Review date: 31 Oct 2021

Orthopaedics: Therapeutic shoulder arthroscopy

Orthopaedics: Therapeutic shoulder arthroscopy for Rotator cuff repair OR Subacromial decompression pathway

1st Presentation

1st presentation in primary care

Clinical assessment

ROUTINE

Primary care and intermediate care treatment over 6 weeks in accordance with **NICE CKS guidance**

Initial Treatment based on:
(1) Rest, analgesia, NSAID's
(2) Self guided therapy (BESS Rehabilitation booklet)
(3) Physiotherapy (6 weeks)
(4) Standard subacromial Injection*

* Injection only by an appropriately trained GP with special interest in MSK, extended scope practitioner or physiotherapist. **Image guided subacromial injections offer no extra value and are now not recommended by NHSE.**

Follow NHSE EBI recommendations on Imaging
Consider X-Ray to detect calcific tendonitis / exclude arthritis. (US / MRI are reserved for secondary care)

Review:
If no improvement or diagnosis uncertain, refer onwards.
2nd Injection - Consider if good response to 1st - but limit to 2 in a primary/intermediate care
Appropriate physiotherapy is of far greater value than a second steroid injection.

Consider a further 6-weeks of physiotherapy if improving after first 6 weeks. Appropriately trained physio can refer directly to secondary services

Discharge with self management written information and advice

URGENT RED FLAGS (1)

SYMPTOMATIC

Referral

MSK specialist triage referral management system

T&O referral with full patient history

Important referral information
1. Working diagnosis and clinical history
2. Impact on quality of life
3. Functional disability
4. Patient expectation
5. Whether patient would consider surgical intervention
6. Suitability for surgery (comorbidities, social setup)
7. Patient engagement and activation

Optimising patient for surgery
Consider optimising treatment for correctable co-morbidities (Anaemia, diabetes, Hypertension etc)
Consider screening for psychological support for pain management and coping strategies
Assess social and living situation
Medicine Optimisation

Note:
(1) **URGENT RED FLAGS**
1. Acute loss of shoulder function after trauma/Acute cuff tear.
2. Unreduced Dislocation
3. Suspected Infection
4. Mass or swelling/Tumour

Surgical review & assessment

Within 6 weeks

1st OPD appointment face to face

Assessment in Shoulder clinic
1. Confirm diagnosis with history and examination
2. Confirm appropriate conservative treatment has taken place in primary care
3. Consider imaging with US / MRI to assess rotator cuff
4. **Used shared decision making to decide on treatment**
5. Assess and treat as part of a multidisciplinary team with physiotherapists and surgeons.

Consider further physiotherapy where further input is required

Surgery is indicated for persistent or significant pain and loss of function despite appropriate non-operative treatment.
This is particularly the case following an appropriate response to a subacromial injection.
Decompression is expected to be performed arthroscopically to accelerate recovery.

Lists for surgery & preparation

List patient for surgery triggering following actions

Preoperative assessment specialist nurses supported by consultant anaesthetists.
physiotherapy advice & education about immediate post-operative management.
Correction of reversible comorbidities
Consider social situation
Educate patients on expected pain levels, discharge planning and anticipated recovery time
Staged consent process begins
Record pre-operative PROM's

Plan for all shoulder arthroscopy cases to be done as a day case

DATA collection:
Recommended minimum dataset
- Inpatient: Clinical hours to contact
- Outpatient: OSS or MSK-HQ, Time to first appointment, Time to discharge, Number of sessions, Loss to follow up (discharge due to *did not attend DNA)*

18 weeks from referral

Day of surgery

Prior to surgery - call to patient to check fitness & medication

Admission on day of surgery

All patients admitted on day of surgery to ring fenced orthopaedic elective wards in an appropriately resourced and staffed unit

Appropriate list utilisation / allocation to ensure adequate time for recovery and discharge

VTE Risk assessment

Reaffirmation of consent process

Begin discharge / TTA process

LocSSIPs based on NatSSIPs / WHO peri-operative check list

Shoulder theatre list to have a dedicated 'block' specialist anaesthetist, to ensure option of GA and inter-scalene block

Standard intraoperative analgesic regime

Use of appropriately regulated implants for rotator cuff repair with appropriate antibiotic cover.
Use absorbable sutures where appropriate.

Routine dressings and sling as per local unit practice and rehab guidelines

Day Case Inpatient management

7 Day services including senior review & physiotherapy

Phase 1 enhanced recovery

Monitoring of vital signs whilst patient is recovered
Step down onto ward

Assessment by physiotherapist whilst on the ward. Give advice on: mobility; transfers; managing ADLs, sling on and off.
Start gentle exercise as prescribed, provide patient education

Removal of pressure dressing if used and change of surgical dressings if saturated with fluid

Nurse criteria led discharge;
reasonably pain free analgesia; voiding urine; therapy goals achieved; ambulant; wound checked; OT equipment in place / scheduled; care packages in place as needed

Discharge & follow-up

Patient information provided on ward prior to discharge.

Discharge

Patient provided with appropriate written physiotherapy instructions (locally agreed).
Post operative physiotherapy appointments (virtual or f2f) to be arranged prior to discharge

Nurse led discharge from the ward

Patient discharged with oral analgesia for a week and information on how they can monitor their pain

At 2 weeks

Wound assessment by nurse led clinics (usually GP nurse)
f2f or video call.

Rehabilitation should follow local post-operative protocols and future BESS Rehab guidelines. Therapy provision based on functional goals with discharge upon achievement of these goals and/or agreed local post-operative protocols. Rehabilitation can include virtual delivery where appropriate including group based rehabilitation

Patients provided with a contact telephone number or email address in case they encounter a post operative complication

At 6 weeks

Review by surgeon or extended scope practitioner to ensure patient is reaching their goals and there are no complications. Up to 3 routine follow ups for reconstructive procedures.

GIRFT recommends that Trusts collect shoulder PROMs at 12 months or at discharge point

References:
1. Beard DJ et al. Arthroscopic subacromial decompression for subacromial shoulder pain (CSAW): a multicentre, pragmatic, parallel group, placebo-controlled, three-group, randomised surgical trial. *Lancet*. 2018;391(10118):329-338.
2. Kulkarni et al. Subacromial shoulder pain. *Shoulder Elbow*. 2015;7(2):135-143.
3. NICE Clinical Knowledge Summary - Shoulder pain. https://cks.nice.org.uk/topics/shoulder-pain/
4. BESS/GIRFT Exercises to treat your subacromial shoulder pain – https://bess.ac.uk/wp-content/uploads/2020/06/SubacromialShoulderPain-A5Booklet.pdf
5. NHS EBI 2 Programme on shoulder imaging *(to be published in late 2020)*.
6. Rees et al. Shoulder Pain Diagnosis, Treatment and Referral Guidelines for primary, community and intermediate care. *Shoulder and Elbow (In Press) and part of the NHS EBI2 Progarmme.*