Shoulder Pathway (V9) – 16.07.2019

SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website: https://sussexmskpartnershipcentral.co.uk/

OUTCOME MEASURES

- MSK-HQ
- Oxford Shoulder Score

Referral reason / Patient presentation	**Traumatic shoulder pain Diagnostics (AP and axillary view for X-Ray requests)**
	Traumatic shoulder pain Suspected fracture
Primary Care Management (including Assessment and Diagnostics)	X-Ray and refer to # clinic
Thresholds for Primary Care to initiate a referral	**N/A**
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	**N/A**
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	**N/A**
Thresholds for referral to Specialist In-patient care ***(Choice)***	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	Traumatic shoulder pain Dislocations (Glenohumeral)
Primary Care Management (including Assessment and Diagnostics)	A/E if not reduced or X-Ray to exclude dislocation if suspected
Thresholds for Primary Care to initiate a referral	**N/A**
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	**N/A**
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	**N/A**
Thresholds for referral to Specialist In-patient care ***(Choice)***	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	Traumatic shoulder pain Dislocation 1st time
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, location of pain, shoulder examination. No diagnostic required, A/E if not reduced, For young traumatic dislocators follow BESS guidance: https://www.boa.ac.uk/wp-content/uploads/2016/11/Traumatic-Anterior-Instability.pdf **Management:** urgent referral to physiotherapy Low threshold for onward referral to iCATS from physio as per BESS guidance.
Thresholds for Primary Care to initiate a referral	For young traumatic dislocators -urgent referral to physio from the virtual fracture clinic. Fracture clinic or A/E. Low threshold for onward referral to iCATS from physio as per BESS guidance. https://www.boa.ac.uk/wp-content/uploads/2016/11/Traumatic-Anterior-Instability.pdf
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Assessment and examination - exclude # or cuff pathology X-ray if suspected unreduced dislocation Consider MRI scan for traumatic dislocators with suspected structural or cuff pathology
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	If considering surgical stabilisation and/or opinion, refer to a co-located clinic or secondary care.
Thresholds for referral to Specialist In-patient care ***(Choice)***	Offer patient choice of provider if patient needs and wants surgery and is fit for surgery Arthroscopic shoulder stabilisation. Anterior Stabilisation of the shoulder - risk
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Traumatic shoulder pain Recurrent dislocation / instability secondary to trauma
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, location of pain, shoulder examination. No diagnostic at this stage. **Management**: If no significant loss of function consider: - pain relief in line with agreed formularies /guidance. Patient education/exercise sheet. (Do we have a link? At A&E) Activity modification. Advise if increase in pain / sudden loss of movement to return to their GP. Routine referral to physiotherapy, if not previously tried
Thresholds for Primary Care to initiate a referral	Routine referral to iCATs if symptoms persist following 3 months physiotherapy rehab
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Consider MRI scan for ongoing symptoms of instability of traumatic origin. Suspected structural pathology e.g. SLAP, Bankart
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	If considering surgical stabilisation and/or opinion, refer to a co-located clinic.
Thresholds for referral to Specialist In-patient care *(Choice)*	Arthroscopic shoulder stabilisation. https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/SE-SC-anterior-stabilisation.docx
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Traumatic shoulder pain ACJ Sublaxation / Pain
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, focal location of pain over ACJ, examination. X-ray – see classification of ACJ injuries https://www.shoulderdoc.co.uk/article/60 **Management**: Pain relief in line with agreed formularies /guidance. Patient education/exercise sheet. Activity modification. Advise if pain increases / sudden loss of movement to return to their GP. Traumatic ACJ: Type I-IV Physio if symptoms persist beyond 6/52 T Grade V/ VI – if open injury – red flag urgent secondary care
Thresholds for Primary Care to initiate a referral	Urgent referral to physiotherapy, if significant pain and functional impairment persists post 6 weeks
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	If symptoms persist beyond 3 months, assessment to determine injection vs surgical opinion. If considering an injection (1st injection - unguided in clinic. Consider USGI for 2 nd injection). Consider orthopaedic review if injection fails and symptoms are persistent
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	Type 3 and above for surgical opinion for ongoing symptoms of pain and/or instability.
Thresholds for referral to Specialist In-patient care *(Choice)*	Arthroscopic distal clavicle excision or Arthroscopic ACJ stabilisation. ACJ excision.docx

Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	**Traumatic shoulder pain Rotator cuff tear**
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, focal location of pain over ACJ, examination. No diagnostic. **Management**: If no significant loss of function or strength consider: -pain relief in line with agreed formularies /guidance. Patient education/exercise sheet. Activity modification. Advise if pain increase / sudden loss of movement to return to their GP. Acute traumatic cuff tear - Urgent referral to iCATS within 2/52 if c/o significant loss of strength and function especially for under 60 age group. Chronic traumatic cuff tear: No diagnostic needed Management: refer for physiotherapy if symptoms persist beyond 6/62
Thresholds for Primary Care to initiate a referral	Urgent referral to iCATS within 2/52 if c/o significant loss of strength and function. If strength and function maintained but symptoms persist beyond 4 weeks, refer to physiotherapy.
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Consider investigations (USS and XR) if symptoms persist despite physio.
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	Based on the level of symptoms and scan results, refer for surgical opinion through SDM process.
Thresholds for referral to Specialist In-patient care *(Choice)*	Arthroscopic/open Rotator Cuff repair. Risk / Benefit information Rotator Cuff Repair https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/SE-Rotator-Cuff-Tendon-Repair-Shoulder.pdf Secondary Care surgical guidelines https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/SE-SC-rotator-cuff-repair.pdf
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	Shoulder pain Non-traumatic
	Shoulder pain – Non-traumatic **Subacromial pain +/- calcific tendinopathy and/or Acromioclavicular joint pain**
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, location of pain - characteristically lateral upper arm for SAP and focally over ACJ for ACJ pain, shoulder examination – may have positive impingement signs for subacromial pain or positive scarf test for aCJ pain No diagnostic at this stage. Red-flag consider referred pain and intrathoracic/ somatic sources of pain **Management**: Pain relief in line with agreed formularies /guidance. Patient education/exercise sheet. http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/11/161125-Subacromial-pain-V5.pdf Activity modification. Advise if pain increase / sudden loss of movement to return to their GP. Consider sub-acromial injection for ongoing pain.
Thresholds for Primary Care to initiate a referral	> 6 weeks of symptoms, refer to physio. Referral to ICATs for patients that have had unsuccessful physio for 3 months and unguided injection or refer into MSK service for injection
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Ongoing symptoms despite physio. Consider unguided injection. Consider x-ray if unsuccessful injection to identify bony pathology / calcification. Consider ultrasound guided injection if unguided unsuccessful. Outcome measures OSS
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	Based on the level of symptoms and scan results, refer for surgical opinion through SDM process.
Thresholds for referral to Specialist In-patient care *(Choice)*	Offer patient choice of provider if patient needs and wants surgery and is fit for surgery Arthroscopic decompression. Risk / benefit information https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/SE-Arthroscopic-Sub-acromial-Decompression-ASAD.pdf Secondary care surgical guidelines Subacromial Decompression https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/SE-SAD.docx Distal clavicular excision secondary care surgical guidelines ACJ Excision https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/SE-SC-ACJ.pdf
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	Shoulder pain – Non-traumatic Cuff tear (degenerative) non-traumatic
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, location of pain. Shoulder examination. Possible muscle wasting in rotator cuff. No diagnostic at this stage. **Management**: Pain relief in line with agreed formularies /guidance. Patient education/exercise sheet. Activity modification. Advise if pain increase / sudden loss of movement to return to their GP. Consider sub-acromial injection for ongoing pain. http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/11/161125-Subacromial-pain-V5.pdf
Thresholds for Primary Care to initiate a referral	> 6 weeks of symptoms, refer to physio. Referral to ICATs for patients that have had unsuccessful physio. If significant loss of function / weakness +/- pain, refer iCATS earlier.
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Consider investigations (USS or MRI and XR) if symptoms persist despite physio. Exclude other sources for weakness /pathology with imaging (clinically determined). If degenerative cuff confirmed, possible re-referral to physio, +/- unguided injection. Consider guided injection if unguided unsuccessful.
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	Based on the level of symptoms and scan results, refer for surgical opinion through SDM process.
Thresholds for referral to Specialist In-patient care ***(Choice)***	Arthroscopic/open Rotator Cuff repair +/- ASAD. Rotator cuff repair.docx Reverse shoulder replacement for cuff arthropathy. https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/SE-SC-Shoulder-Replacement.pdf
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	Shoulder pain – Non-traumatic Frozen Shoulder
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, location of pain - often diffuse shoulder pain,. Shoulder examination. Characteristically reduced passive GHJ ER, and true abduction. Common in diabetes. **Management**: Pain relief in line with agreed formularies /guidance. Patient education/exercise sheet. Activity modification. Consider routine referral to physiotherapy. http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/11/161124-Frozen-Shoulder.pdf http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/12/161125-Frozen-Shoulder-Exercise-sheet.pdf
Thresholds for Primary Care to initiate a referral	Significant pain / not coping with symptoms at 6 weeks.
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Diagnostics at the point of triage (x-ray) to exclude GHJ arthropathy. Consider unguided injection. Consider image guided 2nd injection. Consider re-referral to physio for dominant picture of stiffness. Consider onward referral for hydrodilatation and/or surgical opinion of persistent symptoms with acopia.
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	Based on the level of symptoms and scan results, refer for surgical opinion through SDM process.

Thresholds for referral to Specialist In-patient care *(Choice)*	Hydrodilatation. Arthroscopic release.
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	**Shoulder pain – Non-traumatic Osteoarthritis**
Primary Care Management (including Assessment and Diagnostics)	If a systemic source is suspected, consider Rheumatology referral. Assessment: age, morning stiffness and GHJ restriction into ER. Possible joint crepitus. Pain relief in line with agreed formularies /guidance. Patient education/exercise sheet. Activity modification. **Management**: http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/11/161124-Oesteoarthritis-of-the-Shoulder.pdf
Thresholds for Primary Care to initiate a referral	> 6 weeks, referral to physio. Referral to iCATS with severe pain, crepitus and loss of function not responding to rehab.
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Initiate diagnostics at the point of triage (x-ray). Consider injection for non-surgical patients / early OA symptoms if indicated. Consider guided injection if unguided unsuccessful.
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	Based on the level of symptoms and x-ray results, refer for surgical opinion through SDM process.
Thresholds for referral to Specialist In-patient care *(Choice)*	Total joint replacement or reverse shoulder replacement. Hemiarthroplasty. Shoulder replacement.docx
Management pathway for Specialist In-patient care	Secondary case surgical guidelines for shoulder replacement https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2019/11/SE-SC-Shoulder-Replacement.pdf

Referral reason / Patient presentation	**Shoulder pain – Non-traumatic Habitual subluxation / instability**
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, location of pain, examination. No diagnostic at this stage. Pain relief in line with agreed formularies /guidance. Patient education/exercise sheet. Activity modification. Refer to physio as soon as problem is identified or if unsure of diagnosis http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/11/161125-Shoulder-instability-V5.pdf
Thresholds for Primary Care to initiate a referral	Refer to physio as soon as problem is identified.
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Seek secondary care opinion if symptoms persist despite long-term condition specific rehab.
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	**N/A**

Thresholds for referral to Specialist In-patient care ***(Choice)***	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Referral reason / Patient presentation	**Shoulder pain – Non-traumatic Biceps rupture (long head) For distal biceps rupture see elbow section below**
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, location of pain, characteristically anterior upper arm. Shoulder examination. Possible popeye sign. No diagnostic at this stage. **Management**: Patient education and information Reassure if no pain or loss of function If pain / SAP– follow SAP pathway If suspected cuff tear – follow cuff tear pathway
Thresholds for Primary Care to initiate a referral	Refer to physio with 6 weeks or more of symptoms
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Consider investigations (USS/MRI) for persistent symptoms. Consider unguided injection or guided if unguided unsuccessful.
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	Consider secondary care opinion for persistent symptoms in the location of the bicipital groove for consideration of a tenotomy or tenodesis.
Thresholds for referral to Specialist In-patient care ***(Choice)***	**N/A**
Management pathway for Specialist In-patient care	**N/A**

Shoulder and Elbow service 2019