Dr Andrew McBride

BPhyt MBBS FRACS FAOrthoA
Orthopaedic Surgeon

Dr Dr Andrew McBride interests include:

Shoulder
- Shoulder Arthroscopy / Rotator Cuff Repair
- Shoulder Fractures
- AC Joint Reconstruction

Elbow
- Elbow Fractures
- Elbow Arthroscopy and Joint Replacement Surgery

Sports Injury/Trauma
- Sports Injuries including Fracture and Dislocations
- Wrist acute and chronic injury

To arrange an appointment with Dr Andrew McBride, please contact:

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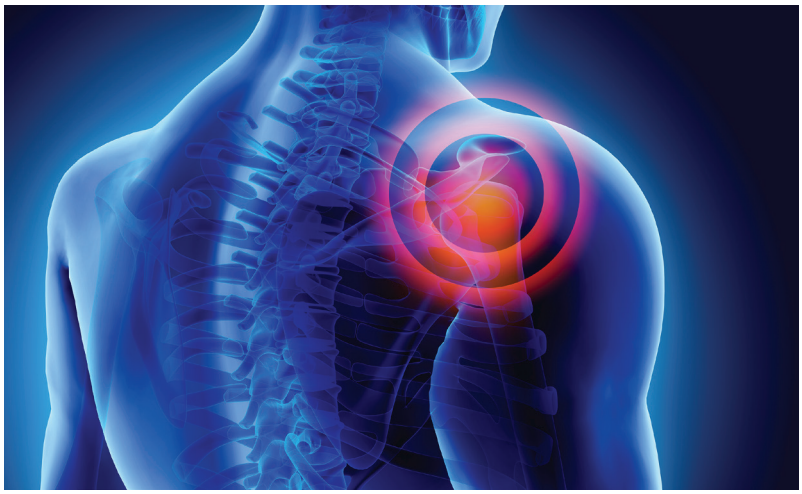
Rotator Cuff Repair

A Fact Sheet by Dr Andrew McBride



What causes shoulder pain and rotator cuff pathology?

The shoulder joint consists of a large humeral head articulating with a small socket. It has a large range of motion and is built for speed, strength and control, at the expense of power and stability.

The rotator cuff muscles stabilise the large ball in the small socket and include the subscapularis, supraspinatus, infraspinatus and teres minor.

Rotator cuff tears can be caused by acute trauma, however are more commonly degenerative in nature, affecting mostly older patients. A number of risk factors exist including:

- Genetics
- Advanced age
- Reduced vascularity of the tendon
- A hook shaped acromion or acromial bone spur
- Shoulder instability and repetitive overload

How do I diagnose a rotator cuff tear?

A rotator cuff tear is the most likely diagnosis for an older patient with shoulder pain, loss of active but not passive range of motion and no arthritis on x-ray.

Most tears can be diagnosed on history and examination and confirmed with ultrasound or magnetic resonance imaging (MRI).

Patients describe a history of either acute trauma or gradual pain onset with weakness, fatigue and limitation of movement. Examination will reveal pain and weakness on rotator cuff strength testing.

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What else can be causing my patient's shoulder pain?

Other pain generators around the shoulder include:

- Biceps tendon pathology
- Acromioclavicular arthritis
- Subacromial spurs and bursitis
- Adhesive capsulitis (frozen shoulder)
- Osteoarthritis of the shoulder joint

Does my patient need surgery?

Non-surgical management should form the first line of treatment for patients without a full thickness tear and for patients with smaller full thickness tears. Management may include:

- Rest and graduated return to gentle exercise with a supervised physiotherapy exercise program to strengthen around the scapular and retrain the deltoid muscle
- Analgesia including the use of NSAIDS and paracetamol
- A single steroid/local anaesthetic injection is a safe, effective treatment in the acute phase to reduce inflammation and pain, however multiple injections should be avoided as they may compromise rotator cuff healing
- Injection of platelet-rich plasma has been shown as a useful adjunct to other treatment for partial thickness tears and encouraging early results are emerging from clinical trials involving the use of stem cell therapy

Surgical repair should be considered for acute traumatic tears, larger degenerative tears in active patients, and small to medium tears where patients have ongoing pain and loss of function despite non-surgical management. Surgery may involve:

- Rotator cuff repair
- Subacromial decompression
- Biceps tenodesis (repair)
- Acromioclavicular joint decompression
- Debridement and denervation of irreparable rotator cuff tendons
- Tendon transfers for irrepairable rotator cuff tendons
- Reverse shoulder replacement for advanced rotator cuff disease where shoulder arthritis has developed

When should I refer?

Patients with partial thickness tears that have ongoing pain despite non-surgical management and all patients with full thickness rotator cuff tears be referred for specialist opinion.

I am happy and available to review all patients with shoulder pain to assist with their diagnostic work up and management.