NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Shoulder Impingement Surgery for Subacromial Pain

Criteria Based Access

Before consideration of referral for management in secondary care, please review advice on the Remedy website (https://remedy.bnssg.icb.nhs.uk/) or consider use of advice and guidance services where available.

Funding approval for assessment for Shoulder Impingement Surgery for Subacromial Pain will only be provided by the ICB for patients meeting criteria set out below:

1. The patient has been assessed (including paper based triage where appropriate) by Musculoskeletal Services and undertaken a minimum of 3 months of conservative treatment, as advised by and documented in primary care, this must include a course of physiotherapy and rehabilitation.

AND

2. Patients have received one steroid injection, when clinically appropriate, from a trained physiotherapist or GP without improvement; (normally, only one injection should be considered as repeated injections may cause tendon damage (Dean B, 2014). A second injection is occasionally appropriate after 6 weeks but should only be administered in patients who received good initial benefit from their first injection and who need further pain relief to facilitate their structured physiotherapy treatment).

AND

3. Patients have been advised of the risks and benefits of the surgery and are willing to undergo surgery.

OR

4. Patients has been assessed by an experienced musculoskeletal clinician and it is deemed that assessment and diagnostics (including significant calcification) show significant structural damage and conservative treatments are considered as not clinically appropriate. These maybe be referred direct without the outcomes of further physiotherapy or rehabilitation.

Commissioned Surgery for those patients meeting the criteria above.

Rotator Cuff Repair for patients who have a clinically identified torn rotator cuff.

Sub Acromial Decompression is commissioned to treat a clinically confirmed Subacromial Impingement.

Combined RCRSAD is only commissioned for patients where there is a confirmed clinical need, i.e. they have a confirmed torn rotator cuff with Subacromial Impingement.

Note:

1. If the patient in question is clinically exceptional compared to the cohort, then an Exceptional Funding Application may be appropriate. The only time when an EFR application should be submitted is when there is a strong argument for clinical exceptionality to be made. EFR applications will only be considered where evidence of clinical exceptionality is provided within the case history/primary care notes in conjunction with a fully populated EFR application form.

   For guidance please see https://remedy.bnssg.icb.nhs.uk/

BRAN

For any health- related decision, it is important to consider "BRAN" which stands for:

- **B**enefits
- **R**isks
- **A**lternatives
- Do **N**othing

Benefits

Although surgery is usually very effective, it should only be considered after other treatments have been tried first and haven't resolved the problem. Key hole surgery over traditional surgery has the following direct benefits:

Less tissue damage
Reduced pain
Lower chance of infection
Less blood loss
Faster recovery time

Risks

Pain, infection, bleeding, bruising, neurovascular damage and anaesthetic complications can occur with any kind of surgery.

After RCR and SAD there is particular concern with the following types of problems:

- Stiffness: all patients initially are stiff, this usually resolves with time and exercises. 10% of patients develop some degree of frozen shoulder. Approx. 5% of patients are left with residual stiffness.
- Weakness: Most patients never regain full strength. This is dependent upon the patient age and type of tear.
- Pain is common early on, and whilst this usually settles with time, approximately 10 to 20% of people still have persistent pain around the shoulder after the surgery.
- Wound ooze: during the procedure the shoulder is pumped full of fluid. This often leaks out over the next 24 hrs.
- Re-tear is very common either due to reinjury or the tendon not healing in the first instance. If the tendon is degenerate and has poor blood supply often healing can be incomplete, or fail early.

Alternatives

Physiotherapy.
Nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen.
Local anesthetic and cortisone into the shoulder.

Do Nothing

Self-help treatment, including rest and avoiding painful movements can be effective.

Shoulder Impingement Surgery for Subacromial Pain – Plain Language Summary

Subacromial shoulder pain is felt on the top and outer side of the shoulder. It is worsened by overhead activity and can cause night pain but patients usually have full passive range of movement of the glenohumeral joint. The pain comes from the subacromial space of the shoulder, which contains the rotator cuff tendons and the subacromial bursa, and NOT from the glenohumeral joint (Royal College of Surgeons).

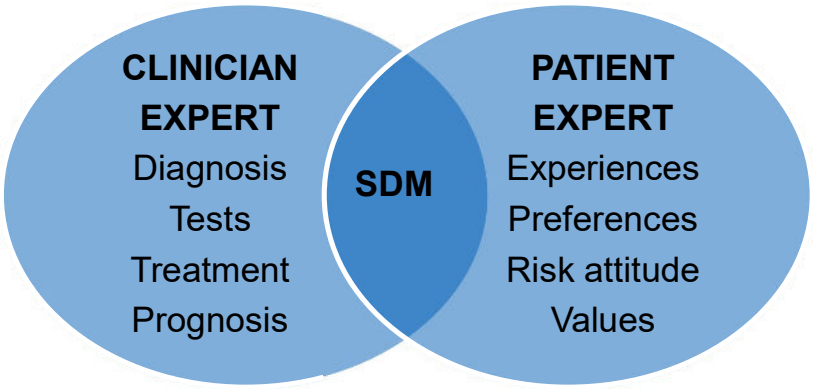
Rotator cuff disorders are considered to be among the most common causes of shoulder pain and disability encountered in both primary and secondary care, with subacromial impingement syndrome in particular being the most common disorder (Khan, 2013). Impingement occurs between the under surface of the acromion and the rotator cuff tendons. These tendons can be either intact or torn. Tendons can tear acutely due to injury, or due to degeneration. The prevalence of shoulder complaints in the UK is around 14%, with 1–2% of adults consulting their general practitioner annually with new shoulder pain. Painful shoulders pose a substantial

socioeconomic burden. This can impair capacity to work, causing time off, and affect performance of household tasks (Royal College of Surgeons).

Shared Decision Making

If a person fulfils the criteria for Shoulder Impingement Surgery it is important to have a partnership approach between the person and the clinician.

Shared Decision Making (SDM) is the meeting of minds of two types of experts:



It puts people at the centre of decisions about their own treatment and care and respects what is unique about them. It means that people receiving care and clinicians delivering care can understand what is important to the other person.

The person and their clinician may find it helpful to use 'Ask 3 Questions':

1. What are my options? (see sections above)
2. What are the pros and cons of each option for **me**?
3. How can I make sure that I have made the right decision?

This policy has been developed with the aid of the following:

1. National Health Service (2020) Health A to Z: Shoulder Impingement Surgery [online] www.nhs.uk/conditions
2. NHS England (2019) NHSE EBI Document www.ebi.aomrc.org.uk/interventions/
3. National Institute for Health Care Excellence (2022) Shoulder Pain [online] www.cks.nice.org.uk/topics/shoulder-pain/
4. Royal College of Surgeons (2014) Subacromial Shoulder Pain - Commissioning Guide www.rcseng.ac.uk

5. The Journal of Family Practice (2015) Is arthroscopic subacromial decompression effective for shoulder impingement [online] www.cdn.mdedge.com
6. National Library of Medicine (2018) Arthroscopic subacromial decompression for subacromial shoulder pain (CSAW): a multicentre, pragmatic, parallel group, placebo-controlled, three-group, randomised surgical trial [online] (29169668) www.pubmed.ncbi.nlm.nih.gov
7. National Library of Medicine (2014) Glucocorticoids induce specific ion-channel-mediated toxicity in human rotator cuff tendon: a mechanism underpinning the ultimately deleterious effect of steroid injection in tendinopathy? [online] (24677026) www.pubmed.ncbi.nlm.nih.gov
8. National Library of Medicine (2009) Conservative or surgical treatment for subacromial impingement syndrome? A systematic review [online] (19286397) www.pubmed.ncbi.nlm.nih.gov
9. National Library of Medicine (2018) Subacromial Decompression Yields a Better Clinical Outcome Than Therapy Alone: A Prospective Randomized Study of Patients With a Minimum 10-Year Follow-up [online] (29543510) www.pubmed.ncbi.nlm.nih.gov
10. National Library of Medicine (2014) Effect of specific exercise strategy on need for surgery in patients with subacromial impingement syndrome: randomised controlled study [online] (25213604) www.pubmed.ncbi.nlm.nih.gov
11. National Library of Medicine (2017) Acromioplasty in patients selected for operation by national guidelines [online] (28688937) www.pubmed.ncbi.nlm.nih.gov
12. National Library of Medicine (2013) No evidence of long-term benefits of arthroscopic acromioplasty in the treatment of shoulder impingement syndrome [online] (23836479) www.pubmed.ncbi.nlm.nih.gov
13. National Library of Medicine (2015) Which patients do not recover from shoulder impingement syndrome, either with operative treatment or with nonoperative treatment?[online] (25809315) www.pubmed.ncbi.nlm.nih.gov
14. National Library of Medicine (2013) The painful shoulder: shoulder impingement syndrome [online] (24082973) www.pubmed.ncbi.nlm.nih.gov
15. National Library of Medicine (2012) Arthroscopic subacromial decompression is effective in selected patients with shoulder impingement syndrome [online] (22844050) www.pubmed.ncbi.nlm.nih.gov
16. National Library of Medicine (2007) Arthroscopic rotator cuff repair with and without subacromial decompression: a prospective randomized study [online] (17210431) www.pubmed.ncbi.nlm.nih.gov
17. National Library of Medicine (2015) Conservative treatment or surgery for shoulder impingement: systematic review and meta-analysis [online] (24694286) www.pubmed.ncbi.nlm.nih.gov

Due regard

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

In carrying out their functions, the Bristol North Somerset and South Gloucestershire Commissioning Policy Review Group (CPRG) are committed to having due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which the ICBs are responsible, including policy development and review.

Document Control

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Governance

Commissioning policies are assessed for their likely level of impact on BNSSG ICB and the population for which it is responsible. This determines the appropriate level of sign off. The below described the approval route for each score category.

Policy Category	Approval By
Level 1	Commissioning Policy Review Group.
Level 2	Chief Medical Officer, or Chief Nursing Officer, or System Executive Group Chair
Level 3	ICB Board

OPCS Procedure codes

Must have any of (primary only):

The ICD10 diagnosis codes will be:
M75.4 – impingement syndrome of shoulder
M75.1 – Rotator cuff syndrome

The OPCS codes will be:
O29.1 – Subacromial decompression
Y767 – Arthroscopic approach to joint
Z94.2 – laterality (right for instance)
W84.4 – Endoscopic decompression of joint
Z81.2 - site code for acromioclavicular joint
Z94.2 – laterality (right side for instance)
T79.1 – Plastic repair of rotator cuff of shoulder
Z94.2 – laterality (right for instance)

Support

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Customer Services Team on: **0117 900 2655** or **0800 073 0907** or email them on **BNSSG.customerservice@nhs.net**.