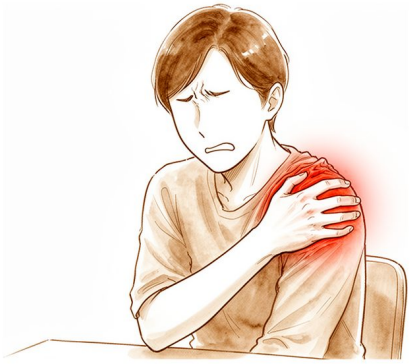
CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

PATIENT INFORMATION — IN DEPTH

Rotator Cuff Disorders



MRI of a full-thickness rotator cuff tear. The bright stripe at the top of the ball of the shoulder is fluid filling the gap left by the torn tendon.

What you're feeling

You may notice pain in the front or side of your shoulder. This discomfort often stems from a complex interaction between your rotator cuff tendons and the soft tissues around them. You might also feel pain in the front of your arm, which can be linked to issues with the long head of the biceps tendon. These tendon disorders frequently occur alongside other shoulder problems, making it hard to pinpoint a single source of pain.

Your symptoms do not always match the size of the tear. A small tear can cause significant pain, while a large tear might cause less discomfort. The length of time you have had symptoms does not tell us how severe the damage is. You might wake up with stiffness or pain, especially if you sleep on that side. Daily tasks like reaching for items on a high shelf, buttoning a shirt, or lifting objects can become difficult or painful.

Some people report a feeling of catching or locking in the shoulder. These mechanical sensations are common complaints. However, these feelings do not always mean the tear is getting worse. Asymptomatic tears and painful tears often progress at similar rates over time. If your diagnosis remains unclear after a thorough check-up, we focus on your specific symptoms, such as shoulder pain, to guide care. This approach helps avoid unnecessary invasive procedures when the cause is not clear.

Mental health plays a significant role in how you experience pain. Your mood and stress levels can influence your shoulder function more than the physical size of the tear. If you have ongoing pain, we look at the whole picture, including your overall well-being. We also check for other issues like bone loss or instability, as treating these associated problems is necessary to improve your function and reduce pain.

What's actually happening

Your rotator cuff is a group of tendons that act like strong ropes. They hold your upper arm bone in place and help you lift your arm. As you get older, these tendons wear down. This wear-and-tear arthritis is common. The

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tendons can stretch or tear. When this happens, the ball of your shoulder joint no longer sits perfectly in its socket.

Think of the joint like a door hinge. The tendons are the hinges that keep the door steady. If a hinge breaks, the door wobbles. In your shoulder, the arm bone moves upward when it should stay down. This is called superior migration. The bone rubs against the bone above it. This rubbing causes pain and weakness. It also changes how your shoulder moves.

This imbalance affects your daily life. Simple tasks like reaching for a shelf become difficult. The pain often gets worse at night. You might feel a catching or grinding sensation. These symptoms happen because the joint is not moving smoothly anymore. The natural cushioning between the bones wears away. This can lead to further joint damage if left untreated.

We understand that this uncertainty is stressful. Your surgeon explains that both surgery and non-surgical treatments can help. The goal is to restore balance to the joint. We aim to reduce pain and improve movement. Your mental health also plays a big role in how you feel. Managing stress and expectations helps your recovery.

Our approach focuses on your specific needs. We look at how your shoulder moves, not just what the scan shows. Sometimes, the scan looks bad, but you feel okay. Other times, the pain is severe even if the tear is small. We tailor the plan to you. This might include therapy, injections, or surgery. We use advanced techniques to repair tears when needed. These methods aim to restore normal joint mechanics.

It is important to know that one-year results do not tell the whole story. Long-term outcomes matter most. Many patients see lasting benefits from treatment. Some may need revision surgery later. This is not uncommon. We monitor your progress closely. We adjust the plan as your shoulder heals. Your active role in recovery is key. We guide you through every step.

What we can do about it

At Mater Private Hospital Rockhampton, Dr Kieran Hirpara approaches rotator cuff care by matching the treatment to your specific tear and lifestyle. We begin with non-operative options because they are effective for many people. At 13 years after diagnosis, about 90% of patients treated conservatively for rotator cuff tears had no or only slight pain. About 70% of those patients had no disturbance in their daily activities. We often recommend a specific physical therapy protocol for atraumatic tears, which is effective for approximately 75% of patients followed up for 2 years. Your physiotherapist will focus on strengthening the muscles around your shoulder to improve function and reduce pain. We advise you to give this approach enough time to work before considering other steps.

Medical management focuses on controlling pain and inflammation to help you stay active. We may suggest pain medication or anti-inflammatories to manage discomfort during your recovery. Regarding injections, there is little reproducible evidence to support the efficacy of subacromial corticosteroid injections in managing rotator cuff disease. We exercise caution with cortisone shots and will withhold them if a rotator cuff repair is planned within the following 6 months. Current limited evidence also suggests that in the short term, PRP injections may not be beneficial for nonoperative treatment of chronic rotator cuff disease. We discuss these options with you based on your individual pain levels and goals.

Surgery is considered when conservative care has reached its limit or if you have an acute structural problem. Arthroscopic rotator cuff repair is an effective and safe option to treat symptoms of rotator cuff tears, with clinical results that are durable with time. We may recommend this if nonoperative treatment fails to provide enough improvement. For massive or irreparable tears, we might discuss partial repair to restore balance to the force couple and reduce pain. In cases where arthritis is present alongside a massive tear, a reverse shoulder prosthesis may be reserved for treatment. We ensure you understand that failure rates for large-to-massive tears remain high despite advances in surgical options. We review patient-specific risk factors carefully to plan your treatment safely.

What to expect

Your outlook depends largely on whether you choose surgery or conservative management. For small-to-medium tears, surgical repair offers superior long-term results compared to physiotherapy alone, with benefits lasting up to 15 years. If you are over 50, your surgeon aims for lasting pain relief. However, you should know that significant improvement in shoulder motion is less common in this age group. For those aged 50 and younger, surgery provides long-term pain relief, but a large proportion of patients still report unsatisfactory long-term results regarding motion.

If you manage your tear without surgery, the course is often gradual. At 13 years after diagnosis, about 90% of patients had no or only slight pain. About 70% had no disturbance in their daily activities. This suggests that for many, the condition may settle into a manageable state rather than worsening significantly. Asymptomatic and symptomatic tears progress at similar rates over time. Untreated chronic tears can, however, lead to arthrosis, which is wear-and-tear arthritis of the joint.

Recovery is a process that unfolds over months. You will experience approximately 60% of your ultimate functional recovery at 3 months after surgery. By 6 months, you will have reached about 75% functional recovery. It is important to note that one-year follow-up does not determine long-term outcomes. Your surgeon may recommend revision repair if needed, as short-term outcomes for revision are similar to primary repair. Revision surgery also provides significant pain relief and functional improvement at long-term follow-up of 10 years or more.

Your mental health has a stronger association with shoulder pain and function than the size of your tear. Directly relating your expectations to realistic outcomes helps guide your treatment path. Whether you undergo repair or not, the goal is to restore your ability to use your shoulder effectively.

When to see someone

See your GP if shoulder pain persists despite rest, or if you notice weakness or instability. Seek a specialist review if symptoms interfere with sleep or work, or if you experience sudden worsening. Locking or giving way also warrants assessment. Do not assume symptom duration matches tear severity. Early evaluation helps prevent long-term wear-and-tear arthritis. Your surgeon can determine if conservative care or repair is right for you.

In more depth

This section goes further than you need for your own treatment decisions. Rotator cuff disorders are worth the extra reading because of one epidemiological fact that reframes every scan report: cuff tears are so common in people without symptoms that finding one does not establish it is causing your pain.

A TORN CUFF IS A NORMAL FINDING WITH AGE

Pooling **6,112** shoulders, the prevalence of rotator cuff abnormalities in **asymptomatic** people is high enough that **degeneration of the rotator cuff should be considered a common aspect of normal human ageing** – and high enough to make it **difficult to determine when an abnormality is new, or is the cause of symptoms** [1].

That is an unusually direct statement from a systematic review, and it should change how a scan report is read. A tear found on your MRI is not automatically the explanation for your pain; it may have been there for years, silently, as it is in a large share of people your age with no shoulder complaint at all.

The clinical consequence is that the diagnosis rests on whether the examination and the history match the imaging – not on the imaging alone. It is also why treating the scan rather than the patient is a recognised trap here.

SURGERY HELPS, AND THE SIZE OF THE BENEFIT IS THE HONEST PART

For degenerative full-thickness tears, surgery does outperform the alternatives. Across **677** patients, **surgical repair produced significantly improved outcomes compared with either conservative treatment or subacromial decompression alone** in older patients – with the authors adding that the **magnitude of the difference between surgery and conservative treatment** deserves attention [2]. A separate comparison across **269** patients found statistically significant differences favouring surgery in both Constant and pain scores at one year [3].

So repair wins, but the authors of the larger study are careful to flag effect size rather than just direction. A difference can be statistically real and still smaller than what a patient would notice – which is why the choice remains genuine rather than obvious, particularly for someone whose demands are modest or whose tear is unlikely to be repairable.

EXERCISE IS NOT A SINGLE TREATMENT, AND THE TYPE APPEARS TO MATTER

Non-operative management is usually described simply as "physiotherapy", which obscures a real finding. Comparing **seven** types of exercise across **947** patients, **concentric strengthening training performed best** for both shoulder pain and dysfunction, with **eccentric strengthening and motor control exercise** as alternatives where concentric work is unsuitable [4].

That is worth knowing because it makes "I tried physio and it didn't help" a question rather than a conclusion – what was actually done, for how long, and was it progressive strengthening or a handout of stretches.

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THE OPERATION THAT GETS ADDED, AND DOES NOT NEED TO BE

Acromioplasty — shaving bone from the undersurface of the acromion — is frequently performed alongside cuff repair on the reasoning that it removes a source of impingement on the repair.

The evidence does not support the addition. Across **373** patients, there was **no statistically significant difference in subjective outcome after arthroscopic rotator cuff repair with or without acromioplasty** at intermediate follow-up [5].

If it is proposed as an addition to your repair, that is a reasonable thing to ask about.

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