Rotator cuff tears are one of the most common causes of chronic shoulder pain and disability of the upper body. This injury is common among athletes, but is not limited to that demographic. In fact, injuries can occur to virtually anyone during everyday activities or with chronic overuse.

Approximately 7.5 million visits are made to physicians’ offices per year for shoulder pain. Greater than 50% of these physician visits result in a diagnosis of rotator cuff tendinopathy, with supraspinatus partial thickness tendon tears and tendonosis being most common. Magnetic resonance imaging (MRI) alone as a diagnostic tool can be inaccurate or inconclusive and should never take the place of a good history and physical examination correlated to a patient’s pain. Musculoskeletal ultrasound has emerged as an effective noninvasive, cost-effective approach with an accuracy rate similar to MRI and the advantage of real-time dynamic imaging, with immediate in-office correlation to a patient’s area of complaint.

Nonoperative treatment has proven to be beneficial to a great majority of patients with rotator cuff partial thickness tears and/or tendinopathy. Surgery has risks such as infection, damage to surrounding nerves and blood vessels, and general anesthesia with recovery taking up to 6 months depending on the severity of the injury. Stiffness, weakness, chronic pain, or incomplete healing after surgery can occur. Nonoperative treatment is therefore attractive and has been shown to have a high success rate. Platelet rich plasma (PRP) prolotherapy continues to increase in use in orthopedics, with the American Academy of Orthopaedic Surgeons summarizing that “available data suggest PRP may be valuable in enhancing soft-tissue repair and wound healing.” The use of ultrasound guidance for PRP injections is also increasing in use in the office setting. Current Reviews in Musculoskeletal Medicine states: “It is recommended to use...
dynamic musculoskeletal ultrasound … in an effort to more accurately localize the PRP injection.”

**Evaluation**

Examination of the patient revealed profound trapezius spasm on the right, with tenderness at the cervical-thoracic interspinous ligaments at C5 through T4. Right shoulder abduction was restricted to 120° with mild “stickiness” indicative of adhesions. There was a positive anterior compression test, with tenderness to palpation anteriorly. An MRI performed 2 years prior showed “mild hypertrophic disease of the acromioclavicular joint with some edema and a type 1 acromion with lateral downsloping but intact rotator cuff tendons with no evidence of tear or tendinopathy.” Musculoskeletal ultrasound performed in our office showed an intact bicep without deficit; however, there was a subscapularis tendon intrasubstance partial thickness tear and tendinosis, and supraspinatus articular surface partial thickness tear with calcific tendonosis at the enthesis. The acromioclavicular joint had a small effusion with degenerative changes but no anterior impingement noted. Glenohumeral joint was normal (Figure 1).

**Diagnosis**

We diagnosed the patient with partial thickness rotator cuff tears (subscapularis, supraspinatus) and diffuse tendinosis treated with PRP prolotherapy using ultrasound-guided injections. This patient also had early adhesive capsulitis (“frozen shoulder”) secondary to her chronic non-use, and compensatory cervicothoracic sprain/strain, which were also addressed during the treatment course.

**Prolotherapy Treatment**

This patient received a total of 6 PRP prolotherapy treatments over 9 months prepared using the SmartPReP II FDA-approved device (Harvest Technologies Corporation, Plymouth, Massachusetts). Ultrasound guidance using the M-Turbo ultrasound system (Sonosite, Inc., Bothell, Washington) was done to direct PRP injections into tendon defect sites. The patient also received a total of 5 dextrose prolotherapy treatments to the cervicothoracic spine (C5-T4). Because of the patient’s early adhesive capsulitis, aggressive osteopathic manipulative treatment (OMT) was done to break adhesions after first administering an intra-articular procaine injection to produce mild joint

![Figure 1. “Before” image of a supraspinatus tendon depicting an intrasubstance partial thickness tear and tendinosis.](image1)

![Figure 2. “After” image of a supraspinatus tendon demonstrating improvement in rotator cuff tendon tears and tendinosis.](image2)
anesthesia. OMT was given four times during the treatment course. The patient was also encouraged to “use” but “not abuse” her shoulder after treatments to discourage the return or increase in her secondary adhesive capsulitis.

**Conclusion**

Rotator cuff tears and dysfunction can be challenging for the primary care, orthopedic, pain, or sports medicine physician, especially where there is an overlay of secondary adhesive capsulitis or compensatory cervicothoracic strain/strain. Our case report demonstrates the effective use of PRP prolotherapy injections to stimulate repair of partial thickness tears of rotator cuff tendons, with good results. Ultrasound guidance to ensure accurate placement is important when these specific deficits exist. PRP prolotherapy should be considered for rotator cuff tears or tendinopathies before operative intervention, especially where surgical necessity is unclear.

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**References**