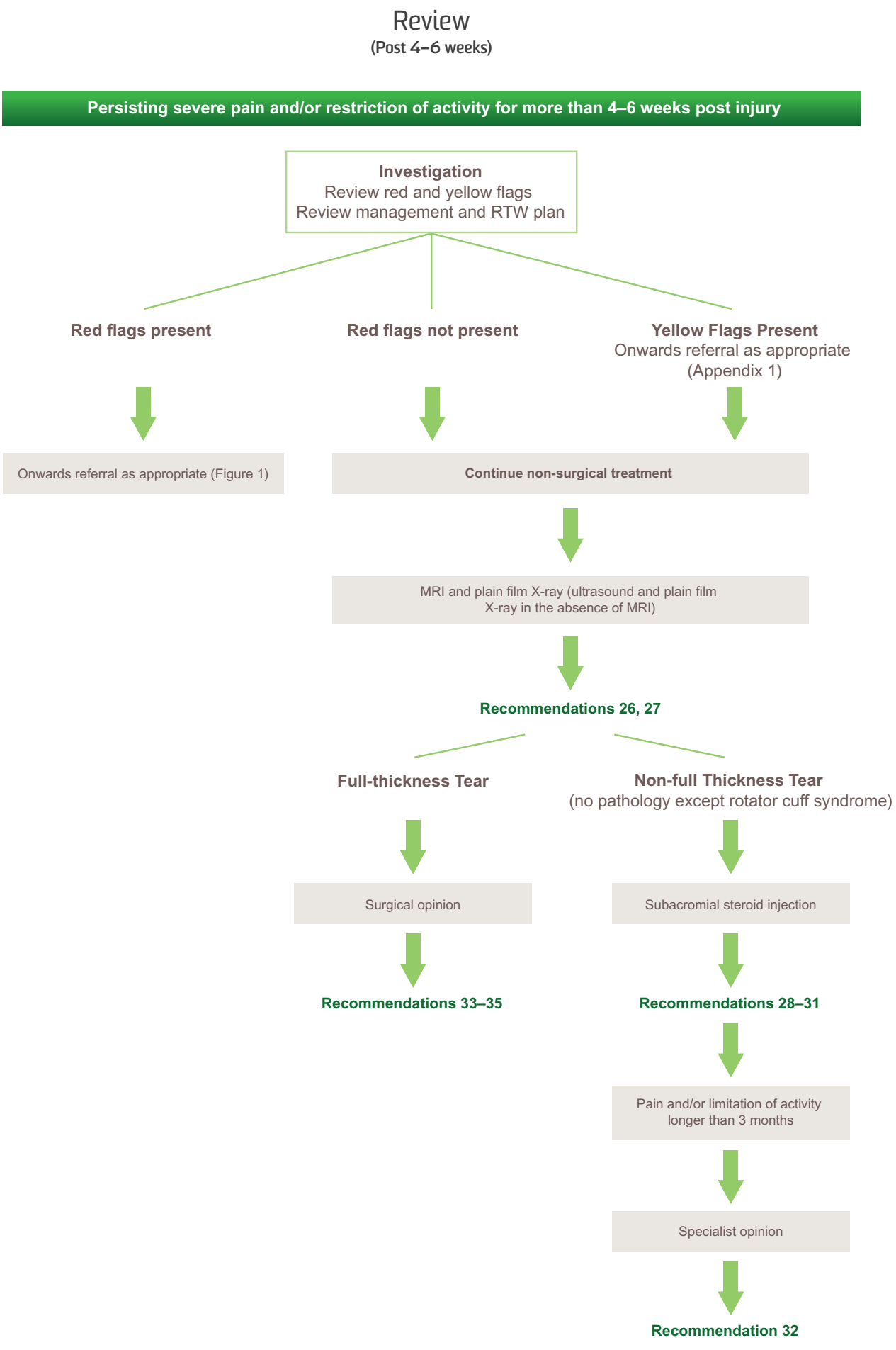
Flowchart: Review (Post 4–6 weeks)



Initial Management

Recommendation 21:

Injured workers should be initially treated with exercise prescribed and reviewed by a suitably qualified health care provider. There is no evidence of adverse impacts for prescribed exercise programs for patients with rotator cuff syndrome.

Recommendation 22:

Manual therapy may be combined with prescribed exercise by a suitably qualified health care provider*, for additional benefit for patients with rotator cuff syndrome.

***** *Under the NSW workers compensation system health care providers who are eligible to be paid for this treatment include physiotherapists, chiropractors and osteopaths. These treatment providers are trained in the prescription and modification of exercises consistent with pathology.*

Recommendation 23:

Clinicians may consider acupuncture in conjunction with exercise; both modalities should be provided by suitably qualified health care providers.

Recommendation 24:

The evidence suggests that therapeutic ultrasound does not enhance outcomes compared to exercise alone. The health care provider should refrain from using ultrasound for either pain reduction and/or increased function for injured workers with subacromial impingement syndrome (SAIS).

Review

Recommendation 25:

Injured workers with suspected rotator cuff syndrome should be reviewed by their clinician within two weeks of initial consultation, with the proviso that the injured worker can contact their clinician earlier if they have had no response to their prescribed treatment, or if they have experienced treatment side effects.

Recommendation 26:

Injured workers with suspected rotator cuff syndrome who have experienced significant activity restriction and pain for four to six weeks following initiation of an active, non-surgical treatment program and have had no response to the treatment program should be referred for MRI and plain film X-ray.

Recommendation 27:

In the absence of access to MRI or for those with contraindications for MRI, refer injured workers with suspected rotator cuff syndrome for ultrasound and plain film X-ray. Ultrasound performed by a skilled clinician provides equivalent diagnostic accuracy to MRI for rotator cuff tears (partial- or full-thickness).

Recommendation 28:

For pain reduction in injured workers with persistent pain or who fail to progress following initiation of an active, non-surgical treatment program, the clinician may consider subacromial corticosteroid injection combined with local anaesthetic.

Recommendation 29:

Injured workers should be educated regarding the possible risks and benefits of corticosteroid injections.

Recommendation 30:

Subacromial corticosteroid injections should only be administered by suitably trained and experienced clinicians.

Recommendation 31:

If pain and/or function have not improved following two corticosteroid injections, additional injections should not be used.

Recommendation 32:

Clinicians should refer for specialist opinion if an injured worker experiences significant activity limitation and participation restrictions and/or persistent pain following engagement in an active, non-surgical treatment program for three months.

Surgery

Recommendation 33:

On review, clinicians should refer injured workers for surgical opinion if there is a symptomatic, established small or medium, full-thickness rotator cuff tear.

Recommendation 34:

Clinicians should refer injured workers for surgical opinion if there is a symptomatic, full-thickness rotator cuff tear greater than 3 centimetres.

Recommendation 35:

The clinician should be aware of factors that may influence prognosis post-rotator cuff surgery (see Table 8).