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**Policy for Subacromial Pain in
Adults.**

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The CCG policy has been reviewed and developed by the Treatment Policies Clinical Development Group in line with the groups guiding principles which are:

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community
6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance;
7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered; AND
8. All policy decisions are considered within the wider constraints of the CCG's legally responsibility to remain fiscally responsible.

Category: Not Routinely Commissioned

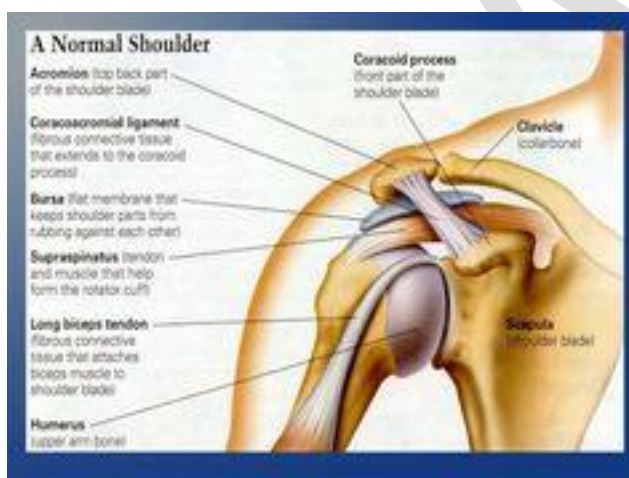
Sub-acromial Pain in Adults

Rotator cuff disease (wear and tear of the rotator cuff tendons) is thought to be a continuum ranging from shoulder impingement syndrome (SIS) through to partial and then full thickness rotator cuff tears [1]. It is one of the most common causes of non-traumatic shoulder pain which presents in primary care and is a normal part of aging [2].

The rotator cuff tendons hold the shoulder joint in place and allow people to lift the arm and reach overhead. When the arm is lifted, the rotator cuff tendon passes through a narrow space at the top of the shoulder, known as the sub-acromial space. The illustration of a healthy shoulder joint below (Figure 1) shows the relationship of tendons, ligaments, soft tissue and bony anatomy of the sub-acromial space.

Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.

Figure 1: Anatomy of a normal shoulder.

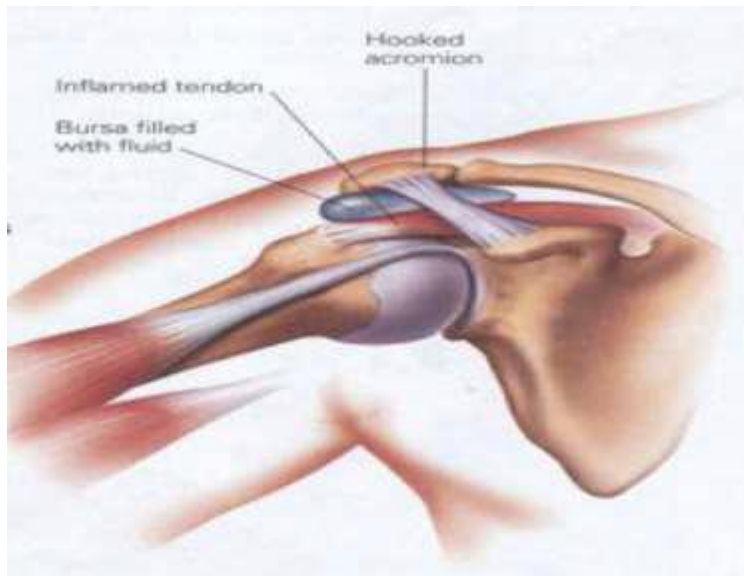


Source: Orthopaedic Surgeons of Long Island Association.
Retrieved from http://www.orthomd.com/procedures/impingement_syndrome.html

Shoulder impingement occurs when the tendon rubs or catches on the acromion and the sub-acromial bursa. Shoulder impingement may start suddenly or come on gradually. As illustrated in Figure 2, it may occur if the tendon is swollen, thickened or torn due to injury, overuse or age-related "wear and tear":

- the subacromial bursa becomes irritated and inflamed (bursitis)
- the acromion is curved or hooked, rather than flat
- there are bony growths (spurs) on the acromion

Figure 2: Anatomy of a shoulder affected by shoulder impingement syndrome



The main problem in shoulder impingement syndrome is of pain in the top and outer side of the shoulder, which is worse when the arm is raised overhead [1]. Pain is associated with dysfunction, affecting usual activities of daily living, sporting activities and ability to work full time. Patients often report a significant reduction in terms of health-related quality of life [3].

Shoulder impingement will often improve in a few weeks or months, especially with prescribed shoulder exercises.

Arthroscopic Sub-acromial Decompression.

The term 'arthroscopic' describes any surgical procedure which is performed using surgical instruments inserted through a small 'keyhole' incision and an endoscope inserted via a separate incision to visualise the area.

Arthroscopic shoulder surgery is not one single surgical procedure; rather it refers to a wide range of procedures to different parts of the shoulder anatomy. These may repair damaged cartilage or torn tendons, remove loose fragments of bone or cartilage, drain excess fluid, or release adhesions.

Arthroscopic sub-acromial decompression (ASD) is the most common surgical procedure in patients with shoulder impingement syndrome (SIS) [3]. The standard procedure is antero-inferior acromioplasty, i.e. the resection of bone spurs under the lateral third of the acromion, as well as the excision of the coracoacromial ligament and the sub-acromial bursa. If a partial or small full-thickness tear of the rotator cuff is present, it may be mildly debrided or left alone [3].

Evidence Review

Shoulder Impingement Syndrome.

Three randomised controlled trials were identified and reviewed, which compared ASD to conservative treatment for patients with SIS (at 24 months in two of the trials and 12 months only in the CSAW RCT). Patients with partial thickness rotator cuff tears were not excluded from these RCTs. The key differences between the study design were that Ketola et al [7] compared ASD plus physiotherapy to physiotherapy alone [7], whereas in the FIMPACT [6] and CSAW [4] RCTs, there were three treatment arms. Both FIMPACT and CSAW included ASD plus physiotherapy and diagnostic arthroscopy plus physiotherapy as two of the three arms. However, in the UK based multicentre RCT known as CSAW, the third arm was no treatment at all, whereas in the FIMPACT RCT, the non-operative third arm was a home exercise regime as well as 15 physiotherapy visits.

- ASD plus physiotherapy versus diagnostic arthroscopy plus physiotherapy. There was no clinically significant difference between ASD plus physiotherapy treatment compared to diagnostic (sham) arthroscopy plus physiotherapy at either 12-month follow-up in the CSAW RCT [4] or at 24 months (FIMPACT RCT) [6]. This was consistent for all of the outcomes measured: OSS, Constant score, pain, depression and anxiety, quality of life, simple shoulder test, 15D and patient satisfaction.
- ASD plus physiotherapy versus no treatment: Although small statistical differences were seen in favour of ASD followed by up to four sessions of physiotherapy, there were no clinically important differences for any outcomes measured at 12 months compared to no treatment at all [4].
- ASD plus physiotherapy versus physiotherapy therapy only: There were no clinically important differences reported between these two treatment groups at 24-month follow-up [6,7] even though the physiotherapy protocol for the FIMPACT RCT was for 15 sessions (compared to just one post-operative session for those being treated with ASD). Both the ASD plus PT and PT only groups in the RCT by Ketola et al [7] had a similar number of physiotherapy sessions (6 and 7 sessions respectively). Within each treatment group, all three trials showed clinically significant improvements at 12 or 24 months, when compared to baseline for the OSS, the Constant score and for pain [4,6,7].

These RCTs showed that ASD for SIS was no more effective than physiotherapy alone or no treatment at achieving clinically important differences at 12 months and 24 months (OSS, Constant Score and pain). In addition, all three treatment groups achieved clinically important improvements over time compared to baseline. This suggests that the natural history of non-traumatic shoulder impingement syndrome, which has previously failed conservative treatment, is for the painful and disabling symptoms to resolve without intervention.

Supraspinatus tear.

There was one single RCT where 180 patients with a supraspinatus tear were treated with arthroscopic acromioplasty and physiotherapy, or tendon repair, acromioplasty and physiotherapy and the outcomes were compared to patients who had 10 sessions of physiotherapy alone. All the patients followed the same physiotherapy plan. There were no between group differences in the Constant score at 12 months. Although the ASD was performed concomitantly with repair of the supraspinatus tendon, the results are consistent with the results of the RCTs which assessed the effectiveness of ASD for the management of shoulder impingement syndrome.

Cost Effectiveness.

No studies generalisable to the NHS were found which measured the cost effectiveness of ASD compared to conservative treatment in patients with subacromial shoulder pain.

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Eligibility Criteria

Due to the lack of evidence for the clinical effectiveness of arthroscopic shoulder decompression (ASD) compared to conservative treatment, ASD followed by physiotherapy for patients with sub-acromial pain is not routinely commissioned.

N.B. Acute Severe Shoulder Pain

- Any shoulder 'red flags' identified during primary care assessment need urgent secondary care referral. . A suspected infected joint needs same day emergency referral. .
- An unreduced dislocation needs same day emergency referral. .
- Suspected tumour and malignancy will need urgent referral following the local 2-week cancer referral pathway. .
- An acute cuff tear as a result of a traumatic event needs urgent referral and ideally should be seen in the next available outpatient clinic.
- Acute calcific tendinopathy is not a red flag, it is severely painful, often mimicking malignant pain and usually necessitates an early secondary care referral for more interventional treatment.
- It should also be noted that patients with subacromial shoulder pain in which the symptoms and signs suggest a more systemic inflammatory joint disease, should be considered as a 'rheumatological red flag'.
- Any new inflammatory oligo or polyarthritis, with symptoms of inflammation in several joints, should be referred urgently (following local rheumatology referral pathways) because time is of the essence with these diseases and a prompt diagnosis with early commencement of disease modifying drugs where appropriate is essential.

This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Guidance

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