

**Clinical Guideline:** Shoulder Impingement Syndrome Site: FPH

History

Common condition involving inflammation, wear and degeneration of the rotator cuff (supraspinatus tendon) within the sub-acromial space.

**Wide spectrum of severity:**

* Acute impingement and temporary restriction of activity (younger pts)
* Chronic degeneration and eventual cuff tear (with increasing age)
* Arthropathy with significant disability
* Often associated with Acromioclavicualr (AC) joint and/or long-head of biceps tendon pathology
* May also occur as a secondary feature to frozen shoulder

Examination

Confirm diagnosis and any associated pathology.

Exclude neck as source of symptoms.

Younger patients (30+) usually acute onset and relate to injury or over-exertion.

Older patients (50+) typically more chronic duration with acute exacerbation suggesting cuff tear.

Investigation

Consider Shoulder X-ray. Exclude fracture (acute injury) or osteoarthritis (gleno-humeral or AC joint).

Referral Guidelines – red flag signs

Failure to respond to conservative measures:

Pain disturbing sleep and activities of daily living for 3 months.

Restriction of function persisting >6-9 months.

**The inability to pursue leisure activity should not be the primary reason for intervention. Pain affecting sleep and immobility are better determinants for referral**

Weakness with suspected cuff tear suitable for surgical repair.

Uncertain diagnosis.

**Patients unlikely to gain from Specialist Referral**

Mild symptoms / activity restriction not sufficient to warrant surgery.

Patient not willing to consider surgical options and activity / work restrictions during rehabilitation.

**Thresholds for Elective Surgical Intervention**

Failure of adequate conservative treatment (minimum 3-6 months)

Significant impact on quality of life

Disturbance of sleep / self-care

Impairment of ability to work / care for others

Willing to accept rehabilitation programme and restricted function during recovery.

**What patients can expect from Referral**

Full clinical assessment with further diagnostic imaging if indicated.

Aim for non-operative treatment where possible through patient education of condition and treatment options, local steroid injections and targeted physiotherapy as indicated.

Discuss surgical options, explaining admission process, procedure and associated risks as well as expected recovery and rehabilitation programme.

**Surgical Options**

Shoulder arthroscopic sub-acromial decompression (ASAD +/- acromioplasty).

Majority performed as Day-Case (or over-night stay), 2-3 8mm scars.

Can be combined with excision of the distal clavicle if AC joint involved.

Sling for comfort only, early motion encouraged.

Return to work 2-4 weeks (desk), 4-6 weeks + (physical).

Return to driving 2-4 weeks (up to 6)

Some discomfort expected at 6 weeks, majority good at 3-6 months, full resolution of symptoms 9-12 months.

85% ‘good’ result at 12 months (higher if previous good response to steroid injection)

Main risk is failure to resolve symptoms.

Patients may be offered other procedures to address associated pathologies (Rotator Cuff repair, Biceps Tendon Tenotomy, Capsular Release). These may have different implications for the patient which will be discussed with the surgeon

**Initial Management**

Activity modification (avoid provoking activities, particularly repetitive actions above chest height)

Regular Paracetamol and NSAIDs as tolerated.

Consider sub-acromial steroid injection if no improvement at six weeks (and/or AC joint if indicated).

**Physiotherapy referral** to maintain motion, restore cuff strength and function often improves pain and resolves symptoms

Advice and Treatment