

<b>Policy title</b>	<b>Shoulder arthroscopy v1.0</b>
<b>Policy position</b>	<b>Criteria Based Access</b>
<b>Date of Forum recommendation</b>	<b>2017</b>

This policy covers the use of shoulder arthroscopy to investigate and treat a number of different conditions. These include labral tears, rotator cuff repair, adhesive capsulitis and non-traumatic joint instability.

For subacromial decompression please see policy 'Shoulder pain: subacromial decompression'.

### **Definition**

An arthroscopy is a form of keyhole surgery that is used to look inside a joint and repair any damage that has occurred.

An arthroscopy has two main uses:

- Diagnosis – an arthroscopy can help diagnose problems with the joint, such as joint pain, stiffness, or limited range of joint movement, and
- Treatment – an arthroscopy can be used to repair damage to the joint.

### **Conservative Management**

The conservative management to be attempted prior to referral to specialist assessment includes the following:

- Activity modification
- Physiotherapy and exercise programme
- Oral analgesics, including non-steroidal anti-inflammatory drugs (NSAIDs) unless contraindicated
- Steroid injections to the affected part of the joint where clinically appropriate

## Criteria for referral for specialist assessment

Shoulder arthroscopy and treatment is supported if clinically indicated, when the patient meets one of the following criteria:

- Full thickness rotator cuff tear as demonstrated by clinical symptoms and radiological imaging.

OR

- Significant superior labrum anterior posterior (SLAP) tear as demonstrated by clinical symptoms and radiological imaging.

OR

- Partial thickness rotator cuff tear as demonstrated by clinical symptoms and radiological imaging which has not responded to 3 months of conservative management.

OR

- Minor (type I\*) SLAP tear as demonstrated by clinical symptoms AND radiological imaging which has not responded to 3 months of conservative management.

OR

- \*Adhesive capsulitis demonstrated by clinical symptoms which has not responded to 6 months of conservative management.

OR

- \*Adhesive capsulitis demonstrated by clinical symptoms and in the view of the treating consultant is having an extraordinarily severe impact on quality of life, and which has not responded to conservative management including corticosteroid injection where clinically appropriate.

OR

- Non-traumatic shoulder joint instability that has not responded to 6 months of conservative management.

OR

- Traumatic shoulder joint instability alongside relevant conservative management as clinically appropriate.

In the above criteria radiological imaging mentioned is to be organised by the Musculoskeletal (MSK) intermediate service as appropriate. Clinical symptoms are to be evaluated by primary, intermediary and secondary care physicians.

Arthroscopy for frozen shoulders or adhesive capsulitis following a fracture is supported as undertaking manipulation under anaesthetic increases the risk of a re-fracture.

Shoulder arthroscopy for diagnostic purposes is **not normally funded**.

### **Rationale**

Rationale for shoulder arthroscopy includes adhesive capsulitis, rotator cuff damage, impingement syndrome and recurrent instability. In these cases, the evidence supports the use of shoulder arthroscopy for treatment purposes. However, the use of arthroscopy for diagnostic purposes is not supported and radiological investigations should be used for this.

In the majority of circumstances a clinical examination (history and examination) by a competent clinician will give a diagnosis and demonstrate if internal joint derangement is present. If there is diagnostic uncertainty despite competent examination or if there are “red flag” symptoms/signs/conditions, then a magnetic resonance imaging (MRI) scan might be indicated.

**Red flag** symptoms or signs include recent trauma, constant progressive non-mechanical pain (particularly at night), previous history of cancer, long term oral steroid use, history of drug abuse or HIV infection, fever, being systematically unwell, recent unexplained weight loss, persistent severe restriction of joint movement, widespread neurological changes, and structural deformity. Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis.

In all cases a number of conservative management options should be attempted first as the evidence shows that these often work and can significantly reduce pain and increase motion in the shoulder.

\*Sydney classification (Synder SJ, Karzel RP, Del Pizzo W, et al. SLAP lesions of the shoulder. Arthroscopy 1990; 6; 274-279)

**References:**

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**NOTE:**

This policy will be reviewed in the light of new evidence or new national guidance, eg, from NICE.

**Clinical coding:**

## Procedure codes:

Z81.4 Shoulder joint

Y76.7 Arthroscopic approach to joint

W78.4 Limited release of contracture of capsule of joint

W78.1 Release of contracture of shoulder joint

W919 Unspecified other manipulation of joint

T79.1 Plastic repair of rotator cuff of shoulder NEC

W88.- Diagnostic endoscopic examination of other joint plus Z81.4 Shoulder Joint

Key words: shoulder arthroscopy, labral tears, rotator cuff repair, adhesive capsulitis, joint instability