Rotherham Shoulder Pathway

Patient Presents Shoulder Symptoms (Pain, Stiffness, Weakness or Instability)

If a patient presents with pain in the shoulder region, first of all determine if the source of the symptoms is from the shoulder or the neck. To do so, ask the patient to move their neck and then their shoulder, to see which influences the symptoms the most. If the pain is aggravated more with neck movements, or there is reported paraesthesia into the hand, please follow the Spinal pathway.

This is **NOT** an exhaustive list of symptoms and conditions

Secondary Care

Urgent Care Pathway
(Refer the following)

Refer to A&E if you suspect fracture, dislocation, or infection.
With a history of or suspected malignancy, investigate and refer as appropriate. Consider the red flags of unexplained weight loss, night pain and high inflammatory markers.
Suspected inflammatory condition, investigate and refer to Rheumatology.
All of the following should be referred directly to an Orthopaedic Consultant.

- Acute distal biceps rupture
- Full thickness rotator cuff tear if < 60 years of age and has gross weakness
- Severe OA, chronic severe capsulitis with marked limitation of function especially with a history of diabetes
- Suspected labral tear

Primary Care

Stiff Shoulders
Lack of passive external rotation

AP X-ray to rule out gross OA changes. If present refer directly to Orthopaedic surgeon.

If not, consider management with active range of motion exercise, analgesia and NSAIDS.

If does not, settle consider x1 steroid injection into the Glenohumeral joint.

If pain and stiffness persists after 6 weeks of conservative management refer for Physiotherapy.

Self help/patient education available from

http://www.therotherhamft.nhs.uk/orthopaedics/

www.shoulderdoc.co.uk

www.arthritisresearchuk.org

Pain and weakness. Suspected Rotator cuff pathology

Consider management with active range of motion exercise, analgesia and NSAIDS.

Patients around the age of 40, with a history of trauma, may have a rotator cuff tear and would warrant an USS.

Injections are not indicated in patients less than 60 years of age.

Referral for a suspected full thickness tear in patients more than 60 years of age should be to MSK CATS and will be investigated as appropriate.

Self help/patient education available from

http://www.therotherhamft.nhs.uk/orthopaedics/

www.shoulderdoc.co.uk

www.arthritisresearchuk.org

Painful arc of movement.
Suspected impingement

Investigations are not indicated.

Consider management with active range of motion exercise, analgesia and NSAIDS.

Consider x1 injection into the sub acromial space.

If there is no improvement after 6 weeks referral should be to Physiotherapy.

Self help/patient education available from

http://www.therotherhamft.nhs.uk/orthopaedics/

www.shoulderdoc.co.uk

www.arthritisresearchuk.org

Pain at the tip of the shoulder.
Suspected AC joint pathology

An AC joint X-ray is appropriate.

Consider management with active range of motion exercise, analgesia and NSAIDS.

Consider x1 injection into the Ac joint, superiorly.

If there is no improvement after 6 weeks referral should be to Physiotherapy.

Self help/patient education available from

http://www.therotherhamft.nhs.uk/orthopaedics/

www.shoulderdoc.co.uk

www.arthritisresearchuk.org

Unstable shoulder

Investigations are not indicated.

Consider appropriate analgesia

Referral should be to MSK CATS unless this is a patient less than 25 years of age who has had a traumatic dislocation for the first time. In which case, referral should be directly to Orthopaedic consultant.

Self help/patient education available from

http://www.therotherhamft.nhs.uk/orthopaedics/

www.shoulderdoc.co.uk

www.arthritisresearchuk.org

Rotherham Shoulder Pathway Supporting Information

AC Joint Pathology

Patient presents with:

- Pain over the shoulder, clavicle and Acromio-clavicular joint when reaching overhead
- Specific pain & tenderness over ACJ on superior shoulder
- Pain on adduction across the body (scarf test)
- Local swelling or distortion (subluxation) on inspection

Management options:

- Exclude other shoulder pathology
- Consider analgesia/ NSAIDS
- Consider injection superiorly into ACJ
- If no improvement in 6 weeks consider referral to Physiotherapy

Rotator Cuff Pathology

Patient presents with:

- Gradual onset of non-specific pain and weakness in the shoulder

Or

- Sudden onset of pain and weakness after a traumatic incident, such as falling on an outstretched hand or directly onto the affected shoulder, OR period of sustained overhead activity. May follow minor activity e.g. pegging washing out
- History of impingement, biceps tendonitis, RA
- Unable to sleep on affected side
- These can be common after 40 years of age, so investigations are not always necessary as not all of them will require surgery.
- Reduced active range of movement but you are able to gain more range when passively tested
- Reduced shoulder strength especially abduction and external rotation.
- Possible muscle atrophy if chronic or degenerative tear
- Full thickness Rotator Cuff tear is indicated by inability to abduct the arm 20-100 degrees and positive LAG signs
- Exclude Cervical origin, dislocation, RA and proximal myopathies
- If traumatic full thickness tear suspected in patients under 60 years of age please refer directly to Orthopaedic Surgeon. If degenerate tear suspected advise to maintain AROM as able and review medication.

Instability

Patient presents with:

- Diffuse / non-specific pain over the gleno-humeral joint, biceps, deltoid and scapula areas.
- Feeling of instability on movement, or reported subluxation or dislocation.
- Traumatic dislocation, followed by recurrent dislocation or subluxation.
- Recurrent dislocations or subluxation without any initial trauma/injury.
- Often the patient is able to actively self-dislocate or sublux the joint. This could be a party trick
- Usually full active range of movement
- Positive instability tests (sulcus and apprehension tests)
- Positive anterior and posterior draw test at the gleno-humeral joint.
- Possible hypermobility syndrome (Beighton scale) and / or underlying hypermobility syndrome e.g. Ehlers Danlos Syndrome
- If structural pathology is suspected such as labral tear following first time traumatic dislocation please refer directly to Orthopaedic Surgeon. Apprehension and O'Briens tests are used to confirm this.
- If non-traumatic pathology please refer directly to MSK CATS
- Steroid injection is not indicated if instability is suspected

Capsulitis/Stiff Shoulder

Patient presents with:

- Shoulder stiffness and pain
- Typical age group 40 +,
- Common in diabetics
- Restricted **active and passive** ROM especially external rotation
- Exclude possible osteoarthritis

Management options:

- Consider analgesia
- Consider capsular steroid injection
- Teach active and active assisted shoulder exercises
- Consider Physiotherapy referral

Gleno-humeral OA/Stiff Shoulder

Patient presents with:

- Progressive onset of shoulder stiffness and pain.
- History of previous trauma such as fracture, dislocation or rotator cuff pathology
- Exclude possible underlying inflammatory pathology e.g. RA

- Typical age group 50+
- Functional impairment and night pain common symptoms
- Restricted **active and passive** ROM with associated muscle weakness

Management options:

- Investigate (AP x-ray)
- Consider analgesia +/or injection into the glenohumeral joint
- Contact MSK team for advice/ treatment
- If gross OA changes on X-ray refer to secondary care, if not consider referral to Physiotherapy

Impingement

Patient presents with:

- Pain typically over lateral aspect of upper arm/shoulder especially over deltoid and biceps muscles
- Possible history of injury.
- Repetitive use of shoulder in occupation or sport, or sustained 'slouched' postures
- Uncommon <40 years
- Painful mid arc on abduction and pain on hand behind back
- On examination Hawkins, Neers or Empty cans test positive
- **Passive ROM greater than active ROM**
- Initial management is for pain relief and advice to avoid the aggravating activity. If symptoms persist a single steroid injection may be undertaken
- If there is no improvement after 6 weeks please refer to Physiotherapy