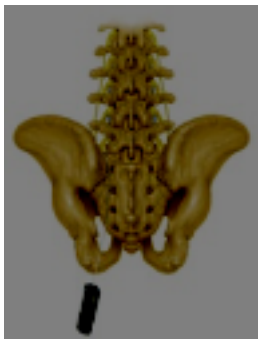


# NeuroTherm Workshop

## Supracscapular Nerve Block for Shoulder Pain

# Agenda

## Suprascapular RF

Indications: Chronic shoulder pain

Current Treatment: Meds, procedures, Surgery, PT

Anatomy

Procedure

Reimbursement

# Treatment Options

Medications
- NSAIDs
- Topicals
- Tramadol

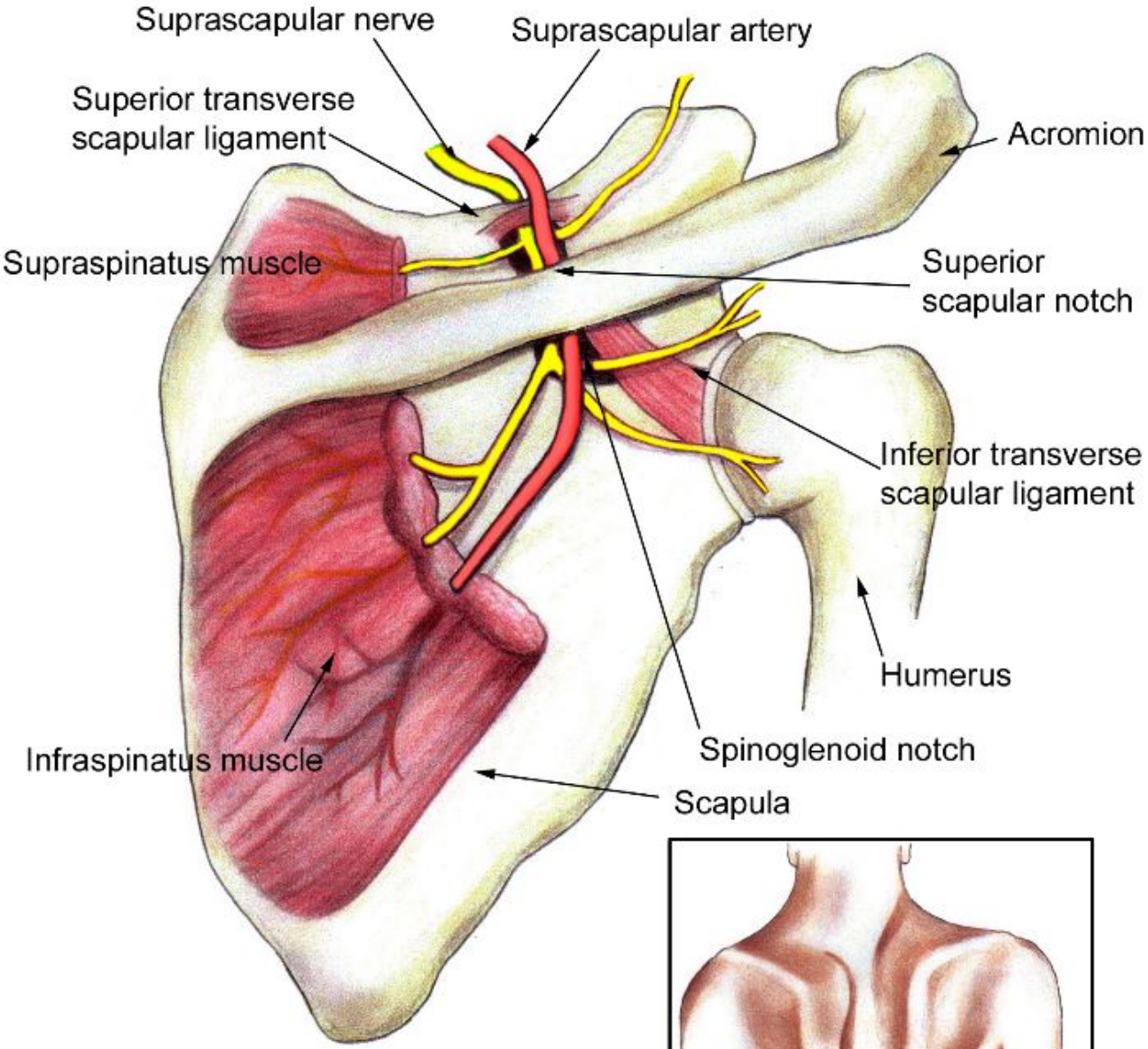
PT/OT, TENS

Injections
- SAB
- GH joint
- RF vs pRF

Arthroscopy, joint replacement

# Anatomy

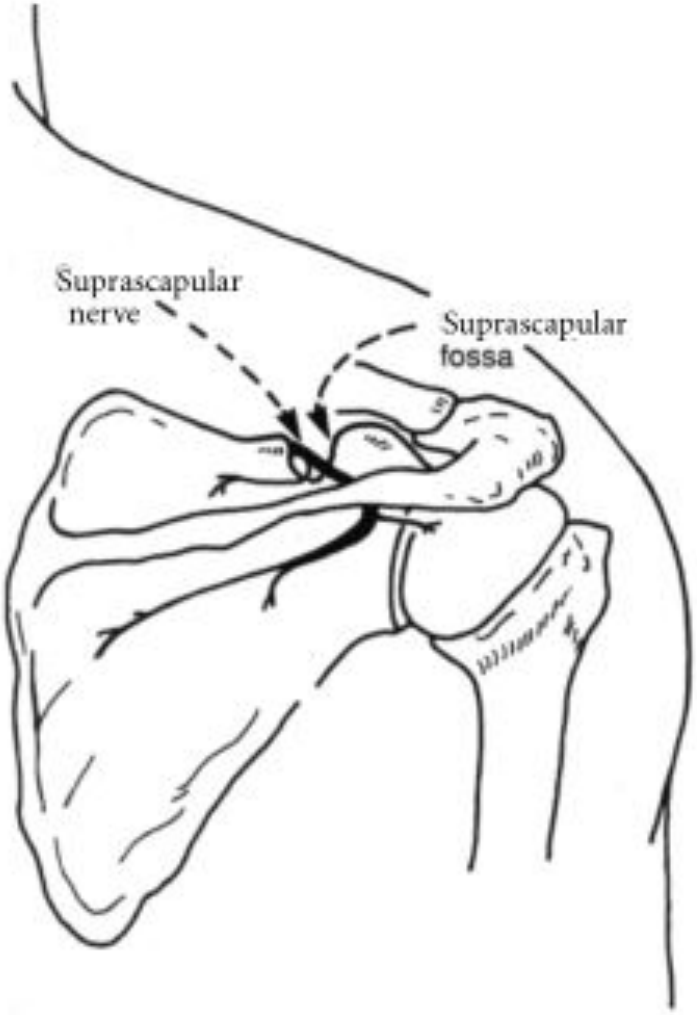
- C5 and C6 roots off of upper trunk of brachial plexus
- Passes under transverse scapular ligament
- Sits in bottom of scapular notch
- Innervates 70% of shoulder girdle
- Innervates supraspinatus and infraspinatus muscles

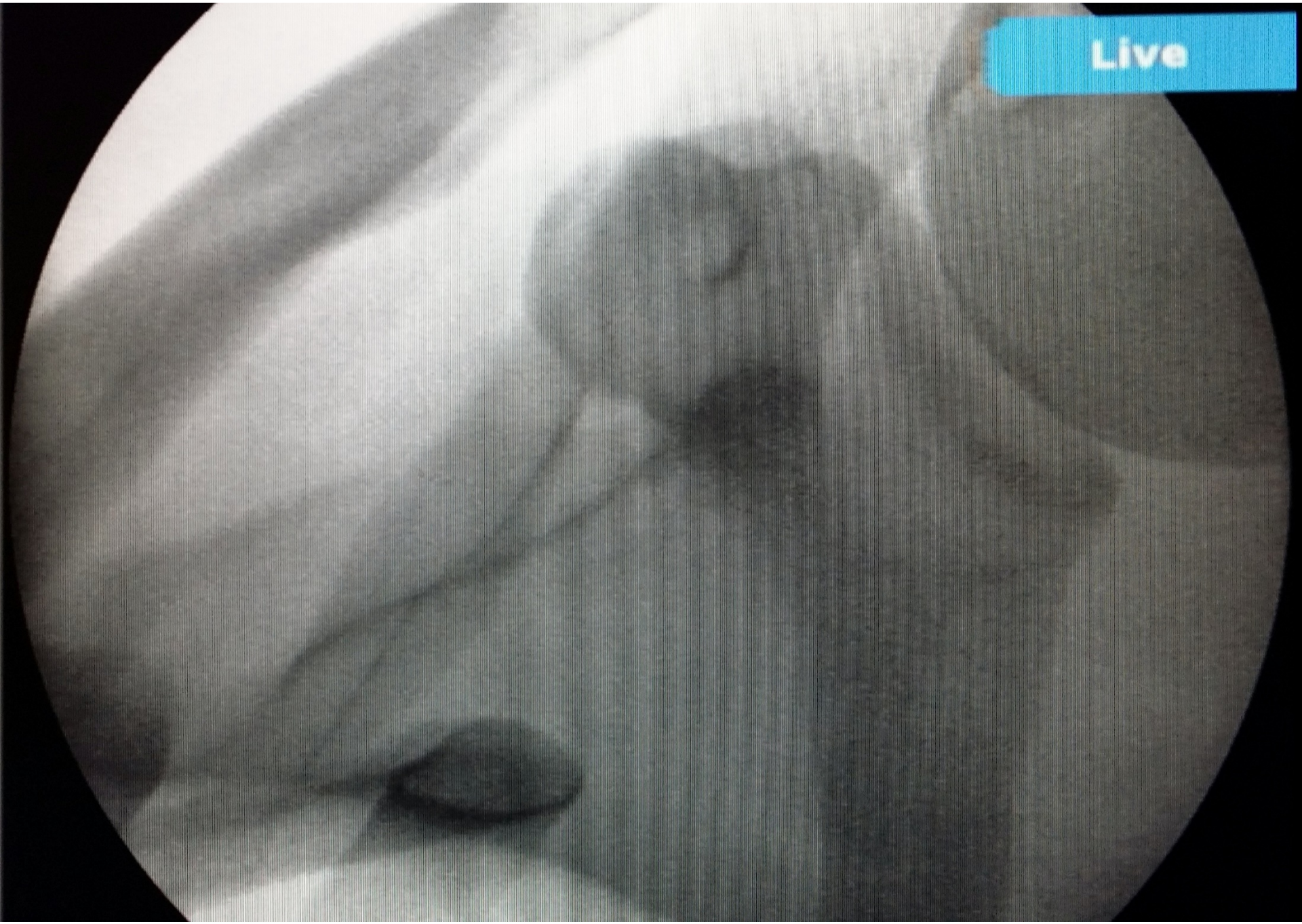

Suprascapular nerve
Suprascapular artery
Superior transverse scapular ligament
Acromion
Supraspinatus muscle
Superior scapular notch
Inferior transverse scapular ligament
Humerus
Infraspinatus muscle
Spinoglenoid notch
Scapula

# Procedure

Procedure

1. Patient is placed prone on the fluoroscopy table
2. Sterile prep and drape.
3. Cranial and oblique rotation
4. Skin and soft tissue are anesthetized with lidocaine
5. RF cannula is advanced towards the notch
6. Touch down on scapula inferomedial to notch to set depth
7. Advance into notch 5mm and inject contrast then 6cc Marcaine and 1cc steroid
8. RF Lesion is created at 70-80 degrees for 90 seconds (or 6min 20/2 pRF)


Suprascapular
nerve
Suprascapular
fossa


Live

# Complications

- Bleeding
- Infection
- Dysesthesia (if thermal)
- Lack of effect
- Shoulder weakness (if thermal)

- Prior to the application of PRF to the SSN, percutaneous neurolysis with either cryoablation or phenol of the SSN has been described previously. 15,16 Using 6% phenol, Lewis 16 documented a reduction in pain intensity and an improved ROM in flexion and abduction. In the present study the author also observed improvements in active ROM without loss
- of function. To reconcile this observation, it is important to realize that abduction and external rotation are not exclusively dependent on the supraspinatus and infraspinatus muscles, respectively. 17 The middle and anterior deltoid muscle and the serratus anterior muscle are involved in abduction. The teres minor muscle and the posterior portion of the deltoid muscle are responsible, in addition to the infraspinatus, for external rotation. Therefore, lesioning of motor nerve fibers to half of the rotator muscles does not consistently result in functional deterioration; rather, it results in improvement, because complimentary muscles are employed in the setting of pain reduction.
- Simopoulis TT et al. J Pain Research 2012 April 20

# Reimbursement

ICD9 includes 840.4

CPT includes 64418 block 64640 (RF of nerve)
If pRF of ganglion, should use unlisted code 64999

# Questions?