

Management of Subacromial Pain in Community Musculoskeletal Service

C. Taylor, S. Baltsezak, Community MSK Service, Primary Care Centre, Colchester, UK

Introduction

Subacromial pain (SAP) is a major cause of shoulder pathology. SAP 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⁽¹⁾. Of those presenting with new onset shoulder pain, up to 70% are reportedly due to SAP from rotator cuff pathology including tendonitis, calcific tendonitis and rotator cuff tears⁽²⁾. The treatment is largely conservative and includes analgesia, self-management advice, exercises, and corticosteroid injections⁽³⁾. Success of treatment is defined individually with patients to include the degree of improvement needed, and the level of residual symptoms that might be acceptable⁽¹⁾.

Referral to secondary care is considered when SAP is not responding to at least 6 weeks of evidence based non-surgical treatments with goal setting. Some patients who need surgery are unfit for anaesthesia or choose not to have surgery. A complex care package should be considered for these patients. This usually includes further non-operative measures such as repeated subacromial injections, suprascapular nerve block and ablation, specialist physiotherapy and Pain clinic referral.

Aim

To assess whether current management of patients presenting with subacromial pain to North East Essex (NEE) community MSK service is effective in reducing number of referrals to orthopaedic care.

Method

All patients who had subacromial steroid injection between June and November 2020 had retrospective review of electronic notes at 12-18 months after last consultation. Presence or absence of secondary care referral was recorded. Patients demographics, referral to physiotherapy, type and dose of injection were noted.

Fig 1. Xray of the shoulder demonstrating inferior subacromial osteophyte and acromioclavicular osteoarthritis. Both can contribute to the development of SAPS



Results

Overall, 134 patients with SAP were analysed. The average age was 58 years old (21-83). 61% (82) of patients were female, 39% (52) male. The pathologies diagnosed were subacromial pain syndrome (SAPS), calcific tendonopathy, and rotator cuff tears (Table 1.).

Table 1. Diagnosis of patients managed with SAP.

% of patients	Diagnosis
69%	Subacromial pain syndrome
19%	Rotator cuff tear
12%	Calcific tendonopathy

70.9% of patients had 40mg triamcinolone acetonide (Kenalog) injection in the subacromial space, 20.9% had 20mg, 7.46% had 30mg and 1 (0.74%) had 10mg. Only 51% of patient had documented physiotherapy rehabilitation after injection.

Table 2. Treatment outcomes.

% of patients	Outcomes
72%	Discharged to GP or Physiotherapy team
24%	Onward referral to Orthopaedics
4%	Onward referral to other specialty (Pain team, Rheumatology & Spinal team)

32 patients (24%) were referred to Orthopaedics (Table 2.) for further management: 6 patients had calcific tendonopathy, 8 patients had rotator cuff tear, 6 patients had acromioclavicular joint osteoarthritis, and 23 patients had SAPS. Further 4% of patients were referred to other secondary care specialties. Of those patients requiring referral, 66% did not have documented exercise therapy after injection.

Conclusion

Physiotherapist led exercise rehabilitation is the main component of SAP management coupled with steroid injection to facilitate the pain free rehab. Majority of patients (72%) presenting to NEE community MSK clinics did not require subsequent referral to secondary care. However, low number of physiotherapy referrals post injection leaves room for further improvement.

References

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2. Kulkarni R et al. Subacromial shoulder pain. *Shoulder Elbow*. 2015 Apr; 7(2): 135-143.
3. Roddy E et al. Optimising outcomes of exercise and corticosteroid injection in patients with subacromial pain syndrome: a factorial randomised trial. *Br J Sports Med* 2021; 55:262-271.