KISS: Shoulder Pain

BESS/BOA Shoulder Pain Guideline for Primary Care 2020 Pathway summary CKS 2017 BMJ 2016

Rule out Red Flags

- **Joint Infection** - red skin, fever, systemically unwell = same day emergency referral.
- Unreduced **traumatic shoulder dislocation** = same day emergency referral.
- **Malignancy** - mass, swelling, unexplained deformity, night pain, previous cancer, consider referred pain from apical lung cancer = 2 week cancer referral.
- **Acute rotator cuff tear** (can be 'easily missed' BMJ 2017;359:j5366) = urgent referral, ideally next available outpatient clinic:
  - Trauma, pain, weakness; unable to abduct arm above shoulder level, especially if not limited by pain.
  - Be alert to acute tears after shoulder dislocations, and do not be reassured by patients discharged from ED with 'normal' Xray.
- **Systemic/widespread symptoms** e.g. PMR, inflammatory arthritis.

General principles of managing shoulder pain (NB quick video reminder on shoulder exam click here):

- Management should be personalised, and **key aspects to consider** are the duration of symptoms, patient expectation, hand dominance, occupation, and level of activity/sports.
- Is it shoulder pathology or **is it pain from the neck or referred pain from elsewhere?**
  - Commonest non-shoulder cause of pain is the neck - see different pain distribution for neck/shoulder (click here) and simply move neck then shoulder to see which part reproduces the pain.
  - Consider also **referred pain** from lung apex (?malignancy) and diaphragm (shoulder tip pain).
- **Physiotherapy/exercise therapy is a key component** to most shoulder problems, but warn patients that improvement will take 6-12 weeks. If physio access is limited see links below for home exercises.
- **Steroid injections:**
  - Can be considered in some situations (see below) but should be done **in addition to** (not instead of) physio/exercise therapy.
  - Do NOT need to be image-guided in primary care.
- **Steroid injections and COVID** (Joint guidance Nov 2020 inc. BSR/BOA/RCGP):
  - The impact of intra-articular (IA) injections on COVID is still unknown but there are concerns they could worsen outcomes.
  - Particular consideration of IA injection risks is needed for more clinically vulnerable groups e.g. aged > 70, adults in BAME groups, those with diabetes, chronic respiratory disease, high BMI.
  - Analgesia, rest and exercise therapy should remain fist line treatments, but IA injections can be considered if first line measures failed or have high levels of pain and disability.
  - If doing IA injection use minimum appropriate dose.
- **Imaging** - X-ray can be considered (see below) but **ultrasound or MRI should NOT be used in primary care**, unless part of a specific local treatment pathway.

Is there a history of instability? Does the shoulder partly or completely come out of the joint?

- If **traumatic** refer urgently to orthopaedics (probably fracture clinic) - younger patients at risk of labral injury and high risk of recurrence, older patients at risk of acute cuff tear.
- If **atraumatic** (typically young patients aged 10-35) = refer physio; warn patients can take 6 months to resolve; consider early referral to shoulder specialist if frequent ED attendance, persistent displacement, aged <18 or regular absence from school or work.

Suspected AC joint pathology (typically aged >30):

- Pain and tenderness localised to AC joint; high arc pain; +ve cross arm ('Scarf') test.
- **Management:**
  - Rest, NSAIDS, analgesia, modify activity (e.g. avoid cross body shoulder abduction, avoid lifting).
  - Consider physio.
  - Consider ACJ steroid injection.
  - Xray and consider secondary care referral if not improving despite the above measures.

Suspected glenohumeral joint (GHJ) disorder:

- Globally restricted painful range of movement.
- Key feature to differentiate from other shoulder disorders is **reduced *passive* external rotation**.
- **Xray** should be considered to help differentiate between frozen shoulder and OA, as well as to rule out other causes e.g. avascular necrosis.

Frozen shoulder:

- **Background:**
  - Generally presents in 35-65 year olds.
  - More common in those with diabetes or cardiovascular disease.
  - 3 phases: painful phase, stiff phase, resolution phase.
  - Generally settles spontaneously over 18-24 months but can be persistent for several years in some.
- **Presentation:**
  - Gradual onset pain in the shoulder/deltoid region and stiffness.
  - Progresses to a globally restricted painful ROM in all planes, disproportionately affecting passive external rotation.
- **Management:**
  - Analgesics, NSAIDs (if appropriate, consider PPI cover).
  - Exercise therapy for 6-12 weeks - physio if available but home exercises are also recommended (for basic home exercises from versus arthritis click here).
  - IA steroid injection can be considered - ideally in the painful/early phase.
  - Refer if no improvement by 3 months (sooner if severe symptoms or unable to manage treatments).

GHJ OA:

- **Background:**
  - Generally presents in > 60 year olds.
  - Primary OA is relatively rare as non-weight bearing joint.
  - Look for signs of OA in other joints which may increase the likelihood of GHJ OA.
- **Presents** in a similar fashion to frozen shoulder hence need to consider Xray to help differentiate.
- **Management:**
  - Analgesics, NSAIDs (if appropriate, consider PPI cover).
  - Exercise therapy - consider physio or home exercises (click here).
  - IA steroid injection can be considered for short term relief of OA flare.
  - Refer if failure of conservative treatments or patient wishes to consider shoulder replacement but there are very limited other surgical options.

Subacromial shoulder pain AKA 'Impingment' or rotator cuff related shoulder pain (RCRSP):

- **Background:**
  - Covers a wide range of underlying pathologies generally caused by rotator cuff tendinopathies or partial/degenerative cuff tears.
  - Commonest cause of shoulder pain in primary care.
- **Presentation:**
  - Shoulder/deltoid pain, generally worse in overhead positions and painful to lie on.
  - Active movements are generally more painful than passive; preservation of passive external rotation.
  - Painful arc of abduction and pain on abduction with thumb down/worse against resistance (Jobe's test/empty can test).
- **Management:**
  - Exercise therapy and physio should be the cornerstone of treatment (click here for home exercises if physio access is limited).
  - IA steroid injections can be considered to aid physio/exercise but NO MORE than 2 (evidence suggest repeated injections increase the risk of tendon damage).
  - Refer (and consider Xray) if no better by 6-12 weeks.