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

**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.**

**Rotherham Shoulder Pathway**

**Primary Care**

**Secondary Care**

**Painful arc of movement.**

**Sub acromial pain**

**Unstable shoulder**

**Pain at the tip of the shoulder.**

**Suspected AC joint pathology**

**Pain and weakness.**

**Suspected Rotator cuff pathology**

**Urgent Care Pathway**

(Refer the following)

**Stiff Shoulders**

**Lack of passive external rotation**

Investigations are not initially indicated.

Consider appropriate analgesia

Referral should be to Orthopaedic triage service 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/>

<https://bess.ac.uk/>

www.arthritisresearchuk.org

mar

An AC joint X-ray is appropriate.

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

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

Consider x1 injection into the AC joint, superiorly.

Self-help/patient education available from

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

<https://bess.ac.uk/>

www.arthritisresearchuk.org

Investigations are not initially indicated.

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

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

If symptoms persist Orthopaedic triage will consider injection into the sub acromial space.

Self-help/patient education available from

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

<https://bess.ac.uk/>

www.arthritisresearchuk.org

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

Patients around the age of 40 or under, with a history of trauma, may have a rotator cuff tear and would warrant imagery, therefore refer to Orthopaedic Triage Service.

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 Orthopaedic triage service and will be investigated as appropriate.

Self-help/patient education available from <http://www.therotherhamft.nhs.uk/orthopaedics/>

<https://bess.ac.uk/>

www.arthritisresearchuk.org

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

**USS is not indicated**.

If OA ruled out, consider management with active range of motion exercise, analgesia and NSAIDS.

In the early stage of frozen shoulder refer to Orthopaedic Triage Service for steroid injection into the Glenohumeral joint and onward referral to Physiotherapy.

Self-help/patient education available from <http://www.therotherhamft.nhs.uk/orthopaedics/>

<https://bess.ac.uk/>

www.arthritisresearchuk.org

Refer to UECC 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

**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

If no improvement in 6 weeks consider referral to Physiotherapy

Consider injection superiorly into ACJ

**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 spine referral, 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, advice is 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 Orthopaedic triage service

Steroid injection is not indicated if instability is suspected

**Capsulitis/Stiff Shoulder**

**Patient presents with:**

Shoulder stiffness and pain

Typical age group 40 to 60

Common in diabetics

Restricted **active and passive** ROM especially external rotation

Exclude possible osteoarthritis

**Management options:**

Consider analgesia

Consider intra capsular steroid injection, which are better carried out in the early stage

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 and axial x-ray)

Review analgesia

Contact MSK team for advice/ treatment

If gross OA changes on X-ray refer to secondary care, if not consider referral to Physiotherapy

**Sub acromial pain**

**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

**Please note all patients who require an opinion regarding Arthroscopic sub acromial decompression must now have a SY ICB threshold form completed and attached to their referral to secondary care. See appendix 1**

**All patients referred to Physiotherapy who are not responding to appropriate management can be escalated to the Orthopaedic triaging service (OTS) without the need for a second referral. Also those referred to OTS that require therapy led management will have their care arranged by the Orthopaedic Physiotherapy Practitioner.**

**Appendix 1.**

|  |  |
| --- | --- |
| Patient Name: <Patient Name> Address: <Patient Address> Date of Birth: <Date of Birth>NHS Number: <NHS number> Consultant/Service to whom referral will be made:       | **Please send this form with the referral letter** |

**Arthroscopic Subacromial Decompression of the Shoulder (ASAD)**

Instructions for use:

Please refer to policy for full details.

Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The SY ICB will only fund ASAD as a standalone procedure when the following criteria are met:

|  |  |
| --- | --- |
| *In ordinary circumstances\*, referral should not be considered unless the patient meets* ***ALL*** *of the following criteria:* | Tick as appropriate |
| Patient has had symptoms for at least 3 months from the start of treatment **AND** | Yes [ ]  | No [ ]  |
| Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat) **AND** | Yes [ ]  | No [ ]  |
| Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks **AND** | Yes [ ]  | No [ ]  |
| Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management **AND** | Yes [ ]  | No [ ]  |
| Referral is at least 8 weeks following steroid injection **AND** | Yes [ ]  | No [ ]  |
| Patient confirms they wish to have surgery  | Yes [ ]  | No [ ]  |

*\*If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the SY ICB Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*