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Clinical Commissioning Group

Shoulder Impingement Surgery for Subacromial Pain Policy CRITERIA BASED ACCESS

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Application Form	Generic IFR application form

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Shoulder Impingement Surgery for Subacromial Pain Policy Criteria Based Access

General Principles

Treatment should only be given in line with these general principles. Where patients are unable to meet these principles, in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the CCG's Individual Funding Request (IFR) Panel by submission of an IFR application.

1. Clinicians should assess their patients against the criteria within this policy prior to treatment.

2. Patients will only meet the criteria within this policy where there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment.

3. On limited occasions, the CCG may approve funding for an assessment only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy.

4. Patients with an elevated BMI of 30 or more are likely to receive fewer benefits from surgery and should be encouraged to lose weight further prior to seeking surgery. In addition, the risks of surgery are significantly increased. (Thelwall, 2015)

5. Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing. (Loof S., 2014)

Background

Subacromial shoulder pain is felt on the top and outer side of the shoulder. It is worsened by overhead activity and can cause night pain but patients usually have full passive range of movement of the glenohumeral joint. The pain comes from the subacromial space of the shoulder, which contains the rotator cuff tendons and the subacromial bursa, and NOT from the glenohumeral joint (Royal College of Surgeons).

Rotator cuff disorders are considered to be among the most common causes of shoulder pain and disability encountered in both primary and secondary care, with subacromial impingement syndrome in particular being the most common disorder (Khan, 2013). Impingement occurs between the under surface of the acromion and the rotator cuff tendons. These tendons can be either intact or torn. Tendons can tear acutely due to injury, or due to degeneration. The prevalence of shoulder complaints in the UK is around 14%, with 1–2% of adults consulting their general

practitioner annually with new shoulder pain. Painful shoulders pose a substantial socioeconomic burden. This can impair capacity to work, causing time off, and affect performance of household tasks (Royal College of Surgeons).

The treatment aim for subacromial pain is to 'improve pain and function'. Success is defined individually with patients to include the degree of improvement needed, and the level of residual symptoms that might be acceptable. Outcome depends on starting level of symptoms, patient demographics and expectations, as well as personal circumstances.

Types of Surgery

The types of surgery to treat shoulder pain include:

- Rotator Cuff Repair [RCR] can be used to treat a torn rotator cuff
- Sub Acromial Decompression [SAD] can be used to treat Subacromial Impingement in order To decompress the impingement of the rotator cuff against the coraco acromial arch (acromium process, spur, coraco- acromial ligament) and thickened /inflamed bursa.
- In addition, where there is a clinical need, a combined RCRSAD can be performed where patients may also have an associated acromioclavicular joint degeneration requiring excision. Patients may also have an associated rotator cuff tear, which may or may not, require separate repair.
- A trial reviewing the benefits of RCR with and without SAD concluded that "subacromial decompression did not seem to significantly affect the outcome of arthroscopic rotator cuff repair" (Milano G1, 2007). Therefore, combined RCRSAD is only commissioned for patients where there is clinical evidence of a torn rotator cuff and Subacromial Impingement.

Risks of Surgery

Pain, infection, bleeding, bruising, neurovascular damage and anaesthetic complications can occur with any kind of surgery. After RCR and SAD there is particular concern with the following types of problems :

- Stiffness: all patients initially are stiff, this usually resolves with time and exercises. 10% of patients develop some degreee of frozen shoulder. Approx. 5% of patients are left with residual stiffness.
- Weakness: Most patients never regain full strength. This is dependent upon the patient age and type of tear.
- Pain is common early on, and whilst this usually settles with time, approximately 10 to 20% of people still have persistent pain around the shoulder after the surgery.
- Wound ooze: during the procedure the shoulder is pumped full of fluid. This often leaks out over the next 24 hrs.
- Re-tear is very common either due to reinjury or the tendon not healing in the first instance. If the tendon is degenerate and has poor blood supply often healing can be incomplete, or fail early.

Evidence Summary

The effectiveness and cost effectiveness of surgical treatment options for shoulder pain is unclear and there are currently two large well designed randomised clinical trials being run in the United Kingdom to evaluate the effectiveness of rotator cuff repair (UKUFF) and arthroscopic subacromial decompression (CSAW). One recent

high quality systematic review found that there was no evidence of surgery being more effective than conservative methods in the treatment of shoulder impingement, but moderate evidence that surgery and conservative treatment have similar effects on the reduction of pain intensity based on a meta-analysis of 4/7 randomised controlled trials .

A recent evidence review published in The Journal of Family Practice highlighted the lack of high quality randomised controlled trial evidence to support the effectiveness of arthroscopic subacromial decompression for shoulder impingement, citing the results from only six observational (cohort) studies with a high degree of heterogeneity in measured outcomes (Ashbaugh, 2015)

In a Finnish randomised controlled trial also published in 2013, a wide range of long-term health and wellbeing outcomes were measured after two and five years following surgical intervention (Ketola S. L., 2013). In this study, the intervention group received arthroscopic acrominoplasty followed by a supervised exercise programme whilst the comparison group received the supervised exercise programme only. No statistically significant differences were found between the two groups at follow up, suggesting that the surgery was not cost effective.

The data from this trial was then reanalysed to look at differences in outcomes for clinical and demographic subgroups to determine whether particular patients could benefit from the intervention (Ketola S. L., 2015). Guidance for commissioners published by the Royal College of Surgeons in England (2014) provides an evidence based pathway for the treatment of shoulder pain which has been adapted locally for this policy.

POLICY – CRITERIA TO ACCESS TREATMENT - CBA

Funding approval for Shoulder Impingement Surgery for Subacromial Pain will only be provided by the CCG for patients meeting criteria set out below:

1. The patient has been assessed (including paper based triage where appropriate) by the Interface Service and undertaken a minimum of six weeks of conservative treatment, as advised by and documented in primary care, such as education, rest, cessation of painful activity, a course of physiotherapy, NSAIDs and analgesia without improvement of symptoms (Saltychev M, 2015)

AND

2. Patients have received one steroid injections from a trained physiotherapist or GP without improvement; (Normally, only one injection should be considered as repeated injections may cause tendon damage (Dean B, 2014). A second injection is occasionally appropriate after 6 weeks, but should only be administered in patients who received good initial benefit from their first injection and who need further pain relief to facilitate their structured physiotherapy treatment)

(Note: Patients with rotator cuff tears, or shoulder pain with weakness indicating structural damage may not be appropriate candidates for an injection, therefore the appropriateness of such treatment should be discussed with the patient. Where these patients do not wish to receive injection therapy, this clause may be disregarded)

AND

AND

3. Patients have been advised of the risks and benefits of the surgery and are fit and willing to undergo surgery.

AND

4. Symptoms are severe

Commissioned Surgery for patients who meet the criteria

- **Rotator Cuff Repair** for patients who have a clinically identified torn rotator cuff
- **Sub Acromial Decompression** is commissioned to treat a clinically confirmed Subacromial Impingement
- **Combined RCRSAD** is only commissioned for patients where there is a confirmed clinical need, i.e. they have a confirmed torn rotator cuff with Subacromial Impingement

RED FLAGS

1. Trauma, pain and weakness - ? Acute cuff tear
2. Any mass or swelling - ? Tumour
3. Red skin, fever or systemically unwell
   - ? Infection
4. Trauma/epileptic fit /electric shock leading to loss of rotation & abnormal shape
   - ? Unreduced dislocation

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Applications cannot be considered from patients personally.

Provided these patients receive the full support of their general practitioner, or clinician, in pursuing their funding request an application may be made to the Individual Funding Request Panel for consideration.

It is expected that clinicians will have ensured that the patient, on behalf of who they are forwarding the application for, is appropriately informed about the existing policies prior to an application to the IFRP. This will reassure the Panel that the patient has a reasonable expectation of the outcome of the application and its context.

An application put forward for consideration must demonstrated some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:

- Significantly different to the general population of patients with the condition in question

- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on Telephone number: 08000 851067.

Or write to us: NHS Somerset Clinical Commissioning Group, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email** us: somccg.pals@nhs.net

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This policy has been developed with the aid of the following references:

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