

Shoulder Pain Pathway (Age 16+)

EXCLUDE Red Flags requiring Emergency treatment

- History of recent significant trauma/Suspected fracture, dislocation or tendon rupture – **Send to ED**
- Clinical suspicion of Infection – **Complete News 2 and Send to ED**
- Please consider any non MSK cause for shoulder pain which would also warrant emergency onwards management e.g. cardiac, diaphragmatic irritation (abdo or thoracic cause)

EXCLUDE Amber Flags requiring urgent treatment

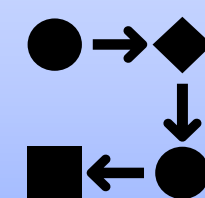
- NEW Atypical mass or Swelling – NICE Guidance - Symptoms suggestive of bone and soft tissue sarcoma Check criteria and Refer for 2WW to Sarcoma Clinic
- Suspected Inflammatory Disease – Consider referral to Rheumatology
- Rapid Deterioration of symptoms following Surgery – Ensure no systemic infection – Urgently refer to Secondary care back to the operating surgeon
- Acute rotator cuff tear – Urgently refer to MSK Hub. If patient is under 75, has definite history of significant trauma and There is severe pain present and loss of active movement then urgently refer to Shoulder Surgeon.
- Acute long head of Biceps rupture - If the patient is 60 years of age, or younger, with signs of a LHB rupture a surgical opinion may be clinically indicated. If less than 4 weeks since rupture **refer to ED** acute LHB rupture.

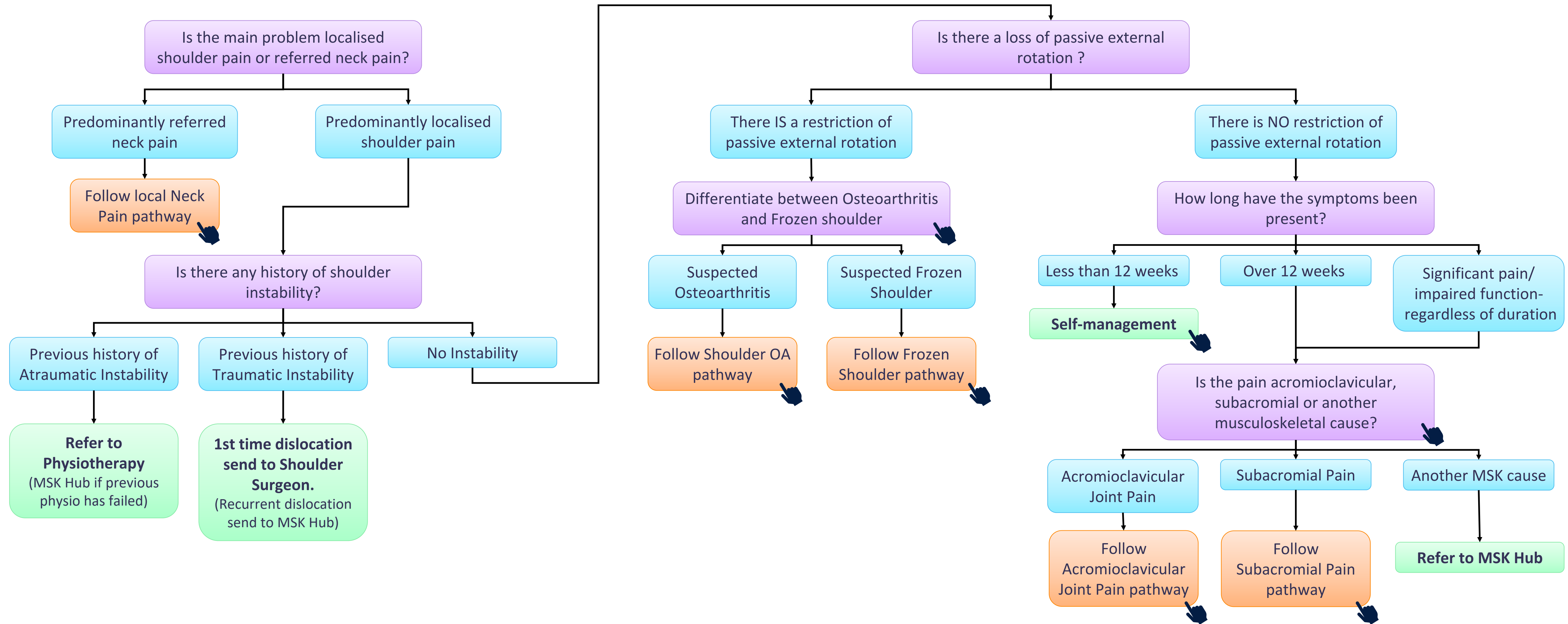
EXCLUDE Non MSK causes of shoulder pain

- Left shoulder-cardiac
- Gallstones
- Spleen
- Liver
- Pancreatitis
- Ruptured Ovarian Cyst / Ectopic
- and other causes of diaphragmatic irritation

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Review date	Every 12 months

Start Shoulder Pain Pathway





Self-Management for Shoulder Pain

Imaging is NOT routinely needed for shoulder pain

NSAIDS / analgesia if no contraindication (available OTC)

Fit note if work not possible/modifications needed

If patient is digitally enabled, prescribe the getUbetter app

Messaging for the patient

- Many shoulder pains can present without injury or obvious cause. However, some will present due to overuse or a strain to the shoulder.
- Manage with simple exercise, posture and relevant work advice and the majority of shoulder problems will get better within 12 weeks.
- Continue normal activities and stay in work where possible
- Return if problem deteriorates or if doesn't improve after 6 weeks of self - management and exercises AND is over 12 weeks since onset

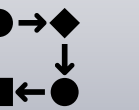
Additional information/support

- <https://www.versusarthritis.org/about-arthritis/conditions/shoulder-pain/>
- <https://bess.ac.uk/exercises-for-shoulder-pain/>

Return to start



Return to Main
Pathway



Differentiate between Osteoarthritis and Frozen shoulder

Osteoarthritis	Frozen Shoulder
• more common in >65's • often a slow and progressive onset of pain and stiffness • painful and restricted range of motion (particularly passive external rotation)	• consider age 35-66 (not exclusive to) • often faster progression of pain and stiffness than in OA • commonly no previous history of restricted range of motion • may be associated with diabetes, a previous frozen shoulder on the opposite side, a genetic predisposition, or underlying inflammatory disease • In most cases there is no clear cause for frozen shoulder • X-ray of a frozen shoulder is expected to show a normal glenohumeral joint
Follow Shoulder OA pathway	Follow Frozen Shoulder pathway

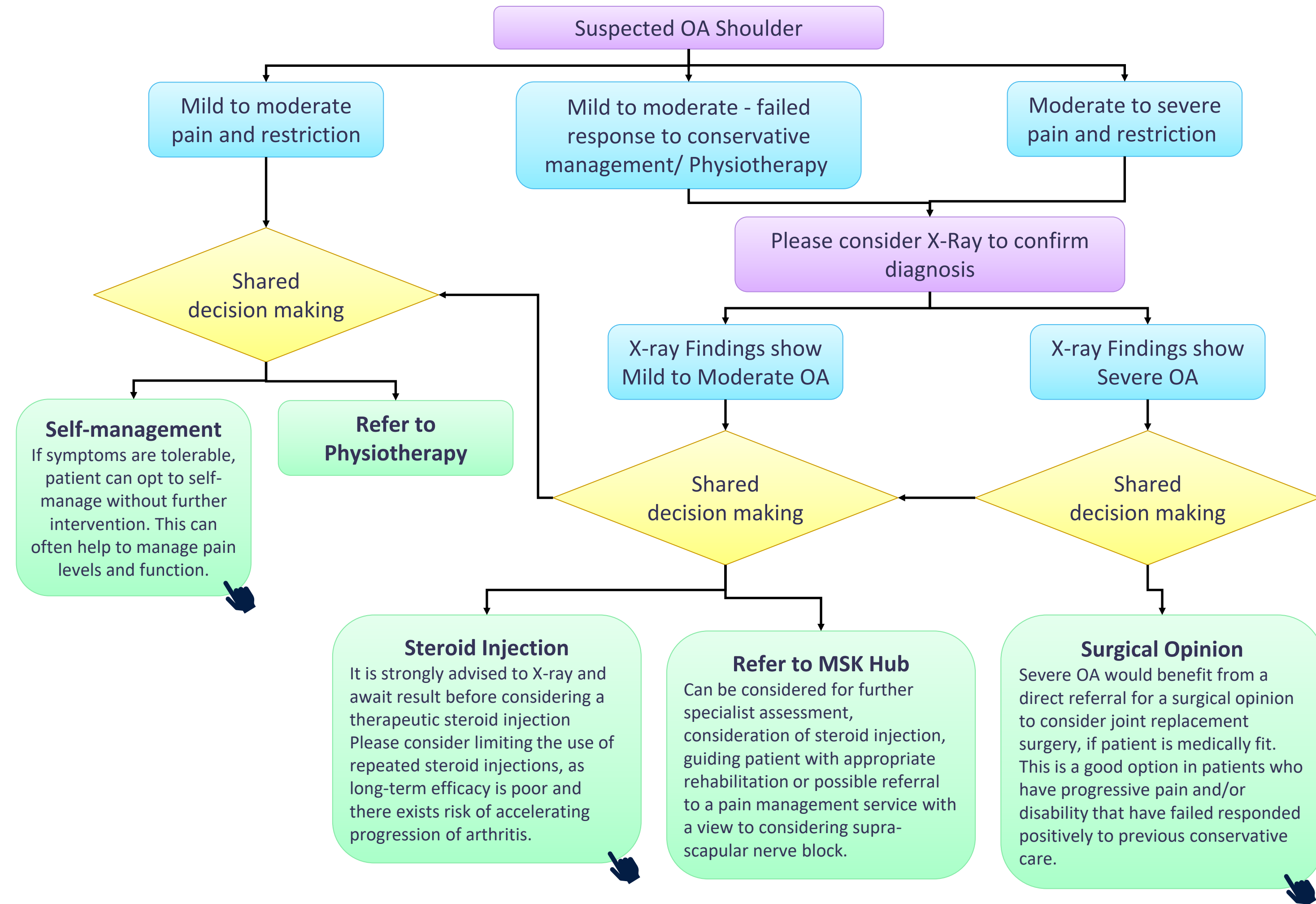
Shoulder Osteoarthritis Pathway

Onset of Symptoms /Risk Factors:

- more common in >65's
- often a slow and progressive onset of pain and stiffness
- painful and restricted range of motion (particularly passive external rotation)

Patient may report;

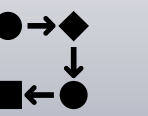
- Difficulty bending or stretching their arm
- Pain when you moving their shoulder
- Simple activities like shaving or brushing their hair can suddenly become much more difficult.
- Might hear some crunching or crackling noises, especially when moving their shoulder.
- The pain may feel worse at the end of the day, or when they move their arm, and it may improve when they rest.
- Might feel a bit stiff in the morning, but this shouldn't last more than half an hour.



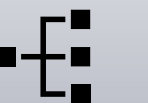
Return to start



Return to Main Pathway



Go to
Differential
Diagnosis



Self-Management for Shoulder OA

Imaging is NOT routinely needed for shoulder pain

NSAIDS / analgesia if no contraindication (available OTC) - [NICE guidance](#)

fit note if work not possible/modifications needed

If patient is digitally enabled, prescribe the getUbetter app

Messaging for the patient

- Osteoarthritis is age related change of the joint which can present as shoulder pain and associated stiffness.
- Despite being a chronic condition it can be managed well through appropriate exercises and activity modification.
- Manage with simple shoulder, neck, and midback exercises and relevant work advice.
- Continue normal activities and stay in work where possible
- Return if problem deteriorates or if doesn't improve after 6 weeks of self - management and exercises AND is over 12 weeks since onset

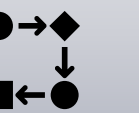
Additional information/support

- <https://www.versusarthritis.org/about-arthritis/conditions/osteoarthritis-oa-of-the-elbow-and-shoulder/>
- <https://www.versusarthritis.org/about-arthritis/exercising-with-arthritis/exercises-for-healthy-joints/exercises-for-the-shoulders/>
- <https://bess.ac.uk/exercises-for-shoulder-pain/>

Return to start



Return to Main
Pathway



Return to
Shoulder OA
Pathway



Steroid Injection for Shoulder OA/ Frozen Shoulder (Glenohumeral joint steroid injection)

- [Formulary link](#)
- A Glenohumeral steroid injection can be considered within primary care
- Injection may provide relief of symptoms but will not treat the underlying cause
- Please consider at this point whether the patient would benefit from a more detailed MSK assessment or whether you feel comfortable proceeding with a steroid injection in primary care

Please consider requesting an X-ray at this point to:

- assess degree of OA, or to exclude OA in Frozen shoulder
- exclude any abnormal pathology (Please be aware that a plain film is not always sensitive in identifying early pathology)

It is strongly advised to await X-ray result before considering a therapeutic steroid injection

Injection is not curative but can reduce pain and inflammation in order to facilitate recovery/ conservative management of the condition.

Glenohumeral joint steroid injections may provide some relief from symptoms, further assessment and treatment is often required to manage the underlying cause of pain

Encourage to continue rehabilitation exercises

Consider monitoring people with diabetes following steroid injection due transient hyperglycaemia.

Safety net regarding accessing ED care if developing signs of infection and/or allergic response.

Messaging for patients

- Glenohumeral joint steroid injections may provide some relief from symptoms, further assessment and treatment is often required to manage the underlying cause of pain
- Read the information link regarding the injection
- Whilst you wait for your injection manage with simple shoulder, neck, and midback exercises and relevant work advice. Continue normal activities and stay in work where possible
- You will be re-examined by the injecting clinician at your next appointment to confirm that this is the best treatment option for you
- Be aware that following an injection we would advise a period of relative rest for 2 weeks and avoidance of excessive overhead activities and heavy lifting

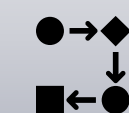
Additional information

- <https://www.versusarthritis.org/about-arthritis/treatments/drugs/steroid-injections/>

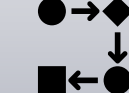
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Pathway



Return to
Frozen Shoulder
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Return to
Shoulder OA
Pathway



Surgical Management for Shoulder OA

Severe OA would benefit from a direct referral for a surgical opinion to consider joint replacement surgery, if patient is medically fit.

This is a good option in patients who have progressive pain and/or disability that have failed responded positively to previous conservative care.

NICE guidance states that patient specific factors (including age, sex, smoking, obesity and comorbidities) should not be a barrier to referral for joint surgery.

It is important to discuss with the patient the risk/ benefit of surgery in the context of their comorbidities so they can make an informed decision. When making a referral for surgical opinion the patient needs an up to date assessment to include the following factors listed below (not an exhaustive list)

Risk factors

- BMI > 36 Kg/m²
- Hypertension (>160/100) OR poorly controlled AF OR other cardiac history of relevance
- HbA1c > 68
- Hb level < 13 male or <12 female
- eGFR <60

Relevant medical history

- Heart failure or History of MI or stroke within 1 year
- Active treatment for Cancer within the past year
- Blood Clotting Disorder

Other Factors

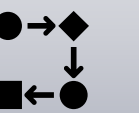
- Smoker
- Long term Steroid use

<https://www.versusarthritis.org/about-arthritis/treatments/surgery/shoulder-and-elbow-replacement/>

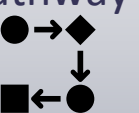
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Pathway



Return to
Shoulder OA
Pathway



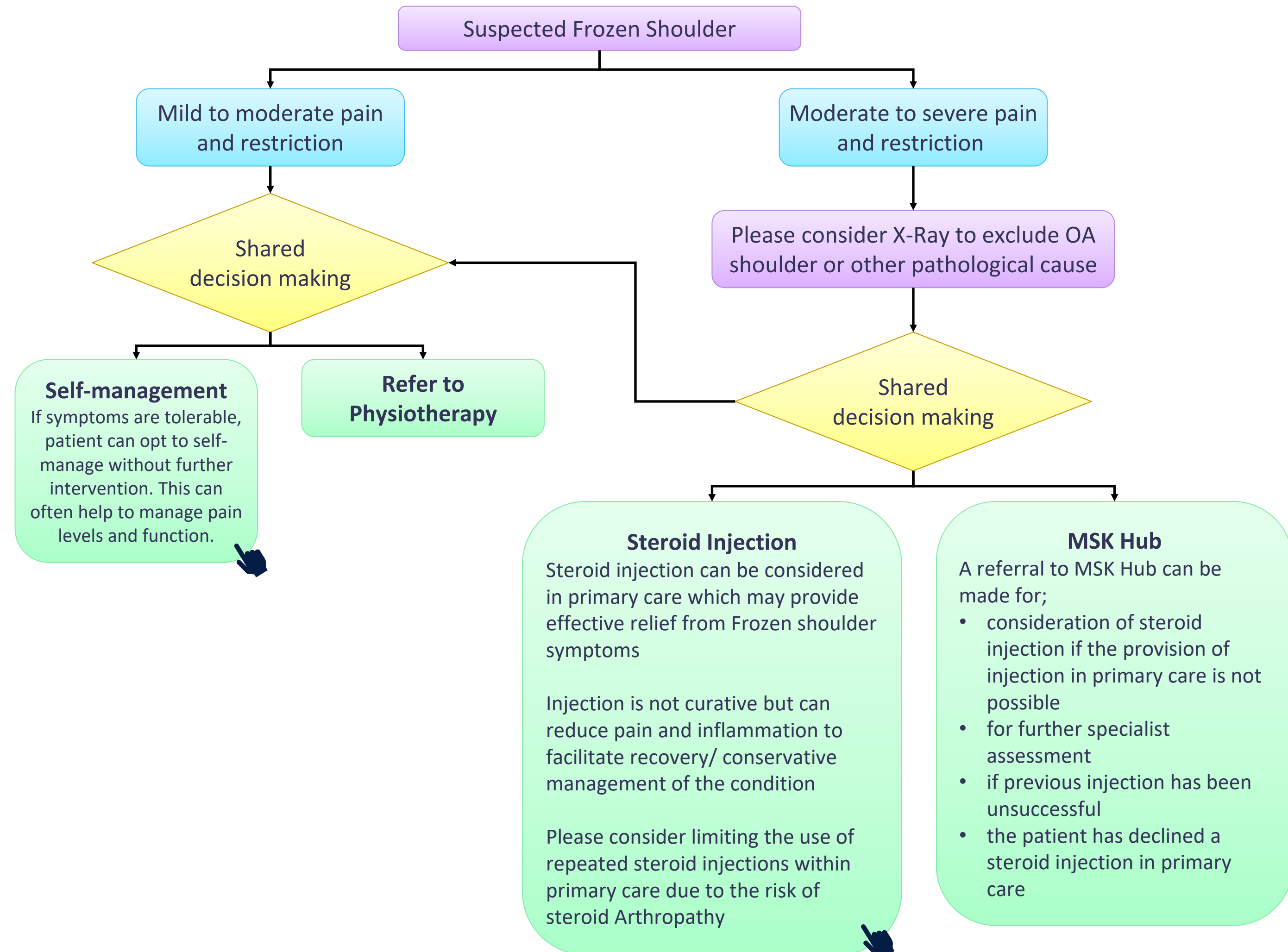
Frozen Shoulder Pathway

Onset of Symptoms /Risk Factors:

- consider age 35-66 (not exclusive to)
- often faster progression of pain and stiffness than in OA
- commonly no previous history of restricted range of motion
- may be associated with diabetes, a previous frozen shoulder on the opposite side, a genetic predisposition, or underlying inflammatory disease
- In most cases there is no clear cause for frozen shoulder
- X-ray of a frozen shoulder is expected to show a normal glenohumeral joint

In mild to moderate cases of frozen shoulder, patients often respond well to self-management or physiotherapy.

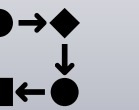
However, if the patient feels they have exhausted conservative care, patients with moderate symptoms may still benefit from a steroid injection and/or assessment by a specialist MSK triage service.



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Return to Main
Pathway



Go to
Differential
Diagnosis



Self-Management for Frozen Shoulder

Imaging is **NOT** routinely needed for shoulder pain

Consider association with diabetes / diabetic control

NSAIDS / analgesia if no contraindication (available OTC)

fit note if work not possible/modifications needed

If patient is digitally enabled, prescribe the getUbetter app

Messaging for the patient

- It is often not clear why people get a frozen shoulder.
- Frozen shoulder can happen because:
 - you had an injury or surgery that keeps you from moving your arm normally
 - you have diabetes – it's still unclear why this is, but it's important to have your regular diabetes check-ups to catch any problems early
- Frozen shoulder happens when the tissue around your shoulder joint becomes inflamed
- The tissue then gets tighter and shrinks, which causes pain
- Unfortunately, a frozen shoulder does last for a year or more but does tend to become less painful over the months.
- Continue to keep moving your neck and shoulder within your available range.
- Frozen shoulder will respond well to graded exercise including shoulder stretches to increase mobility, there will likely be some discomfort with these stretches but this is not harmful. It is important to perform exercises regularly and therefore you should avoid excessive pain during or after.
- Return if problem deteriorates or If you wish to reconsider management plan

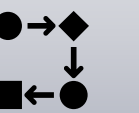
Additional information/support

- <https://www.nhs.uk/conditions/frozen-shoulder/>
- <https://www.versusarthritis.org/about-arthritis/exercising-with-arthritis/exercises-for-healthy-joints/exercises-for-the-shoulders/>
- <https://bess.ac.uk/exercises-for-shoulder-pain/>

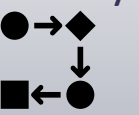
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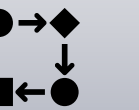


Return to Main
Pathway



Return to
Frozen Shoulder
Pathway





Is the pain acromioclavicular, subacromial or another musculoskeletal cause?

Acromioclavicular Joint Pain	Subacromial Pain	Another MSK cause
• Positive scarf test • Pain is localised to the AC joint and is associated with tenderness. • High arc pain	• Positive empty can test • Pain more likely to be in the deltoid area • Painful mid arc	• If your patient does not fit either category, pain could be due to another MSK cause such as biceps pathology.
Follow Acromioclavicular Joint Pain pathway	Follow Subacromial Pain pathway	Refer to MSK Hub

Acromioclavicular Joint Pain Pathway

Examination

- Positive scarf test.
- Pain is localised to the AC joint and is associated with tenderness.
- High arc pain

Acromioclavicular pain is likely a result of osteoarthritis in the AC joint and/or a stress or strain of the joint. Most cases will respond to activity management and physiotherapy management

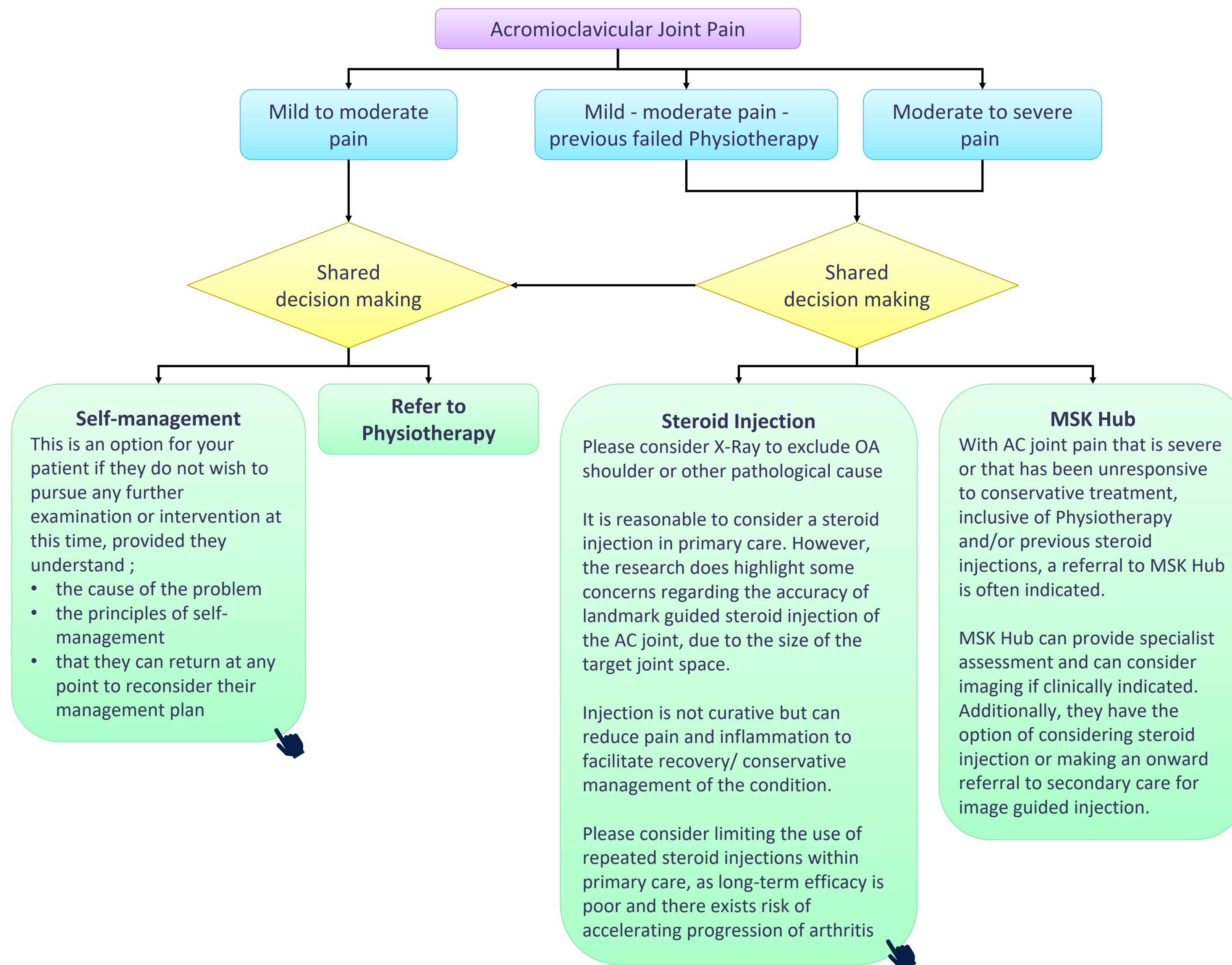
Please consider the severity of symptoms:

Mild - moderate:

- Patient can lift and reach above head height but with pain.
- Sleep is affected but not significantly.
- Most daily activities, including work are achievable

Severe:

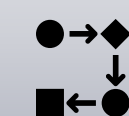
- Severe pain,
- unable to do activities such as reaching or lifting above head height.
- Sleep affected every night without relief from analgesics.
- Off work due to pain



Return to start



Return to Main Pathway



Go to Differential Diagnosis



Self-Management for Acromioclavicular Joint Pain

Imaging is NOT routinely needed for shoulder pain

NSAIDS / analgesia if no contraindication (available OTC)

fit note if work not possible/modifications needed

If patient is digitally enabled, prescribe the getUbetter app

Messaging for the patient

- The joint at the end of your collar bone is likely to be the cause of your discomfort
- It will often be aggravated when fully elevating the shoulder above head height, when reaching across the body and when loading through the affected arm or lying on the affected shoulder.
- Being sensible and modifying activities to avoid unnecessary aggravation of pain can be useful in the short term.
- Simple postural correction, basic strength exercises like shoulder shrugs will likely be beneficial
- Return if problem deteriorates or If you wish to reconsider management plan

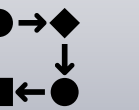
Additional information/support

- <https://www.versusarthritis.org/about-arthritis/conditions/shoulder-pain/>
- <https://www.versusarthritis.org/about-arthritis/exercising-with-arthritis/exercises-for-healthy-joints/exercises-for-the-shoulders/>
- <https://bess.ac.uk/exercises-for-shoulder-pain/>

Return to start



Return to Main
Pathway



Return to AC
Joint Pain
Pathway



Steroid Injection in Primary Care for Acromioclavicular Joint Pain

[Formulary Link](#)

- A steroid injection can be considered within primary care
- Injection may provide relief of symptoms but will not treat the underlying cause
- Please consider at this point whether the patient would benefit from a more detailed MSK assessment or whether you feel comfortable proceeding with a steroid injection in primary care

Please consider requesting an X-ray at this point to:

- assess if any degenerative change is present
- exclude any abnormal pathology (Please be aware that a plain film is not always sensitive in identifying early pathology)

It is strongly advised to await X-ray result before considering a therapeutic steroid injection

Encourage to continue rehabilitation exercises

Consider monitoring people with diabetes following steroid injection due transient hyperglycaemia.

Safety net regarding accessing ED care if developing signs of infection and/or allergic response.

Messaging for patients

- Read the information leaflet regarding the injection
- Whilst you await your injection, try and keep your shoulder and neck moving as pain allows. If you experience increased pain with overhead activities, reaching across your body and loading through the arm, it may be helpful to avoid or modify these activities
- You will be re-examined by the injecting clinician at your next appointment to confirm that this is the best treatment option for you
- Be aware that following an injection we would advise a period of relative rest for 10 days and avoidance of excessive overhead activities, heavy lifting or weight-bearing through the arms.

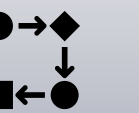
Additional information

- <https://www.versusarthritis.org/about-arthritis/treatments/drugs/steroid-injections/>

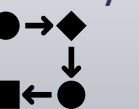
Return to start



Return to Main
Pathway



Return to AC
Joint Pain
Pathway



Subacromial Pain Pathway

Examination

- Positive empty can test as above
- Pain more likely to be in the deltoid area
- Painful mid arc

Subacromial pain is likely a result of a rotator cuff tendinopathy +/- bursitis
Most cases will resolve within 3-4 months with appropriate activity modification and physiotherapy management.

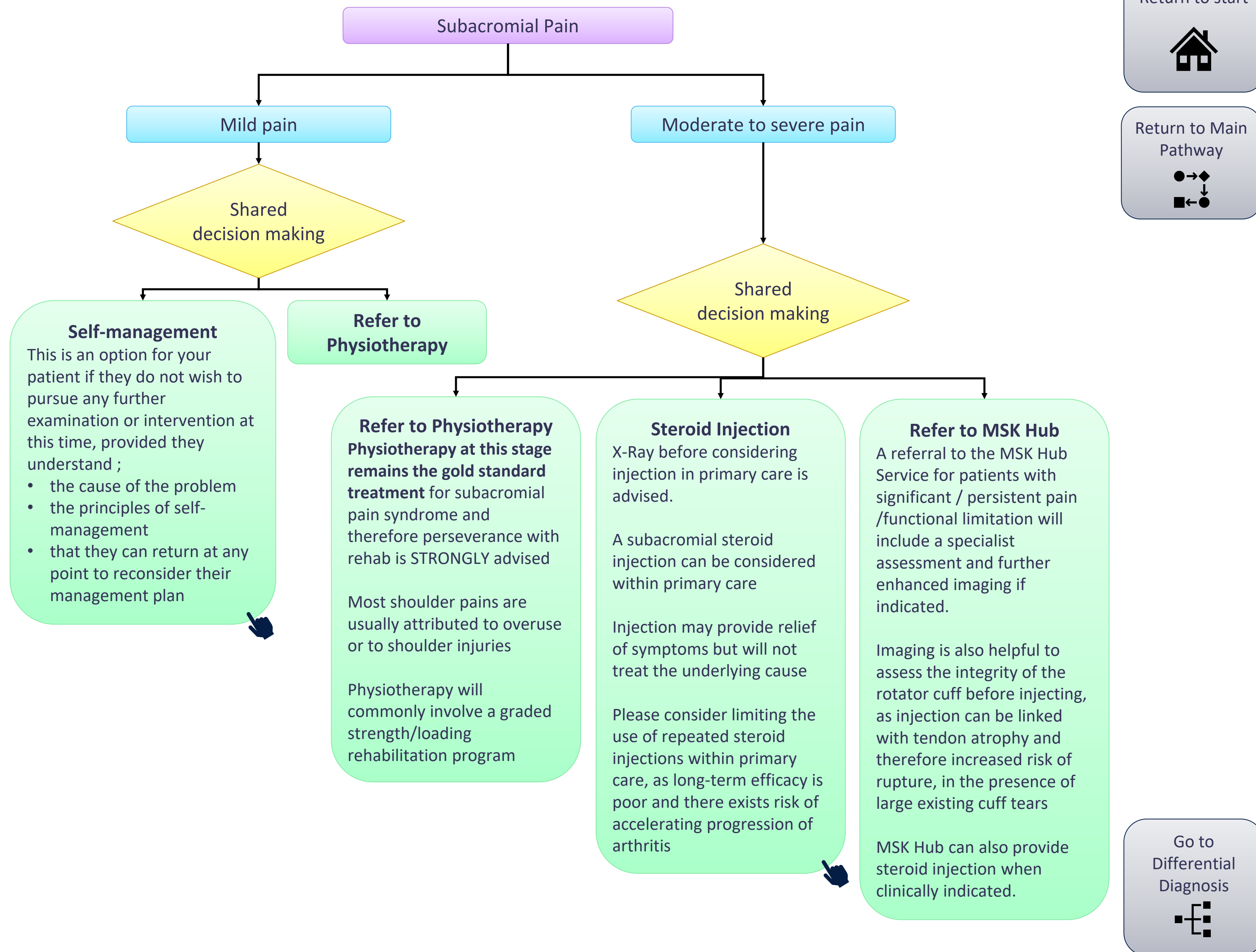
Definition of severity of symptoms:

Mild:

- Patient can lift and reach above head height but with pain
- Sleep is minimally affected
- Most daily activities, including work are achievable

Moderate or severe:

- Unable to do activities such as reaching or lifting above head height
- Sleep affected most nights without relief from analgesics
- Where relevant, symptoms are affecting work due to pain



Self-Management for Subacromial Pain

Imaging is NOT routinely needed for shoulder pain

NSAIDS / analgesia if no contraindication (available OTC)

Fit note if work not possible/modifications needed

If patient is digitally enabled, prescribe the getUbetter app

Messaging for the patient

- Subacromial pain syndrome is the most common mechanical pain disorder in the shoulder
- Usually aggravated by elevating the shoulder and lifting/carrying tasks
- It is safe and helpful to continue to use the arm and neck to maintain range of motion and muscle activity in the area
- Symptoms should settle with appropriate exercises and advice
- Return if problem deteriorates or If you wish to reconsider management plan

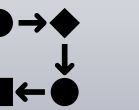
Additional information/support

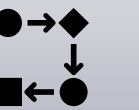
- <https://www.versusarthritis.org/about-arthritis/conditions/shoulder-pain/>
- <https://www.versusarthritis.org/about-arthritis/exercising-with-arthritis/exercises-for-healthy-joints/exercises-for-the-shoulders/>
- <https://bess.ac.uk/exercises-for-shoulder-pain/>

Return to start



Return to Main
Pathway





Steroid injection in primary care for Subacromial Pain

- [Formulary Link](#)
- A subacromial steroid injection can be considered within primary care
- Injection may provide relief of symptoms but will not treat the underlying cause
- Please consider at this point whether the patient would benefit from a more detailed MSK assessment or whether you feel comfortable proceeding with a steroid injection in primary care

Please consider X-ray at this point

- Investigation prior to injection in primary care is limited to X-ray
- X-Ray before considering injection in primary care is advised. Whilst this will not visualise the tendon tissue, it can highlight changes like superior humeral head migration which can be indicative of a cuff tear. The clinician is strongly advised not to inject if this is shown on the X-Ray.

Encourage to continue rehabilitation exercises

Consider monitoring people with diabetes following steroid injection due transient hyperglycaemia.

Safety net regarding accessing ED care if developing signs of infection and/or allergic response.

Messaging for patients

- Subacromial joint steroid injections may provide some relief from symptoms, further assessment and treatment is often required to manage the underlying cause of pain
- Read the information leaflet regarding the injection
- Whilst you wait for your injection manage with simple shoulder, neck, and midback exercises and relevant work advice. Continue normal activities and stay in work where possible
- You will be re-examined by the injecting clinician at your next appointment to confirm that this is the best treatment option for you
- Be aware that following an injection we would advise a period of relative rest for 2 weeks and avoidance of excessive overhead activities and heavy lifting

Additional information

- <https://www.versusarthritis.org/about-arthritis/treatments/drugs/steroid-injections/>