TOOLKIT GUIDE

Management of rotator cuff tendinopathies

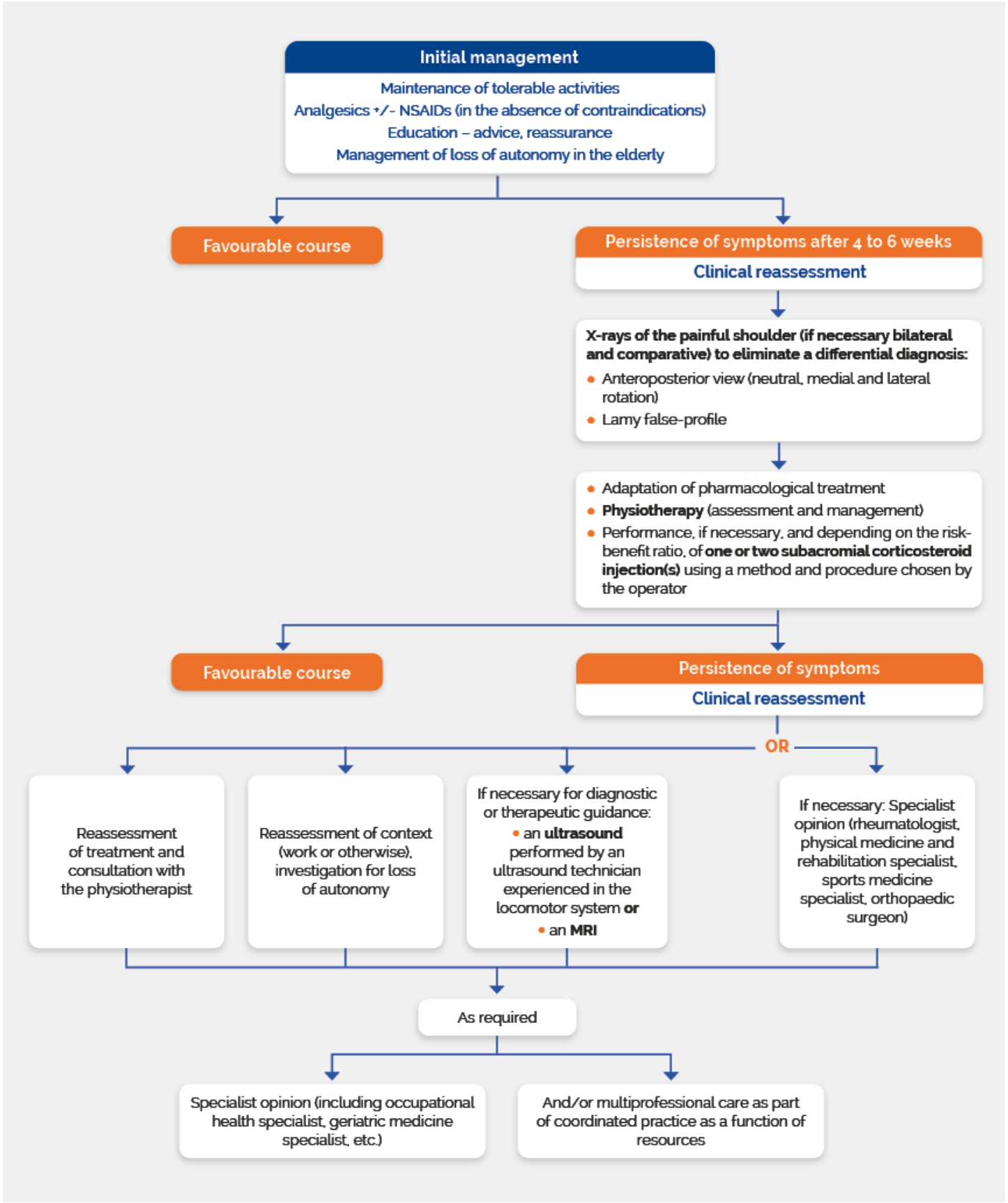
Validated by the HAS Board on 31 August 2023

Updated on Jan 2024

Key messages

- The main treatment is medical and functional: analgesics, NSAIDs, physiotherapy, corticosteroid injection, education and advice (including advice on personal and professional prevention).
- To date, injections of hyaluronic acid or platelet-rich plasma have not demonstrated their efficacy on subacromial pain syndrome.
- Standard X-rays can eliminate a number of differential diagnoses. It is essential that these be performed as a first-line approach (after pain has been present for four to six weeks). The decision to prescribe an ultrasound or MRI will be made on the basis of the clinical reassessment.
- Referral to a shoulder specialist (rheumatologist, physical medicine and rehabilitation specialist, sports medicine specialist or orthopaedic surgeon) is useful if symptoms do not improve.
- In rotator cuff tendinopathy, in the absence of a full-thickness tear, surgery has not been shown to provide benefit based on the current evidence and should only be considered after failure of appropriate conservative management, including medical and functional treatment.

This toolkit guide concerns the management of non-traumatic, non-hyperalgic rotator cuff disease.


Initial management
Maintenance of tolerable activities
Analgesics +/- NSAIDs (in the absence of contraindications)
Education – advice, reassurance
Management of loss of autonomy in the elderly
Favourable course
Persistence of symptoms after 4 to 6 weeks
Clinical reassessment
X-rays of the painful shoulder (if necessary bilateral and comparative) to eliminate a differential diagnosis:
Anteroposterior view (neutral, medial and lateral rotation)
Lamy false-profile
Adaptation of pharmacological treatment
Physiotherapy (assessment and management)
Performance, if necessary, and depending on the risk-benefit ratio, of one or two subacromial corticosteroid injection(s) using a method and procedure chosen by the operator
Favourable course
Persistence of symptoms
Clinical reassessment
OR
Reassessment of treatment and consultation with the physiotherapist
Reassessment of context (work or otherwise), investigation for loss of autonomy
If necessary for diagnostic or therapeutic guidance:
an ultrasound performed by an ultrasound technician experienced in the locomotor system or
an MRI
If necessary: Specialist opinion (rheumatologist, physical medicine and rehabilitation specialist, sports medicine specialist, orthopaedic surgeon)
As required
Specialist opinion (including occupational health specialist, geriatric medicine specialist, etc.)
And/or multiprofessional care as part of coordinated practice as a function of resources

		Methods	Grade
First line	Advice	No immobilisation, continuation of tolerable activities, maintenance of work activities depending on constraints and functional limitation	EC
	Paracetamol, combined or otherwise with step 2 analgesics depending on the intensity of the pain	Special precautions in patients over 75 years of age: – the maximum recommended paracetamol dose is 3 g/d in elderly patients weighing over 50 kg. For patients with a lower bodyweight, the paracetamol dosage should be adjusted downwards on the basis of their weight; – step 2 analgesics should be prescribed with caution, due to the risk of adverse effects; – to limit the risk of iatrogenic effects, treatment via injections may be preferable to systemic treatment in a context of multiple health conditions.	EC
	NSAIDs, in the event of acute pain, in combination with analgesics	At anti-inflammatory doses, as a short course of treatment, in the absence of contraindications, in combination with PPIs[1] if necessary. It is essential to assess the risk/benefit ratio of prescribing NSAIDs in the elderly. The dosage should be adapted to the patient's profile and the course should be as short as possible. Subacromial corticosteroid injections may be preferable in these patients.	B
Second line	Physiotherapy	A physiotherapy programme requires at least: – an initial assessment (physiotherapy diagnostic assessment); – active recentring of the humeral head; – progressive strengthening of the rotator cuff and shoulder muscle complex (scapulothoracic and deltoid muscles); – work to recover and/or maintain joint range of motion; – manual therapy, in combination with other active techniques; – work to correct the posture of the spine and shoulder girdle; – sensorimotor – proprioception training or neuromuscular control; – teaching patients to implement a self-rehabilitation programme; – work to combat kinesiophobia and other factors predictive of a poorer response. The pace, duration and frequency of sessions should be adapted to the evolution of symptoms and regularly reassessed. A clinical improvement is expected after six weeks to three months.	B
	Subacromial corticosteroid injections	Shoulder X-rays must be performed before injection. The choice of the corticosteroid injected is left to the operator's discretion, in line with the marketing authorisations of products for peri-articular injection. The choice of method (approach, volume injected, clinical or imaging identification) is left to the operator. An interval of at least three weeks must be left between two injections. An injection report must be produced. A subacromial injection can be performed in patients on antiplatelet drugs or VKAs (if INR < 3, to be checked before the procedure)[2]. As regards direct oral anticoagulants: for procedures involving a risk of minor bleeding, such as rheumatology injections, a good practice sheet suggests interrupting treatment for 24 hours before the procedure and resuming it at least six hours after the end of the invasive procedure, in the absence of any particular haemorrhagic event.[3] Collaboration with the physician having prescribed the anticoagulant is essential. Other guidelines on the management of direct oral anticoagulants during invasive procedures have been published, but without any consensus. After a corticosteroid injection, increased monitoring of blood sugar levels should be scheduled in patients with diabetes.	B

[1] fiche_bum_-_bon_usage_des_inhibiteurs_de_la_pompe_a_protons_ipp.pdf (has-sante.fr)

[2] https://www.has-sante.fr/upload/docs/application/pdf/2013-12/fiche_de_synthese_antiagregants_plaquettaires_-_gestes_percutanes.pdf
https://www.has-sante.fr/upload/docs/application/pdf/2008-09/surdosage_en_avk_situations_a_risque_et_accidents_hemorragiques_-_synthese_des_recommandations_v2.pdf

[3] Fiche_bon_usage_anticoagulants_oraux (has-sante.fr)

This document presents the main points of the publication: Management of rotator cuff tendinopathies, “Clinical practice guideline” method, August 2023
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