Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain Policy

Statement

Derby and Derbyshire CCG (DDCCG), in line with its principles for procedures of limited clinical value, has deemed arthroscopic shoulder decompression for subacromial shoulder pain to not be routinely commissioned.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by DDCCG.

To clarify, ‘pure subacromial shoulder impingement’ means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain or calcific tendinopathy. Non-operative treatments, such as physiotherapy and exercise programmes, are effective and safe in many cases.
1. Description of the Intervention
Recent research has indicated that in patients with pure subacromial impingement (with no other associated diagnoses such as rotator cuff tears, calcific tendinopathy and acromio-clavicular joint pain), non-operative management with a combination of exercise and physiotherapy is effective in the majority of cases.

Treating clinicians and surgeons should refer to the 2015 BESS/BOA/NICE commissioning guidelines (guideline update due in 2018/19) for details of appropriate treatment of these patients. [https://www.boa.ac.uk/resources/subacromial-shoulder-commissioning-guide.html](https://www.boa.ac.uk/resources/subacromial-shoulder-commissioning-guide.html).


2. Summary of Intervention
Arthroscopic sub-acromial decompression is a surgical procedure that involves the decompression of the sub-acromial space by removing bone spurs and soft tissue arthroscopically.

3. Recommendation
Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only be offered in appropriate cases. To clarify, ‘pure subacromial shoulder impingement’ means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment, such as physiotherapy and exercise programmes, are effective and safe in many cases.

For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.

4. Rationale for Recommendation
Recruiting patients with pure subacromial impingement and no other associated diagnosis, a recent randomised, pragmatic, parallel group, placebo-controlled trial investigated whether subacromial decompression compared with placebo (arthroscopy only) surgery improved pain and function\(^1\). While statistically better scores were reached by patients who had both types of surgery compared to no surgery, the differences were not clinically significant, which questions the value of this type of surgery.
On the other hand, a more recent prospective randomised trial comparing the long term outcome (10 year follow up) of surgical or non-surgical treatment of subacromial impingement showed surgery to be superior to non-surgical treatment.

Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non-operative management fails. There is also some evidence to show the benefit of surgery when used selectively and applying national clinical guidelines.

A review of the literature identified one further systematic review that looked at the effectiveness of surgery. The review was limited by the quality of evidence but their findings showed no difference between patients treated with surgery and those treated with non-surgical options.

Healthcare professionals treating patients with subacromial pain should be familiar with the NICE approved commissioning and treatment guidelines for the management of subacromial pain.

Risks associated with arthroscopic sub-acromial decompression are low but include infection, frozen shoulder, ongoing pain, potential damage to blood vessels or nerves and those associated with having a general anaesthetic.

5. References
Adopted from NHSE Evidence-Based Intervention: Guidance for CCGs cited as:


7. https://www.boa.ac.uk/uploads/assets/uploaded/f4bfe04a-0450-4eab-b9acad9d8b5d8c86.pdf

6. Appendices

Appendix 1: Consultation

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<thead>
<tr>
<th>Consultee</th>
<th>Date</th>
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<tbody>
<tr>
<td>Update based on Evidence-Based Intervention: Guidance for CCGs</td>
<td>11 Jan 2019</td>
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<tr>
<td>Public Health Input – Consultant in Public Health</td>
<td>April 2019</td>
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<td>Derbyshire Affiliated Commissioning Committee</td>
<td>April 2019</td>
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<tr>
<td>Consultant Orthopaedic Surgeon UHDB</td>
<td>June 2019</td>
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<td>Shoulder and Elbow Physiotherapist CRHFT</td>
<td>June 2019</td>
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<tr>
<td>Clinical Polices Advisory Group</td>
<td>June 2019</td>
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<td>Clinical and Lay Commissioning Committee</td>
<td>July 2019</td>
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Appendix 2- Document Update

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