Subacromial decompression surgery for adults with shoulder pain: a clinical practice guideline

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ABSTRACT

Clinical question Do adults with atraumatic shoulder pain for more than 3 months diagnosed as subacromial pain syndrome (SAPS), also labelled as rotator cuff disease, benefit from subacromial decompression surgery? This guideline builds on two recent high quality trials of shoulder surgery.

Current practice SAPS is the common diagnosis for shoulder pain with several first line treatment options, including analgesia, exercises, and injections. Surgeons frequently perform arthroscopic subacromial decompression for prolonged symptoms, with guidelines providing conflicting recommendations.

Recommendation The guideline panel makes a strong recommendation against surgery.

How this guideline was created A guideline panel including patients, clinicians, and methodologists produced this recommendation in adherence with standards for trustworthy guidelines and the GRADE system. The recommendation is based on two linked systematic reviews on (a) the benefits and harms of subacromial decompression surgery and (b) the minimally important differences for patient reported outcome measures. Recommendations are made actionable for clinicians and their patients through visual overviews. These provide the relative and absolute benefits and harms of surgery in multilayered evidence summaries and decision aids available in MAGIC (www.magicapp.org) to support shared decisions and adaptation.

The evidence Surgery did not provide important improvements in pain, function, or quality of life compared with placebo surgery or other options. Frozen shoulder may be more common with surgery.

Understanding the recommendation The panel concluded that almost all informed patients would choose to avoid surgery because there is no benefit but there are harms and it is burdensome. Subacromial decompression surgery should not be offered to patients with SAPS. However, there is substantial uncertainty in what alternative treatment is best.
**RAPID RECOMMENDATIONS**

**Visual summary of recommendation**

**Population**

Adults with shoulder pain for more than 3 months

**Interventions compared**

- **Subacromial decompression surgery**
  - Arthroscopic subacromial decompression plus nonoperative management

- **Nonoperative management only**
  - Including guided physical therapy, exercise programmes, NSAIDs, and steroid injections

**Recommendation**

We recommend against subacromial decompression surgery

**Comparison of benefits and harms**

<table>
<thead>
<tr>
<th></th>
<th>Favours surgery</th>
<th>No important difference</th>
<th>Favours nonoperative management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>After 1 year</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain (Mean)</td>
<td>2.6</td>
<td>2.9</td>
<td><strong>5</strong> High</td>
</tr>
<tr>
<td>Constant score (0–100)</td>
<td>No important difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Function (Mean)</td>
<td>72</td>
<td>69</td>
<td><strong>5</strong> High</td>
</tr>
<tr>
<td>EQ-5D scale (-0.59–1)</td>
<td>No important difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of life (Mean)</td>
<td>0.70</td>
<td>0.73</td>
<td><strong>5</strong> High</td>
</tr>
<tr>
<td>Global perceived effect</td>
<td>699</td>
<td>635</td>
<td><strong>4</strong> Moderate</td>
</tr>
<tr>
<td>At work</td>
<td>859</td>
<td>818</td>
<td><strong>3</strong> Low</td>
</tr>
<tr>
<td><strong>Within 30 days</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious harms</td>
<td>6</td>
<td>6 fewer</td>
<td><strong>3</strong> Moderate</td>
</tr>
<tr>
<td>Events per 1000 people</td>
<td></td>
<td></td>
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</tbody>
</table>

**Key practical issues**

**Surgery**

- Recovery time varies from months to years and may include sick leave
- Day surgery with general anaesthesia and/or nerve block
- After surgery, 2 weeks off work are typically needed
- Avoid heavy lifting for one to three weeks, overhead activities for 3 months

**Nonoperative management**

- Including guided physical therapy, exercise programmes, NSAIDs, and steroid injections

**Values and preferences**

The panel believes that all or almost all patients would place a high value on avoiding even minimal risk of complications and burden from surgery, if it is not helpful.
**Table 1 | Major guideline recommendations on subacromial decompression surgery for subacromial pain syndrome (SAPS)***

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>European Society for Surgery of the Shoulder and the Elbow</td>
<td>No recommendation for or against subacromial surgery</td>
</tr>
<tr>
<td>British Elbow and Shoulder Society/British Orthopaedic Association 2015. Statement of upcoming update 2018f</td>
<td>Recommended in the absence of a rotator cuff tear if impingement symptoms fail to resolve with nonoperative treatment</td>
</tr>
<tr>
<td>Dutch Orthopaedic Association 2014f</td>
<td>Not recommended</td>
</tr>
<tr>
<td>American Academy of Orthopaedic Surgeons, 2010 (AOA guidelines)</td>
<td>No recommendation for or against subacromial surgery, suggests initial nonoperative management</td>
</tr>
<tr>
<td>Australian Orthopaedic Association 2017 (AOA Statement 2017)</td>
<td>Recommended for significant and persistent symptoms unresponsive to nonoperative management (including injections and physiotherapy)</td>
</tr>
<tr>
<td>Canadian Medical Association and Canadian Orthopaedic Association-Arthroscopy Association of Canada</td>
<td>No recommendation for or against subacromial decompression surgery</td>
</tr>
</tbody>
</table>

*These guidelines have not included new evidence captured in our Rapid Recommendation.

**Box 1 | Details of subacromial pain syndrome (SAPS)**

**Common symptoms**—Pain at the upper outer arm when lifting the arm (classically a painful arc through shoulder abduction), difficulty moving the arm (especially with forward flexion, external rotation, and abduction), reduced strength in the arm, and sleep problems due to pain.

**Key differential diagnoses**—Adhesive capsulitis ("frozen shoulder") and glenohumeral osteoarthritis.

**Imaging**—Patients with SAPS can have degeneration and partial thickness rotator cuff tears or abnormalities in the subacromial bursa on imaging. These imaging findings are also common in people without symptoms.

**Pathophysiology**—Remains poorly understood. Cadaver studies suggested that pain might occur from rotator cuff tendons being caught ("impinging") between the acromion or coracoacromial ligament and the humerus.

**Current practice**

First line treatment options for SAPS include simple analgesia such as paracetamol, non-steroidal anti-inflammatory drugs (NSAIDs), glucocorticoid injections, and exercise therapy. Subacromial acromial decompression surgery is a second line treatment option for patients with more longstanding symptoms. Current guidelines provide inconsistent recommendations (table 1). Such surgery includes removal of the subacromial bursa (bursalectomy) and removal of bone from the under surface of the acromion (acromioplasty).

Despite trials dating back to 1993 and systematic reviews failing to demonstrate benefit from surgery, the number of arthroscopies performed has risen dramatically, although there is substantial geographical variation. There were 21,000 procedures performed in NHS hospitals in 2010, which cost approximately £50 million.

**Box 2 | Linked articles in this BMJ Rapid Recommendation cluster**

  - Summary of the results from the Rapid Recommendation process
  - Review of minimally important differences in outcomes from shoulder conditions
  - Review and meta-analysis of all available randomised trials that assessed effects of surgery for SAPS
  - Updated Cochrane systematic review on subacromial decompression surgery for rotator cuff disease
- MAGICapp (www.magicapp.org/public/guideline/nBMa0L)
  - Expanded version of the results with multilayered recommendations, evidence summaries, and decision aids for use on all devices (see appendix 3 on bmj.com)
RAPID RECOMMENDATIONS

DATA SOURCES

Use this information to gauge how similar your patients’ conditions are to those of people studied in the trials.

NUMBER OF TRIALS 7

NUMBER OF PATIENTS 1014

TRIAL CHARACTERISTICS

Follow-up duration
- 1 - 3 years: 3 (631)
- 4 - 8 years: 2 (156)
- 9 - 14 years: 2 (227)

Risk of bias
- Low risk of bias: 2 (606)
- High risk of bias: 4 (508)

Setting
All included trials took place in hospital outpatient clinics.

PATIENT CHARACTERISTICS

MEAN AGE at baseline
- Min: 44, Mean: 49.1, Max: 58

SEX
- % women
- Min: 36, Mean: 57, Max: 70

MEAN SYMPTOM DURATION* years prior to enrolment
- Min: 1.6, Mean: 2.1, Max: 2.6

Previous treatments
Conservative treatments (including exercise therapy, corticosteroid injections, and rest) were variably applied by most patients before entering the trials.

FUNDING
2 trials reported no industry funding

PATIENT PARTNERSHIP
No trials reported patient involvement

* Data for mean symptom duration prior to enrollment comes from two trials (N=333)
Rapid Recommendations

HOW THIS RECOMMENDATION WAS CREATED

Our international panel included patients with lived experience of shoulder pain and surgery, orthopaedic surgeons, physiotherapists, a rheumatologist, general internists, a general practitioner, epidemiologists, and methodologists. No person had financial conflicts of interest; intellectual and professional conflicts were minimised and managed (see appendix 1 on bmj.com for details of panel members and their competing interests). The panel initially decided on the scope of the recommendation and the outcomes that are most important to patients.

The panel identified the following important outcomes: pain, patient global perceived effect, physical function, participation in work and recreation activities, health related quality of life, development of full-thickness rotator cuff tears, and potential harms from surgery (such as frozen shoulder, death, infection, venous thromboembolism, and anaesthesia related events). This selection was also informed by the Outcome Measures in Rheumatology (OMERACT) preliminary shoulder trial core domain outcome set.26

To inform the recommendation the panel members requested two systematic reviews addressing the following questions:

1. What is the smallest change in pain, function and quality of life that patients with shoulder conditions such as SAPS consider important—the minimally important difference—to make surgery worthwhile? Such patient-reported outcomes measures (PROMs) were measured with a variety of instruments in the trials and are challenging to interpret.22

2. What are the benefits and harms of subacromial decompression surgery in patients with SAPS, as compared to placebo and nonoperative management strategies?

Parallel teams conducted these systematic reviews.13 Another team updated a Cochrane systematic review synchronised with this BMJ Rapid Recommendation.11 The panel asked the review team to explore potential subgroup effects for risk of bias in trials and different types of comparisons to surgery, such as exercise therapy.

The panel used this evidence and followed BMJ Rapid Recommendations procedures for creating a trustworthy recommendation. This includes the GRADE approach. The panel met by videoconference to discuss the evidence and formulate a recommendation (see appendix 2 on bmj.com).27 28 The panel considered the balance of benefits, harms, and burdens of surgery versus placebo surgery and nonoperative treatments, the certainty of the evidence for each outcome, typical and expected variations in patient values and preferences, as well as feasibility and acceptability (practical issues).29 Recommendations using GRADE can be strong or weak, for or against a course of action.30 The panel made the recommendation from an individual patient’s perspective assuming that all options were available and affordable to the patient. It does not take a public health, societal, or health payer perspective. Healthcare systems can adapt these recommendations by including costs and other key issues of relevance, contextualised to national and local circumstances.23

The evidence

What is the minimum difference in symptoms and function important to patients?

The systematic review of minimally important differences (MIDs) identified 22 original studies of 5562 patients. They reported results for 74 MID estimates judged to be of variable and mostly low credibility.14 The most credible MID estimates were used to help interpret the results of the systematic review, as shown in the infographic.

The panel were, due to credible estimates, confident that patients valued

- A difference in pain of at least 1.5 units as important (visual analogue scale 0-10)
- A difference in function of at least 8.3 units as important (constant score 0-100)

The panel were less confident in the difference in health related quality of life reported by patients to be important (EQ 5-D, MID 0.07 units, low credibility median estimate).

What are the benefits and harms of subacromial decompression surgery?

The linked systematic review and meta-analysis pooled data from seven randomised controlled trials with 1014 participants diagnosed with SAPS.31 In general, the patients included in the trials are representative of patients with SAPS presenting to primary care centres and outpatient clinics (fig 2). Participants were around 49 years (median) and had had symptoms for around two years (median).

Planned evaluation of trials at lower risk of bias

The panel planned to focus on evidence at lower risk of bias. Two trials included placebo surgery and were at low risk of bias.32 At one year after treatment, they showed that surgery did not have meaningful benefit over placebo surgery:

- High certainty evidence for little or no effect on
  - Pain (mean difference −0.26 (95% confidence interval −0.84 to 0.33), MID 1.5)
  - Function (mean difference 2.8 (−1.4 to 6.9), MID 8.3)
  - Health related quality of life (mean difference −0.03 points (−0.11 to 0.06), MID 0.07)

- Moderate certainty evidence for little or no global perceived effect (risk ratio 1.10 (0.94 to 1.30))

- Low certainty evidence for little or no effect on return to work (risk ratio 1.05 (0.89 to 1.23)).

Similar results were seen at six months, two years, and at five year follow-up, with the latter supported by low certainty evidence due to imprecise estimates from unblinded trials.13

Planned evaluation of surgery compared with exercise therapy

This analysis compared subacromial decompression surgery (including postoperative exercise therapy) with exercise therapy alone. Six trials reported such comparisons, and all were at high risk of bias due to lack of blinding. Some had imprecise estimates of effect. Compared with exercise therapy, there was no important benefit of surgery on pain, function, quality of life, global perceived effect, and return to work.15

About a third (32%) of all participants included in the trials continued to have more than minor symptoms (such as mild to moderate pain) at one year, irrespective of treatment. The average pain scores in the trials at two years were 1.6 to 3.0 units (0-10 scale), reflecting mild to moderate pain.

Harms

Potential harms from surgery were incompletely reported in the trials. The trials were also underpowered to detect rare events. There were around 12 more frozen shoulders per 1000 patients undergoing subacromial decompression surgery, based on the two placebo controlled trials (low certainty evidence).

Because harms data from randomised trials were anticipated to be so limited, the guideline panel requested the systematic review to include observational studies designed to evaluate harms after subacromial decompression surgery.12 The systematic review assessed 140 publications in full text, of which four reported results from a large prospective cohort study from the United States considered to represent best current evidence on serious harms.10 23 This registry study investigated 30-day complications resulting in readmission to hospitals after mixed arthroscopic procedures including subacromial decompression surgery from 2006 to 2013.7 23
### PRACTICAL ISSUES

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Non-operative management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICATION ROUTINE</strong></td>
<td>Day surgery performed in an outpatient clinic</td>
</tr>
<tr>
<td><strong>TEST &amp; VISIT</strong></td>
<td>Need for outpatient visit to an orthopaedic surgeon before surgery</td>
</tr>
<tr>
<td><strong>PROCEDURE &amp; DEVICE</strong></td>
<td>General anaesthesia and/or local nerve block during keyhole surgery. Recovery period of 2–10 hours with numbness up to 24 hours after surgery</td>
</tr>
<tr>
<td><strong>RECOVERY &amp; ADAPTATION</strong></td>
<td>Recovery directly related to surgery takes four to six weeks. You may use a sling for a few days after surgery</td>
</tr>
<tr>
<td><strong>COORDINATION OF CARE</strong></td>
<td>You may need someone to drive you home after surgery</td>
</tr>
<tr>
<td><strong>COSTS &amp; ACCESS</strong></td>
<td>Out of pocket costs for surgery is generally high</td>
</tr>
<tr>
<td><strong>EXERCISE &amp; ACTIVITIES</strong></td>
<td>Avoid heavy lifting for 7–21 days</td>
</tr>
<tr>
<td><strong>WORK &amp; EDUCATION</strong></td>
<td>Sick leave is typically offered the first few weeks after surgery</td>
</tr>
<tr>
<td><strong>TRAVEL TIME &amp; DRIVING</strong></td>
<td>You can start driving as soon as you feel able to steer, normally after one week</td>
</tr>
</tbody>
</table>

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Fig 3 | Practical issues for surgery and nonoperative management of subacromial pain syndrome (SAPS)
RAPID RECOMMENDATIONS

EDUCATION INTO PRACTICE

• What would be your approach to managing subacromial pain syndrome (SAPS), based on the information you have read in this article?
• How can this article help you explain the new evidence to patients considering surgery for their shoulder pain? How would you respond if patients ask about surgery?
• What would you tell your colleagues about best practice for managing SAPS?

HOW PATIENTS WERE INVOLVED IN THE CREATION OF THIS ARTICLE

Four people with lived experience of subacromial pain syndrome and shoulder surgery were full panel members. These panel members identified important outcomes and participated in the teleconferences and email discussions on the evidence and the recommendation. They contributed to the identification of practical issues related to the decision to have surgery and met all authorship criteria for the present article. We thank them for their time and contribution.

The risk of serious harms after mixed shoulder arthroscopic procedures was 0.5% (95% confidence interval 0.4% to 0.7%) during years 2006-11 and 0.6% (0.5% to 0.7%) during 2011-13. Reported harms included events such as major bleeding, deep infections, serious anaesthetic complications, venous thromboembolism, and peripheral nerve injury. The indirectness caused by inclusion of mixed arthroscopic shoulder procedures in the registry study results in moderate certainty evidence for estimated harms.

Understanding the recommendation

The panel concluded that almost all well informed patients would decline surgery and therefore made a strong recommendation against subacromial decompression surgery. The panel was confident that surgery provides no important benefit on pain, function, quality of life, and global perceived effect informed by moderate to high certainty evidence in a one year timeframe. Surgery also comes with burdens and the risk of harm (see main infographic).

Clinicians should not offer patients subacromial decompression surgery unprompted, and clinicians, public healthcare providers, and others should make efforts to educate the public regarding the ineffectiveness of surgery. Although we did not take costs and resources into account beyond direct costs to patients (such as out-of-pocket costs), surgery cannot be cost effective given the lack of important benefit, potential for harm, and associated costs.

Figure 3 includes the practical issues linked to surgery, compared with physical therapy because this was the key comparison in the trials and a relevant treatment option. This would differ for other treatment options such as analgesia or injection.

Uncertainty

Clinicians and patients might question what other therapies could be offered to patients diagnosed with SAPS or rotator cuff disease and whether any therapy is effective. Here we recognise the limitation of our BMJ Rapid Recommendations, made to provide guidance on new evidence that might change practice. For guidance on treatment alternatives beyond surgery, we point readers to a clinically focused overview article and to guidelines with a broader scope (table 1).8

The whole area of best management of SAPS is uncertain, as reflected in the following brief summary on available treatment options:

- Glucocorticoid injections and NSAIDs may provide moderate to small short term benefits on shoulder pain compared with placebo.8,24
- Exercise, manual therapy, and electrotherapies are of uncertain benefit to patients compared with watchful waiting, and guidelines vary in their recommendations.7,25-26
- A holistic approach to care, with appropriate communication including reassurance and education, is likely to benefit patients but is poorly studied.27

Key research questions to inform decision makers and future guidelines include:

- What are the best strategies to de-implement inefficient and potentially harmful subacromial decompression surgery for SAPS?
- How can we educate patients and clinicians to understand and adopt evidence, particularly when it goes against accepted beliefs?

Updates to this article

Table 2 shows evidence that has emerged since the publication of this article. As new evidence is published, a group will assess the new evidence and make a judgement on the extent it is expected to alter the recommendation.

Competing interests: All authors have completed the BMJ Rapid Recommendations interest disclosure form and a detailed, contextualised description of all disclosures is reported in appendix 1 on bmj.com. As with all BMJ Rapid Recommendations, the executive team and The BMJ judged that no panel member had any financial conflict of interest. Professional and academic interests are minimised as much as possible, while maintaining necessary expertise on the panel to make fully informed decisions.

Funding: The Dutch Orthopaedic Society has provided the MAGIC Foundation with €35 000 to support development of two rapid recommendations for orthopaedic surgery. The society had no role in the guideline development process for this BMJ Rapid Recommendation. The recommendation on shoulder surgery will be adapted into an updated recommendation in their guidelines.

Transparency: R Poolman and P O Vandvik affirm that the manuscript is an honest, accurate, and transparent account of the recommendation being reported; that no important aspects of the recommendation have been omitted; and that any discrepancies from the recommendation as planned (and, if relevant, registered) have been explained.

Provenance and peer review: Commissioned; externally peer reviewed

Table 2 | New evidence which has emerged after initial publication

<table>
<thead>
<tr>
<th>Date</th>
<th>New evidence</th>
<th>Citation</th>
<th>Findings</th>
<th>Implications for recommendation(s)</th>
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<tr>
<td></td>
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There are currently no updates to the article.

Rapid Recommendations


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