

Etiology

Duplay was one of the first physicians to present the concept of periarticular tissue pathology rather than periarticular arthritis as the cause of frozen shoulder [2]. Despite a lack of evidence linking frozen shoulder to a specific etiology, various triggers that may predispose patients to this problem appear to exist. Some of etiologic agents include the following: Trauma Surgery (including but not limited to shoulder surgery), inflammatory disease, Diabetes Regional conditions, various shoulder maladies.

In addition, an autoimmune theory has been postulated, with elevated levels of C-reactive protein and an increased incidence of HLA-B27 histocompatibility antigen reported in patients with frozen shoulder versus controls [17-18]. DePalma proposed that muscular inactivity was a major etiologic factor, while Bridgman [19] identified an increased incidence of FS in patients with diabetes mellitus. Finally, frozen shoulder also has been associated with the following disorders:

- Cervical spine disease Parkinson disease
- Hypothyroidism
- Hyperthyroidism
- Ischemic heart disease

Most patients with FS have undergone a period of shoulder immobilization. Reasons for immobilization can be diverse; however, the common finding in all of these patients is a period of restricted shoulder motion.

In a study of neurosurgery patients who immobilized their shoulders for varying periods, Bruckner noted an incidence of frozen shoulder that was 5-9 times greater than that found in the general population [20].

Pathophysiology

The main cause of painful restriction of movement in FS is an inflammatory contracture of the joint capsule [21]. Lundberg reported an increased amount of collagen in the joint capsule, and proposed that inflammation is an important event that leads to stiffness, pain, and capsular fibrosis [22]. Ozaki *et al.* documented fibrosis, fibrinoid degeneration, and hyalinization in the rotator interval capsule and the coracohumeralligament of the patients with recalcitrant shoulder stiffness.

In an immunohistochemical study, Rodeo *et al.,* found type-III collagen in the anterosuperior capsule of FS, indicating new deposition of collagen [23]. They also reported that cell and matrix staining for transforming growth factor (TGF)-beta, platelet-derived growth factor (PDGF), and hepatocyte growth factor was greater in FS than nonspecific synovitis, suggesting a fibrotic process in FS. Presence of vimentin-positive cells confirms the fibrotic process in the joint capsule. As a result of progression of fibrosis, FS capsule has a greater stiffness than that of shoulders with rotator cuff tear, when measured with scanning acoustic microscopy. Some investigators associated the fibrotic changes in FS to Dupuytren's contracture. Investigation of the rotator interval capsule and coracohumeral ligament obtained from FS patients disclosed active fibroblastic proliferation accompanied by some transformation to myofibroblasts, but at least with inflammation and synovial involvement, which was very similar to those in Dupuytren's disease.

Much work has been done to characterize the microscopic pathology and histochemical findings of the glenohumeral and subacromial synovium in FS. Kumagai *et al.* reported the absence of multiplation of the superficial synovial layers and the absence of interleukin (IL)-1a-positive synoviocytes, and insisted that there is no inflammation in the synovium of primary FS.

In contrast, Rodeo *et al.* demonstrated a variety of inflammatory cytokines such as tumor necrosis factor (TNF)-alpha, IL-1 alpha, IL-1 beta, and IL-6 in the FS synovium, in addition to growth factors related to fibrotic process such as TGF-beta, PDGF, and fibroblast growth factors (aFGF, and bFGF). Similarly, both fibrinogenic (matrixmetalloprotease \MMP) and inflammatory (IL-6) cytokines are shown in the synovium.

Inflammatory cytokines are known to appear both in the

glenohumeral and subacromial synovium. Hand *et al.* first documented the presence of immune system cells, i.e., B-lymphocytes, T-lymphocytes and macrophages, as well as the presence of mast cells, in the rotator interval synovium and capsule, suggesting an immunological response in FS.

Sign and Symptoms: Frozen shoulder, also known as adhesive capsulitis, is characterized by pain and progressive restriction of both active and passive shoulder movements due to inflammation and fibrosis of the joint capsule. The condition typically follows a self-limiting course, progressing through distinct clinical stages.

1. Onset and Progression

1. The condition usually develops gradually and is idiopathic in most cases.
2. Onset may be spontaneous or follow minor trauma, immobilization, or surgery.
3. Commonly affects individuals between 40-60 years of age, with a higher incidence in females and diabetic patients.

2. Pain

1. Dull, aching, poorly localized pain around the shoulder joint, often radiating to the deltoid region or upper arm.
2. Night pain is a characteristic feature, especially when lying on the affected side.
3. Pain is aggravated by movement and relieved by rest.
4. Pain intensity is greatest in the freezing (initial) phase.

Stiffness: Progressive loss of both active and passive range of motion [3].

Capsular pattern of restriction

- External rotation- most limited
- Abduction- moderately limited
- Internal rotation - least limited

3. Stiffness becomes the dominant symptom as pain subsides in the frozen phase

Difficulty with daily activities such as:

- Combing hair
- Reaching overhead or behind the back
- Dressing or fastening undergarments

4. Functional Limitation

- Marked restriction in functional movements involving the shoulder joint.
- Activities of daily living (ADLs) such as grooming, dressing, and lifting are severely affected.
- Gradual muscle weakness may occur secondary to disuse, not due to muscle injury.

5. Palpation Findings

- Mild tenderness over the deltoid region or anterior shoulder due to referred pain.
- No localized swelling or deformity.
- Shoulder contour remains normal.

6. Stages and Corresponding Symptoms

Frozen shoulder typically progresses through three overlapping stages, each with distinct clinical characteristics [8, 9]:

Stage	Duration	Predominant Symptom	Clinical Features
Stage I - Freezing (Painful) Phase	2-9 months	Pain	Gradual onset of diffuse shoulder pain; increasing stiffness; pain aggravated at night; loss of external rotation begins.
Stage II - Frozen (Stiff) Phase	4-12 months	Stiffness	Pain gradually decreases; marked restriction of both active and passive movements; difficulty performing daily tasks.
Stage III - Thawing (Recovery) Phase	6-24 months	Recovery	Pain minimal; gradual improvement in range of motion and function.

7. Associated Findings

- Guarded shoulder movements due to pain and stiffness.
- Muscle atrophy around deltoid and supraspinatus regions due to disuse.
- No signs of infection, redness, or effusion, distinguishing it from inflammatory arthropathies.
- In secondary cases, symptoms may follow trauma, surgery, or immobilization.

Summary Table of Key Clinical Features

Symptom	Description
Pain	Dull, aching, diffuse; worse at night
Stiffness	Restriction of active and passive motion
Movement pattern	Capsular pattern (ER > Abd > IR)
Function	Difficulty with overhead and behind-the-back activities
Muscle changes	Mild disuse atrophy
Palpation	Mild tenderness, no swelling

Diagnosis

Frozen shoulder, or adhesive capsulitis, is a condition characterized by progressive pain and restriction of both active and passive shoulder movements due to capsular fibrosis and contracture[9,24], in the absence of intrinsic shoulder pathology such as rotator cuff tear or arthritis.

1. Clinical Diagnosis

Diagnosis is primarily clinical, based on history and physical examination.

A. History

- Gradual onset of shoulder pain and stiffness.
- Pain is typically dull, aching, and poorly localized often felt over the deltoid region.
- Night pain is common, disturbing sleep
- Progressive loss of motion especially external rotation, followed by abduction and internal rotation.
- Usually unilateral, though bilateral involvement may occur (especially in diabetic patients).

B. Phases (Stages)

- Freezing (Painful) phase (2-9 months)
- Increasing pain and stiffness.
- Motion gradually becomes limited.
- Frozen (Adhesive) phase (4-12 months)
- Pain may decrease, but stiffness predominates.
- Marked restriction of both active and passive movements.
- Thawing (Recovery) phase (6-24 months)
- Gradual improvement in range of motion.

2. Physical Examination: Restriction of both active and passive range of motion, particularly:

External rotation (earliest and most limited) [3].

- Abduction
- Internal rotation
- Capsular pattern: external rotation > abduction > internal rotation.
- No significant weakness unless secondary to disuse.
- No localized tenderness except mild deltoid tenderness due to referred pain.

3. Diagnostic Criteria

Criterion	Description
Pain	Insidious onset, night pain common
Motion restriction	≥25-30% restriction in at least two planes (especially external rotation)
Duration	Symptoms lasting ≥4 weeks
Exclusion	No radiographic evidence of arthritis, fracture, or rotator cuff tear

4. Imaging Studies

Although frozen shoulder is a clinical diagnosis, imaging is useful to exclude other causes.

A. Plain Radiographs (X-ray)

1. Usually normal
2. May show osteopenia due to disuse.
3. Rule out arthritis, calcific tendinitis, or other pathology.

B. MRI / MR Arthrography

Used when diagnosis is uncertain or to rule out rotator cuff tear.

Findings suggestive of adhesive capsulitis

1. Thickening of the coracohumeral ligament (>4 mm).
2. Thickening and enhancement of joint capsule in axillary recess (>4 mm).
3. Obliteration of the subcoracoid fat triangle.

C. Ultrasound

May show capsular thickening or decreased joint volume. Helps exclude rotator cuff pathology.

5. Differential Diagnosis

Condition	Key Differentiating Features
Rotator cuff tear	Weakness > stiffness, positive drop arm test
Glenohumeral osteoarthritis	Radiographic changes present
Subacromial bursitis	Painful but full passive motion
Cervical radiculopathy	Neck pain, dermatomal distribution, positive Spurling test

6. Diagnostic Tests: SPADI (Shoulder Pain and Disability Index) - assesses pain and disability, useful for baseline and follow-up in clinical studies [17].

Capsular volume measurement (arthrography): volume <10 mL (normal ≈15-20 mL) supports diagnosis.

Conventional management of frozen shoulder

- Conventional (non-surgical) management remains the first-line treatment for frozen shoulder. The primary goals are to reduce pain, restore range of motion, and improve function.
- Most patients improve with conservative treatment, though recovery may take 12-24 months.

1. Patient Education and Counseling

- Explain the natural course of the disease typically self-limiting but prolonged.
- Reassure the patient that pain and stiffness will gradually resolve with appropriate care.
- Encourage compliance with physiotherapy and home exercise programs.
- Avoid overuse or forceful stretching in the painful stage, which can worsen inflammation.

2. Pharmacological Management

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Commonly used in the painful (freezing) phase to reduce inflammation and pain [9, 28, 29].

Examples

- Ibuprofen 400-600 mg TDS
- Diclofenac 50 mg TDS
- Naproxen 250-500 mg BD

Provide symptomatic relief but do not alter disease progression.

B. Oral Corticosteroids

- Short course (e.g., prednisolone 20-40 mg/day tapered over 2-3 weeks).
- Effective for short-term pain relief and improving range of motion in early stages.
- Not recommended for long-term use due to systemic side effects.

C. Intra-Articular Corticosteroid Injections

Most effective pharmacologic intervention in the early painful phase.

Commonly used agents
- Triamcinolone acetonide (40 mg)
- Methylprednisolone acetate (40 mg)

Mechanism: Reduces capsular inflammation and pain, enabling better physiotherapy participation. Often combined with local anesthetic (e.g., 1-2 mL of 2% lidocaine).
Can be repeated every 6-8 weeks (maximum 3-4 injections).

3. Physical Therapy and Exercise
Physiotherapy is the cornerstone of conventional treatment.

A. In Painful (Freezing) Phase
- Gentle pain-free mobilization to prevent further stiffness.
- Pendulum exercises, assisted range-of-motion exercises
- Avoid aggressive stretching or strengthening exercises.

Modalities for pain relief
- Hot packs / moist heat
- Shortwave diathermy
- Ultrasound therapy
- TENS (Transcutaneous Electrical Nerve Stimulation)

B. In Frozen and Thawing Phases
Gradual progression to active and passive stretching exercises:
- Forward flexion
- Abduction
- External and internal rotation stretches
- Capsular stretching and joint mobilization techniques (Maitland or Kaltenborn methods).
- Strengthening exercises for rotator cuff and scapular stabilizers.
- Frequency: Daily supervised therapy or home program 2-3 times per day.

C. Hydrotherapy
Warm-water exercises improve relaxation and ease of movement.

4. Manipulation and Injection Techniques (Conservative Adjuncts)
A. Hydrodilatation [30] **(Distension Arthrography)**
1. Injection of sterile saline mixed with steroid and local anesthetic into the glenohumeral joint to expand the capsule.
2. Restores joint volume and improves motion.
3. Performed under ultrasound or fluoroscopic guidance.
4. Effective in frozen phase if physiotherapy alone is insufficient.

B. Suprascapular Nerve Block [30]
1. Provides pain relief and facilitates early physiotherapy.
2. Can be used as an adjunct to intra-articular steroid therapy.

5. Duration and Prognosis [31]
- Majority of patients respond to conservative treatment within 6-12 months.
- Full recovery may take up to 24 months.

Poor prognosis associated with
- Diabetes mellitus
- Thyroid disorders
- Prolonged immobilization

Homoeopathic view on frozen shoulder
From a homoeopathic perspective, frozen shoulder is considered a manifestation of suppressed musculoskeletal inflammation, often influenced by an underlying constitutional imbalance [32]. It represents a chronic miasmatic expression involving functional limitation and fibrotic changes within the shoulder capsule. Homoeopathy approaches this condition holistically, considering both the local pathology and the individual's general symptoms

1. Homoeopathic Conceptual Understanding
A. Disease Expression
Frozen shoulder is viewed not merely as a local joint disorder but as a systemic functional derangement that manifests locally. The affection involves fibrositis, periarticular inflammation, and capsular contraction reflecting a sycotic or syphilitic miasmatic background (33).
The progression from pain to stiffness to rigidity symbolizes the chronic, slow, and degenerative nature of the disease process.

B. Miasmatic Background
- According to homoeopathic philosophy:
- Psoric element: Functional disturbances with neuralgic pain, worse at rest and at night.
- Sycotic element: Fibrosis, thickening, and rigidity of soft tissues.
- Syphilitic element: Degenerative or destructive changes with marked limitation of motion.
- Thus, frozen shoulder is commonly interpreted as a mixed miasmatic disorder, requiring a deep-acting constitutional remedy for permanent cure.

2. Etiological Considerations
Homoeopathy identifies both predisposing and exciting causes, emphasizing the "totality of symptoms."

Type of Cause	Examples / Interpretation
Predisposing	Sedentary lifestyle; chronic rheumatic diathesis; diabetes; emotional stress; suppressed eruptions or discharges
Exciting	Exposure to cold or damp conditions; trauma; overexertion; suppressed inflammation (e.g., due to excessive use of analgesics or steroids)

The constitutional susceptibility of the patient determines the site and intensity of disease manifestation.

3. Symptomatology (Homoeopathic Perspective)
Pain: Dull, aching, tearing, or stitching; may extend to neck or arm.

Modalities
1. **Aggravation:** At night, from rest, cold air, or lying on affected side.
2. **Amelioration:** From warmth, gentle movement, or hot fomentation.

Stiffness: Marked limitation of motion, especially abduction and external rotation.
General Symptoms:

- Restlessness, irritability, chilliness, or weakness accompanying local symptoms.
- Sleep disturbed due to pain when lying on affected side.

4. Approach to Management
Homoeopathic management involves

1. Symptomatic treatment in the acute phase to relieve pain and inflammation.
2. Constitutional treatment to address underlying susceptibility and prevent recurrence.
3. Miasmatic treatment to correct deep-seated tendencies toward fibrosis and chronicity.
4. Commonly Indicated Homoeopathic Remedies-

Remedy	Indications / Keynotes
Ferrum metallicum	Stiffness and pain in deltoid; worse at night; pain radiates to elbow; weak muscular tone
Rhus toxicodendron	Pain and stiffness better by motion and warmth; worse after rest or exposure to cold; tearing pain extending to arm
Bryonia Alba	Stitching pain aggravated by slightest motion; relieved by rest; shoulder feels heavy and tense
Sanguinaria canadensis	Right-sided frozen shoulder; pain radiating to neck and scapula; worse at night; difficulty combing hair or dressing
Ledum palustre	Pain and stiffness after cold exposure or injury; relief from cold applications; soreness of shoulder joint
Causticum	Contracture of tendons; marked stiffness with burning pain; better by warmth; left-sided predominance
Calcarea fluorica	Chronic fibrotic changes; rigidity of ligaments; slow recovery
Ruta graveolens	Periarticular fibrositis following overuse or strain; bruised soreness and limited motion

Selection of remedy is based on the "totality of symptoms," individual constitution, and miasmatic background rather than local diagnosis alone [34, 35].

6. Role of Auxiliary Measures

- Gentle shoulder mobilization and warm compresses aid in recovery.
- Avoid suppressive measures such as repeated local steroid injections.
- Diet and regimen: balanced diet, adequate rest, avoidance of cold/damp exposure, and gentle daily movement are recommended.
- Prognosis (Homoeopathic View):
- Early cases respond well to indicated remedies within 6-12 weeks.
- Chronic or secondary cases (e.g., diabetic frozen shoulder) may require long-term constitutional treatment.
- Recurrence is uncommon when underlying miasmatic and constitutional tendencies are corrected.

Homoeopathic Medicine [36-41]

1. Bryonia Alba
Bryonia Alba is one of the chief remedies for frozen shoulder in the acute (painful or inflammatory) stage, particularly when pain is aggravated by motion and relieved by absolute rest. It acts deeply on the serous membranes and fibrous tissues, reducing inflammation and pain.

Indications

- Sharp, stitching or tearing pain in the shoulder joint.
- Pain aggravated by the slightest motion, even of the opposite arm.
- The patient supports or immobilizes the affected shoulder to avoid movement.
- Relief from rest and firm pressure.
- Shoulder feels heavy, tense, and immovable, as if paralysed.
- The pain may extend from the neck or scapula down the arm.
- The joint may appear slightly swollen, warm, and tender in early stages.

Modalities

- **Aggravation:** From motion, touch, cold air, after eating, in the morning, from exertion.
- **Amelioration:** By absolute rest, pressure, lying on the painful side, and from warmth.

Constitutional Features

- Suited to robust, irritable, business-minded individuals who prefer quiet and dislike being disturbed.
- Often associated with dry mucous membranes and thirst for large quantities of water at long intervals.
- The patient is typically constipated, with dry, hard stools.

Characteristic Symptoms
> "Pain in shoulder joint, worse on the slightest motion and relieved by absolute rest; stitching, tearing pain with a sensation as if the joint would burst; patient wants to keep the arm still."

2. Rhus toxicodendron
Rhus toxicodendron is one of the most commonly indicated remedies in cases of frozen shoulder, especially in the early (painful or freezing) stage where inflammation and stiffness coexist.

Indications

- Pain and stiffness of the shoulder joint, worse after rest, better by continuous movement.
- Pain as if the joint were sprained or dislocated.
- Shoulder feels stiff on first motion, but gradually loosens up with activity.
- Pain often extends down the arm to the hand or up to the neck.
- Associated with rheumatic or muscular inflammation due to exposure to cold damp weather.

Modalities

- **Aggravation:** After rest, at night, in damp cold weather, exposure to rain, and from overexertion.
- **Amelioration:** By warmth, gentle motion, warm bathing, and stretching.

Constitutional Features
- Restless, anxious patients who feel better by continuous movement.
- History of exposure to cold or wet conditions.
- Suited to individuals of rheumatic diathesis.

Characteristic Symptoms
>"Pain and stiffness in the shoulder, worse on first movement and better by continued motion; worse in damp weather; relieved by warmth."

3. Sanguinaria canadensis
Sanguinaria canadensis is a highly valuable remedy for right-sided frozen shoulder, especially when pain radiates to the neck and scapular region. It acts primarily on the muscular and fibrous tissues of the shoulder joint, and is particularly useful in cases with marked nocturnal pain and limited abduction.

Indications
- Right-sided frozen shoulder with severe pain and stiffness.
- Pain starts in the shoulder joint and extends to the neck, scapula, or upper arm.
- Difficulty in raising the arm or performing overhead activities such as combing hair or dressing.
- Pain worse at night, disturbing sleep; the patient cannot lie on the affected side.
- The shoulder feels heavy, sore, and contracted, with burning or tearing sensation.
- Useful in periarthritis and fibrositis following strain or exposure to cold wind.

Modalities
- **Aggravation:** At night, from motion, exposure to cold air, lying on the affected side.
- **Amelioration:** By warmth, rest, and pressure.

Constitutional Features
- Suited to individuals of bilious temperament with a tendency to right-sided complaints.
- Often associated with vascular headaches, flushes of heat, and burning sensations in various parts.
- Patient may have a sensitive, nervous temperament, with irritability and restlessness.

Characteristic Symptoms
>"Pain in the right shoulder extending to the neck and back; worse at night; cannot raise the arm or comb the hair; relieved by warmth and rest."

4. Ferrum metallicum
Ferrum metallicum is a valuable remedy for left-sided frozen shoulder characterized by pain, weakness, and stiffness of the deltoid region, often worse at night. It acts on muscles and fibrous tissues, restoring tone and relieving pain associated with chronic periarticular inflammation.

Indications
- Pain and stiffness in the left shoulder and upper arm.
- Pain extends down to the elbow and forearm.
- The shoulder feels weak, heavy, and tired, with restricted movement.
- Pain is worse at night, disturbing sleep.
- Useful in cases where the shoulder has become rigid from long-standing disuse or muscular weakness.
- Often follows anaemia, chronic weakness, or prolonged illness.

Modalities
- **Aggravation:** At night, from rest, while lying down, or after exertion.
- **Amelioration:** By gentle motion, slow movement, and open air.

Constitutional Features
- Suited to weak, anaemic, sensitive individuals with flushed face and easy fatigue.
- Alternate states of pallor and redness of face.
- Weakness of muscles and trembling on exertion.
- Tendency to cold extremities and general debility.

Characteristic Symptoms
>"Pain and stiffness in the left shoulder, worse at night, extending down the arm to the elbow; sensation of weakness and heaviness in the limb."

Conclusion

Frozen shoulder (Adhesive Capsulitis) is a chronic, painful, and disabling condition of the shoulder joint characterized by progressive stiffness and limitation of both active and passive movements. It commonly affects individuals in the middle age group, particularly females and patients with metabolic disorders such as diabetes mellitus.

The condition typically progresses through three overlapping stages freezing, frozen, and thawing and may last for several months to years, significantly impairing the quality of life and functional capacity of the patient.

Conventional management primarily aims at pain relief, reduction of inflammation, and restoration of joint mobility through physiotherapy, NSAIDs, corticosteroid injections, and rehabilitative exercises. Although effective to some extent, such approaches may offer only symptomatic relief and are often associated with recurrences or prolonged recovery periods.

From a homoeopathic perspective, frozen shoulder is viewed as a chronic miasmatic disorder involving fibrotic and rheumatic tendencies. Homoeopathy emphasizes individualization selecting remedies based on the totality of symptoms, modalities, constitution, and miasmatic background of the patient rather than the local pathology alone [35, 37, 40]. Remedies such as Rhus toxicodendron, Bryonia Alba, Sanguinaria canadensis, Ferrum metallicum, Causticum, Ruta graveolens, and Calcarea fluorica have shown beneficial effects in relieving pain, reducing stiffness, and restoring shoulder mobility.

The study and clinical experience suggest that homoeopathic management offers a gentle, holistic, and effective therapeutic alternative, addressing both the local affection and the underlying constitutional predisposition. Early intervention and regular follow-up are crucial for favorable outcomes.

In conclusion, frozen shoulder can be effectively managed with homoeopathic medicines, particularly when treatment is individualized and supported by proper physiotherapeutic

exercises and lifestyle modification. Homoeopathy not only aids in functional recovery but also helps in preventing recurrences by correcting the underlying susceptibility, thereby promoting overall well-being and quality of life.

References

1. Neviaser JS. Adhesive capsulitis of the shoulder: A study of the pathological findings in periarthritis of the shoulder. J Bone Joint Surg Am. 1945;27(2):211-222.
2. Duplay S. De la périarthrite scapulo-humérale et des raideurs de l'épaule qui en sont la conséquence. Arch Gén Méd. 1872;20:513-542.
3. Zuckerman JD, Rokito A. Frozen shoulder: A consensus definition. J Shoulder Elbow Surg. 2011;20(2):322-325. doi:10.1016/j.jse.2010.07.008
4. Bridgman JF. Periarthritis of the shoulder and diabetes mellitus. Ann Rheum Dis. 1972;31(1):69-71.
5. Cakir M, *et al.* Musculoskeletal manifestations in patients with thyroid disease. Clin Endocrinol (Oxf). 2003;59(6):769-773.
6. Wong CK, *et al.* Adhesive capsulitis of the shoulder: A systematic review of the pathophysiology and management. Phys Ther Rev. 2017;22(1-2):9-18.
7. Dias R, Cutts S, Miller N. Frozen shoulder. BMJ. 2005;331(7530):1453-1456.
8. Hand C, *et al.* The stages of frozen shoulder: Clinical, radiologic, and histologic correlations. Clin Orthop Relat Res. 2008;466(4):1066-1071.
9. Lewis J. Frozen shoulder contracture syndrome - Aetiology, diagnosis and management. Man Ther. 2015;20(1):2-9.
10. Banerjea SK. Miasmatic prescribing: Its philosophy, diagnostic classification and practical application. New Delhi: B. Jain Publishers; 2010.
11. Carette S, Moffet H. Adhesive capsulitis and shoulder stiffness. Rheum Dis Clin North Am. 2012;38(2):367-377.
12. Neviaser AS, Neviaser RJ. Adhesive capsulitis of the shoulder. J Am Acad Orthop Surg. 2011;19(9):536-542.
13. Zreik NH, Malik RA, Charalambous CP. Adhesive capsulitis of the shoulder and diabetes: A meta-analysis of prevalence. Muscles Ligaments Tendons J. 2016;6(1):26-34.
14. Chuang TY, *et al.* Association between thyroid disorders and adhesive capsulitis. J Shoulder Elbow Surg. 2010;19(4):592-598.
15. Wong CK, *et al.* Epidemiology and prognosis of frozen shoulder. Clin Orthop Relat Res. 2015;473(1):88-94.
16. Hand GC, Athanasou NA, Matthewson MH, Carr AJ. The pathology of frozen shoulder. J Bone Joint Surg Br. 2007;89(7):928-932.
17. DePalma AF. The role of muscular inactivity in the etiology of frozen shoulder. Clin Orthop. 1963;29:39-44.
18. Bruckner FE, Nye CJ. Frozen shoulder A prospective study. Clin Rheumatol. 1981;1(3):231-239.
19. Lundberg BJ. The frozen shoulder. Acta Orthop Scand. 1969;119(Suppl):1-59.
20. Ozaki J, *et al.* Pathology of frozen shoulder. Clin Orthop Relat Res. 1989;223:283-298.
21. Rodeo SA, *et al.* Immunohistochemical analysis of frozen shoulder. J Shoulder Elbow Surg. 1997;6(5):425-436.
22. Kumagai J, *et al.* Inflammatory cytokines in frozen shoulder. J Orthop Sci. 2002;7(1):34-39.
23. Neviaser RJ. Diagnosis and management of frozen shoulder. Instr Course Lect. 1987;36:210-214.
24. Manske RC, Prohaska D. Clinical commentary: Diagnosis and management of adhesive capsulitis. J Orthop Sports Phys Ther. 2008;38(12):750-758.
25. Sharma A, Singh N, Gupta R. Role of homoeopathy in musculoskeletal disorders: A review. Indian J Res Homoeopathy. 2019;13(4):230-236. doi:10.4103/ijrh.ijrh_74_19
26. Roach KE, *et al.* Development of a shoulder pain and disability index (SPADI). Arthritis Care Res. 1991;4(4):143-149.
27. Page MJ, *et al.* Manual therapy and exercise for adhesive capsulitis. Cochrane Database Syst Rev. 2014;8:CD011275.
28. Buchbinder R, *et al.* Intra-articular corticosteroid injection for shoulder pain. Cochrane Database Syst Rev. 2006;1:CD004016.
29. Jacobs LG, *et al.* Hydrodilatation, corticosteroids and physiotherapy in adhesive capsulitis. BMJ. 2009;339:b4226.
30. Shaffer B, Tibone JE, Kerlan RK. Frozen shoulder: A long-term follow-up. J Bone Joint Surg Am. 1992;74(5):738-746.
31. Boericke W. Pocket manual of homoeopathic materia medica. New Delhi: B. Jain Publishers; 2008.
32. Hahnemann S. Organon of medicine. 6th ed. New Delhi: B. Jain Publishers; 1994.
33. Kent JT. Lectures on homoeopathic philosophy. New Delhi: B. Jain Publishers; 1993.
34. Allen HC. Keynotes and characteristics with comparisons of some of the leading remedies. New Delhi: B. Jain Publishers; 2002.
35. Nash EB. Leaders in homoeopathic therapeutics. New Delhi: B. Jain Publishers; 1998.
36. Clarke JF. Dictionary of practical materia medica. London: Homeopathic Publishing Company; 1902.
37. Boericke W. Materia medica with repertory. New Delhi: B. Jain Publishers; 2008.
38. Gupta VK, *et al.* Homoeopathic management of adhesive capsulitis: Case series. Indian J Res Homoeopathy. 2020;14(2):115-122.
39. Mathur P. Clinical efficacy of homoeopathic remedies in frozen shoulder. Homoeopathic Heritage. 2018;44(3):20-24.

How to Cite This Article
Saroj AK, Verma S, Das AK, Kumar R, Singh A. Homoeopathic approaches in the management of frozen shoulder: A clinical review. International Journal of Homoeopathic Sciences. 2025;9(4):1511-1518.

Creative Commons (CC) License
This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-Non Commercial-Share Alike 4.0 International (CC BY-NC-SA 4.0) License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.