East Sussex MSK Community Partnership

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Shoulder & Elbow Triage Guidelines

V2 July 2025

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Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Traumatic Shoulder Pain – Previous Dislocations (Glenohumeral / ACJ) Rotator cuff tears **If fracture or dislocation send to A&E** **Acute Trauma/A&E: Most missed RC tears diagnoses are from A&E**	**Assessment:** • History • Examination • Working / differential diagnosis • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Consider previous history of dislocation (first time or recurrent?) **Diagnostics** **Shoulder xray required first line investigation** **Please be explicit on your radiology request as to why you are requesting an x-ray ie T**his will inform a change in management such as consideration of differential diagnostic,an invasive technique or surgical intervention. Please include key findings eg • Moderate to severe pain • Loss of function eg reaching / lifting • Loss of range of motion • Significant injury If these criteria are met please request X-ray AP & axillary (Follow RCR Guidelines) **Management (including condition-specific self-care options):** • Activity modification • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working If no fracture or dislocation, assess for: • Acute cuff tear: loss of strength and function ➢ Refer urgently to MSK service within 2/52 • If under 25, with first time dislocation ➢ Refer to fracture clinic for orthopaedic shoulder review) (BESS Patient care pathways 2015) • Traumatic ACJ injury ➢ Mild – manage conservatively ➢ Moderate – refer to physiotherapy ➢ Severe – refer to Fracture clinic • If no significant loss of function or strength, consider: ➢ Pain relief in line with agreed formularies / guidance ➢ Patient education / condition specific information ➢ Reassurance ➢ Activity modification	**Refer to Physiotherapy if:** • Symptoms persist > 6 weeks • Strength / movement maintained • No suggestion of an RC tear **Refer to Advanced practitioner if:** **Urgently if:** • Suspected rotator cuff tear with significant weakness / loss of function **Routinely if:** • Severe pain since injury • Deteriorating or persisting symptoms • GH recurrent instability • Symptomatic ACJ dislocation / subluxation **Refer to Orthopaedics if:** • Radiographic evidence of structural instability and has recurrent dislocation.	**Assessment:** **Diagnostics:** • If recurrent instability, patient 25-40, and still symptomatic 3-6 months consider specialist diagnostic imaging (MRI, MRA) • X-ray plain film AP and axillary • Ultrasound scan • MR (if acute or chronic) Urgent MR: Acute / Young group **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM **Refer to Advanced Practitioner (from Physiotherapy) if:** **Urgently if:** • If traumatic rotator cuff tear suspected • Primary dislocation and over 40 with ongoing symptoms consider Cuff integrity. **Routinely if:** • No response to conservative treatment • Recurrent instability despite individualised rehabilitation for shoulder instability • Recurrent instability, patient 25-40, and still symptomatic 3-6 months refer to AP for specialist diagnostic imaging **Refer to Orthopaedics (from Advanced Practitioner) if:** • < 25 First time dislocation • No response to comprehensive physiotherapy treatment • Radiographic evidence of structural instability and patient wants/ needs surgery **Refer to Physiotherapy from AP/Ortho if:** • Pt declined or not fit for surgery • Patient Choice • Would benefit from further rehabilitation

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Shoulder Pain Non-traumatic – Rotator Cuff related pain and ACJ pain **(Imping-ement and calcific tendinosis - treat as rotator cuff related shoulder pain)**	**Assessment:** • History • Duration of symptoms • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Examination • Assess for typical clinical presentation: ➢ Painful arc ➢ Passive range of movement (usually maintained) ➢ Strength (usually maintained) **Diagnostics** **Shoulder xray required first line investigation** **Please be explicit on your radiology request as to why you are requesting an x-ray ie Diagnostic clarity, T**his will inform a change in management such an invasive procedure / surgery or exclusion of bony / non bony pathology (i.e. calcific tendinosis, subluxation of ACJ, clinically relevant OA ACJ) Please include key findings eg 1. Moderate to severe pain 2. Loss of function eg reaching / lifting 3. Loss of range of motion If these criteria are met, please request X-ray AP & axillary (Follow RCR Guidelines) • Repeat X-ray not required within 18 months unless significant deterioration or change in symptoms • X-Ray not required for referral into physiotherapy **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Activity modification • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Patient education and information • Subacromial Shoulder Pain – British Elbow & Shoulder Society (bess.ac.uk) • Exercise - Exercises for Shoulder Pain - British Elbow & Shoulder Society (bess.ac.uk) • Consider sub-acromial injection if pain persists and ADLs limited / affected (i.e. sleep, work, driving) **NOTE: Limit to 2 injections, appropriate physiotherapy is of far greater value than 2nd injection (GIRFT 2021)** **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy if:** • No response to treatment after 6 weeks. • Limited improvement with an injection + primary care management **Refer to Advanced practitioner if:** • No response to physiotherapy or conservative treatment at > 3 months • For consideration of injection if not offered in primary care (GIRFT 2021)	**Assessment:** **Diagnostics:** • X-ray (AP and axillary +/- outlet view) if not already done • Consider ultrasound if suspect a cuff pathology • Consider MRI to exclude other possible diagnosis **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM • Sub-acromial Injection (Limit to 2 injections, appropriate physiotherapy is of far greater value than 2nd injection – GIRFT 2021) **Refer to Advanced Practitioner (from Physiotherapy) if:** • No or limited response to physiotherapy > 3 months and patient wants further intervention **Refer to Orthopaedics (from Advanced Practitioner) if:** • No response to conservative treatment and/or steroid injection and patient wants / needs surgery following SDM conversation **Refer to Physiotherapy from AP / Ortho if:** • Provided steroid injection for pain relief and needs further rehabilitation • Patient declined or not fit for surgery • Patient Choice • Would benefit from further rehabilitation

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Shoulder Pain Non-traumatic - AC joint pain	**Assessment:** • History • Duration of symptoms • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Assess for typical signs/symptoms: ➢ Focal tenderness across ACJ ➢ Pain on cross arm/ horizontal adduction ➢ Pain on end of range elevation **Diagnostics:** **Shoulder xray required first line investigation** **Please be explicit on your radiology request as to why you are requesting an x-ray ie Diagnostic clarity, t**his will inform a change in management such as consideration of an invasive technique or surgical intervention or you are concerned about an uncertain diagnosis having failed to respond to conservative treatment Please include key findings eg • Moderate to severe pain • Loss of function eg reaching / lifting • Loss of range of motion If these criteria are met, please request X-ray (AP & axillary) • Repeat X-rays are not required within 18 months unless significant deterioration or change in symptoms • X-rays are not required for referral to physiotherapy **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance. • Reassurance • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Patient education and information • Activity modification • Consider ACJ injection **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy if:** • Symptoms persisting >6/52 **Refer to Advanced practitioner if:** • Failed to respond to physiotherapy treatment	**Assessment:** **Diagnostics:** • X-ray (AP and axillary +/- outlet view) if not already done • Consider ultrasound if suspect a cuff pathology • Consider MRI to exclude other possible diagnosis **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM • ACJ Injection **Refer to Advanced Practitioner (from Physiotherapy) if:** • No or limited response to physiotherapy > 3 months and patient wants further intervention **Refer to Orthopaedics (from Advanced Practitioner) if:** • No response to conservative treatment and/or steroid injection and patient wants / needs surgery following SDM conversation **Refer to Physiotherapy (from Advanced Practitioner / ortho) if:** • Provided steroid injection for pain relief • Patient declined surgery or not fit for surgery • Patient Choice • Would benefit from further rehabilitation

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Shoulder Pain Non-traumatic-Cuff Tear **(degenerate)**	**Assessment:** • History • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Examination • Assess for muscle weakness and range of motion • Typically presents with weakness on muscle testing but maintains passive range • **NOTE: Massive cuff tears on patients >75 generally not repairable (BESS Care Pathway 2023)** **Diagnostics:** **Shoulder xray required first line investigation** **Please be explicit on your radiology request as to why you are requesting an x-ray ie Diagnostic clarity, t**his will inform a change in management such as consideration of an invasive technique or surgical intervention or you are concerned about an uncertain diagnosis having failed to respond to conservative treatment Please include key findings eg • Moderate to severe pain • Loss of function eg reaching / lifting • Loss of range of motion If these criteria are met please request X-ray (AP & axillary) • Repeat X-rays are not required within 18 months unless significant deterioration or change in symptoms • X-rays are not required for referral to physiotherapy **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Condition specific information sheet/ signposting • Consider sub-acromial injection **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy if:** • Patient has persistent pain and loss of function (ADL's) Torbay Shoulder Exercise Programme - Torbay and South Devon NHS Foundation Trust **Refer to Advanced practitioner if:** • Increased pain and loss of function • Poor response to physiotherapy at 6-12 weeks	**Assessment:** **Diagnostics:** • Ultrasound scan • MR **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM **Refer to Advanced Practitioner (from Physiotherapy) if:** • Poor response to 6-12 week course of physiotherapy (Including anterior deltoid/ Torbay programme) and patient wants further intervention **Refer to Orthopaedics (from Advanced Practitioner) if:** • No response to conservative treatment and / or steroid injection / Suprascapular nerve block and patient wants / needs surgery following SDM conversation **Refer to Physiotherapy (from Advanced Practitioner / ortho) if:** • Provided steroid injection/ supra scapular nerve block for pain relief • Patient declined surgery or not fit for surgery • Patient Choice • Would benefit from further rehabilitation **NOTE: Massive cuff tears on patients >75 generally not repairable (BESS Care Pathway 2023)**

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Shoulder Pain Non-traumatic - Frozen Shoulder **(Adhesive Capsulitis)**	**Assessment:** • History • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Examination • Typically presents insidiously with globally restricted ROM (especially external rotation) in 5th and 6th decade) • Consider prevalence with Diabetes **Diagnostics:** **Shoulder xray required first line investigation** • X-ray plain film (AP & axillary) in line with RCR and BESS guidelines if considering a change in management eg invasive intervention • Please be explicit in your referral the timescale since onset, pain levels and degree of restriction in range of motion. • X-rays not required if referring only to physiotherapy • Consider blood tests (Common in Diabetes) **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance for up to two weeks • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Education and information about frozen shoulder pain: Pain dominant phase / Stiff dominant phase. Shoulder and Elbow – East Sussex Healthcare NHS Trust (esht.nhs.uk) • Consider an early glenohumeral injection if pain severe and persistent (If not available in primary care please refer urgently to AP). • Self-directed exercises for Frozen shoulder: Frozen Shoulder – British Elbow & Shoulder Society (bess.ac.uk) **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy if:** • Pain manageable • Patient happy to manage conservatively • Urgent physio referral should be requested following injection **Refer to Integrated MSK Service (Advanced Practitioner):** **Urgently if:** • For steroid injection for pain relief • If severe pain and not coping with symptoms **Routinely if:** • Patient has tried 6 weeks of physiotherapy with limited response or unable to tolerate physiotherapy. (BESS 2015) **NOTE: Physiotherapy can aggravate in early stages**	**Assessment:** **Diagnostics:** • X-Ray • Consider MRI if atypical symptoms **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM • Injection for pain relief **Refer to Advanced Practitioner (from Physiotherapy) if:** • No or limited response to physiotherapy 6 weeks • Severe pain not tolerating physiotherapy - injection indicated for pain relief **Refer to Orthopaedics or Interventional radiology (from Advanced Practitioner) if:** • No response to conservative treatment and steroid injection if appropriate and patient wants / needs surgery / distension procedure following a SDM conversation **Refer to Physiotherapy (from Advanced Practitioner / Orthopaedics):** **Urgently if:** • Provided steroid injection for pain relief and needs further rehabilitation • Following distension procedure if patient choses to have further rehabilitation **Routinely if:** • Patient declined surgery or not appropriate for surgery

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Shoulder Pain Non-traumatic - Osteoarthritis	**Assessment:** • Age • History • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Examination • Co-morbidities • Painful active ROM • Reduced passive ROM • Morning stiffness • Crepitus in joint • Consider differential diagnosis of PMR if bilateral shoulder pain and stiffness >50 (NICE) - Consider referral to Rheumatology **Diagnostics:** **Shoulder xray required first line investigation** **Please be explicit on your radiology request as to why you are requesting an x-ray ie Diagnostic clarity, t**his will inform a change in management such as consideration of an invasive technique or surgical intervention or you are concerned about an uncertain diagnosis having failed to respond to conservative treatment Please include key findings eg • Moderate to severe pain • Loss of function eg reaching / lifting • Loss of range of motion If these criteria are met, please request X-ray (AP & axillary) • Repeat X-rays are not required within 18 months unless significant deterioration or change in symptoms • X-rays are not required for referral to physiotherapy • X-ray plain film (AP & axillary) • Repeat X-ray not required within 18 months unless significant deterioration or change in symptoms **Management (including condition-specific self-care options):** • Patient education • Activity modification • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Analgesia • Consider steroid injection GH joint • Exercise: Exercises for the shoulders | Versus Arthritis **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Integrated MSK Service Physiotherapy if:** • Patient has persistent pain and loss of function (ADL's) **Refer to Advanced Practitioner if:** • Diagnostic uncertainty • Pain or loss of function persisting despite conservative treatment **Refer to Orthopaedics if:** • Severe OA • Limited function • Patient wants and needs surgery following SDM conversation	**Assessment:** **Diagnostics:** • X-ray if not done/up to date imaging required **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM • Injection for pain relief **Refer to Advanced Practitioner (from Physiotherapy) if:** • No or limited response to physiotherapy including Individualised exercise programme and patient wants further intervention • If not a surgical candidate with persistent symptoms and restricted ADL consider suprascapular nerve block for pain relief **Refer to Orthopaedics (from Advanced Practitioner) if:** • No response to conservative treatment and/or steroid injection and patient wants/ needs surgery following SDM conversation. **Refer to Physiotherapy (from Advanced Practitioner / Orthopaedics):** • Provided steroid injection / suprascapular nerve block for pain relief and needs further rehabilitation • Patient declined surgery or not appropriate for surgery

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Shoulder Pain Non-traumatic - Recurrent Instability	**Assessment:** • History • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Clinical examination • Explore history of previous Physiotherapy • Consider screening for Hypermobility and connective tissue disorders ie EDS (See rheumatology pathway) **NOTE: Atraumatic shoulder instability happens without any history of significant preceding injury and predominantly affects patients <25** **Diagnostics:** • Imaging not indicated in primary care **Management (including condition-specific self-care options):** • Patient education and reassurance – Successful outcomes maybe achieved following non-operative treatment in 50-80% of cases, this can take up to 6 months • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Exercises (Shoulder Instability – British Elbow & Shoulder Society (bess.ac.uk) **NOTE: Corticosteroid injections should not be used for pain relief (BESS 2017)** **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy if:** • Significant symptoms and affecting ADLs	**Assessment:** **Diagnostics:** • Consider MRI/ MR Arthrogram to exclude labral pathology **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM **Refer to Advanced Practitioner (from Physiotherapy) if:** • If diagnostic uncertainty and fails to respond to physiotherapy. **NOTE: Some patients may present with significant functional impairment and can prove resistant to standard conservative measures. In these cases, patients often need multidisciplinary team approach with consideration of psychosocial factors and other barriers to recovery (BESS 2019).**

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Lateral / Medial Elbow Tendinopathy **(Tennis and Golfer's Elbow)**	**Assessment:** • History • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Examine for typical presentation: ➢ Focal tenderness ➢ Lateral – pain on resisted wrist extension ➢ Medial – pain on resisted wrist flexion ➢ Full passive ROM elbow • If associated radicular symptoms from the cervical spine are present – refer to the spinal pathways **Diagnostics:** • Imaging not indicated in primary care **Management (including condition-specific self-care options):** • Patient education / information - Self-limiting condition and tends to self-resolve, 89% of pts noticed improvement or resolution of symptoms within a year (BESS 2023) • Pain relief in line with agreed formularies / guidance • Tennis elbow clasp • Avoid Steroid injection (BESS care pathway 2023) • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Exercises ➢ Tennis Elbow – British Elbow & Shoulder Society (bess.ac.uk) ➢ Shoulder and Elbow – East Sussex Healthcare NHS Trust (esht.nhs.uk) **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy if:** • No improvement >6 weeks **Refer to Advanced Practitioner if:** • No response to physiotherapy or recurrent symptoms • Diagnostic uncertainty **NOTE: Patients should be made aware that there is no evidence of the benefits of tennis elbow surgery over placebo (BESS Care Pathway 2023)**	**Assessment:** **Diagnostics:** • Consider X-ray to check for radio-capitellar arthritis • Consider US to confirm diagnosis **Management:** • Comprehensive Physiotherapy • Patient education • Patient choice following SDM • Steroid injection should be avoided • Tennis elbow clasp **Refer to Advanced Practitioner (from Physiotherapy) if:** • No or limited response to physiotherapy and patient wants further intervention **Refer to Orthopaedics (from Advanced Practitioner) if:** • Symptoms persist > 6 -12 months despite conservative treatment and other causes of elbow pain excluded with appropriate investigation • NOTE: There is no evidence of the benefits of tennis elbow surgery over placebo (BESS Care Pathway 2023) **Refer to physiotherapy (from Advanced Practitioner/Orthopaedics) if:** • Patient declined surgery or not appropriate for surgery

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Olecranon Bursitis	**Assessment:** • History • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Consider infection**: If Infected olecranon bursitis treat with antibiotics and rest. If persists, refer directly to orthopaedics** • Consider gout tophus: **If confirmed, refer to rheumatology** **Diagnostics:** • Imaging not indicated in primary care **Management (including condition-specific self-care options):** • Conservative management including: ➢ Rest ➢ Ice ➢ Activity modification ➢ Compressive bandage ➢ Use of protective pads and avoid resting elbow on hard surfaces • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Analgesia / NSAIDs	**Refer to Orthopaedics if:** • Non-resolving • Diagnostic uncertainty	**N/A**

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Ulnar Neuropathy	**Assessment:** • History • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Working / differential diagnosis. If cervical spine suspected follow spine pathway • Examine for typical presentation: ➢ Tenderness over ulna nerve ➢ Muscle wasting in ulna nerve innervated regions (Abductor digiti minimi in the hypothenar eminence / and Adductor policis in the first web space. NOTE: This can be a sign of severe neuropathy ➢ Sensory disturbance in the little finger and ½ of the ring finger (side adjacent to little finger) ➢ Positive Wartenberg's and Froment's sign • If presents as cervical radiculopathy – refer to the spinal pathways **Diagnostics:** • Imaging not indicated in primary care **Management (including condition-specific self-care options):** • Patient education - Cubital tunnel syndrome | The British Society for Surgery of the Hand (bssh.ac.uk) • Conservative management including: ➢ Avoid sustained elbow flexion and repetitive flexion ➢ Advice on night splinting (elbow extension splint) up to 12 weeks ➢ Avoid local pressure over elbow (cubital tunnel) or Wrist (Guyon's Canal) • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working	**Refer to Advanced Practitioner if:** • Progression of intrusive symptoms • Diagnostic uncertainty **Refer to Orthopaedics if:** • Fixed sensory loss in ulna distribution • Muscle wasting of ulna nerve innervated muscles in hand (Severe)	**Assessment:** **Diagnostics:** • Nerve conduction studies • Consider X-ray elbow **Management:** • Patient education • Patient choice following SDM • Steroid injection should be avoided • Trail of conservative management strategies **Refer to Orthopaedics (from Advanced Practitioner) if:** • Urgent if severe symptoms • Not responding to conservative treatment and positive nerve conduction studies.

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Biceps Rupture	**Assessment:** • History • Identify patients' beliefs and needs, include psychosocial issues and chronicity • Examination and assessment • Working/differential diagnosis • For distal biceps check Hook test, palpation of distal biceps tendon and signs of biceps weakness – **if positive, needs urgent fracture clinic referral or A+E** • Biceps bulge – typical 'popeye' sign • Check rotator cuff to exclude injury **Diagnostics** • None **Management (including condition-specific self-care options):** • Patient education • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working • Long head of biceps – reassure if no pain or loss of function • If rotator cuff related pain - **follow rotator cuff pathway** • If suspected cuff tear - **follow cuff tear pathway** **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Fracture Clinic Urgently if:** • Distal biceps rupture - refer directly to fracture clinic immediately. **Refer to Advanced Practitioner if:** • Diagnostic uncertainty • Significant pain and/ or significant loss of movement and function	**Assessment:** **Diagnostics:** • Urgent Ultrasound Scan if distal biceps suspected or uncertain diagnosis **Management:** • Patient education • Patient choice following SDM **Refer to Physiotherapy (from Advanced Practitioner) if:** • Presents as RC pain • Distal biceps rupture identified and appropriate for physiotherapy intervention • Patient choice • Patient declines or is not fit for surgery **Urgent referral to Orthopaedics (from Advanced Practitioner) if:** • Distal biceps rupture confirmed either clinically or by Ultrasound Scan