

Clinical Practice Guideline Overview

Management of Rotator Cuff Injuries

Published March 11, 2019

This clinical practice guideline addresses the management of rotator cuff tears in adults. It is not intended to address management of pediatric patients with rotator cuff tears.



Literature Review

9,464
abstracts reviewed



2,115
articles recalled
for full review



213
articles included
after full text review
and quality analysis



Strong and Moderate Guideline Recommendations*



Strong evidence supports that both physical therapy and operative treatment result in significant improvement in patient reported outcomes for patients with symptomatic small to medium full-thickness rotator cuff tears.



Moderate evidence supports the healed rotator cuff repairs show improved patient-reported and functional outcomes compared to physical therapy and unhealed rotator cuff repairs.



Strong evidence supports that clinical examination can be useful to diagnose or stratify patients with rotator cuff tears; however, combination of tests will increase diagnostic accuracy.



Moderate strength evidence does not support the routine use of acromioplasty as a concomitant treatment as compared to arthroscopic repair alone for patients with small to medium sized full-thickness rotator cuff tears.



Strong evidence supports that MRI, MRA, and ultrasound are useful adjuncts to a clinical exam for identifying rotator cuff tears.



Moderate strength evidence supports the use of distal clavicle resection as a concomitant treatment to arthroscopic repair for patients with full-thickness rotator cuff tears and symptomatic acromioclavicular joints.



Strong evidence suggests similar postoperative clinical and patient-reported outcomes for small to medium sized fullthickness rotator cuff tears between early mobilization and delayed mobilization up to 8 weeks for patients who have undergone arthroscopic rotator cuff repair.

Moderate evidence supports the use of a single injection of corticosteroids with local anesthetic for short-term improvement in both pain and function for patients with shoulder pain.



Strong evidence supports the use of either conversion to fullthickness or transtendinous/ in-situ repair in patients that failed conservative management with high-grade partial thickness rotator cuff tears.



Moderate evidence supports that higher BMI is correlated with higher re-tear rates after rotator cuff repair surgery; however, strong evidence supports that there is no correlation between higher BMI and worse patient-reported outcomes following rotator cuff repair.



Strong evidence supports that older age is associated with higher failure rates and poorer patient reported outcomes after rotator cuff repair.



Moderate evidence supports the association of poorer patient reported outcomes in patient with more comorbidities.



Strong evidence supports the presence of a worker's compensation claim is associated with poorer patient outcomes after rotator cuff repair.



Moderate evidence suggests that patients with diabetes will have higher re-tear rates and poorer quality of life and patient reported outcome scores after rotator cuff repair.



Strong evidence does not support biological augmentation of rotator cuff repair with platelet-derived products on improving patient reported outcomes; however, limited evidence supports the use of liquid platelet rich plasma (PRP) in the context of decreasing re-tear rates.



Moderate evidence correlates higher preoperative patient expectations for surgery with higher patient reported outcomes after rotator cuff repair.



Moderate strength evidence supports the use of multimodal programs or non-opioid individual modalities to provide added benefit for postoperative pain management following rotator cuff repair

Strong evidence does not support double row rotator cuff repair constructs on improving patient-reported outcomes compared to single row vertical mattress repair constructs.

Strong evidence supports lower re-tear rates after double row repair compared to single row vertical mattress repair when evaluating for both partial and full thickness retears after primary repair; however, when evaluating the data for only full thickness re-tears, limited evidence does not support lower re-tears rates after double row primary repair.



Strong evidence supports no difference in long-term (>1 year) patient reported outcomes or cuff healing rates between open and arthroscopic repairs; however, arthroscopically technique is associated with better short-term improvement in post operative recovery of motion and decreased visual analog scale (VAS) scores.

Strong evidence supports that patient reported outcomes (PRO) improve with physical therapy in symptomatic patients with full thickness rotator cuff tears. However, the rotator cuff tear size, muscle atrophy, and fatty infiltration may progress over 5 to 10 years with non-operative treatment.



Future Research

Consideration for future research is provided for each recommendation within this document are based on the work groups clinical experience and perceived need for better guiding data.

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* Please visit **OrthoGuidelines.org** to view the limited and consensus recommendations and all recommendation rationale for this guideline.

