

Orthopaedic Shoulder (and Anatomical Arm) Referral Guideline

Austin Health Orthopaedic Unit holds weekly multidisciplinary meetings to discuss and plan the treatment of patients with Orthopaedic and Fracture conditions.

Department of Health clinical urgency categories for specialist clinics					
For all emergency cases that require immediate review, or pose an immediate risk to life or limb, please dial 000 or send the patient to the Emergency Department.					
Urgent: A referral is urgent if the patient has a condition that has major functional impairment and/or moderate risk of permanent damage to an organ/bone/tissue/system if not seen within 30 days. For urgent referrals, please contact the Orthopaedic Registrar to discuss – most urgent					
Semi-Urgent: Referrals should be categorised as semi-urgent if that patient has a potential to deteriorate within 30-90 days.					
Routine: Referral will be triaged by the Orthopaedic Liaison Nurse and Director of Orthopaedic Surgery. Appointments will be booked accordingly.					
Exclusions: Nil					
Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
Glenohumeral Osteoarthritis	<ul style="list-style-type: none"> Medications (Paracetamol, glucosamine, chondroitin sulphate, fish oil, NSAIDs if appropriate) Physiotherapy Corticosteroid injection of shoulder (glenohumeral) joint 	<p>History -Symptoms, ADLs affected? -Treatment and responses to date</p> <p>Examination Findings</p> <p>Investigation (report with referral) X-rays: <i>Shoulder XRs</i> – True AP Glenohumeral Joint (Grashey View) & Scapular Lateral (Neer View) & Axillary Lateral (3 views)</p> <p>Please send US or MRI if performed for exclusion of differential diagnoses</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Urgent: N/A</p> <p>Routine: Refer if maximal non-operative treatment (at least 2 modalities for at least 3 months) has failed</p> <p>The patient may be assessed first by a specialist shoulder physiotherapist. This allows them to be seen more rapidly and for non-operative management to be further expanded and optimised. All patients will subsequently be seen by an orthopaedic surgeon with shoulder subspecialty interest</p>	<ul style="list-style-type: none"> Initial Outpatient Appointment Review appointments to establish diagnosis & treatment Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) Discharge back to referrer for ongoing conservative management 	As required

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Inflammatory Arthritis of Shoulder (Rheumatoid, Other)	<ul style="list-style-type: none"> • Patient referred to a Rheumatologist as appropriate 	<p>History -Symptoms, ADLs affected? -Treatment and responses to date</p> <p>Examination Findings</p> <p>Investigation (report with referral)</p> <p>X-rays: <i>Shoulder XRs</i> – True AP Glenohumeral Joint (Grashey View) & Scapular Lateral (Neer View) & Axillary Lateral (3 views)</p> <p><i>and</i></p> <p>Bloods: FBE, ESR, CRP, RF, ANA, ANCA</p> <p>Please send US or MRI if performed for exclusion of differential diagnoses</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Urgent: N/A</p> <p>Routine: Refer if patient referred to rheumatologist and non-operative measures have failed</p>	<ul style="list-style-type: none"> • Initial Outpatient Appointment • Review appointments to establish diagnosis & treatment • Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) • Discharge back to referrer for ongoing conservative management 	As required
Acromioclavicular Joint Osteoarthritis	<ul style="list-style-type: none"> • Medications (paracetamol, glucosamine, chondroitin sulphate, fish oil, NSAIDs if appropriate) • Avoid triggering events • Physiotherapy • Corticosteroid injection of acromioclavicular joint 	<p>History -Symptoms, ADLs affected? -Treatment and responses to date</p> <p>Examination Findings</p> <p>Investigation (report with referral)</p> <p>X-rays: <i>Shoulder XRs</i> – True AP Glenohumeral Joint (Grashey View) & Scapula Lateral (Neer View) & Axillary Lateral (3 views)</p> <p>Please send US or MRI if performed</p>	<p>Urgent: N/A</p> <p>Routine: Refer if maximal non-operative treatment (at least 2 modalities for at least 3 months) has failed</p> <p>The patient may be assessed first by a specialist shoulder physiotherapist. This allows them to be seen more rapidly and for non-operative</p>	<ul style="list-style-type: none"> • Initial Outpatient Appointment • Review appointments to establish diagnosis & treatment • Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) • Discharge back to referrer for ongoing conservative management 	As required

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		<p>Patient must bring the films or the links for any online imaging.</p>	<p>management to be further expanded and optimised. All patients will subsequently be seen by an orthopaedic surgeon with shoulder subspecialty interest</p>		
<p>Total (or Hemi) Shoulder Replacement (TSR) existing with:</p> <ul style="list-style-type: none"> - Pain - Loosening - Other concern 	<ul style="list-style-type: none"> Refer all patients after appropriate history, examination and investigations performed for <i>urgent</i> assessment If an acutely septic prosthetic joint is suspected, the patient should be sent to the Emergency Department <i>without</i> antibiotics (unless discussed with, and approved by, the orthopaedic unit) 	<p>History</p> <p>-In a previously well-functioning joint replacement there is:</p> <ul style="list-style-type: none"> new pain new sounds other new or concerning symptoms <p>Examination Findings</p> <p>Investigation (report with referral)</p> <p>X-rays: (Loosening, cysts, eccentric joint, change prosthetic position) <i>Shoulder XRs</i> – True AP Glenohumeral Joint (Grashey View) & Scapula Lateral (Neer View) & Axillary Lateral (3 views)</p> <p><i>and</i></p> <p>Bloods: FBE, ESR, CRP</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Urgent: All patients with new symptoms or XR changes or abnormal blood tests</p> <p>Routine: Refer for routine review as required if no particular concerns</p>	<ul style="list-style-type: none"> Initial Outpatient Appointment Review appointments to establish diagnosis & treatment Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) Discharge back to referrer for ongoing conservative management 	<p>As required</p>
<p>Acute Rotator Cuff Tear (injury-related)</p> <p>For chronic, non-injury related cuff tears – see below</p>	<ul style="list-style-type: none"> All patients with <i>acute</i> rotator cuff tears should be referred for urgent assessment 	<p>History</p> <p>New and significant injury with no or minimal shoulder symptoms prior</p>	<p>Urgent: Acute RC Tears. Patients will be directed to our ASTI (Acute Soft Tissue Injury) Clinic and seen within 1-2 weeks</p>	<ul style="list-style-type: none"> Initial Outpatient Appointment Review appointments to establish diagnosis & treatment 	<p>As required</p>

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		<p>Examination Findings Marked <i>weakness</i> rotator cuff</p> <p>Investigation (report with referral) X-rays: <u>Shoulder XRs</u> – True AP Glenohumeral Joint (Grashey View) & Scapula Lateral (Neer View) & Axillary Lateral (3 views)</p> <p><i>and</i></p> <p>Ultrasound or MRI shoulder</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Routine: If pre-existing symptoms, onset, or imaging suggest long-standing rotator cuff pathology</p>	<ul style="list-style-type: none"> • Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) • Discharge back to referrer for ongoing conservative management 	
<p>Rotator Cuff Tear Tendinitis/Tendinosis</p> <p>(Chronic, not injury-related)</p> <p>Subacromial Impingement</p> <p>Acromioclavicular Pain</p> <p>Long Head Biceps Rupture</p>	<ul style="list-style-type: none"> • Medications (paracetamol, NSAIDs if appropriate) • Physiotherapy • Corticosteroid injection of subacromial space (radiological if confirmation required) 	<p>History -Night pain? ADLs affected? Can't sleep on affected side? -Treatment and responses to date</p> <p>Examination Findings Weakness? Impingement?</p> <p>Investigation (report with referral) X-rays: <u>Shoulder XRs</u> – True AP Glenohumeral Joint (Grashey View) & Scapula Lateral (Neer View) & Axillary Lateral (3 views)</p> <p><i>and</i></p> <p>Ultrasound or MRI shoulder</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Urgent: N/A (unless <i>acute</i> – see above)</p> <p>Routine: Refer if maximal non-operative treatment (at least 2 modalities for at least 3 months) has failed</p> <p>The patient may be assessed first by a specialist shoulder physiotherapist. This allows them to be seen more rapidly and for non-operative management to be further expanded and optimised. All patients will subsequently be seen by an orthopaedic surgeon with shoulder subspecialty interest.</p>	<ul style="list-style-type: none"> • Initial Outpatient Appointment • Review appointments to establish diagnosis & treatment • Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) • Discharge back to referrer for ongoing conservative management 	As required

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<p>Distal Biceps Rupture</p> <p>(Note: Proximal Biceps (Long Head) rupture is not urgent – see above)</p>	<ul style="list-style-type: none"> Urgent referral to clinic 	<p>History</p> <p>Examination Findings -Proximal Biceps migration/position (not 'Popeye' deformity (more distal-appearing biceps muscle belly)) -Weak supination</p> <p>Investigation (report with referral) Ultrasound: Shows DISTAL rupture</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Urgent: Patients will be directed to the ASTI (Acute Soft Tissue Injury) Clinic and seen within a week</p> <p>Routine: N/A</p>	<ul style="list-style-type: none"> Initial Outpatient Appointment Review appointments to establish diagnosis & treatment Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) Discharge back to referrer for ongoing conservative management 	<p>As required</p>
<p>Proximal (Long Head) Biceps Rupture</p>	<ul style="list-style-type: none"> Manage as with Chronic Rotator Cuff/Subacromial Impingement 	<p><u>Note these are usually degenerative and surgery is very rarely required</u></p> <p>History Usually other shoulder symptoms</p> <p>Examination Findings 'Popeye' deformity biceps (more distal and ball-like)</p> <p>Investigation (report with referral) X-ray and Ultrasound: as with Rotator Cuff/Impingement</p> <p>Ultrasound shows rupture LONG HEAD only</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Urgent: N/A</p> <p>Routine: as with Chronic Rotator Cuff/Subacromial Impingement</p>	<ul style="list-style-type: none"> Initial Outpatient Appointment Review appointments to establish diagnosis & treatment Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) Discharge back to referrer for ongoing conservative management 	<p>As required</p>

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<p>1st Time Shoulder Dislocation</p>	<p>Refer for <u>urgent</u> assessment if:</p> <ul style="list-style-type: none"> • Patient <30 years old (high risk recurrence) • Any age and persisting weakness post reduction (Rotator Cuff Tear) • Any age and persisting neurology post reduction • Imaging shows a fracture (however small, or even suspected, or glenoid +/- Humerus) <p>Otherwise treat patient as per recurrent dislocation (as below)</p>	<p>History 1st time dislocation</p> <p>Examination Findings Weakness? Neurology?</p> <p>Investigation (report with referral) X-rays: <u>Shoulder XRs</u> – True AP Glenohumeral Joint (Grashey View) & Scapula Lateral (Neer View) & Axillary Lateral (3 views)</p> <p><u>and</u></p> <p>Ultrasound or MRI shoulder if weakness</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Urgent:</p> <ul style="list-style-type: none"> • <30 years old • Persisting weakness • Persisting neurology • Any fracture <p>Routine: Remainder of cases.</p> <p>Refer if maximal non-operative treatment (at least 2 modalities for at least 3 months) has failed</p>	<ul style="list-style-type: none"> • Initial Outpatient Appointment • Review appointments to establish diagnosis & treatment • Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) • Discharge back to referrer for ongoing conservative management 	<p>As required</p>
<p>Recurrent Shoulder Dislocation</p> <p>Or</p> <p>Instability of Shoulder</p>	<p>For 1st time dislocation – see above</p> <ul style="list-style-type: none"> • Medications (paracetamol, NSAIDs if appropriate) • Avoid of trigger events (extension abduction, external rotation) • Physiotherapy 	<p>History -Frequency, ease and method of dislocations, work/activities affected?</p> <p>Examination Findings Weakness? Neurology?</p> <p>Investigation (report with referral) X-rays: <u>Shoulder XRs</u> – True AP Glenohumeral Joint (Grashey View) & Scapula Lateral (Neer View) & Axillary Lateral (3 views)</p>	<p>Urgent: N/A (unless <i>acute</i> – see above)</p> <p>Routine: Refer if maximal non-operative treatment (at least 2 modalities for at least 3 months) has failed.</p> <p>The patient may be assessed first by a specialist shoulder physiotherapist. This allows them to be seen</p>	<ul style="list-style-type: none"> • Initial Outpatient Appointment • Review appointments to establish diagnosis & treatment • Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) • Discharge back to referrer for ongoing 	<p>As required</p>

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		and MRI shoulder if possible Patient must bring the films or the links for any online imaging.	more rapidly and for non-operative management to be further expanded and optimised. All patients will subsequently be seen by an orthopaedic surgeon with shoulder subspecialty interest.	conservative management	
Frozen Shoulder Adhesive Capsulitis	Note that this condition has a fairly predictable course of symptoms (of pain then stiffness) with resolution after 2 years, so rarely requires surgery <ul style="list-style-type: none"> • Medications (paracetamol, NSAIDs if appropriate) • Physiotherapy • Corticosteroid injection • Hydrodilatation of Shoulder (Glenohumeral) Joint 	History -Frequency, ease and method of dislocations, work/activities affected? Examination Findings Weakness? Neurology? Investigation (report with referral) X-rays: <i>Shoulder XRs</i> – True AP Glenohumeral Joint (Grashey View) & Scapula Lateral (Neer View) & Axillary Lateral (3 views) – <i>to exclude other causes</i> MRI shoulder if completed to exclude other causes (will also show evidence of adhesive capsulitis) Patient must bring the films or the links for any online imaging.	Urgent: N/A Routine: Refer if maximal treatment (at least 2 modalities for at least 6 months) has failed. The patient may be assessed first by a specialist shoulder physiotherapist. This allows them to be seen more rapidly and for non-operative management to be further expanded and optimised. All patients will subsequently be seen by a orthopaedic surgeon with shoulder subspecialty interest.	<ul style="list-style-type: none"> • Initial Outpatient Appointment • Review appointments to establish diagnosis & treatment • Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) • Discharge back to referrer for ongoing conservative management 	As required
Undifferentiated Shoulder or Arm Pain/Other	<ul style="list-style-type: none"> • Consider other diagnoses in these guidelines • Consider referred pain 	History Exclude red flag symptoms (below) Examination Findings	Urgent: If suspected malignancy or infection Routine: If you are <i>unable to establish a diagnosis</i> and the	<ul style="list-style-type: none"> • Initial Outpatient Appointment • Review appointments to establish diagnosis & treatment 	As required

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	<ul style="list-style-type: none"> If you suspect malignancy or infection, please see appropriate specific condition management 	<p>Exclude red flag signs</p> <p>Investigation (report with referral) X-rays: <i>Shoulder XRs</i> – True AP Glenohumeral Joint (Grashey View) & Scapula Lateral (Neer View) & Axillary Lateral (3 views)</p> <p>Consider MRI if <i>XRs normal</i></p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>patient has <i>significant symptoms</i></p>	<ul style="list-style-type: none"> Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) Discharge back to referrer for ongoing conservative management 	
Suspected Malignancy of Shoulder Arm	<p>Urgently refer all patients with red flag symptoms, signs or investigations suspicious for malignancy</p>	<p>History Red flag symptoms (loss of weight, appetite or energy; relatively short history of pain or lump (6 weeks rather than 6 months); pain that is unrelenting/unremitting/at night; past or present history of malignancy elsewhere)</p> <p>Examination Findings Red flag signs</p> <p>Investigation (report with referral) Suspicious imaging or blood tests</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Urgent: All Routine: N/A</p>	<ul style="list-style-type: none"> Initial Outpatient Appointment Review appointments to establish diagnosis & treatment Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) Discharge back to referrer for ongoing conservative management 	As required
Suspected Infection of Shoulder Arm	<ul style="list-style-type: none"> Refer to ED immediately all patients with suspected <i>septic</i> 	<p>History Red flag symptoms (fevers/sweats/chills/rigors; loss of weight, appetite or energy;</p>	<p>ED: If septic joint or unwell Urgent: All others</p>	<ul style="list-style-type: none"> Initial Outpatient Appointment 	As required

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	<p><i>arthritis</i> (history of hours, swollen joint, very limited ROM). Do NOT start antibiotics unless discussed with the orthopaedic unit</p> <ul style="list-style-type: none"> Refer to ED immediately all patients with fever/chills/rigors/sweats, or otherwise unwell Urgently refer other patients to clinic with red flag symptoms, signs or investigations suspicious for infection 	<p>relatively short history (6 weeks rather than 6 months); pain that is unrelenting/unremitting/at night; past or present history of infection elsewhere)</p> <p>Examination Findings Red flag signs</p> <p>Investigation (report with referral) Suspicious imaging or blood tests (FBE, ESR, CRP)</p> <p>Patient must bring the films or the links for any online imaging.</p>	<p>Routine: N/A</p>	<ul style="list-style-type: none"> Review appointments to establish diagnosis & treatment Consent for Surgery (if surgery is required + Preadmission appointment +/- Anaesthesia preadmission) Discharge back to referrer for ongoing conservative management 	