

MANAGEMENT OF SHOULDER PAIN (INCLUDING REFERRAL FOR SURGICAL ASSESSMENT)

Definition

This policy covers the treatment of shoulder pain, including conservative management and, where necessary, referral to a specialist for surgical assessment.

Policy

Referral for treatment should be through the MSK service/pathway.

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the [referral proforma](#).

Patients may be referred as shown in the pathway over the page.

Patients with a traumatic injury or dislocation may be referred to Trauma and Orthopaedics.

Patients with **non-traumatic** shoulder pain should be given conservative management:

- Self-care advice on **modifying activities**, use of **NSAIDs** and **home exercises**.
- If these are not effective, patients should be referred for **physiotherapy**.
- **Steroid injections** will only be funded for patients whose pain is not controlled by NSAIDs or in whom the use of NSAIDs are contraindicated and other conservative management has failed. **NB:** in cases where injections are necessary to enable a patient to undergo physiotherapy, these may be used at the time of the first course of physiotherapy.

MRI Scans: An MRI scan will be funded where a first course of physiotherapy (≥3 months) is judged to be ineffective and a rotator cuff, or superior labral anterior-posterior, tear is suspected. Referral for MRI scans should only be made by secondary care consultants or specialists working in CCG commissioned musculoskeletal (MSK) services. Where patients are referred for a surgical assessment, these scans should be made available to the receiving institution.

Surgery: Where an MRI scan/ultrasound has demonstrated evidence of a full thickness rotator cuff tear or significant superior labral anterior-posterior tear (detachment of labrum), shoulder surgery will be funded.

For other conditions, before shoulder surgery will be funded, patients should have undergone **further** conservative management of:

- 3 months: partial thickness tears or minor superior labral anterior-posterior tears (fraying).
- 6 months: adhesive capsulitis, impingement syndrome, non-traumatic instability, calcific tendonitis, biceps tendonitis or acromioclavicular or glenohumeral arthritis*.

Shoulder arthroscopy will not be funded as a diagnostic tool.

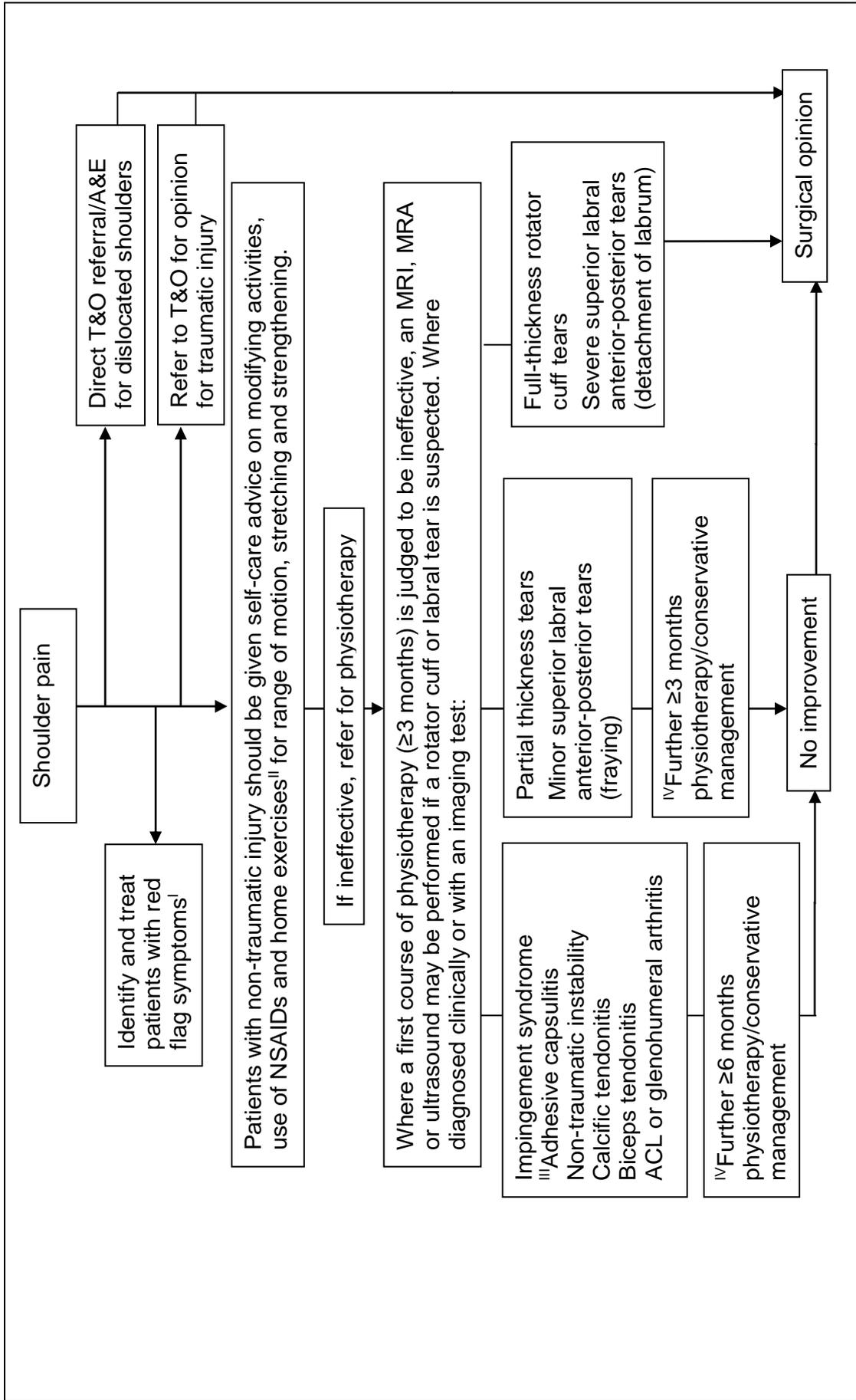
* Where there is clear evidence of severe progressive osteoarthritis, **physiotherapists** may refer patients before 6 months.

Shoulder replacement will be funded as per the [Shoulder Replacement Policy](#)

NOTE:

Patients who smoke should be advised to attempt to stop smoking and referred to stop-smoking services – [see stop smoking policy](#).

Patients who are overweight or obese should be offered referral to the appropriate weight management service.



I Recent fractures or dislocations, infection, malignancy, neurological lesion, cervical pathology or polymyalgia rheumatic.
 II Physio resources: <http://www.eoemskservice.nhs.uk/advice-and-leaflets>
 III May include manipulation under anaesthetic.
 IV Where other conservative measures have failed, corticosteroid/anaesthetic injections may be used in cases where pain is not controlled by NSAIDs or in whom the use of NSAIDs is contraindicated.

Shoulder Surgery:

An RCT of **rotator cuff tears** suggest that, for patients with traumatic or atraumatic **full thickness rotator cuff tears**, physiotherapy may be effective in some cases, but in others, surgery may be needed^{1, 2}. For **partial thickness rotator cuff tears**, physiotherapy is likely to be effective in many cases³ and surgery may be unnecessary and, for patients with **impingement syndrome**, physiotherapy is likely to be effective for most, with surgery needed in fewer cases⁴⁻⁶.

For **calcific tendonitis** no RCTs compared the use of rest, exercise or physiotherapy with surgical interventions. One RCT compared ultrasound-guided barbotage (needling and washout) with corticosteroid injections and suggested that surgery gives a greater improvement in pain and function⁷. Surgery is unlikely to be necessary in most cases, but may be helpful in severe refractory calcific tendonitis. Similarly, for **biceps tendonitis**, there were no RCTs comparing the use of conservative treatment with surgical interventions, although case series suggest that surgery may be beneficial⁸⁻¹⁰. Surgery should be reserved for patients who are refractory to conservative management, but where there are superior labral anterior-posterior (SLAP) tears, surgery may be necessary¹¹.

For **adhesive capsulitis**, one small RCT compared arthroscopic capsular release with exercise therapy and suggested that surgery may be no more effective¹². There were no RCTs comparing it with other interventions. Surgery should be reserved for patients who are refractory to conservative management. For **acromioclavicular and glenohumeral osteoarthritis**, there were no RCTs comparing the use of conservative with surgical interventions. NICE recommends advice to exercise as a core treatment, including local muscle strengthening and general aerobic fitness¹³ and the use of surgery may not be necessary in most cases.

For **glenohumeral joint dislocation/instability**, following traumatic dislocations, RCTs suggest that surgery may be necessary and a surgical opinion is needed^{14, 15}. For multidirectional (non-traumatic) dislocations, conservative therapy may be effective^{16, 17} and surgery may not be necessary. For **acromioclavicular separation/instability** trials suggest that, for many patients with ACL separation/dislocation, conservative treatment is sufficient¹⁸. For patients with grade IV or greater dislocation, surgery is likely to be necessary. For patients with grade I-II dislocation surgery is unlikely to be necessary and, for grade III dislocation, surgery may not always be necessary^{19, 20}.

Manipulation under anaesthetic: There were no RCTs of manipulation under anaesthetic compared with conservative treatments. It is likely to benefit some patients^{21, 22}, but should be used after other conservative interventions.

Diagnostic tests: For many conditions associated with shoulder pain may be difficult to distinguish between different pathologies with physical examination²³⁻²⁵ and an imaging test (MRI, MRA or ultrasound) may be necessary²⁶.

Steroid injections: RCTs and comparative studies suggest that steroid injections may be useful for short-term pain relief for rotator cuff disease²⁷⁻²⁹ calcific tendonitis³⁰ and adhesive capsulitis³¹, and NICE recommend corticosteroid injections for patients with moderate to severe osteoarthritis pain¹³. However, there is inadequate evidence to suggest that they improve function.

Numbers of People Affected

In Cambridgeshire and Peterborough, the estimated 2014/15 rate of procedures associated with surgery for rotator cuff tears/impingement and adhesive capsulitis was 418 per year (costing £1.8 million), equating to approximately 0.04% of the local population.

Glossary

Acromioclavicular separation:	The disruption of the acromioclavicular joint where the collarbone (clavicle) meets the highest point of the shoulder blade (acromion)
Adhesive capsulitis:	Known as 'frozen shoulder'. The flexible tissue that surrounds the shoulder joint, becomes inflamed and thickened leading to pain and stiffness.
Arthroscopy:	Key-hole surgery using an arthroscope (light source and video camera).
Biceps tendonitis:	Inflammation in the main tendon that attaches the top of the biceps muscle to the shoulder

Calcific tendonitis (Shoulder):	Build-up of calcium deposits in the rotator cuff tendons
Debridement:	Removal of dead, damaged, or infected tissue.
Extracorporeal shock wave therapy:	procedure where shock waves (low energy sound waves) are passed through the skin
Glenohumeral dislocation:	Ball joint of upper arm has popped out of the shoulder socket.
Impingement syndrome:	Friction between tendon in the shoulder and the bone under which it passes, causing pain
NSAIDs:	Non-steroidal anti-inflammatory drugs. Medication used to relieve pain and inflammation and reduce temperature.
Osteoarthritis:	Degenerative joint disease that occurs when the cartilage that covers the tops of bones degenerates or wears down, causing swelling, pain and sometimes 'bone spurs' (additional bone growth where bones rub together)
Rotator cuff:	Group of four muscles that are positioned around the shoulder joint. The tendons of these muscles join together to form the rotator cuff tendon
Shoulder instability:	Instability of the shoulder joints due to acromioclavicular separation or glenohumeral dislocation

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